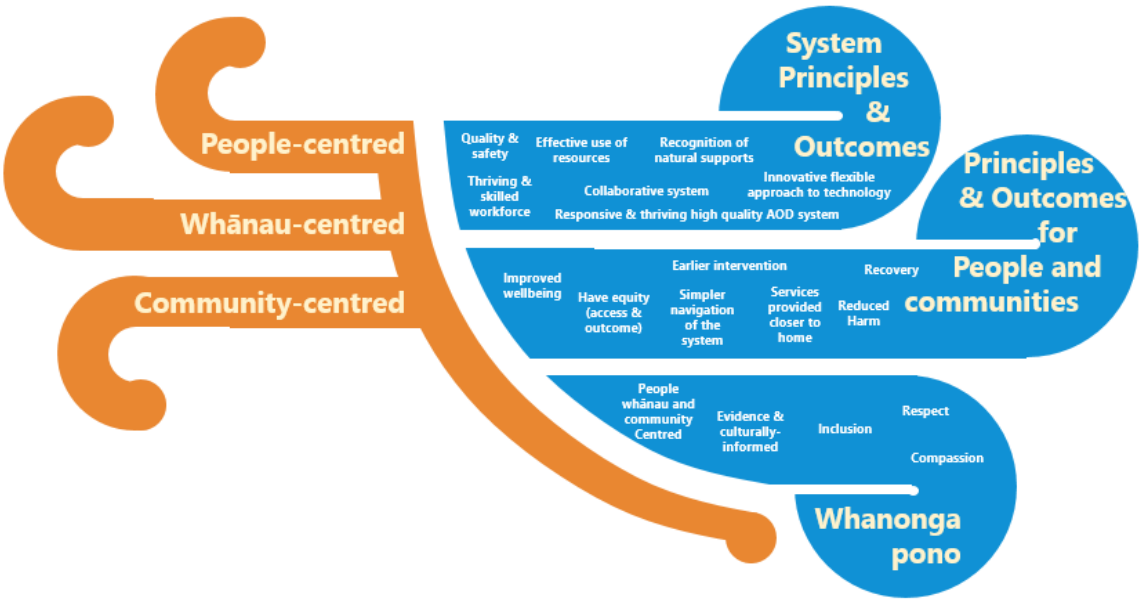
# Capital and Coast, Hutt Valley and Wairarapa Alcohol and Other Drug Model of Care

He aha te mea nui o te ao

He tangata he tangata he tangata




Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

# Contents

# The Development of the 3DHB Alcohol and Other Drug Model of Care

## Introduction

The purpose of this document is to present the 3 DHB (Hutt Valley, Wairarapa and Capital & Coast) Alcohol and Other Drug (AOD) Model of Care (the Model of Care) for implementation across the Wellington subregion. It also describes the development of the Model of Care and the synergies with both the government's and the subregion's strategies. Finally, it identifies the implementation priorities.

## The process

The project to develop the Model of Care began in early 2019 with the bringing together of a diverse group of stakeholders from across the subregion to be the Steering Group for the project. The Steering Group included representation from those with lived experience of addiction, a Primary Health Care Organisation (PHO), Regional Public Health, NGO AOD providers, DHB mental health and addiction clinicians and operational managers, Kaupapa Māori AOD providers and a Pacifica AOD provider.

### The process followed was robust

The Model of Care project employed a mix of methods in order to understand need, demand, service use and best-practice combining a literature review, a service stock-take (both funded and voluntary), and locality-based integrated data-modelling utilising both New Zealand[1] (2006) and Australian[2] (2019) population prevalence studies.

### There was extensive stakeholder engagement

The AOD sector was asked, via a survey and over 30 interviews with providers, to give information about gaps in service delivery and opportunities for future investment.

Over 80 individuals with lived experience of addiction were consulted over the lifetime of the Model of Care project. They identified barriers and challenges that impacted their recovery and also provided significant positive comment about their experiences of services. Appendix Two is a 'Stakeholder Engagement Map'.

## The findings – the system of care is failing

The Model of Care project found that the AOD system of care, while providing a range of specialist and NGO based counselling services for a significant part of the population across the subregion, is invisible, disconnected and inadequately resourced to meet the needs of the people it serves.

Unmet need is difficult to predict due to both the lack of recent New Zealand prevalence data and because a proportion of people with AOD issues will recover naturally, meaning that they will address their problems without AOD services and supports.

The Model of Care project reviewed the demographic mix in each locality and the deprivation index to mesh block level within localities. This information was matched to other information such as access rates to services with prevalence data to better understand unmet need at locality level and

[1] MA Oakley Browne, JE Wells, KM Scott. 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

[2] A Ritter, J Chalmers, M Gomez. 2019. Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model. *Journal of Studies on Alcohol and Drugs, Supplement 2019*: s18, 42-50.

across the subregion. The Model of Care project was also informed by stakeholder and provider reports on waiting lists for services.

The locality-based integrated data-modelling showed unmet need and the qualitative information provided by AOD service providers, particularly from the kaupapa Māori and Pacific providers, confirmed the findings.

The stock-take and locality-based integrated data modelling showed there is:

- unmet demand for AOD services for people in the 0-14 and 15-24 age group across all localities
- high unmet demand for AOD services across all age groups in North Porirua and in the 25-44-year-old age group in Wellington
- inequitable access to AOD services across the subregion, and within each DHB area – services run out of main centres cannot adequately cover the subregion
- in some areas service utilisation rates exceed predicted treatment demand — however these rates included streamed referrals (single point of referral assessments) in the main for people in the criminal justice system
- limited AOD focussed services for youth with no youth specific residential beds
- social detox and AOD respite facilities in the Wairarapa only
- limited access to services specifically for family and whānau
- no access to a funded AOD service for Pacific peoples in both HVDHB and WDHB
- large variation in the number of FTEs in Kaupapa Māori AOD services
- AOD services are funded to respond to moderate to severe presentations with little funding for either early intervention or post-treatment recovery, including harm reduction for severe problems
- a mix of clinical and non-clinical AOD counselling roles and inconsistent staff remuneration within each DHB and across the subregion
- no funded AOD peer workforce and a limited AOD specialist workforce
- investment in AOD treatment accounts for only around 11 percent of the subregion's mental health and addiction budget.

People with lived experience stated that they had experienced access barriers including waitlists, stigma, difficulty finding help or finding the right service, no information or support while waiting, and no after-hours support.

Engagement with AOD providers confirmed these findings and identified other challenges:

- limited access to secondary services for both youth and adults
- with the exception of CCDHB, there is limited AOD clinical governance in secondary services when compared to mental health services
- no clear pathway for people exiting compulsory treatment under the Substance Addiction and Compulsory Assessment and Treatment Act 2017
- challenges transitioning people to NGO providers
- gap in the provision of services for coexisting mental health and AOD needs (coexisting issues)

- little available resource for step-down and post-treatment support services to meet the ongoing needs of people with enduring AOD issues or coexisting issues.

## Current state

The locality-based integrated data modelling was refreshed for the 2019 and 2020 calendar years for HVDHB and CCDHB confirming the picture of unmet need particularly for young people, and for adults in North Porirua, Lower Hutt and Wellington.

