



Northern DHB Support Agency

**On behalf of
Network North Coalition**

**A Review of
Detoxification Services in Auckland and
Northland Regions**

November 2006

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Network North Coalition

The establishment of Network North Coalition in 2003 provided an opportunity for the Northern Region District Health Boards (DHBs) to identify its' key priority areas for service development and improvement. Six workstreams were established to identify the key issues that informed the development of the Northern Region Mental Health and Addictions Services Strategic Direction 2005-2010.

These workstreams are – Older People, Adult, Child and Youth, Alcohol and Other Drugs, Primary Care and Information Systems. Each workstream identified their key areas for service development and improvement, which have informed the commissioning of a number of projects.

One of the strategic priorities for the Alcohol and Other Drugs (AOD) workstream is to formulate a regional inter-sectoral approach and establish regional benchmarks for detoxification services in the Northern Region.

Executive Summary

The review was established to formulate a regional inter-sectoral approach and establish regional benchmarks for Detoxification Services in Northland and Auckland, with emphasis on the following:

- A regional approach to detoxification services
- Inter and intra agency working
- Improved access
- Review service configurations

To achieve these objectives a Project Manager was commissioned to undertake the work programme, who was assisted by a reference group comprised of both specialist alcohol and other drug services, and a wider range of related health, social and law enforcement services. This group met on four occasions to consider, and comment, on the findings.

Interviews were held with a range of professionals from services that provide detoxification and services that are affected by persons presenting with intoxication.

Consumers who have used detoxification services and other alcohol and drug services were also interviewed.

The review considers the Mental Health Commission's Blueprint recommendations for alcohol and other drugs (AOD) detoxification services and evaluates these against the existing detoxification services and service demand in the Auckland and Northland regions.

The review shows that detoxification services fall short of the recommended "Blueprint" resources.

In addition, there is evidence that the five hospitals in Auckland and Northland admit significant numbers of people requiring withdrawal management and related alcohol and drug problems. The review indicates that currently hospital staff is poorly equipped to manage these people and that improvements in terms of efficiency and quality of services can be made.

Emphasis in this review has been placed on improving and strengthening community detox resources as opposed to major restructuring of services. The review promotes better access to detoxification services through better coordination with mental health and hospital settings.

This review recognises that a wide range of services come in to contact and provide care for intoxicated persons such as the police and homeless services. Recommendations are provided to address these issues however, for the purpose of this review emphasis has been placed on the services that provide detoxification for people who are dependent on alcohol and other drugs and require withdrawal management.

Summary of Recommendations

1. Provide contracted community services in Northland for people requiring social and medical detoxification. These services will provide an additional AOD nurse/practitioner FTE in each area hospital alcohol and other drug service to provide medical and social detoxification services and improve management of alcohol dependent patients in area hospitals.
2. Increase community detox options in Auckland through improved service coordination.
3. Maximise the existing resources within the CADS Medical Detoxification Services by providing “day programmes and clinics”.
4. Place an alcohol and other drug (AOD) nurse in the psychiatric liaison teams in each of main hospitals in Auckland to improve management of alcohol and drug dependent patients.
5. Create a detoxification network across Auckland linking the AOD nurses (in the psychiatric liaison teams), the Auckland City Mission, CADS Inpatient Detox Unit and the CADS Community and Home Detox Service to form one co-ordinated access point.
6. Provide additional social work resource for CADS Detoxification Services and Northland AOD services to manage homelessness and other social issues.
7. Develop opportunities for AOD trained staff to provide AOD brief interventions to persons in police cells and emergency departments who are intoxicated.
8. Create formal links between CADS Auckland and Northland AOD services to facilitate access to Auckland CADS detoxification services for people in Northland who have complex poly drug dependencies who require inpatient detoxification.

Definitions and Terms

The following definitions and key terms are used throughout this report.

