The Treatment of People with Drug and Alcohol Problems

A Consensus Development Conference Report to The National Advisory Committee on Core Health and Disability Support Services
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Consensus Development Conferences

This report is from a consensus development conference co-hosted by the Core Services Committee and the Mental Health Section, Health and Disability Services Policy Group, Ministry of Health.

The Core Services Committee, through its terms of reference, is charged with providing the Minister of Health with advice on the health and disability support services the Government should ensure are purchased, in order that people have access to effective services on fair terms.

In arriving at this advice, the Committee is required to consult widely with relevant professionals in specified fields, with users of services, and with the general public.

Purpose

Consensus development conferences are a means of intensive consultation with professionals and lay experts on specified topics identified by the Core Services Committee.

Reports from the consensus development conferences are in the form of advice to the Core Services Committee which, in turn, considers this advice in making recommendations to the Minister of Health in its annual report.

Publication of the consensus reports provides regional health authorities (RHAs) and service providers with an indication of the advice the Committee is receiving and the possible direction of the Committee—which can help RHAs in their contract negotiations and specification of services. The public will also have a reference on which to base their expectations.

Panel Selection

Panellists in these conferences are professionals and lay experts. They are not chosen as representatives of any particular organisation or professional group, but rather, for what they can contribute as individuals.

Independence of advice is maintained by keeping the panel selection at arm’s length from the Core Services Committee. Selection of the panel is primarily the responsibility of the project manager and clinical co-ordinator who, in turn, are chosen for their standing.
in the field and project management skills. This particular conference was the responsibility of a project manager and two clinical co-ordinators.

**Method**

Background material, selected by the project manager and the clinical co-ordinator(s), is distributed for reading prior to the conference. This material consists of international and local literature, working papers and in some cases commissioned work and survey information.

The conferences are held over two days with no opportunity for over-run. The proceedings are managed by a facilitator. Representatives of the Core Services Committee and (for this conference) Mental Health Services Section of the Ministry of Health were present throughout to clarify the brief.

Consensus is defined as a recommendation that all panellists can support. It does not mean it is the preferred option of every panellist, and it is not a majority vote.

Consensus is first sought on whom the services are intended to benefit, and what relevant outcomes should be sought from these services. This sets the scene for more specific recommendations on how these outcomes might be achieved.

Consensus is identified verbally, and the clinical co-ordinator(s) and project manager take responsibility for accurately reflecting the consensus achieved. Panellists have the opportunity to comment on the draft reports.

**Topic Selection**

A range of criteria is used to select the topics for consensus conferences. Topics need to be: ones that the public, professionals, planners and users are concerned about; ones where there is a reasonable chance of reaching consensus; and a likelihood that the consensus can be generalised beyond the specific area of discussion.

**Other Reports**

(The first ten topics were chosen before the Committee took on the responsibility for disability support services).

* Hip and knee joint replacement
* Management of raised blood pressure
* Management of endstage renal failure
* The baby under 1000 grams
* The use of minor tranquillisers
The Treatment of People with Drug and Alcohol Problems

Investigation of the issues surrounding *The Treatment of People with Drug and Alcohol Disorders* was suggested by the Mental Health Section of the Ministry of Health.

This is a report to the Core Services Committee which the Committee has published to encourage discussion. The report is of interest to people working in the field of drug and alcohol treatment and to the wider public because it recommends the development of a national policy which would outline prevention, treatment and research development planning. Such a policy would allow purchasers, providers, educational institutions, the Alcohol Advisory Council and the Drugs Advisory Committee to work more closely together to identify service provision and training needs and research gaps.

The fifteen panellists were drawn from throughout New Zealand and comprised consumers, community and primary health care providers, specialist clinicians and managers involved in the treatment of people with drug and alcohol problems.

The conference considered general treatment goals for individual clients, and goals and objectives for the whole population, with the overall objective of reducing the social and personal costs of alcohol and drug problems to the community.

The panellists were concerned at the lack of information about drug and alcohol services, waiting lists, duplicated services, and services which fail to respond to groups of clients with special needs.

The conference was critical of the lack of evaluation of the effectiveness of residential treatment programmes. From the literature and expert opinion presented to the conference, panellists recommended that each client should receive a “rehabilitation package” which included a comprehensive assessment, initial treatment by primary care providers...
and outpatient services, and only if these are unsuccessful should admission to a short term residential programme be considered. However, for people with alcohol related brain damage or a chronic dependence which has not responded to outpatient or residential treatment, longer term supportive care is recommended, preferably within the community. For those people with severe dependence and who also have histories of criminality, psychiatric conditions and/or poor family relationships, then a habilitation programme in a Therapeutic Community is recommended. The panellists also recommended that a national alcohol and drug policy be developed.

The Committee invites feedback on the recommendations made in this report.

Inquiries

Inquiries and correspondence should be directed to the Core Services Committee Secretariat, PO Box 5013, Wellington, Tel. (04) 496-2296, Fax (04) 496-2340.
Executive Summary

The panel of consumers, community and primary health care providers, specialist clinicians, and managers, drawn from throughout New Zealand, met for a two day consensus conference to consider the treatment of people with alcohol and drug problems.

The outcomes most desired by the conference panellists were listed under the following headings:

- general treatment goals
- whole population goals and objectives
- treatment and process outcomes
- individual client outcomes.

In achieving these outcomes the perspective concentrated on is that of harm reduction; which has the overall objective of reducing the social and personal costs of alcohol and drug problems to the community.

The panel was concerned about the following factors in alcohol and drug assessment and treatment:

- access to treatment and referral
- assessment and case management
- national and regional planning
- residential treatment
- methadone treatment
- special needs groups
- quality assurance.

Panellists were concerned that:

- information available to the public about alcohol and drug services is often inadequate
- waiting lists impede access to services
- alcohol and drug services are poorly marketed
alcohol and drug services accept clients who should be referred to other, more appropriate, services.

An important principle derived from the conference was that there should be a distinction between primary care and specialist secondary services. Secondary providers should give priority to assessing and treating referrals from primary care providers.

Panellists considered comprehensive assessment a priority in the treatment process. Assessment should include an overall health and social evaluation. They recognised that different kinds of assessment should be available for differing client needs and that at the primary care level, briefer assessment is generally sufficient. It was acknowledged that no single alcohol and drug service provider is always able to deliver the variety of treatment options individual clients may require.