The data also shows a pattern of access to single services, either a DHB specialist service, or one NGO provider, suggesting that people may not be accessing AOD services and supports in the most helpful setting and/or at the right level of intensity. Recovery from addiction nearly always involves setbacks, sometimes relapse, and the appropriate services on the continuum and system of care need to engage or reengage.

## Strategic alignment

### Government

The Model of Care is aligned to and can be a key enabler for implementing the Government's plan to transform mental health and addiction care nationally.

*Taking Mental Health Seriously - He Ara Oranga, the Report of the Government Inquiry into Mental Health and Addiction*[3] confirmed that a new approach to mental health and addiction in New Zealand is needed with an increased emphasis on wellbeing and community, more prevention and early intervention, expanded access to services, more treatment options, treatment closer to home, whānau and community-based responses and intersectoral action.

Through Budget 2019, the Government is providing significant investment for a wide range of health and social sector initiatives to support the transformation of the mental health and addiction system. The Model of Care will enable the subregion to make the best use of existing and new investment (see page 16, Implementing the Model of Care).

The *Health and Disability System Review – Final Report – Purongo Whakamutunga*[4] emphasises the importance of maintaining health and wellbeing rather than treating illness and signals that the health system needs to take a more collaborative, cooperative approach and that changes in both attitude and culture are necessary. The four key themes are:

1. Ensuring consumers, whānau and communities are at the heart of the system.
2. Culture change and more focused leadership.
3. Developing more effective Te Tiriti based partnerships within health and disability and creating a system that works more effectively for Māori.
4. Ensuring the system is integrated and deliberately plans ahead with a longer-term focus.

The Government has accepted the direction of travel outlined in the Review and has established an implementation team to lead the policy and design work.

[3] New Zealand Government (2018). *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington.

[4] Health and Disability System Review (2020). *Health and Disability System Review – Final Report – Pūrongo Whakamutunga*. Wellington.

## The Subregion

The Model of Care is a key enabler for implementing the subregion's health strategies that taken together aim to eliminate health inequities in the subregion.

*Living Life Well A strategy for mental health and addiction 2019-2025* (*Living Life Well*) sets the direction for mental health and addiction care in the subregion committing the 3DHBs to moving towards a consistent, coordinated and integrated whole of system model of care. *Living Life Well* has two service directions – life-course care and people-based care, supported by three enabling directions – information intelligence, quality and safety, and commissioning.

The subregion's other population-based strategies identify people with mental health and addiction issues as a priority major service user group for whom the system needs to work better:

- *Health System Plan 2030* (CCDHB) – will undertake people-centred service design for people with enduring mental health and addiction and to achieving health equity by 2030
- *Our Vision for Change 2017-2027* (HVDHB) – people experiencing mental health and addiction illnesses are a priority population
- *Te Pae Amorangi, Māori Health Strategy 2018-2027* (HVDHB) – focus area 4 is mental health and addictions
- *Toe timata le upega – Pacific Action Plan 2017-2020* (subregion) – supporting Pacific people to better access mental health and addiction services is a priority
- *Taurite Ora Māori Health Strategy 2019-2030* (CCDHB) – service focus area 2 is mental health and addiction
- *Our Wellbeing Plan 2018 A Thriving Hutt Valley* (HVDHB) - recognises mental wellbeing as critical to overall wellbeing and aims to support and strengthen mental wellbeing
- Mental health and addiction care for people with disabilities is embedded into the *Sub-Regional Disability Strategy 2017-2022 Enabling Partnerships: collaboration for effective access to health services.*

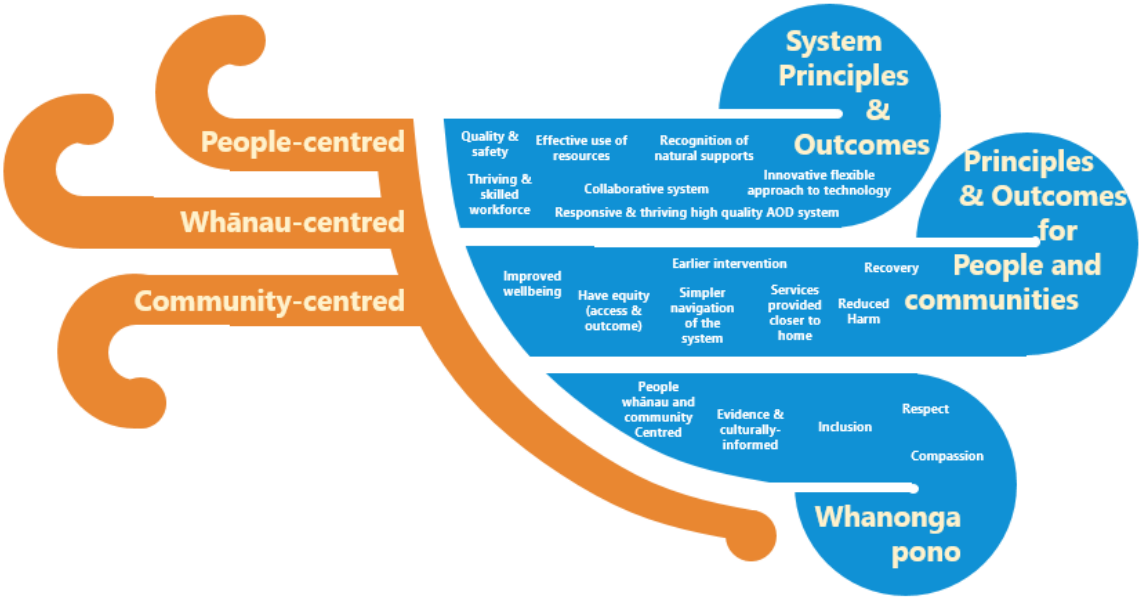
# The Alcohol and Other Drug Model of Care

## Overview

Hazardous and harmful use of alcohol and other drugs is one of the greatest risks to health and wellbeing – affecting individuals, families, whānau, communities and society. Harmful consumption contributes to health and social inequalities and is among the foremost underlying causes of disease including mental health issues, injury, family violence, fetal harm, disability and premature death. The 'prevention paradox' is that the majority of substance-related harm occurs in populations who consume only small amount of substances (mostly alcohol).

The collaboratively developed Model of Care proposes a whole-of-population approach to reducing substance-related harm, by enabling early intervention in places that work for the people experiencing and exposed to the harms.

The graphic incorporates the subregion's prevailing wind, waves and sea. At the heart of the Model of Care are people, whānau and communities.




## Te Tiriti o Waitangi

Te Tiriti is a statement of individual and collective rights, a charter for New Zealand as a whole, and a reminder to Government, and its agencies of their collective obligations in respect of the Tāngata Whenua of New Zealand. Our DHBs have obligations to the mana whenua of the subregion to:

- ensure that health outcomes for Māori are equal to those of non-Māori
- provide for Māori self-determination and mana motuhake in the development, design, delivery and monitoring of health services
- provide for and properly resource kaupapa Māori health services, offering kaupapa Māori services and supports first to those who identify as Māori to ensure choice
- ensure that all health services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care

- work in partnership with Māori, including Māori with lived experience of addiction, and Māori AOD providers, indecision-making, development, design, delivery and monitoring of health and disability services.