- **Prevalence of alcohol and drug disorders**
The prevalence of alcohol and drug disorders is estimate at 3.5 % of the adult population in the New Zealand Mental health Epidemiological Study. Very few of these individuals will require a medical or social detoxification.
- **Rehabilitation for alcohol and drug disorders**
The recovery process from alcohol and drug disorders is the transition form a maladaptive pattern of alcohol and drug use to controlled use, or abstinence, resulting in significant improved health, social and psychological functioning. Detoxification alone does not support long-term controlled use or abstinence. For chronic dependence detoxification may be necessary first step in the rehabilitation process, but will need to be followed up with changes in life style, psychological functioning, and social environment before a sustainable recovery is achieved.
- **Substance Dependence**
Substance dependence occurs with daily, prolonged and increasing amounts of alcohol and/or other drugs. Dependence is defined as a maladaptive pattern of use, leading to clinically significant impairment or distress, as manifested by 3 (or more) of the symptoms listed in the DSM 1V manual. Physiological Substance Dependence is present if substance use is accompanied by symptoms of tolerance or withdrawal. Persons with a physiological dependence may require medical interventions to manage withdrawal during detoxification.
- **Detoxification**
Detoxification is required for those persons who are dependent on alcohol and or other drugs, who will experience withdrawal symptoms on cessation. It is a process of supportive care, which can contain a medical component and pharmacotherapy (substitution) to manage the withdrawal syndrome and assist the body to return to physiological normal levels of functioning. Withdrawal from some drugs can be life threatening e.g. alcohol.
- **Intoxication**
The development of a reversible substance specific syndrome, due to the recent ingestion of a substance e.g. alcohol. The specific clinical picture of substance intoxication varies dramatically among individuals and also depends on which substance is involved. The behaviour changes such as belligerence, mood lability, impaired judgement, impaired social or occupational functioning and cognitive impairment generally places individuals at significant adverse effects (accidents, violence, medical complications, social & family disruption, financial and legal problems). Intoxicated persons will not necessarily be dependent nor require detoxification.
- **Medical Detox**
Community or inpatient services that use pharmacological interventions to manage withdrawal. These services are provided by registered health care professionals including nurses and medical officers i.e. CADS Detox Services
- **Social Detox**
A residential service providing psychological and social support for people undergoing withdrawal who do not require pharmacological interventions i.e. Auckland City Mission Detox.
- **Community Detox**
A community detox is generally suitable for those clients free from serious health conditions and who have good social supports and may include medication to manage withdrawal. It is organised through a patient's General Practitioner in consultation with the CADS Community and Home Detox Service (CHDS). In some cases a CHDS Medical Officer may prescribe.
- **AOD**
Alcohol and other drugs
- **CADS**
Community Alcohol and Drug Services Auckland

- **CHDS**
CADS Community and Home Detox Service
- **IPU**
CADS Inpatient Detox Unit

Detoxification Services

The following services are contracted to or provide detoxification interventions to people who meet the criteria for substance dependence and require medical or social support to manage withdrawal symptoms. These services are not contracted to manage intoxicated persons.

Northland Detoxification Services (NDHB)

- No contract for the provision of detoxification services exists in Northland. Currently persons requiring alcohol detoxification are admitted to medical wards in Whangarei Base Hospital, or one of the four local hospitals, and supported by Northland Mental Health and Addiction Service, or they are admitted to the Auckland City Mission in Auckland. Other than in emergencies, there is currently no provision for medical detoxification for drugs other than alcohol in Northland.

Auckland Detoxification Services (WDHB, ADHB and CMDHB)

Currently there are 21 DHB contracted beds available in Auckland that provides designated detoxification services for a population of 1.3 million. These are provided by the Auckland City Mission and CADS. Auckland City Mission provides social detoxification and CADS provides medical detoxification services for Counties Manukau, Auckland and Waitemata District Health Boards. CADS are a WDHB service provider that covers WDHB, ADHB and CMDHB.

- **Auckland City Mission Federal Street Detox**
Auckland City Mission provides a 10 bed residential facility (Federal Street Detox) that provides social support for substance dependent persons who are withdrawing. This service is staffed 24 hours/day and does not provide medical intervention. If clients experience complications as a result of withdrawal they are referred to General Practitioner's in the local community or to the CADS Medical Detoxification Services. The service is not designed to manage people with acute psychotic symptoms.
- **CADS CHDS**
CADS CHDS is an outpatient service for persons requiring nursing, medical, and pharmacological interventions whilst withdrawing. The service operates Monday-Friday. The majority of outpatient care occurs in people's homes with the support of their GP (the client is required to pay GP costs).

CHDS also coordinates admissions and manage the waitlist for the CADS Inpatient Detox Unit.

- **CADS IPU**
CADS Inpatient Detox Unit is an 11 bed residential facility, for persons requiring medical, nursing and pharmacological interventions who are unable to safely withdraw in the community due to ill health, the likelihood of complications such as seizures or social reasons. The unit is staffed 24 hours/day by multidisciplinary health professionals. The service is not designed to manage people with acute psychotic symptoms.