Panellists felt strongly that New Zealand now requires a national alcohol and drug policy supported by politicians, workers in the field and the general community. This policy would outline prevention, treatment and research development planning, and enable Regional Health Authorities, Crown Health Enterprises, educational establishments, the Alcohol Advisory Council, the Public Health Commission, the Drugs Advisory Committee, community-based organisations and the liquor industry to work more closely together, and to identify service provision, training needs and research gaps.

Perhaps the most contentious recommendations from this consensus conference concern residential treatment, and the concept of a “rehabilitation package”. The panellists recommended that there is a place for long-term support services for people with alcohol and drug related disabilities and for Therapeutic Community programmes. From the literature and expert opinion presented to the conference, short-term residential treatment of longer than three weeks duration could not be supported.

Panellists agreed that methadone services of high quality result in good outcomes for clients. They also agreed that properly resourced methadone treatment programmes are an inexpensive way of providing family and employment stability, reducing crime and illicit drug use, and reducing the transmission of blood borne diseases (e.g. HIV, Hepatitis B & C). Significantly, the conference recommended that Regional Health Authorities provide additional funding to methadone programmes to reduce waiting lists, improve service quality and to ensure that HIV and blood borne virus transmission is further reduced.

The conference recommended that alcohol and drug workers continue to work in the closest possible co-operation with Justice Department staff to ensure adequate continuity of care for shared clients, and that competent comprehensive assessments be available to Justice Department clients with alcohol and drug problems and dependencies. A further
recommendation states that the Justice Department should contribute to methadone service funding.

Panellists were of the view that the various special needs groups discussed during the conference—women, older people, young people, gay and lesbian clients—did not have adequate access to the services they required, and that all of these groups deserve increased financial resources and greater attention from appropriately skilled personnel in the alcohol and drug field.

Alcohol and other drug problems have significantly contributed to the destruction of Maori wellness, self esteem and cultural autonomy. There continues to be a predominance of Maori males amongst the heaviest drinkers. The conference endorsed the following:

- Maori must be involved from the outset in the development, implementation, monitoring and evaluation of all service contracts
- Maori should be consulted on a regional or iwi basis about the location of services for Maori people
- The development of criteria to evaluate and monitor Maori services should be determined with Maori providers
- The education of all alcohol and drug workers in New Zealand should include issues relating to the Treaty of Waitangi in basic and post-graduate courses and as part of ongoing staff training and development
- Services should have policies and procedures in place enabling the delivery of culturally appropriate services to Maori
- Services should provide adequate numbers of appropriately trained staff who practise in a culturally safe manner.

A Pacific Island panellist stated that alcohol and drug agencies should always take into consideration differing cultural values and beliefs and that:

- the interpretation of these values and beliefs must be undertaken by knowledgeable cultural advisers
- there should be placement of Liaison Cultural Advisers in treatment institutions to monitor progress
- research should be undertaken on drug and alcohol use and abuse by Pacific Island people
- there should be a register of traditional healers and healing practices and that traditional healers should be used when appropriate
• interpreters should be readily available whenever necessary.

Where pathological gambling is the primary problem for the client at assessment, the majority of alcohol and drug services will continue to refer clients to gambling addiction services. The conference consensus was that gambling is a serious problem which needs to be addressed, but not as part of the primary business of alcohol and drug services.

The conference recommended that Regional Health Authority funding favour alcohol and drug agencies which develop valid standardised performance measures for their services, and that Regional Health Authority funding favour agencies demonstrating meaningful consumer input into the design, delivery and evaluation of services.
Recommendations

Access to treatment and referral

1. Funders and providers recognise (and sharpen) the distinction between the primary and secondary aspects of alcohol and drug treatment, improve the client’s access to primary care and be more discriminating about who should have access to secondary specialist care.

2. To reduce waiting lists and improve access to services, treatment providers refocus on the importance of discharge planning in the context of overall treatment planning for each individual and their family/whanau.

Asset and case management

3. Community based outpatient alcohol and drug services should remain the entry point for assessment. The matching of clients to treatment and case management planning should also take place within such community based services. There should be some flexibility in the implementation of this recommendation for that group of rural alcohol and drug clients who have limited access to community based alcohol and drug services.

4. Clients must be fully involved in decisions about their case management and treatment.

5. Training must be made available to increase the assessment competency of all workers and particularly those at the primary care level.

6. Pilot projects be funded for the training of primary care providers in alcohol and drug assessment. An example is the Asthma Action programme in General Practice.

7. Clients referred to gazetted treatment centres for assessment under Section 30A, Transport Act, always undergo a comprehensive alcohol and drug assessment.

8. This conference fully supports the work of the New Zealand Accreditation Board in the maintenance of high standards for the alcohol and drug assessment field.

Residential treatment

9. A variety of residential treatment programmes should be purchased by RHAs and continue to be available throughout New Zealand.

10. Good access be available in each RHA region to longer term residential care and especially to Therapeutic Community care. The emphasis in such treatment should
be on habilitation rather than rehabilitation. (It was agreed that each RHA should
gather data on the need in each region for such services.)

11. Clients with a chronic dependency (including brain damage) who have a history
of unsuccessful residential treatment should have access to continuing and
intermittent supportive care.

12. There is a place for long-term Therapeutic Community programmes and support-
ive residential care for clients with disabilities associated with alcohol and drug
disorders.

13. On the basis of the literature and expert opinion presented at the conference,
panellists accepted that short-term residential treatment (following detoxifica-
tion) of greater than three weeks duration could not be supported.

14. Halfway houses are an important part of the continuum of care, and must continue
as a post-treatment (low cost residential and non-residential) supportive option for
care.

15. The Department of Social Welfare and the Ministry of Health ensure changes are
made so that the benefit entitlements for patients of all residential treatment
programmes are the same.

16. RHAs should ensure that a range of detoxification services is available including
specialist hospital beds, social detoxification facilities and home detoxification.

**Methadone services**

17. RHAs provide additional funding to methadone programmes in order to reduce
waiting lists, improve service quality and ensure that HIV and blood-borne virus
transmission is further reduced.

18. The existing National Methadone Protocol be a guide for methadone programme
providers.

19. The Justice Department contribute to methadone service funding.

**Special needs groups**

20. Competent comprehensive assessments be available to Justice Department cli-
ents.

21. Alcohol and drug workers in non Justice settings continue to work in the closest
possible co-operation with Justice Department staff to ensure adequate continuity
of care for their shared clients.