## Principles

The Model of Care recognises the following principles:

- People, whānau and communities with substantially improved wellbeing through equity of access and outcomes, for those with the greatest need.
- Sector partners working inclusively and respectfully to create a person, whānau and community-centred system of a care using integrated and collaborative approaches.
- A system of care that is visible, easy to navigate, accessible earlier, and closer to home.
- Effective use of resources, with an innovative approach to technology-use.
- High quality, safe services based equally on evidence and culturally informed best practice.
- A thriving and skilled workforce.[5]

## Scope

The Model of Care takes a life-course approach and includes those exposed to and experiencing substance-use harm 'from the womb to the tomb' recognising that the nature and degree of substance-use harm varies considerably across the life-course and requires evidence-based, tailored services and supports.

The Model of Care takes a whole of population approach and responds to the full continuum of substance-use harm from people who are not currently experiencing harm through to the services and supports for people with severe substance use disorders.

The Model of Care promotes a systems approach to service delivery emphasising integration (service connectedness and collaboration) across the whole continuum of care to achieve better outcomes for both people and their families and whānau; individual services; and the AOD system of care.

The Model of Care does not include services and supports for those experiencing solely gambling-related harms, or other behavioural addictions. The Model of Care is however recovery-focused emphasising a holistic approach and the importance of working collaboratively with all relevant services and supports including other organisations providing these services.

Implementing the Model of Care will require new investment and reinvestment in reconfigured services to increase the AOD sector's capacity and capability. The Model of Care recognises that service reconfiguration includes the decommissioning of services.

## Definitions

**Evidence** includes non-traditional evidence including the ways of knowing, doing and understanding the world of Māori (mātauranga Māori), Pacific peoples and those with lived experience of AOD issues.

A **peer** is someone who has had similar experience to another person or people, such as **a lived experience of addiction** that has had a significant impact on a person's life.

[5] Agreed by the AOD Model of Care Steering Group at their meeting on 18 April, 2019.

The service user, consumer and **peer workforce** include all people with openly identified lived experience of mental distress or addiction and recovery. They can be in paid or unpaid employment and use their experience to benefit others with mental distress or addiction in the work they do.

**Recovery** is a process of change in which people improve their health and wellness, regain control over their choices, live happy lives, and reach their full potential.

**Specialist services** are services that provide AOD care that cannot be provided in primary care settings.

The Model of Care defines **substance-use harm** as any pattern of substance use (including alcohol use) that causes harm to individuals, whānau and communities and recognises all harms including those that are subjectively identified by people, whānau and communities.

## Key Components of the Model of Care

The Model of Care has five direction-setting and overlapping components:

1. Driving equity of access and outcomes
2. Privileging the voice and contribution of those with lived experience
3. Growing a whole of population approach
4. Building a recovery-focused system of care
5. Working collaboratively.

### 1. Driving equity of access and outcomes

Equity is a human right that is embedded in the legislative frameworks of health, specifically the New Zealand Public Health and Disability Act 2000. Establishing equity is a core commitment for all three of the subregion's DHBs.

Māori experience the highest levels of mental illness and addiction (MHA) of any ethnic group in New Zealand. Pacific peoples also experience MHA at higher rates than others with 25 percent experiencing MHA in a given year compared to 20 percent overall. The harm is more common for Māori and Pacific peoples and people facing socio-economic disadvantage because these groups have less access to support, are more likely to live in poverty, and to be disabled.

The intergenerational effects of colonisation including loss of land, language and culture and the ongoing experience of institutional racism and ableism perpetuate disadvantage and poor health and other outcomes for Māori, Pacific people and people with disabilities – the priority populations. Many people identify with more than one disadvantaged group compounding their health burdens.

#### *Overview: Equity Goal, Definition and Principles*

The Hutt Valley DHB and Capital & Coast DHB Board have endorsed an **Equity Definition**, an **Equity Goal** and **Equity Principles** in response to the breadth of inequities experienced by Māori, and our priority populations: Pacific peoples and people with disabilities.

These Equity fundamentals were developed by a Steering Group and are the product of extensive engagement with partner and stakeholder groups.[6]

The Equity Definition, Equity Goal and Equity Principles provide a framework for action and will be supported by a policy framework, an education and communication strategy, and ongoing monitoring and review.

[6] The Māori Partnership Board, the Sub-Regional Pacific Strategic Advisory Group, the Sub-Regional Disability Advisory Group and the Citizens' Health Council.

### *Equity Definition*

In the Hutt Valley and Capital and Coast districts, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

### *Equity Goal*

To achieve health equity by 2030, as measured by:

- consumer input, access, quality, experience and direct results.
- influence on fundamental causes and social determinants.

### *Equity Principles*

| | |
|---|---|
| **1. Privilege their Voice** | **Amplify and value the voice of individuals and whānau from priority groups. Put them at the centre**. Seek out and give favourable treatment to their views. Ensure these sit at the heart of information gathering and decision making – in strategy, policy, process, service design and delivery. |
| **2. Focus on Whānau** | **Expand the focus from individuals to include the family unit**. Design and deliver services that are oriented not just to individuals – but also to their whānau and household realities and circumstances. Explore and design so as to mitigate confounding factors to good health in the whānau environment. |
| **3. Empower Consumers (Rangatiratanga)** | Actively work to **empower individuals, whānau and communities to take control of their health, and become agents of their own change**. Foster their mana motuhake (autonomy, independence, self-management). Share power, influence and decision-making over the design, delivery and governance of health services. |
| **4. Prioritise Access** | Prioritise service access, quality and experience - by adapting service strategy, policy, process, design and delivery to ensure key services for individuals and whānau from priority groups are available, accessible, affordable, acceptable and appropriate. |
| **5. Offer Kaupapa Māori (and equivalent) Options** | **Transform health services by developing and fostering Kaupapa Maori services** alongside generic service models - to enable choice for Māori, Pacific, Disability, other priority group consumers. Kaupapa services cover models of care and services designed and delivered by Māori, Pacific, Disability and other priority groups for all.<br><br>Equally, hold general healthcare models and services accountable for transforming and prioritising culturally safe care that caters for Māori and other indigenous traditions and worldviews, and disability worldviews, in ways that address disadvantage in care access or quality. |
| **6. Invest Proportionately** | **Intensify care for those who have less resources and experience the greatest levels of avoidable poor health**. Deploy reasonable additional resources where required, proportionate to address the inequities that exist. |
| **7. Challenge Discrimination** | Advance an environment of open communication, supported inquiry, learning and development around discrimination in all forms, including racism, ableism and bias. Support employees and partners in the conversation. Call out conscious and unconscious discrimination on all levels - personal, institutional and structural. |

The Model of Care requires that all AOD workforces including managers, clinicians, support-workers and health commissioners adopt a pro-equity approach to their work. Being pro-equity means actively challenging the status quo at every step, and committing to redistributing resources (for

example, budgets, services and supports, networks) that are within each team and worker's control or sphere of influence in order to achieve health equity.

The Model of Care includes the development of 5 Priority Pathways to facilitate commitment and action to redressing inequities (see page 15, The Priority Pathways, and Appendix One). The Māori and Pacific priority pathways are maps for designing, producing and delivering culturally responsive and safe services and supports.

## 2. Privileging the voice and contribution of those with lived experience

Peer work benefits the people who use services, the peer worker and the organisation. Peer support worker roles can provide effective acute care and help maintain recovery. The contribution of those with lived experience comes in many forms including consumer advisors who provide strategic and operational advice to design, develop and improve services, educators, researchers, evaluators, auditors and peer supervisors.