Referral to IPU, CHDS and the Auckland City Mission is via self or by a health professional. On acceptance of the referral a booking is made for the next available admission date. During their detox clients are encouraged to engage with residential treatment programmes or community treatment and support options such as CADS, Salvation Army, Higher Ground, Odyssey House, Wings Trust, and AA/NA meetings in preparation for their discharge.

Contracted Detoxification Services in Northland and Auckland

Facility	Organisation	Actual number beds/ FTE's	Blueprint Guidelines	Admissions (05/06)	Access	Location
IPU	CADS, WDHB	11 actual (beds) contracted for 10	39 (for Medical and social beds)	403	Booked admissions	WDHB, ADHB, CMDHB
Federal Street Detox	Auckland City Mission	10 (beds)	Included in above	291	Booked admissions	WDHB, ADHB, CMDHB, NDHB
CHDS	CADS, WDHB	7 (FTE)	9.75	133	Mon-Fri.	WDHB, ADHB, CMDHB
Northland Mental Health and Addiction Services	NDHB	0 (beds) 0 (FTE)	4.2 (beds) 1.05 (community FTE)	64-70 (estimated)	Hospital	NDHB

The average length of stay in CADS IPU per admission is 8.2 days.

The Mental Health Commission Blueprint guidelines recommend three (3) detox inpatient beds (medical and social) per 100,000 population. This equates to 39 beds in Auckland, leaving an actual shortfall of 18 beds. In Northland (based on a population of 140,000) there is a shortfall of 4.2 beds.

The Blueprint guidelines for community detox services are 0.75 FTE per 100,000 population. Auckland Community and Home Detox Services are short 2.75 FTE's and Northland are short 1.05 FTE.

Stakeholder Consultation

Interviews were held with a range of professionals from the services that provide detoxification and the services that are affected by persons presenting with intoxication. Consumers who have used detoxification, and alcohol and drug services were also interviewed. Four main areas of concern emerged:

1. Access

Informants identified a need for improved co-ordinated access to medical and social detoxification services based on the following:

- The two Auckland based residential detoxification services have waiting lists.
- There is no inpatient or community detoxification services contracted in Northland.
- Accident and Emergency Departments, Mental Health Services, Homeless Services and the Police are dealing with substantial numbers of people suffering the effects of alcohol and drug misuse, and some of these people will require detoxification. These services do not have immediate access to the Northland and Auckland detoxification services.

There is no specialist facility for Northland clients who require medical interventions during withdrawal and they are unable to access Auckland CADS detox services. Northland Mental Health and Addiction Services support detoxification in the local NDHB hospitals or in the community in consultation with General Practitioners. The Northland region has access to Auckland City Mission for residential social detoxification. However this is less than ideal, as people are required to travel a minimum of two hours to access the service.

In Auckland barriers exist for CHDS. These include a lack of public awareness of their service, the financial cost to the patient for a visit a GP, a lack of social supports in the community, and the logistical constraints of a small team servicing the entire Auckland region.

The CHDS service has been working towards reducing these access barriers and has made significant improvements by increasing the number of community detoxes. Sixty-six people undertook a community detox over a 12 month period in 2004/05 and this was increased to 133 over the same period in 2005/06. Opportunities exist to further develop these services.

The waitlist for a booked admission to the IPU and Federal Street Detox varies between one to four weeks. Acute admissions can be arranged depending on acuity and availability of beds.

If the access barriers to community detox services were reduced and more people were provided with community detox options then the waitlist for residential services would be significantly further reduced. IPU and Federal Street Detox could be used more efficiently and provide services for those whose needs are more acute.

2. Service Co-ordination

• Detox Services

There are 21 specialist beds available to the Auckland region, managed by two organisations. They have different access criteria but have a great deal in common, most notably the people who need their services. Reducing waiting times could be achieved by streamlining their procedures, supported by other agencies. Further gains could be achieved in this area, through four initiatives, which are:

- Regular meetings between residential alcohol and drug services providers, CADS and Auckland City Mission to establish joint arrangements aimed initially at reducing waiting times.
- Establishment of a solution focused forum involving alcohol and other drug rehabilitation providers, with the purpose of identifying system blockages and implementing solutions.
- Promotion of community and home based detoxification interventions.

The two services have an occupancy rate in 80% - 100% range. This could be further enhanced, by admissions management, which fully utilises all the beds available, as well as increasing community

options. This practice is common within hospitals, and is focused on maximising resources to the greatest effect.

A short-term secondment to CADS and Auckland City Mission would allow this aspect to be further analysed, and more detailed recommendations to be made.