22. Alcohol and drug workers must be competent to assess for gambling problems as
part of a comprehensive alcohol and drug assessment.
23. Alcohol and drug services for young people should be planned regionally in cooperation with a range of other appropriate services.

24. Emphasis must be placed on skilled comprehensive assessments of young people’s alcohol and drug and other problems.

25. RHAs must purchase services which provide for special needs groups.

26. RHAs’ purchasing plans for special needs groups must be flexible enough to respond to, and provide for, the special needs of various groups as needs arise.

Quality assurance

27. RHAs and other purchasing bodies provide increased funding to alcohol and drug agencies for staff training, for in-service training and regular attendance at seminars and appropriate courses of study.

28. RHA funding should favour those alcohol and drug agencies which develop valid standardised performance measures for their alcohol and drug services.

29. RHA funding should favour agencies which demonstrate meaningful consumer input into the design and delivery of their services—“consumer voices must be heard”.

30. RHAs and treatment agencies continue to support and encourage the positive contribution the New Zealand Accreditation Board for Alcohol and Drug Services has made to the development of optimum standards of assessment and treatment in alcohol and drug services.
Background

Alcohol and drug services in New Zealand have developed in an unco-ordinated and ad hoc fashion in the absence of adequate locally sourced information and research. Alcohol and drug services are consequently unevenly distributed with much evidence of duplication and a failure to respond to groups of clients with special needs, especially Maori.

Expensive and often lengthy residential treatment has been provided for years with little or no evaluation, and considerable confusion remains about which assessment and treatment methods are effective.

It has become apparent in the last decade that the skills and expertise of treatment staff have failed to match the complexities of the alcohol and drug treatment field; training remains a luxury for most workers.

Referral and interface issues now urgently require clear policies and procedures based on meaningful liaison between treatment agencies, government departments, community and voluntary workers and penal institutions.

More recently, co-morbidity\(^1\) issues in alcohol and drug treatment have received renewed attention. The substantial gaps and deficiencies for dually diagnosed clients in alcohol and drug services have highlighted the inadequate numbers of psychiatrists and others who are trained, skilled and available to work with alcohol and drug dependent people who are also mentally ill. At the very least, workers need the expertise to screen for psychiatric disorders as part of a comprehensive assessment.

It is now widely believed that alcohol and drug services and the community at large will benefit from the formulation of a national alcohol and drug policy which would provide a framework for the development of research, prevention and treatment services.

Many issues of urgent concern are often the responsibility of small numbers of dedicated and overworked personnel in treatment settings, including:—how to work effectively with alcohol and drug impaired health professionals; with drinking drivers; how to best match client needs to services when the necessary variety of treatment options is not available; how to provide adequate supervision training for agency staff; or to undertake research without adequate financial and other resources.

These and other concerns were brought to the Treatment of People with Drug and Alcohol Problems Consensus Conference held in Wellington on 8 and 9 November 1994.

\(^1\) In this context co-morbidity refers to one or more psychiatric disorders in addition to an alcohol and drug disorder. Also referred to as dual diagnosis and co-existing disorders.
Outcomes Sought

The conference was in agreement on the following priority outcomes for alcohol and drug treatment:

**General treatment goals**
- To reduce the harm to and promote the health of all people with alcohol and drug problems
- To maintain changed behaviour.

**Whole population goals**
- To improve the health of all who receive treatment
- To improve the understanding New Zealanders have of drug and alcohol problems and their treatment, and in this way, to reduce the stigma attached to them.

**Whole population objectives**
- achieve greater recognition of the needs of those requiring treatment
- reduce the social cost to the community of alcohol and drug problems
- reduce the numbers of fatal road accidents
- reduce alcohol and drug related crimes
- reduce the transmission of blood borne viruses (especially HIV, Hepatitis B & C), and STD among injecting drug users
- reduce the incidence of injecting drug use
- improve the work place performance and productivity of those formerly affected by alcohol and drug problems
- reduce the incidence of liver cirrhosis
- reduce the incidence of STD/HIV by adopting safer sex guidelines.

**Treatment outcomes**
- improve the identification of people with alcohol and drug problems
- lower the incidence of relapse
- improve the safety of injecting behaviours
- reduce or eliminate injecting drug use
• achieve cost effective alcohol and drug treatment services.

Process outcomes

• greater use of early intervention skills in the assessment and treatment of alcohol and drug problems

• increased family/whanau and community support for people in treatment, and for those with chronic dependencies

• abstinence to be the ideal short-term goal for those with moderate to severe alcohol and drug dependence.

Clinical practice should be flexible enough to take account of the degree of problem severity, the type of drug, and the patient’s readiness to change. (Opioid dependence is a special case where abstinence may not be achieved before a number of years of methadone maintenance and withdrawal treatment.)

Outcomes for the individual client

• the consumer has greater autonomy, dignity, and self awareness as a result of negotiated treatment

• the consumer makes choices based on relevant up to date information about alcohol and drug problems and their management

• individuals in treatment will have more opportunities to make changes in their lives

• individuals will have the skills to deal with their own alcohol and drug problems in the future (self-treatment and relapse prevention)

• clients from diverse cultures experience intercultural tolerance, and have a strong sense of cultural identification. These clients will have access to culturally safe practices.
Access to Treatment and Referral

Conference panellists were concerned that:

• information available to the public about alcohol and drug services is often inadequate
• waiting lists impede access to services
• alcohol and drug service providers market their services poorly
• clients are sometimes referred to services when other services are more appropriate.

In general, conference panellists thought there was a real lack of information about how to gain access to existing alcohol and drug services. Sometimes clients were concerned about confidentiality of information and were reluctant to be referred to other services if they thought sensitive personal information might not be respected. There was a strong feeling that primary care workers were poorly resourced to assess and treat people with alcohol and drug problems and that there should be more training opportunities for this group.

Conference panellists were of the view that “self-referred” clients, who often had mild or moderate alcohol and drug problems, would be more properly managed by primary care providers, (eg general practitioners, school guidance counsellors, community corrections officers). They thought there should be a distinction between primary care, and specialist secondary services. This would mean that secondary level providers would not assess and treat all self-referred clients, but instead they would give priority to the assessment and treatment of those clients referred by primary care providers. While there was not unanimous approval for this idea, it was accepted as an important principle.