This second component of the Model of Care, 'Privileging the voice and contribution of those with lived experience', is an enabler for the first component 'Driving equity of access and outcomes' in particular Equity Principle 3. 'Empower Consumers'. The voice and contribution of our priority populations: Māori, Pacific people and people with disabilities with lived experience of addiction is needed in all parts of both the evolving continuum of care and the system of care.

The Model of Care recognises the need to grow the peer workforce and create flexible access pathways to increase individual and family and whānau access to peer support. The Model of Care also recognises the importance of developing sustainable, funded peer services with equitable pay and conditions of employment.

The Model of Care privileges the voice of Māori whānau recognising the interdependence and interconnectedness of whānau is central to wellbeing, both individually and collectively, and supporting whānau well-being is essential for recovery. Listening to the voice of whānau, means valuing and prioritising both the autonomy and the collective wellbeing of whānau.

The Model of Care will help drive whānau ora approaches recognising that it is the right way to deliver holistic care and is closely aligned to a whole of population response to need. Whānau Ora encompasses the diverse needs of all population groups, particularly, developmentally specific needs across the life course.

Together the voices of those with lived experience and whānau, communicated using codesign principles, will inform how services are developed within the Model of Care and define the investment and planning priorities.

## 3. Growing a whole of population approach

The harms that result from AOD use exist on a continuum from no harm to severe addiction. Some people use substances recreationally with none or only minor harms resulting. At the other end of the continuum is severe dependence that exacts a heavy toll on individual health, wellbeing and life-expectancy as well as family, whānau and community wellbeing and functioning.

Addiction treatment services have been primarily focused on those with moderate to severe problems. This means that mild problems can progress to the point where they are much harder to address, in part because of the sometimes-devastating personal losses sustained along the way - the consequence of growing reliance on substance-use and increased tolerance of the ill-effects.

The Model of Care takes a whole-of-population approach recognising the continuum from no harm to severe harm and aims to grow a system of care that responds to the greatest need across the continuum.

The Model of Care recognises the need for innovative harm minimisation approaches across the continuum of care; and the importance of establishing an evidence-base (that recognises both traditional and non-traditional forms of evidence) for new and reconfigured services.

The whole of population approach requires our DHBs to commit to investment in a full range of evidence-based approaches, including tailored programmes for priority groups, as follows:

- programmes to influence the social determinants of health and support the creation of healthy environments
- health promotion activities to educate and increase awareness to reduce AOD harm
- primary and community care
- specialist services.

### *Whole of population: addressing the social determinants*

Addiction is a complex and challenging condition with many contributing factors. Successful behaviour change depends on consideration of the physical and social environments in which people live, work, and play.

The person's exposure to longstanding psychosocial stressors and their physiological response to their environment has a big influence on treatment outcomes. It is essential that immediate needs such as housing, mental and physical health, and income support are addressed in parallel to treatment for AOD problems. Interaction with the criminal and family justice system can be important to support people with legal problems including addressing family violence (both perpetration and victimisation).

The Model of Care promotes the strategic alliances and collaborative approaches that are needed to underpin the services and supports that can improve access to the determinants of health.

### *Whole of population: health promotion prevention and education*

The Model of Care requires an increased focus on collaboration with existing national, regional, and local health promotion and education programmes to raise awareness of harms and harm reduction supports and services. It is important that these activities are tailored for those groups experiencing the greatest harms.

### *Whole of population: primary and community care*

The Model of Care requires increased capacity and capability for screening and brief advice to intervene early in health, criminal justice and social service settings to prevent substance-related harms.

A range of primary and community services are needed to effectively meet the needs of the whole of population with a particular focus on Māori, Pacific people, young people, people living rurally and/or remotely and to meet the broader health care needs of people with severe addiction.

The Model of Care focuses attention on developing effective working relationships with primary and community health services and building strategic alliances to provide timely and seamless access to AOD services and supports.

### *Whole of population: specialist services*

The Model of Care recognises the broad array of accessible, high-quality specialist services that are needed to undertake responsibility for the care of those at greatest risk.

The specialist service part of the continuum is located mainly in community treatment settings, with programmes focused on recovery, support for safe withdrawal, intensive outreach, social detoxification, whānau support, and access to inpatient or residential treatment.

The programmes delivered by specialist services target prioritised parts of the community, for instance services for young people, co-existing problems and Kaupapa Māori programmes of care including support for whānau.

*Whole of population: visual*

The concentric circles visual has people at the centre surrounded by their main sources of support: families and whānau and support networks.

Next, community and primary services provide an early response in places close to where people live. Then, the priority pathways of care layer (for Māori, Pacific people, young people, people living rurally/remotely and people with severe problems) are maps that recognise inequities of access and outcomes and support the AOD sector to integrate to provide the necessary services and supports for Māori and the priority populations.

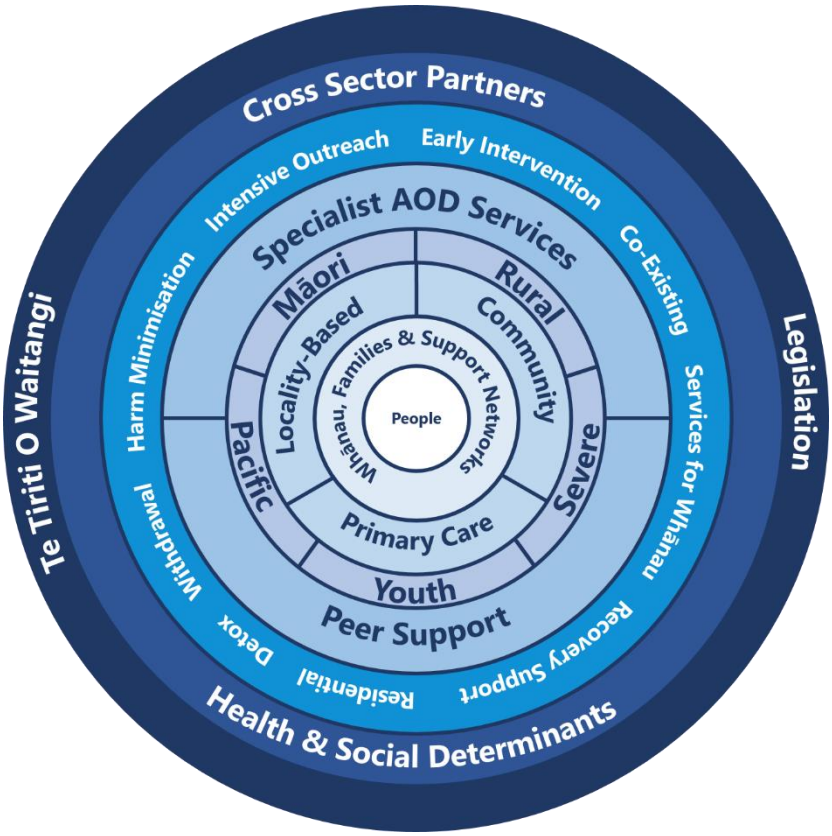
The next two layers depict the integrated AOD sector − specialist secondary, specialist community and peer-based services. The integrated AOD sector has the capacity and capability to deliver a range and choice of interventions and resources (including harm minimisation and recovery support) in a holistic response to the unique needs of the person in recovery.