- **Mental Health Services**

There are high numbers of co-existing mental health and alcohol and other drug problems; studies show 50 to 80% of people accessing mental health services have a substance use problem. Both services report access barriers to each other's service.

The best practice approach to treating co-existing substance use and mental health problems is to provide integrated care. One clinician or one service provides care for both mental health and substance use problems, including detoxification when required.

Strengthening the capability of alcohol and drug interventions within a hospital psychiatric liaison team would reduce the need to refer the client out to another service. This could be achieved through employing an alcohol and other drug nurse with the psychiatric liaison teams. It is noted that in addition to detoxification, the psychiatric liaison teams are confronted with a wider range of alcohol and other drug issues within the people they assess. The alcohol and drug nurse would be able to assess, provide brief interventions and refer or liaise.

In Northland Community Mental Health and Addiction Services are integrated. However there is a need for AOD input in the Inpatient Psychiatric Unit to enable to provide medical detoxification for mental health patients.

Whangarei Hospital has a psychiatric liaison service that would benefit from the addition of an AOD practitioner, particularly to provide training and support for medical staff in the assessment and management of alcohol related problems and detoxification across the four area hospitals in Northland.

There is also a need for AOD input in the Mental Health Crisis Teams to support mental health services to manage the needs of clients with acute presentations of co-existing disorders.

Services in Northland could be developed by employing staff with an AOD speciality in each of the four district Mental Health and Addiction Teams in Northland.

3. Marginalised Groups such as the Homeless and Transient or Permanently Disabled Populations

There is a group of people in Auckland and Northland regularly using a range of addiction, mental health and related services. They are probably known to each agency, but rarely if ever, do agencies meet to identify who these people are, and identify what they need which should result in the design and delivery of medical and/or social care packages. In a sense this group of people are caught in "revolving doors", going round and round services, support and advice agencies, hostels and at times coming into contact with the criminal justice system.

They often have complex needs, are without a permanent address or struggle to live independently, and have been known to agencies for sometime.

Whilst not all of the homeless/rough sleepers/transient population are alcohol or drug dependent, international studies have identified that there is a high level of alcohol and drug use amongst people who are homeless and sleeping rough. Knowing these people, would help develop co-ordinated responses to assist them. Interventions will clearly require strong case management from the lead agencies, and assertive outreach to maintain engagement.

ADHB provides a mental health service for homeless people in the Auckland City region, but this service is not provided in other parts of the region.

4. Intoxicated Persons Presenting to Frontline Services

In addition to the contracted providers of detoxification services, other agencies also make a major contribution in terms of supporting, accommodating and assisting people who are intoxicated. These include The New Zealand Police, hostels, and hospitals and emergency departments.

a. Police Cells

New Zealand Police may detain intoxicated people under section 37A of the Alcoholism and Drug Addiction Act 1966, in situations where the person is either too drunk to be able to give an address; where there is no one at the address to safely care for the person, or where the persons presence at the address may present a danger to themselves or others.

In addition, the Police detain a significant number of people suffering from alcohol and other drug misuse. In 2005, the Police were called on approximately 24,000 times in New Zealand to securely detain intoxicated people. In many cases these people are taken home or a safe address, but at times they will be taken into up to 24 hours custody. The busiest Police Station that deals with the most intoxicated people in the region is Auckland Central.

In 2004, New Zealand Police North Shore Division identified 70 people being detained in this way. For the first nine months in 2005/06 they have indicated a similar number for the year.

Counties Manukau Police Division has estimated that in 2004/05 the number detained was over 500 intoxicated people.

Papakura Police Station estimates approximately 520 plus people a year are detained in police cells.

Two out of four divisions in the Northern Region reporting 600 people detained in police cells due to being intoxicated.

In general intoxicated persons are detained for up to 24 hours. They are monitored through regular checks, but almost always do not receive any mental health or alcohol and other drug intervention. They are released once sober, unless charged with other crimes.

This population of intoxicated persons is very diverse. It included for example intoxicated gang members as well as intoxicated teenagers. Because this diversity it is very difficult to develop a standardised response or facility.

This is a national issue, in which various Government Departments have been involved. The Police is developing a strategy on intoxicated persons in consultation with the Ministry of Health and ALAC.

b. Hostels and Supported Accommodation

The three main Auckland providers, Epsom Lodge, the Auckland City Night Shelter and the James Liston Hostel, play an important role. They provide 153 beds in Auckland for homeless people, with a significant group amongst them who will be intoxicated or will suffer from substance abuse or dependence disorders.

These services accept people who have been drinking and may be are intoxicated, but not if their behaviour is such that it will disturb other residents and be disruptive. There is no data available that quantifies this population.