General practitioners and other primary health care workers in rural areas are generally unable to refer their patients to the variety of services available in cities. Distance and lack of supportive and affordable accommodation limits access to treatment/care for the rural alcohol and drug client, especially to outpatient facilities. It is also difficult for general practitioners to get urgent help for their alcohol and drug dependent patients. Some primary health care workers require additional skills to work more effectively with alcohol and drug patients.

In order for services to be placed in either primary or secondary care categories, service providers would need to be very clear about their core business and the skills and training needs of the staff, and market their services accordingly.
Some panellists thought that in rural or poorly resourced locations, it would be inappropriate to try to make a distinction between primary and secondary level services.

Recommendations

1. Funders and providers recognise (and sharpen) the distinction between the primary and secondary aspects of alcohol and drug treatment, improve the client’s access to primary care and be more discriminating about who should have access to secondary specialist care.

2. To reduce waiting lists and improve access to services, treatment providers refocus on the importance of discharge planning in the context of overall treatment planning for each individual and their family/whanau.
Assessment and Case Management

Adequate and appropriate assessment is a priority in the treatment process and involves a total health and social evaluation. The panel recognised that different kinds of assessment should be available for different client needs. For instance, not all clients would need the "ideal" comprehensive assessment, including objective assessment of mental state, full medical and physical examination. At the primary care level, a briefer assessment would generally be sufficient.

It was agreed that, broadly speaking, there are three kinds of assessments:

- screening assessment (usually at a primary health care level)
- comprehensive assessment with a physical examination, when appropriate (ie when patients are referred to a secondary level service)
- ongoing monitoring assessments.

Panellists agreed that:

- the needs of the client come first in assessment and not the needs of the provider
- cultural safety must be addressed during the assessment—"appropriate cultural workers should be part of the assessment team"
- assessments must conclude with "clear diagnostic formulations and suggestions for management"
- diagnostic formulations and treatment plans should be fed back to, and understood by clients
- assessment reports must be written
- assessments should be made by workers competent and skilled in assessment and knowledgeable about the services available in their regions
- assessments are the beginning of therapy, and the beginning of a therapeutic relationship. Continuity, from assessment throughout the rehabilitation process, may have an important impact on treatment outcomes.

The consensus of the panel was that:

- there was a need for increased rigour in assessment and referral. Special attention needs to be paid to defining the nature of the alcohol and drug dependency problem, and its relationship to other dependencies or disorders (psychiatric disorder, eating disorder, pathological gambling)
when a specialist secondary service is involved, a comprehensive assessment must always be made. Comprehensive assessments, by definition, involve close liaison with referring agencies.

Currently the treatment needs of clients with alcohol and drug dependence are neither independently assessed nor independently matched to services. The client is “captured” by the service provider undertaking the assessment and may remain with that service for the duration of treatment. The conference discussed whether assessments should be undertaken by objective assessors who would refer clients to the most appropriate treatment service. Some panellists thought case management should also be provided independently of any one assessment or treatment service.

It was agreed that no single alcohol and drug service provider is always able to deliver the variety of treatment options that clients may require as the treatment process proceeds (e.g., detoxification, assessment, outpatient, day patient or residential treatment services, case management or co-ordination of ongoing support). This is especially the case for clients in less well resourced, mostly rural, areas where there is limited access to services and little or no chance of independent assessment or case management.

Recommendations

1. Community based outpatient alcohol and drug services should remain the entry point for assessment. The matching of clients to treatment and case management planning should also take place within such community based services. There should be some flexibility in the implementation of this recommendation for that group of rural alcohol and drug clients who have limited access to community based alcohol and drug services.

2. Clients must be fully involved in decisions about their case management and treatment.

3. Training must be made available to increase the assessment competency of all workers and particularly those at the primary care level.

4. Pilot projects be funded for the training of primary care providers in alcohol and drug assessment. An example is the Asthma Action programme in General Practice.

5. Clients referred to gazetted treatment centres for assessment under Section 30A, Transport Act, always undergo a comprehensive alcohol and drug assessment.

6. This conference fully supports the work of the New Zealand Accreditation Board in the maintenance of high standards for the alcohol and drug assessment field.
National and Regional Planning

Historically alcohol and drug services have been established on an ad hoc basis in most regions without the benefit of any national alcohol and drug policy. The Alcohol Advisory Council has played an important role in co-ordinating training at local, regional and national levels, and has supported the setting up of tertiary alcohol and drug training courses. Local and regional co-ordinating councils have, with varying degrees of success, attempted to co-ordinate the development of services during the last ten to fifteen years.

The meeting was strongly of the opinion that New Zealand now requires a national alcohol and drug policy supported by politicians and bureaucrats at the highest level, and supported by workers in the field, and by the clients of alcohol and drug services.

Such a policy would ideally spell out prevention, treatment, and research plans. It would thereby enable Regional Health Authorities, Crown Health Enterprises, educational establishments, the Alcohol Advisory Council, the Public Health Commission, the Drugs Advisory Committee community-based organisations and the breweries to work more closely together to identify service provision, training needs and research gaps.

Until New Zealand does have a national alcohol and drug policy, the conference recommended that RHAs continue to fund current essential services, namely:

- assessment and detoxification services
- outpatient/day patient treatment
- residential treatment,

with each RHA able to make provision for services for the special needs groups identified in this report.
Residential Treatment

The panel reviewed the status of residential care in New Zealand and found there were four main residential care categories.

1. Continuing and intermittent care

This is generally offered to clients with chronic alcohol and drug dependence with a previous history of unsuccessful residential treatment. This form of residential care will offer clients the significant periods of abstinence they require, given the risk of further serious neurological and other consequences of any continued consumption of alcohol or drugs. Clients of these services have usually exhausted their social networks and have previously shown little gain from outpatient residential and short-term treatment. (This level of care provides treatment of lower intensity than 3 below.)

2. Long-term care

Primarily for clients, with alcohol related brain damage. This service is available in some areas to clients who are neurologically damaged and not amenable to other forms of alcohol and drug treatment. Increasingly, such clients remain in the community in supportive accommodation such as boarding houses and rest homes.

3. Long-term residential treatment (six months or more)

Therapeutic Communities will generally treat those people with severe alcohol and drug dependence, who have histories of criminality and legal problems and/or anti-social personality disorders, a history of family disruption and poor family support and often significant mood problems and other psychiatric conditions. Research shows that Therapeutic Community programmes may fail if the residents' reintegration into their own community is not well managed. Therapeutic Community programmes involve residents in habilitation (rather than rehabilitation) and in an intensive resocialising experience within a behavioural programme.