The penultimate circle recognises the importance of cross-sector partners in preventing harm and supporting recovery and wellbeing.

The outer circle signals the AOD sector's obligations to mana whenua under the Treaty of Waitangi and the broader legislative framework within which the sector operates.

The ever-widening circles can also symbolise the dynamics of substance-use, the continuum of substance-use related-harms and the fluidity needed in the service response.

Finally, the visual references the ripple effects of the recovery journey that first improves the life of the person in recovery, and next the lives of their families and whānau and support networks, and then, rippling outwards. ultimately contributes to the wellbeing and functioning of the whole.



## 4. Building a recovery-focused system of care

Addiction treatment services provide acute treatment and care for people with moderate to severe problems in times of crisis, and ongoing management including continuing treatment for a small group of people with the most severe problems.

Clinical interventions that treat, stabilise and minimise the harmful effects of substance use are an important part of the recovery journey but cannot restore social losses, or address the factors that reinforce substance dependence creating vulnerability to relapse such as unstable relationships, housing need, unemployment and involvement in crime.

There are multiple pathways to wellness and the Model of Care signals a shift away from an exclusive focus on clinical interventions towards addressing the long-term supports that will support people to concentrate on their recovery, reduce substance-related harm and build meaningful lives.

The Model of Care emphasises that a focus on recovery is important on every part of the continuum of care. Services and supports are there to empower people to define what recovery means for them and to assist them to achieve their recovery goals while addressing both the determinants of health and continuing care needs.

A recovery-focus is holistic and consistent with Māori health and wellbeing frameworks including Te Whare Tapa Whā and Whānau Ora that recognise the relationship between mana, whānau and whanaungatanga and their vital connection to individual, whānau and community wellbeing.

The Model of Care needs to build innovative systems and services that support activities that exist outside of the traditional remit of treatment and build the evidence-base for what works. This will include:

- a network of peer support including peer-led recovery groups
- engaging the wider community to reduce stigma against people who have experienced substance misuse problems
- drawing on the assets and resources that exist within communities to grow these communities and build the self-esteem of the people in them.

### *Recovery capital*

The concept of 'recovery capital' is helpful for understanding the process of recovery. Recovery capital is the extent and quality of resources that can support an individual through the initiation and maintenance of their recovery. Resources can be both internal (such as family support, or a skill or occupation) and external (such as access to secure accommodation and transport). The role of AOD services and supports is then to promote individual resilience, increase intrinsic and extrinsic resources and minimise external risk factors.

### *Relapse and harm minimisation*

The Model of Care understands the value of relapse because of the role it can play in strengthening an individual's resolve to change as both they, and their family and whānau, gain familiarity with triggers and experience in dealing with setbacks. Relapse can however result in people giving up on their recovery journey.

Services and supports in the Model of Care emphasise the learning opportunity presented by the relapse and recovery cycle, and when there are setbacks provide timely access to both formal and informal supports, to reduce their duration and severity.

The Model of Care understands that for some people harm minimisation is a stage on the recovery journey and for others it is a recovery goal. Self-defined milestones and goals can and often will change. For example, long-term opioid substitution treatment provides a platform of stability and safety that enables many people to live meaningful lives. Other people will use short-term treatment as a springboard for a managed reduction and eventual withdrawal.

*Peer support*

The Model of Care recognises that the peer workforce is uniquely equipped to provide ongoing, recovery-focused support that is complementary to treatment. Peer support workers are role models for a life in recovery, and the experience of supporting the recovery of others can provide hope and motivation for sustaining their own recovery.

Peer support has many benefits for people in recovery. It can improve relationships with providers and social supports, increase satisfaction with the treatment experience, reduce rates of relapse, and increase retention in treatment.

### 5. Working collaboratively

The importance of working collaboratively both within health and across community, social and justice services is a strong emphasis in all the Model of Care components but, especially in 3. 'Growing a whole of population approach' and 4. 'Building a recovery-focused system of care'.

People's needs can include housing, employment, education and training as well as liaison with the criminal and family justice system. Unmet psychosocial needs can be a barrier to recovery and compounding barriers can make accessing services and supports impossible for people, especially when they are socially and economically marginalised.

The Model of Care recognises that services and supports are fragmented and disconnected and vertical and horizontal integration across AOD services, the wider health sector as well as integration with other agencies are key enablers for implementation. This includes ensuring a shared philosophy of treatment and commitment to sharing resources to meet population need.

Establishing a mechanism for collaboration between AOD providers is essential to supporting the Model of Care's ambition to take a whole of population approach and ensure that priority pathways for targeted populations are fully integrated.

The collaboration of the AOD sector will ensure there is awareness of the range of interventions and available, clear pathways for transition between services as well as people-centred services that understand where people have come from and help them seamlessly transition on towards recovery.

## The Priority Pathways

The five priority pathways for main groups of AOD service users complement the Model of Care. They are designed to ensure that we are responding to those with the greatest needs and providing early intervention both in the life-course and in the life of the problem. The five priority pathways are still draft and are included as an Appendix to the Model of Care.

The priority pathways are essentially maps for AOD health professionals so they can see at a glance key considerations that will help them to tailor services and supports that respond to the needs, aspirations and cultural frame of reference for people presenting from one (or more) of these five groups:

1. Māori
2. Pacific people
3. Young people
4. People living rurally and/or remotely
5. People with severe problems.

The priority pathways are being developed with the communities they are designed to serve using co-design principles and the data and insights that informed the Model of Care project.

### Common themes

Each priority pathway links to all the other priority pathways.

People have a choice of priority pathway or can use more than one pathway.

All the priority pathways identify the social, cultural and economic determinants of health that contribute to people needing help and the health, social and other partners and agencies that are part of the wider system of care.

All the priority pathways recognise that there are both workforce and technology enablers that are needed for the pathway to work effectively.

### Next steps

The priority pathways require further testing with the AOD sector, development and refinement and this will occur as part of the implementation plan for the Model of Care.

## Implementing the Model of Care

The Model of Care Steering Group identified the following system and service development priorities:

- the need for collaboration and partnership across the system of care
- the need for an improved ability to evidence impact of interventions
- the need for both flexible funding and service access criteria
- the importance of taking a life course approach to addiction needs
- the importance of both clinically and culturally informed best practice
- the need for increased visibility of the AOD system of care.

These key sector development areas will form the areas of focus for the implementation of the model of care

### The AOD Collaborative

A first step is to establish an 'AOD collaborative', as a key enabler for the successful implementation of the Model of Care including the further development of the five priority pathways.

The proposed AOD Collaborative is a provider-led platform to enable the AOD sector to work together to implement the key recommendations in the Model of Care. The collaborative will coordinate developmental activity and integrate the system of service delivery as well as address the challenges and opportunities, including:

- further develop and increase the viability, and equity of access of the Priority Pathways inclusive of outreach and enhanced access locations such as Marae based service provision
- address system of care visibility issues by mapping services along the continuum and providing this to the sector and wider community
- building locality-based service design and delivery aligned to the Model of Care grounded in clinically and culturally informed best practice
- creating a collective workforce plan to address resource and workforce developmental gaps
- developing relationships that enable improved care coordination and service integration
- developing and implementing an alcohol and drug outcomes framework and setting key indicators to measure improved health status when implementing the Model of Care.