They rarely refer to detoxification services.

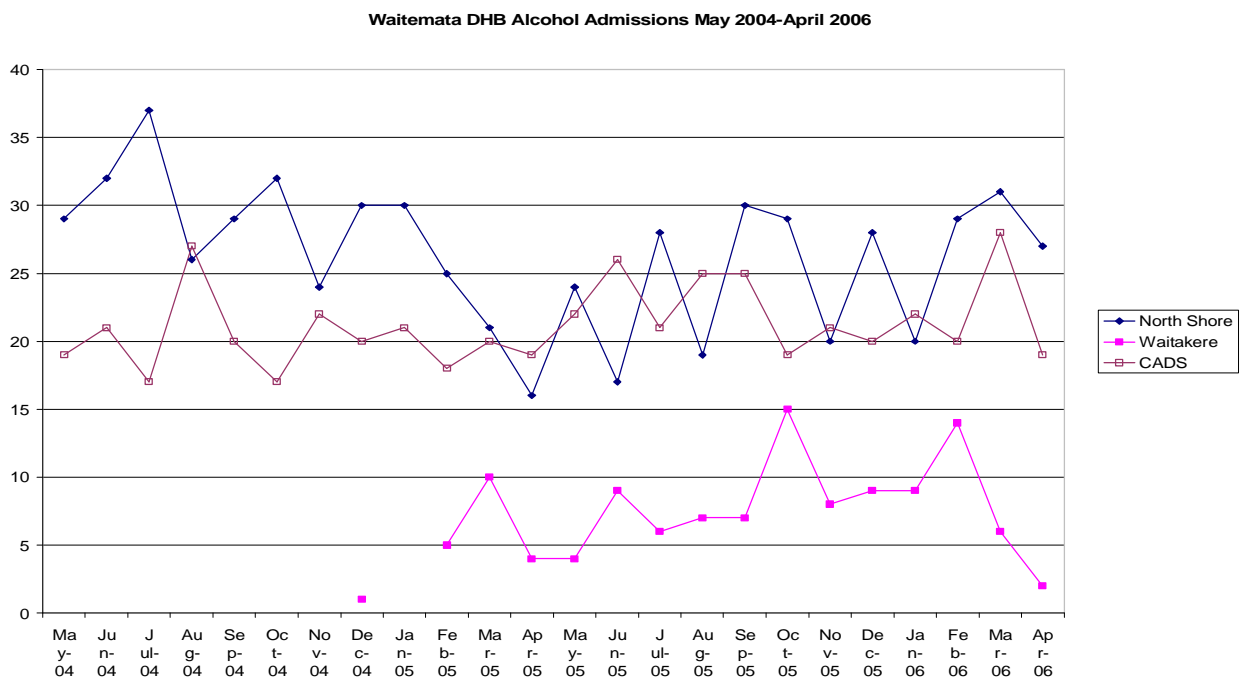
c. Hospitals and Emergency Departments (Alcohol Related only)

Alcohol is responsible for substantial amounts of accident and emergency hospital admissions. Estimates of alcohol related admissions vary depending on times the sample is taken (weekend and evenings experience a higher rate of intoxicated patients), or on the age group that is researched.

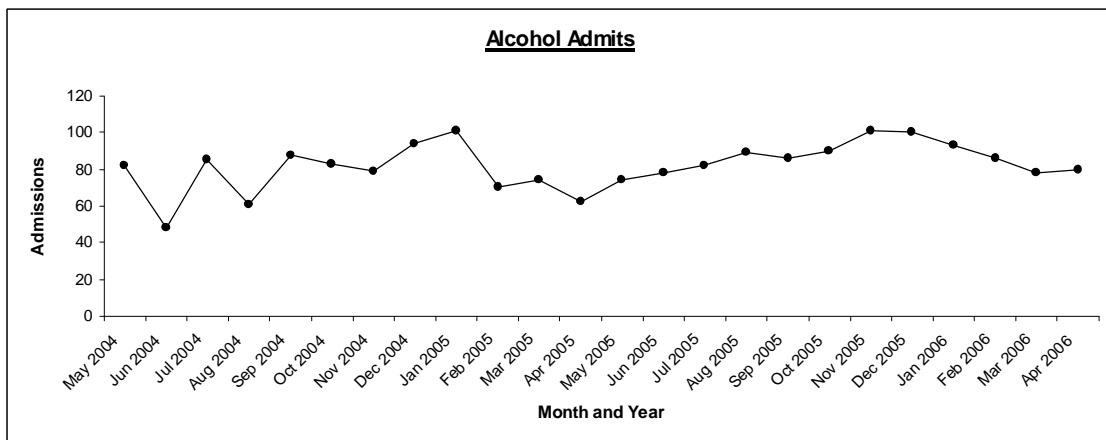
The tables below show the number of alcohol related diagnoses to the four main hospitals in Auckland over a two year period, including the acute mental health inpatient units.