4. Short-term residential treatment

The conference considered that short-term residential treatment could be divided into three categories:

- more than three weeks
- less than three weeks
- intermittent, including hospital care for clients with acute alcohol and drug related psychiatric or physical disorders.
The panel heard that programmes of more than three weeks duration (except Therapeutic Communities) had not generally demonstrated greater benefits for their clients over outpatient non-residential programmes. However, panellists thought that short-term programmes of less than three weeks should be available for clients requiring respite (time out) from damaging social and family environments. Such respite services provide a practical and humane response to the needs of some clients but, to be productive, they need to be part of a treatment package of case managed services including outpatient and day patient care. There were obvious gains, in the short-term at least, from this form of treatment (including for the client’s family). For some clients it may also provide an opportunity for a comprehensive assessment which would be difficult to achieve in an outpatient setting.

It was recognised that shorter-term residential care may be less disruptive to family life and careers, than long-term residential treatment.

It was clear that clients in rural areas would continue to want access to short-term residential care in the absence of adequate rural outpatient and day patient services.

The panellists agreed that the following criteria should apply in selecting clients for admission to short-term residential care:

- clients would have been detoxified
- clients would have been comprehensively assessed
- clients would have moderate-severe alcohol and drug dependence. Outpatient treatment approaches would have been attempted prior to the admission (except, perhaps, where clients from rural areas have limited access to outpatient services)
- preference for admission would be given to people with severe life crises involving significant family and work disruption
- clients would have full cognitive functioning
- clients would not have a current diagnosis of active anti-social personality disorder and/or current severely disruptive behaviour
- clients would not be currently psychotic or suicidal
- clients should be able to demonstrate the presence of post treatment support from an alcohol and drug treatment agency, as well as family and the community.

The conference was aware that within treatment services there exists a “hierarchy” which often assumes that the pinnacle in the treatment process is completion of a reputable residential programme. However, the conference was of the view that various treatment services should be accessible to clients in the context of a care plan or rehabilitation package, which might include detoxification, day or outpatient treatment.
and residential treatment, as well as after care. Each of these treatments should be a valid and necessary intervention and in combination provide the treatment required to effect and maintain a change.

Clearly some programmes would always be regarded in some circles as exceptional. However, the conference advocated a change in the alcohol and drug treatment culture in New Zealand which would see clients, services, workers and the community acknowledging the place of a variety of appropriate and effective treatment options. It was again expected that there be interlinked “episodes of care” as part of a rehabilitation package for each individual. Such a package could include comprehensive assessment, detoxification, short-term (respite) residential care, day patient and outpatient services, after care and ongoing rehabilitation. Such a package might span 12-24 months.

Some panellists thought RHAs should fund treatment services by purchasing rehabilitation packages for individuals which would include the above treatment components. Other components when shown to be effective might include, for example, cognitive/behavioural and psychodynamic psychotherapy, Maori alcohol and drug programmes, Outward Bound or similar courses. It was anticipated that the RHAs would want to evaluate such programmes using treatment outcome research techniques.

Panellists agreed there should be ready access for all clients to a range of detoxification services—though not necessarily in each region—including dedicated acute hospital detoxification beds, home and social detoxification. The conference was concerned that social detoxification services are often unavailable, and insisted that RHAs must fund such services. Remand and sentenced inmates with alcohol and other drug dependence, including narcotic dependence, frequently detoxify uncomfortably in prison cells with poor recognition of their needs. Measures to improve services to prison inmates would include the careful assessment of alcohol and drug problems when inmates enter the prison system; training of prison medical and nursing staff; access to appropriate Methadone withdrawal and maintenance programmes; and improved liaison with alcohol and drug agencies.

The Department of Social Welfare benefits received by patients attending different residential treatment programmes vary. In some programmes, the patient receives a full unabated benefit for up to 13 weeks, while in other programmes the benefit is reduced after two weeks, although the patient has limited access to the balance of the benefit entitlement for up to 52 weeks as a rehabilitation grant at the end of treatment. In some programmes, almost all the benefit is paid as “board” with the patient only having access to a “comfort allowance”.

Regional Health Authorities now purchase treatment services from all these residential programmes on an equal basis. The continuing anomalies in benefit payments create unintended competitive advantages (and disadvantages) for some centres.
Recommendations

1. A variety of residential treatment programmes should be purchased by RHAs and continue to be available throughout New Zealand.

2. Good access be available in each RHA region to longer term residential care and especially to Therapeutic Community care. The emphasis in such treatment should be on habilitation rather than rehabilitation. (It was agreed that each RHA should gather data on the need in each region for such services).

3. Clients with a chronic dependency (including brain damage) who have a history of unsuccessful residential treatment should have access to continuing and intermittent supportive care.

4. There is a place for long-term Therapeutic Community programmes and supportive residential care for clients with disabilities associated with alcohol and drug disorders.

5. On the basis of the literature and expert opinion presented at the conference, panellists accepted that short-term residential treatment (following detoxification) of greater than three weeks duration could not be supported.

6. Halfway houses are an important part of the continuum of care, and must continue as a post-treatment (low cost residential and non-residential) supportive option for care.

7. The Department of Social Welfare and the Ministry of Health ensure changes are made so that the benefit entitlements for patients of all residential treatment programmes are the same.

8. RHAs should ensure that a range of detoxification services is available including specialist hospital beds, social detoxification facilities and home detoxification.
Methadone Services

The conference was satisfied that high quality methadone services result in good outcomes for clients. There are now plentiful research findings pointing to the efficacy of methadone maintenance treatment and the importance of proper attention to dose and retention issues.

It was agreed that properly resourced methadone treatment is a relatively inexpensive way of reducing crime, reducing illicit drug use, improving family and employment stability, and reducing the transmission of HIV and other blood borne viruses.

Panellists were concerned that no one should enter a methadone programme without a comprehensive drug and alcohol assessment and without clear evidence of physiological dependence on opiates.

Panellists understood that despite the research evidence for the efficacy of methadone, and its relatively low cost, there were still large gaps in service provision throughout New Zealand, with methadone services frequently struggling with long waiting lists and insufficient staff. Methadone client numbers have continued to grow in recent years, and in some areas, clients must wait more than six months before entering the programmes. Research also shows that there is marked variability in outcomes depending on the quality of the service available.