The aim of the AOD collaborative is to develop a collective provider response which more effectively meet the needs of people with AOD issues in an integrated approach to service development.

An aligned and second implementation step (step two) will be to identify opportunity for investment and implement proposals as funding becomes available. The following investment has been proposed in response to initiatives from the Ministry of Health.

## The enhanced primary and community AOD supports initiative

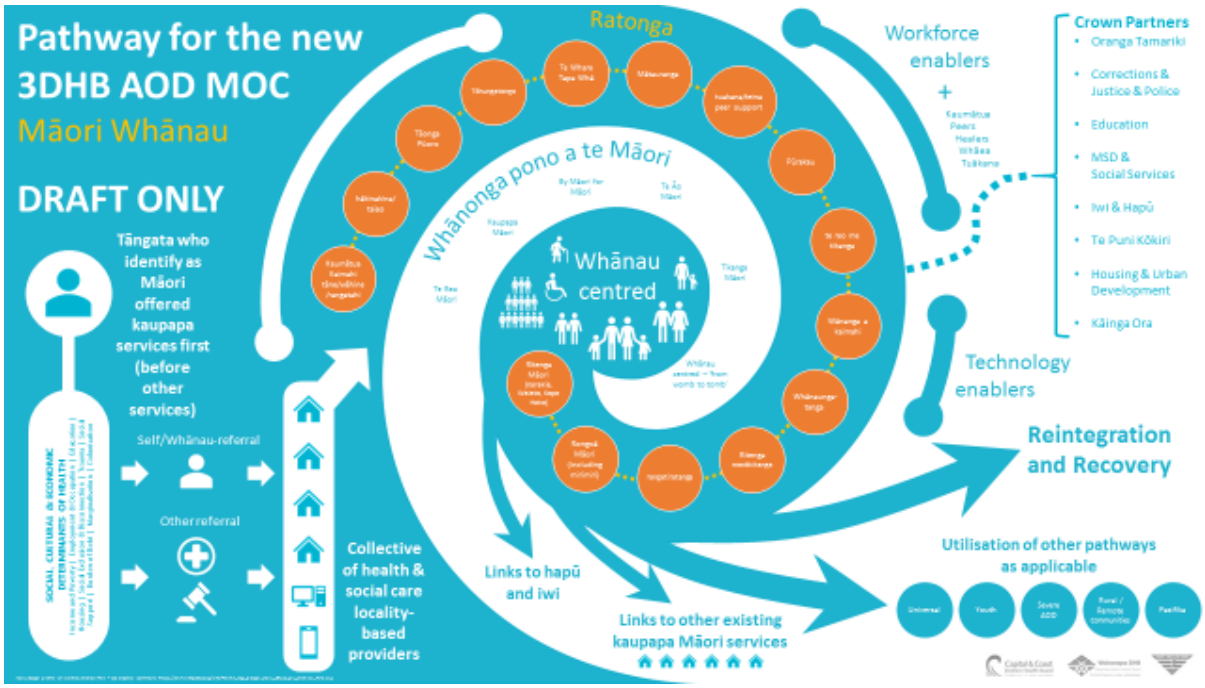
The Ministry of Health invited CCDHB and HVDHB to submit a proposal for investment in order to increase access to primary and community AOD services and supports. The Ministry is supporting the proposal with $3m of investment over three years to establish:

- **Enhanced kaupapa Māori and Pacific counselling services** –accessible, culturally responsive counselling services and supports to address substance-related harm targeted to Māori and Pacific communities and delivered close to home
- **Innovative peer support network and coordination** – providers chosen to deliver the counselling services will also offer the enhanced peer support component to aid wellbeing and recovery. The initiative includes: a peer support coordinator role, the establishment of an AOD peer network, and training and supervision for the peer workers
- **Project management** – to support implementation of the primary and community AOD services and implementation of the AOD Collaborative (see the section above).

This proposal if successful, the new services and supports will be aligned with the Model of Care beginning with establishment of the AOD Collaborative.

# Appendix One – Priority Pathways

## Draft Priority Pathway 1 – Māori




The pathway is presented as a koru – an unfurling fern frond. The circular shape suggests perpetual movement and the inward coil, a return to the point of origin – in this case whānau. The koru symbolises the way in which life can change, but also how it stays the same. The arrows emerging from the unfurling koru show that recovery is possible at any point on the pathway.

The values that underpin the framework are whanonga pono a te Māori and are shown in the white centre of the koru. The services (Ratonga) that could form part of the services and support are listed in the orange circles. The workforce for this pathway will include kaumātua (elders), peers, healers, whāea (Aunties) and tuākana (elder siblings, senior members of a whānau).

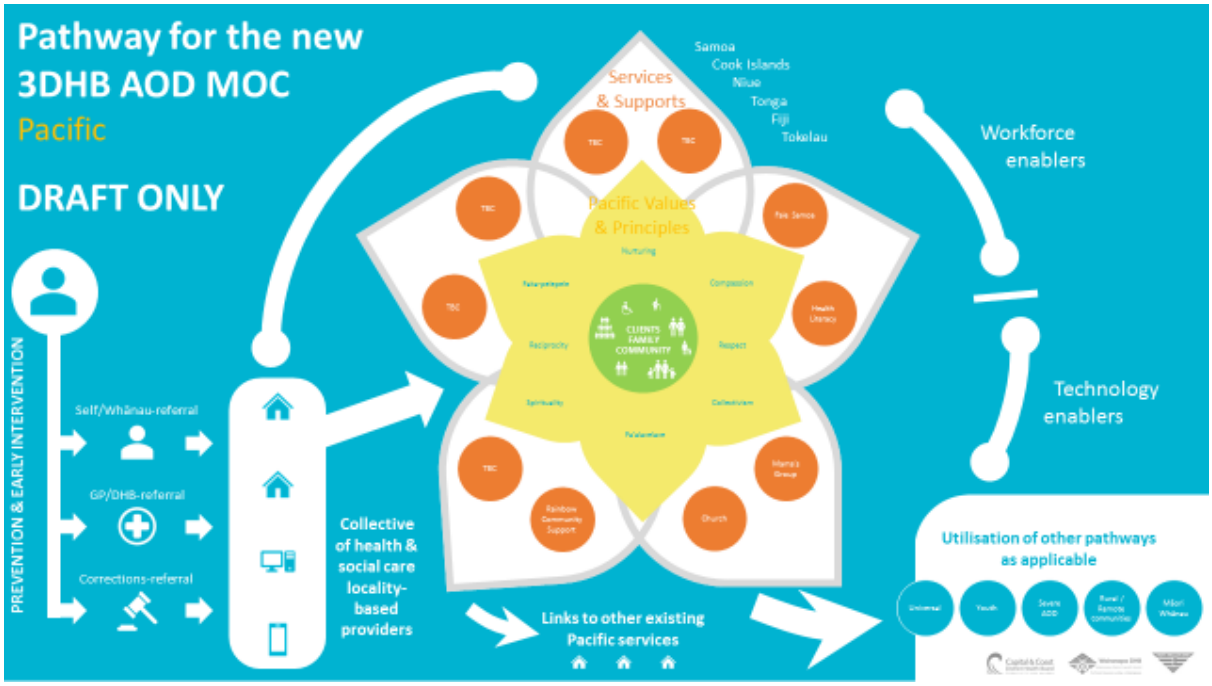
The pathway is whānau centred and offers services and supports across the life course. The pathway emphasises the importance of offering kaupapa Māori services and supports to those who identify as Māori, before offering mainstream services and supports.