These figures are likely to be under represented due to low routine alcohol and other drug screening rates in hospitals and mental health services. The table of included alcohol ICD Codes is shown in appendix 3.

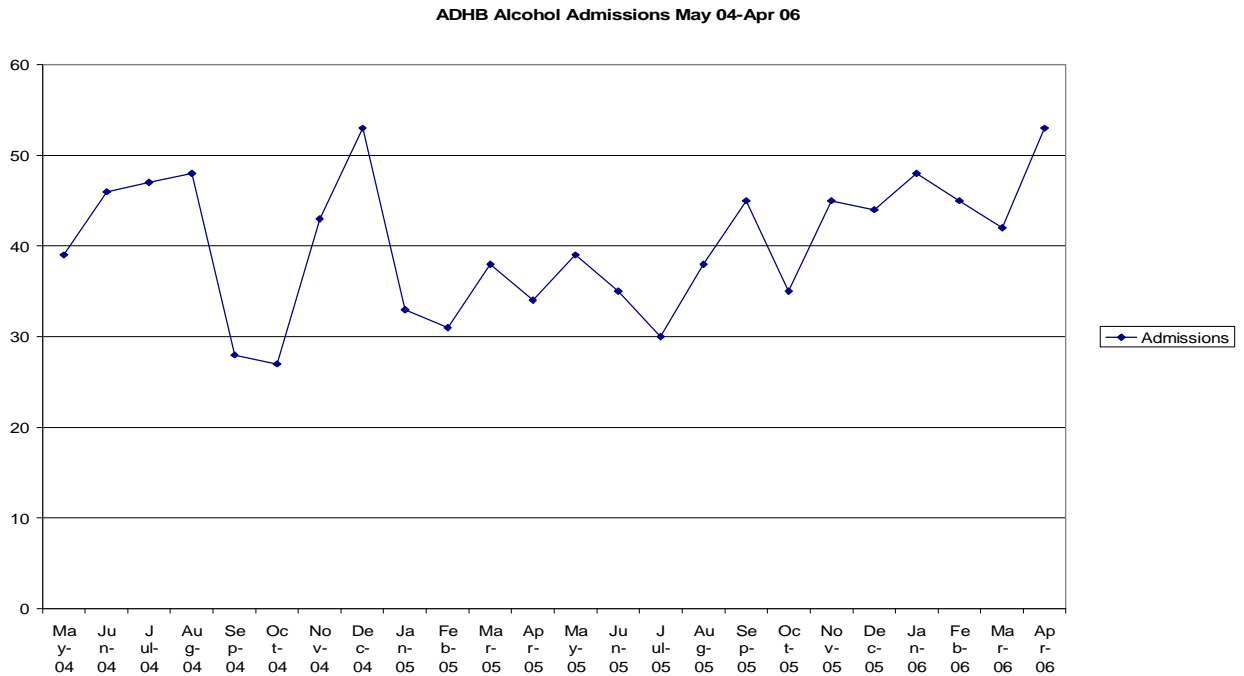
Admissions with alcohol related diagnosis to Waitemata District Health Board over the period May 2004 – April 2006 are show below. They include North Shore and Waitakere Hospitals and CADS IPU.



Alcohol related admissions to Middlemore Hospital (CMDHB) over the period May 2004 – April 2006 are shown below.



Alcohol related admissions to the Auckland City Hospital (ADHB) for the period May 2004 – April 2006 are show below.