The following service quality issues were identified:

- clients' ability to access skilled counselling (including crisis intervention counselling)
- whether counsellors have sufficient skills and expertise to deliver these counselling services
- clients' access to social skills learning, employment, accommodation, and general social welfare advice.

Panellists thought that the Justice Department should contribute to overall methadone service funding given the shared responsibility both Health and Justice demonstrably have in this area.

The conference acknowledged that almost all methadone programmes in New Zealand are now guided by harm reduction philosophies which recognise that abstinence will be a long-term goal for most clients.

The conference also acknowledged that service providers need to work harder to make their services more user friendly to clients who don't wish to abstain from injecting drug use.
The conference recognised that there are probably large numbers of “recreational” drug users who from time to time use alcohol and drug services but who, in general terms, do not consider themselves drug dependent.

Accordingly, the conference wished to make the following statement—"that it is legitimate for treatment services to work with clients who wish, without an abstinence goal, to make an established pattern of injecting or other drug use safer”.

**Recommendations**

1. RHAs provide additional funding to methadone programmes in order to reduce waiting lists, improve service quality and thereby ensure that blood-borne virus transmission is further reduced.

2. The existing National Methadone Protocol be a guide for methadone programme providers.

3. The Justice Department contribute to methadone service funding.
Special Needs Groups

Justice Department clients

The panellists noted that while there was a long standing positive relationship between the Justice Department’s Community Corrections Services and alcohol and drug services, there continued to be difficulties in organising care when clients were sentenced to prison. Frequently there was poor continuity of care, especially for methadone clients, from outpatient services through prison services, and beyond, including after-care planning and delivery.

Conference panellists considered that there should be a commonality of assessment content and process for both Justice and non-Justice alcohol and drug services, based on common understanding of which assessment and treatment forms work best.

The provision of alcohol and drug services to prison inmates is inadequate in many localities and there is ongoing ambivalence within the Justice Department about the provision of even short-term methadone for detoxification to prison inmates.

The panellists thought that continuity of care problems would be enormously assisted by increased numbers of skilled alcohol and drug counsellors and educators in prisons and by enabling the prescribing and dispensing of methadone in prisons.

Women

Panellists were concerned that the special needs of women in treatment were often not addressed by alcohol and drug agencies, and that, in general, agencies should devote more of their resources to women and their families. Many panellists reported an increase in the number of women, especially younger women, being referred for treatment, and the growing recognition that women’s alcohol and drug problems were different from their male counterparts.

The Conference acknowledged that women working in the alcohol and drug treatment field are increasingly providing a range of services to meet the needs of their women clients.

Some of the issues of special concern for women in alcohol and drug treatment are:

- poor support from family/whanau and employers for women’s alcohol and drug rehabilitation
- lack of autonomy and financial independence
• poor access to childcare
• poor self esteem aided by feelings of rejection and guilt about alcohol and drug problems
• history of sexual or other abuse
• polydrug problems
• eating disorders
• pregnancy.

Older people

Conference panellists were aware that older people make up a small proportion of total referrals to alcohol and drug agencies. However, in future years, with larger numbers of older people in the community, alcohol and drug treatment services should expect greater numbers of referrals of older people.

Health care professionals have often ignored or underestimated the significance of alcohol and drug problems in their older clients, but these problems in older people deserve the same response as those in any other client group, as alcohol and drug problems have a marked effect on the health of older people and on their families.

People with gambling disorders

Conference panellists debated at some length whether or not pathological gambling should be treated as part of substance abuse services. They heard that some alcohol and drug programmes readily treat clients with gambling disorders while others treat only clients with alcohol and drug problems. The majority of services work with people whose gambling problems are secondary to their alcohol and drug problems. The Conference panellists’ position was that alcohol and drug treatment should remain primarily focused on alcohol and drug problems. Where pathological gambling is the primary problem for the client at assessment, the majority of alcohol and drug services will continue to refer their clients on to gambling addiction services. It was noted that when clients have primary eating disorders, clinical depression, and/or anxiety disorders, they are also generally referred elsewhere to other specialist services.

The following statement was supported by most panellists of the consensus conference—"that gambling is a serious problem which needs to be addressed, but not as part of the primary business of alcohol and drug services".
Younger people

Panellists reported increasing numbers of younger people being referred for treatment. Many services had begun providing special programmes for these younger clients with some providing mainly outdoor activities while others offered counselling and family therapy or group work. There was an acknowledgment that amongst younger people, many Maori and Pacific Island clients were still not able to access treatment as easily as their Pakeha counterparts. As well, there were access problems for rural young people compared to those who lived in towns and cities. Programmes for younger people have been set up not only because of increases in client numbers but also because adult programmes are often not suitable for young people.

Research has shown that young people tended to “bring all their problems to their alcohol and drug abuse” which in turn maintains and exacerbates pre-existing problems such as eating disorders and truanting. The meeting agreed that young people’s problems should always be viewed systemically and holistically, not in isolation.

Some panellists considered that if a younger person presented with significant alcohol and drug problems, he/she would almost certainly be experiencing conduct disorder problems, sexuality problems, depression, and family dysfunction. Alcohol and drug services for young people should therefore be planned in conjunction with other appropriate services including Child and Family clinics, eating disorder units etc.

Maori and Pacific Island clients

The conference recognised that other ethnic minorities, including increasing numbers of people belonging to refugee communities, will need programmes designed according to their own special needs. A separate report was prepared by the Maori members of the conference (see Appendix 2).

Alcohol and other drug problems have significantly contributed to the destruction of Maori wellness, self esteem and cultural autonomy. There continues to be a predominance of Maori males amongst the heaviest drinkers. The conference endorsed the following:

- Maori must be involved from the outset in the development, implementation, monitoring and evaluation of all service contracts
- Maori should be consulted on a regional or iwi basis about the location of services for Maori people
- The development of criteria to evaluate and monitor Maori services should be determined with Maori providers
The education of all alcohol and drug workers in New Zealand should include issues relating to the Treaty of Waitangi in basic and post-graduate courses and as part of ongoing staff training and development.

Services should have policies and procedures in place enabling the delivery of culturally appropriate services to Maori.

Services should provide adequate numbers of appropriately trained staff who practise in a culturally safe manner.