Services and supports offered must be provided by kaupapa services who are governed and embedded in te ao Māori. There are also links to hapū and iwi and other kaupapa services.

Anyone can refer to kaupapa services including the person seeking services and whānau. Services and supports are offered via a collective of kaupapa health and social care providers in a community or locality.

For this pathway to function it is vital that it is visible to whānau and community. All doorways into services and supports and workforces will need to understand the requirement to offer kaupapa services and how to support access to them.

## Draft Priority Pathway 2 – Pacific people




Pacific peoples is an umbrella term used to describe a population made up of 16 distinct and diverse cultures of peoples from Melanesia, Polynesia and Micronesia. In the subregion the seven largest ethnic groups are Samoan, Tongan, Cook Island Maori, Niuean, Fijian, Tokelauan and Tuvaluan.

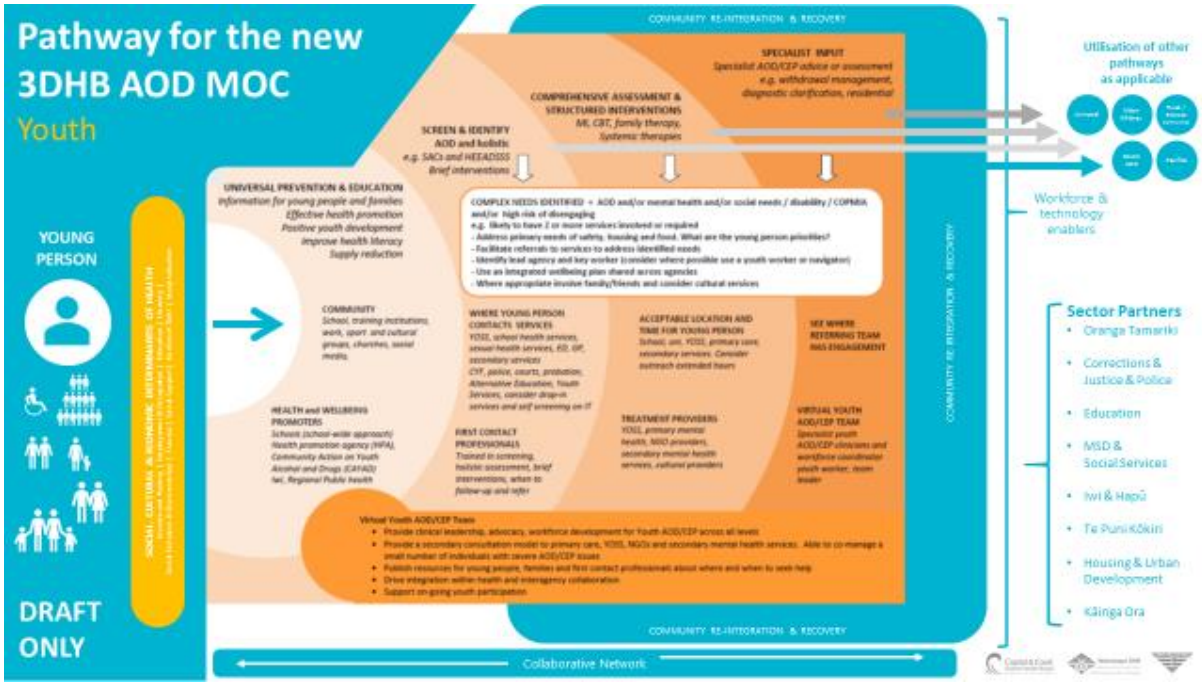
While each of these countries and cultures have their own languages and customs, this pathway attempts to show values and principles that are similar across the Pacific in the yellow centre of the flower and Pacific services and supports are in the orange circles.

The pathway has clients, families and communities at the centre and offers services and supports across the life course. The pathway emphasises the importance of offering Pacific services and supports to those who identify as Pacific, before offering mainstream services and supports.

Anyone can refer to Pacific services including the person seeking services and their family. Services and supports are offered via a collective of Pacific people health and social care providers in a community or locality, by services who focus on Pacific communities.

For this pathway to function it is vital that it is visible to Pacific people. All doorways into services and supports and workforces will need to understand the requirement to offer Pacific services and how to support access to them.

## Draft Priority Pathway 3 – Young people




The Youth AOD/Coexisting Problems (CEP) Model of Care was collaboratively developed in 2016 and has been partially implemented.

The young person, their family, whānau and their peers are at the centre of a population-based model that emphasises the importance of universal preventive interventions for all young people.

Young people use alcohol and drugs in potentially harmful ways as part of developmentally appropriate risk-taking and this takes place within a social context that normalises and even celebrates excessive AOD use.

Young people use substances very differently from adults:

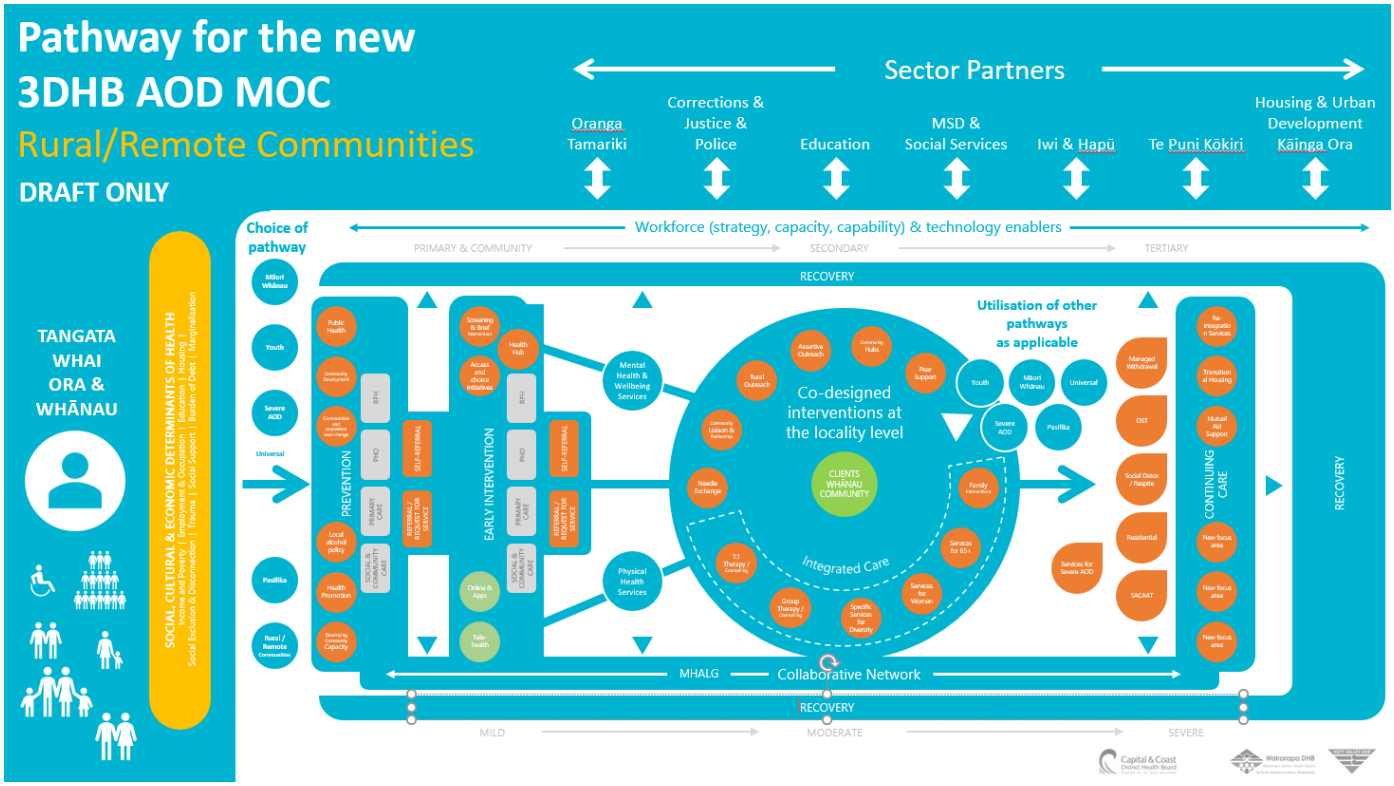
- it is very rare for young people to be substance dependent however, the harms that result from substance use can be higher
- young people will often not understand that their substance use is problematic
- interventions need to be appropriate to the developmental stage of the young person and this does not necessarily correlate with their chronological age
- nearly all young people live within some form of family unit or whānau so it important that services and supports can include family and/ or whānau.