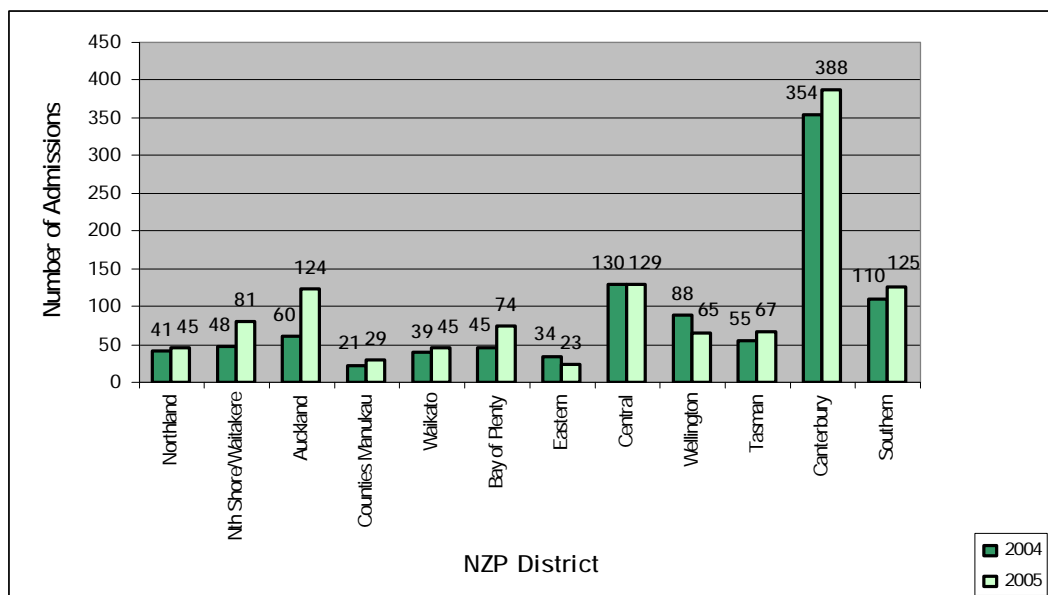
The percentage of these persons who are physically dependent and may require detoxification is not known. However, anecdotal reports suggest that a proportion require detoxification. This group (if identified) are prescribed withdrawal medication during their admission in hospital or referred to CHDS.

Figures for alcohol related admissions for NDHB were requested but could not be provided.

d. Hospitals and Emergency Departments (opiate related only)

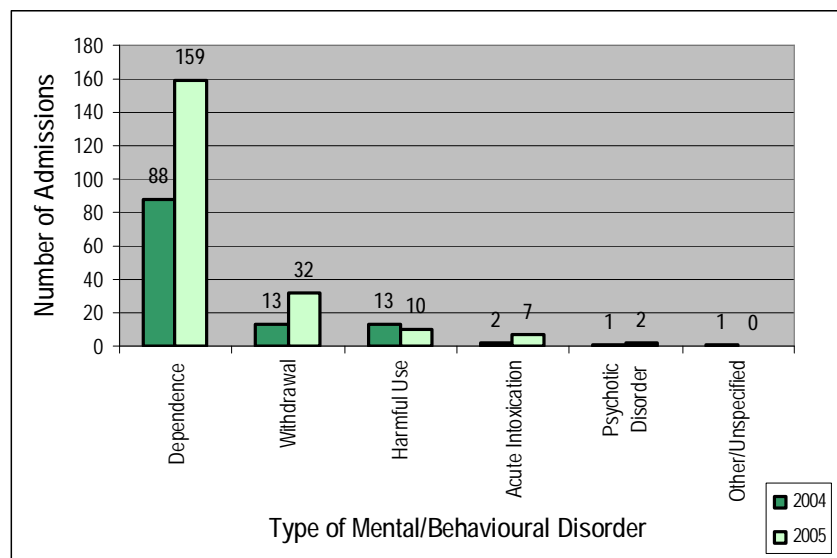
The National Drug Intelligence Bureau reported that there were 1,024 opiate-related hospital admissions in 2004, and 1,196 in 2005 in New Zealand. The increase of 172 represented a 16.8 percent increase in admissions between 2004 and 2005. In the Auckland region, opiate dependence-related admissions had the greatest actual increase, of 71 admissions (an increase of 80.7 percent) between 2004 and 2005. This percentage increase is greater than the national increase of 18.3 percent. In addition, the Auckland region's increase of 71 admissions represents 49 percent of the national increase of 144 admissions.

The figure below shows all opiate related hospital admissions in New Zealand.



For the four northern DHB's the Police Districts are similar to the DHB areas. None of the three Auckland districts featured significantly in 2004, but in 2005, the Auckland district was ranked fourth.

The table below shows a breakdown of the opiate related diagnosis.



Recommendations

1. Develop Community Detox Options in Northland

Provide contracted Detoxification Services based in the Northland based on Blueprint guidelines. Given that this is a large rural region this may be best achieved by providing Nurse/AOD practitioner FTE's within each of the four community mental health and addiction services settings. These positions would work with local General Practitioners, the AOD specialist medical practitioners and the four area hospitals to provide community-based detoxification. The four area hospitals would provide medical detoxification from alcohol and emergency detoxification from other drugs. The positions would have links to the Auckland detox network. They would be embedded in local teams of the Northland Mental Health and Addiction Services and maintain links to local hospitals.