A Pacific Island panellist stated that alcohol and drug agencies should always take into consideration differing cultural values and beliefs and the conference endorsed the following:

- the interpretation of these values and beliefs must be undertaken by knowledgeable cultural advisers
- there should be placement of Liaison Cultural Advisers in treatment institutions to monitor progress
- traditional healers should be used when appropriate
- there should be a register of traditional healers and healing practices
- research should be undertaken on drug and alcohol use and abuse by Pacific Island people
- interpreters should be readily available whenever necessary.

Lesbian and Gay clients

The conference noted that the special needs of lesbian and gay clients are now better understood by most alcohol and drug services and that changes in alcohol and drug worker attitudes have occurred alongside legislative reform. Also contributing to changed attitudes in treatment settings are the ALAC publication *Making Visible* and national conferences for gay and lesbian alcohol and drug workers.

The conference also noted tertiary training for alcohol and drug workers now includes material on the particular problems gay and lesbian clients bring to treatment including: family and community discrimination, polydrug dependencies and relationship difficulty. However, there is a paucity of ongoing training in treatment centres, and a failure to acknowledge or affirm gay and lesbian clients in some treatment settings.
Recommendations

1. Competent comprehensive assessments be available to Justice Department clients.

2. Alcohol and drug workers in non Justice settings continue to work in the closest possible co-operation with Justice Department staff to ensure adequate continuity of care for their shared clients.

3. Alcohol and drug workers must be competent to assess for gambling problems as part of a comprehensive alcohol and drug assessment.

4. Alcohol and drug services for young people should be planned regionally in co-operation with a range of other appropriate services.

5. Emphasis must be placed on skilled comprehensive assessments of young people’s alcohol and drug and other problems.

6. RHAs must purchase services which provide for special needs groups.

7. RHAs’ purchasing plans for special needs groups must be flexible enough to respond to, and provide for, the special needs of various groups as needs arise.
Quality Assurance

In recent years increasing demands have been placed on alcohol and drug agencies to improve the quality of all their services by paying greater attention to culturally safe practices, staff training and supervision, service audits and evaluations, service policies and procedures, and consumer involvement in service planning and evaluation.

Increasingly, funding bodies require agencies to provide real evidence that quality assurance measures are in place and working before funding is considered.

These and other quality assurance measures were endorsed as essential by the conference panellists who observed that quality services are not “bits of paper” in the form of policies, procedures and training manuals, but are achieved by competent and experienced staff whose work is regularly appraised.

The conference was aware that in general terms training is continuing to fall behind the skills required in the field. In the majority of treatment services, in-service training is poorly resourced and has low priority, due mostly to the enormous pressures on staff to respond to the demands of day to day clinical work. The general view was that there is currently no organisation in New Zealand properly able to teach clinical skills in the assessment and management of alcohol and drug problems to the secondary specialised service being offered by increasing numbers of alcohol and drug agencies. These agencies are asked on a daily basis to give expert advice and consultation to a wide variety of colleagues on complex alcohol and drug assessment and treatment matters.

It was agreed that increased funding must be made available for the training of primary care workers (including general practitioners) in the assessment of alcohol and drug problems.

Recommendations

1. RHAs and other purchasing bodies provide increased funding to alcohol and drug agencies for staff training, for in-service training and regular attendance at seminars and appropriate courses of study.

2. RHA funding should favour those alcohol and drug agencies which develop valid standardised performance measures for their alcohol and drug services.

3. RHA funding should favour agencies which demonstrate meaningful consumer input into the design and delivery of their services—“consumer voices must be heard”.

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4. RHAs and treatment agencies continue to support and encourage the positive contribution the New Zealand Accreditation Board for Alcohol and Drug Services has made to the development of optimum standards of assessment and treatment in alcohol and drug services.
Appendix 1

List of panellists

Project Manager
Kate Cosgriff
Alcohol and Drug Services
Western Bay of Plenty
Private Bag 12024
Tauranga
(unable to attend due to family bereavement)

Clinical Co-ordinator
Geoff Robinson
Alcohol and Drug Services
Capital Coast Health
265 Adelaide Rd
Wellington

Panellists
Takatu Ahomiro
Te Rangimarie Trust
PO Box 406
Te Puke
Janne Bills
Rotherham Medical Centre
Wilkin Street
Rotherham
North Canterbury
John Challis
Odyssey House
PO Box 19403
Avondale
Auckland

Report Writer
Neil Thornton
Alcohol and Drug Services
Capital Coast Health
265 Adelaide Rd
Wellington

Clinical Co-ordinator
Doug Sellman
Department of Psychological Medicine
School of Medicine
Private Bag
Christchurch

Panellists
Daryle Deering
Community Alcohol and Drug Centre
262 Armagh Street
Christchurch

Dr Leopino Foliaki
26 Main Highway
Ellerslie
Auckland

John Hannifin
71 Jickell Street
Palmerston North

Robert Kemp
NZAIDS Foundation
PO Box 6663
Wellesly Street
Auckland
Appendix 2

Maori perspective

The Maori view of health embraces a holistic philosophy in which health and sickness are seen as being inseparable from the spiritual family, with environmental as well as physical dimensions. The alienation of many Maori people from their cultural roots, land, tribal, whanau systems, language and customs has been blamed for a wide range of problems. Alcohol abuse is but one problem, although it has played a major role in destroying the self esteem, independence and wellness of Maori.

- Available statistics suggest that Maori people suffer excessive morbidity and mortality from alcohol related causes.
- During the 1970's, the estimated Maori alcohol related death rate was 75% higher than non-Maori.
- Age standardised rates for the period 1980-84 show alcohol related deaths including alcoholic cirrhosis to be 2.5 times greater in Maori males than non Maori.
- Alcohol is the commonest cause of admission of Maori males to mental hospitals and rates have increased four-fold since 1970.
- Motor vehicle accidents are the most common cause of admission for Maori people to hospital and the cause of an excessive number of deaths.
- About half of all fatalities from road crashes are alcohol related and the rate of Maori arrests for drink driving is four to five times higher than the non Maori rate.
- The gazetted assessment centres in Auckland have cited a significant increase in the number of older (45 years and older) Maori males presenting under section 30A, Ministry of Transport referrals.
- Maori drinkers also reported drinking less frequently on average than did non Maori drinkers, but the amount consumed during a drinking session was nearly twice as much as non Maori. In terms of alcohol consumption, a 1978 survey indicated that a smaller proportion of Maori people were regular drinkers than was the case with non Maori.
- Alcohol exacts a heavy toll on the Maori community from young to old.
- Maori women by comparison are not heavy drinkers; indeed, four out of 10 in a large survey carried out by the Maori Women’s Welfare League were found to be
non drinkers. However, in 20% of young urban Maori women, drinking was heavy as gauged by the consumption of more than five bottles of beer regularly at one time. The consumption of alcohol by young Maori women was twice as much as non Maori women.