The model draws attention to those young people with complex problems to highlight the limitations of a one-dimensional, severity-based, stepped-care model.

The model recognises that the level of need in young people often fluctuates and the importance of ensuring they can move seamlessly between services.

The model emphasises the importance of the specialist youth AOD/CEP team providing clinical leadership, driving integration and workforce development and ensuring youth participation across all levels of the model.

## Draft Priority Pathway 4 – People living rurally and/or remotely

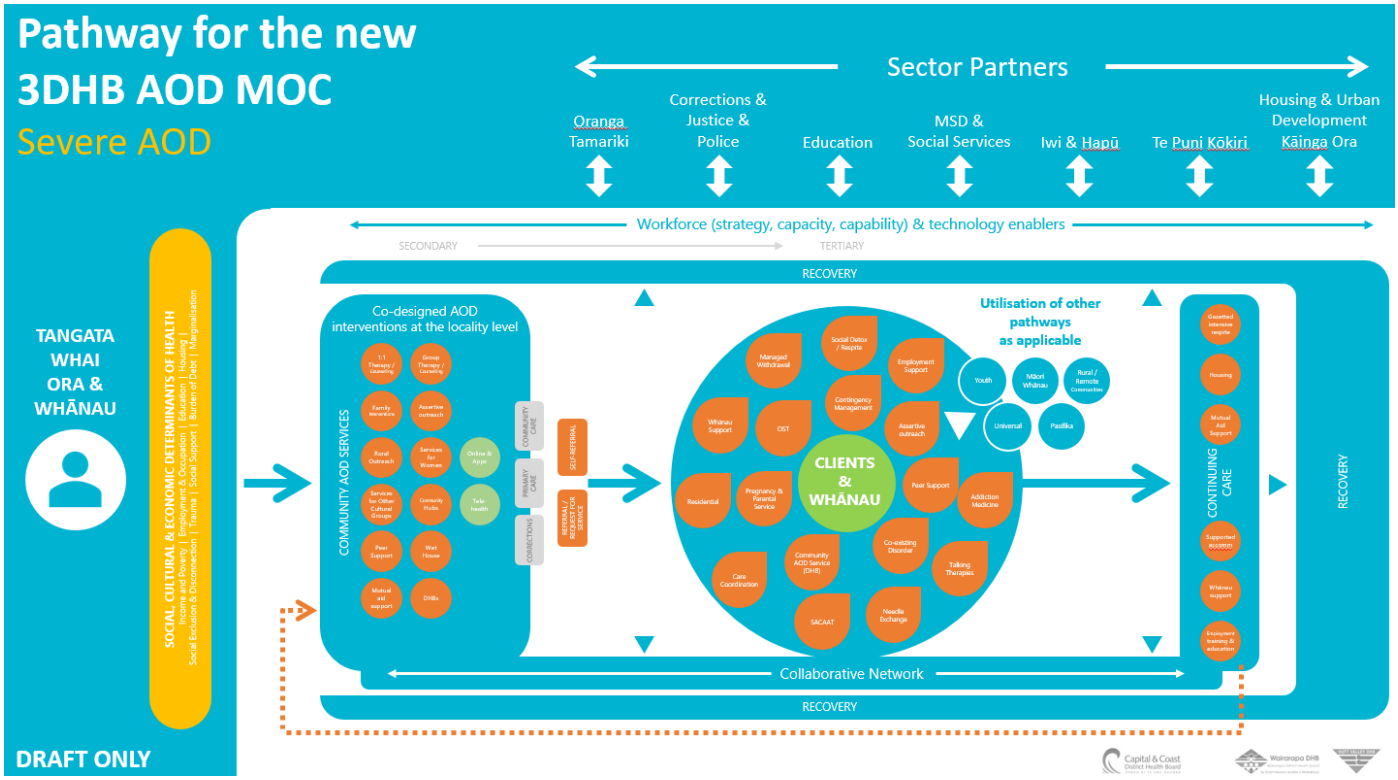



Wairarapa is a rural region and includes some very remote areas and as a result service delivery can be significantly different from the services and supports offered in our other two DHB areas. Assertive out-reach and mobile services are essential and described in the model as rural outreach.

Wairarapa is unique in that all AOD services and supports are provided by two NGO providers: a kaupapa Māori provider, and a mainstream provider (also the only NGO provider of opioid substitution treatment services in New Zealand). These small NGO providers need to cater to diverse groups in terms of both age and ethnicity. The model describes this as integrated care.

Wairarapa providers and providers in other rural areas need to work closely with other health providers and other sectors to utilise places where people already go to access support. For example, services and supports can be provided from GP clinics, community services or churches. The model describes this as community liaison and partnership.

## Draft Priority Pathway 5 – People with severe problems




Services for people with a severe addiction or substance use disorder are very limited across the subregion. The new Substance Addiction (Compulsory Assessment and Treatment) Act 2017 enables people to be committed for addiction treatment to a Canterbury treatment centre. There are very few housing or support options for housing or support for the high needs group of people returning to the subregion following release from compulsory treatment.

Recent investment in AOD treatment services has been in primary and community services. Most people with severe addictions are supported by secondary services in DHBs and additional investment in these services is needed to support this group.

The priority pathway model shows the services and supports that this group needs and the system of care. Crucial to the effectiveness of this pathway is the availability of supported housing options and a gazetted intensive respite service. Unique to this pathway are the following services and supports:

- outreach and innovative approaches of care
- residential treatment services
- addiction medicine
- neuropsychological assessment
- specialist psychological therapies (for example, Motivational Interviewing, Cognitive Behavioural Therapy, Dialectical Behaviour Therapy)
- contingency management
- managed withdrawal.

## Appendix Two – Stakeholder Engagement Map