Perhaps more disturbing though, is the high prevalence of alcohol consumption in New Zealand secondary school children, particularly males, and the fact that there is a predominance of Maori males amongst the heaviest drinkers.

Maori health

Probably the most comprehensive description of Government’s objectives for Maori health is contained in Whaia te ora mo te iwi, a government statement circulated as a response to Maori issues in the health sector. In a foreword, the Minister of Health emphasised that the government “regards the Treaty of Waitangi as the founding document of New Zealand, and acknowledges that government must meet the health needs of Maori and help address the improvements of their health status.” Despite the absence of a Treaty statement in the Ministry of Health’s Corporate Plan, Whaia te ora mo te iwi spelled out Government responses to Maori health in a number of critical areas

(1) “A statement requiring the new health agencies, Crown Health Enterprises, the Public Health Commission and Regional Health Authorities, to utilise the surplus land protection mechanism which is being developed, will be inserted in the instructions covering the transfer of assets to these entities.”

(2) “Specific reference is made to the special needs of Maori in Section 8(e) of the Health and Disability Services Act, in respect of which the Crown may give to a purchaser written notice of the Crown’s social and other objectives.”

(3) “The Government will ensure that all health sector agencies are required, through the Statements of Intent and the contractual and administrative arrangements outlined in the Act, to reflect Government’s commitment to improve Maori health.”

(4) “The Government will encourage the participation of Maori in the health sector through the “Good employer” provisions of the Health and Disability Services Act.”

Treaty of Waitangi

Arising from the decade of Maori development, the Treaty of Waitangi has been promoted as a suitable framework within which to consider social and economic development. Though essentially a political statement, Maori have come to regard the Treaty as a statement of individual and collective rights, a charter for New Zealand as a whole, and a reminder to the Government of its obligations in respect of Maori people.
Treaty provisions

There are three key Treaty provisions each derived from an article of the Treaty. The first, *kawanatanga*, is from article one. It is a provision for the Government to govern and is relevant not only to central government but also to agencies of state, regional government, state owned enterprises and Crown Health Enterprises.

The second key provision is *tino rangatiratanga* (article two) which provides for tribes to exercise authority in respect of their own affairs. The term ‘tino rangatiratanga’ is loosely applied to Maori people generally, in the pursuit of greater Maori autonomy. However, the provision, tino rangatiratanga, is at its strongest when it refers to the position of iwi/hapu as tangata whenua in a particular area or region. A characteristic of tino rangatiratanga is iwi autonomy.

The third key provision is *oritetanga*, a provision which stems from article three and guarantees equity between Maori individuals and other New Zealanders.

Treaty principles

The three Treaty principles are *partnership, participation* and *active protection*.

Partnership refers to an ongoing relationship between the Crown or its agencies and iwi. A partnership with one iwi does not exclude a partnership with others, nor should it be presumed that one iwi can speak for another. Iwi may organise as Maori Trust Boards, Runanga or Incorporated Societies. Within a single iwi there may be more than one constituted authority and a prerequisite for the implementation of any partnership is the prior identification of the appropriate authority as well as the identification of iwi in the area/region who are tangata whenua.

Participation is a principle which emphasises positive Maori involvement in all aspects of New Zealand society. There are at least three levels of participation: participation by Maori individuals (who may or may not hold a mandate), participation by iwi or hapu, and participation by invitation (but without necessarily a right to vote on all matters).

Active protection, the third principle, creates an obligation on the Crown to actively protect Maori interests. In health terms active protection is essentially about health promotion and preventive strategies and implies that the State will adopt proactive approaches and seek opportunities for the enhancement of Maori health.

A combination of Treaty provisions and Treaty principles can be used as the basis for a framework in which Maori health objectives can be realised. This dual focussed framework (provisions and principles) provides a sufficiently encompassing template for the development of strategies that will achieve gains in Maori health.
Treaty practice

- That Maori people be involved from the outset in the development, implementation, monitoring and evaluation of all contracts and that this becomes a statutory obligation.
- That a policy be established of assisting stable Maori health initiatives to succeed until such groups are able to demonstrate that they can continue to succeed without further support.
- That Maori be consulted on a regional or iwi basis about the location of services to be delivered to Maori people.
- That the development of criteria to evaluate and monitor Maori services needs to be determined with Maori providers.
- That education of all alcohol and drug workers should include issues relating to the Treaty of Waitangi and health development and practice in New Zealand in basic and post-graduate courses and as part of ongoing staff development.

Cultural safety

Cultural safety relates to the Maori desire to define, protect and preserve tino rangatiratanga. Sensitivity, awareness, appropriateness and acceptability are all components of cultural safety. Cultural safety in health occurs when people feel fully able to use health services provided by people of another culture without risk to their own culture.

Alcohol and drug services will be culturally safe by provision of all of the following:

- Services’ definition, design and delivery are consistent and non-threatening to the cultural values of all individuals or groups who use them
- Services have policies and procedures in place which enable the delivery of culturally appropriate services to Maori
- Services develop effective consultative relationships with Maori consumers and/or local iwi and, in this way, ensure the cultural needs of Maori are met
- Services ensure that all staff are aware of the impact of their own culture upon people from other cultures, particularly Maori
- Services provide adequate numbers of appropriately trained staff who practise in a culturally safe manner, to meet the needs of Maori.
Appendix 3

Pacific Island perspective

Important cultural issues to remember in drawing up final recommendations of the consensus conference.

Pacific Islanders: Alcohol agencies have a responsibility to ensure that clients are not discriminated against while using their services—this can be achieved by:

1. Use of good interpreters whenever necessary
2. Cultural values and traditional beliefs must always be taken into consideration
3. Interpretation of values and beliefs must be done by knowledgeable cultural advisors
4. Placement of a Liaison Cultural Advisor in institutions providing treatments and monitoring progress
5. Use of traditional healers, for example Tohunga, Taulasea and Faito’o when appropriate
6. Properly organised research on drug and alcohol use and abuse by Pacific Islanders
7. Register of Traditional Healing Practices.
Appendix Four

Bibliography


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The treatment of people using and alcohol