Northland is unable to provide medical detoxification for drugs other than alcohol in its area hospitals, therefore CADS medical detoxification services in Auckland will provide a consultation service for Northland detoxification services and facilitate admission for the most complex poly drug dependent clients referred from Northland.

2. Increase Community Detox Options in Auckland

a. Paradigm shift from 'Inpatient' to 'Community'

Best practice is to detox the majority of dependent people through outpatient care and use inpatient detox services for those persons with more severe need who are likely to experience complications during withdrawal.

Despite this evidence the consultations demonstrated that detoxification services are viewed as 'inpatient' rather than 'community' services. Some health care providers did not know that CHDS exists. Furthermore the majority of people referred to CHDS and IPU request inpatient admissions and this is reflected in admission data where approximately two thirds is inpatient with the remaining third accessing the community detox service.

An enhanced community focus for CHDS will need to be communicated throughout CADS and other Auckland based alcohol and drug services. In addition, improved liaison and co-ordination between detoxification services and residential alcohol and drug providers should result in more patients being detoxed away from in patient settings. .

b. Integrate and maximise the existing resources within CHDS and IPU by providing 'day programmes and clinics' for clients who are withdrawing in the community.

For those people for whom community and home detoxification is not a suitable option, there is an opportunity to create day programmes. Day care is based on the participants attending facilities during the day and returning home in the evenings. They offer the opportunity for medical supervision, peer support, counselling programmes and day time occupation. They offer another point along the continuum service, providing more intensive treatment than community and home detoxification thereby allowing some people who may have the risk of medical complications to participate. They also offer additional reinforcement for participants who do not have social support systems or who live in an environment which might have some detrimental affect on their treatment.

If day programmes are developed, they could also be extended to those using methadone programmes.

Day programmes could be developed within CADS with minimal additional resources required. This would be achieved by further integration of the CHDS and IPU resources and improved social work cover.

3. Place an AOD nurse in the psychiatric liaison teams in each of the main hospitals in Auckland

A recent project implemented by CADS (The Auckland City Hospital Intervention Project) has provided some indicators of the beneficial outcomes from improved liaison between alcohol and drug services, mental health services and hospitals. The project involved an alcohol and drug nurse specialist working in Auckland City Hospital who provided AOD consultation or liaison and training to hospital staff. This role was viewed as highly relevant by hospital staff, including the Psychiatric Liaison Team.

It is recommended that the alcohol and drug nursing positions are placed within the psychiatric liaison teams within the hospitals to support the best practice approach of 'integrated care' between the mental health services, the hospital and detoxification or other alcohol and drug services.

Improved liaison between services aims to improve detox treatment outcomes, hospital bed utilisation, and service co-ordination and follow up.

4. Create a detoxification network across Auckland

It appears that lack of knowledge amongst stakeholders about detox services prevents maximum efficient usage. A formalised network would increase communication between the key stakeholders and improve access to detoxification services for those clients presenting to hospitals and mental health services who require detoxification. Alcohol and drug nurses in the psychiatric liaison teams, the Auckland City Mission and CADS CHDS and IPU could be working more effectively together within a formalised network. This network would co-ordinate improved access and greater efficient usage of the services.

5. Place an additional social worker within CADS Detox Services and Alcohol and Drug Services in Northland to address homelessness and other social issues and to develop day programme.

This review showed that homelessness and social problems are significant issues for people with substance use problems who are accessing detoxification services. Better outcomes are achieved for people who are employed, self supporting and have family and other social supports.

Currently the CADS Detox Services only have 1.0 FTE Social Worker and this person works across both the CHDS and IPU. NDHB AOD services has no social work FTEs and minimal access to social work resources in community mental health services. Additional social work FTEs should be provided for Northland Mental Health and Addiction services in the four district teams to ensure the availability of social work services for people with substance use problems who are accessing detoxification services.

As the acuity of admissions further increases as a result of greater efficiency, additional social work resources in detoxification services will address these issues.

The CADS social workers will need to develop and maintain links to the Auckland City Mission's Community Social Service team.

6. Explore employing AOD trained staff to provide AOD screening and brief interventions for persons in police cells and other frontline services for intoxication.

There is evidence of the positive effects of brief intervention on individuals at key moments. Being arrested is one of these key moments as is presenting with acute drug or alcohol related medical conditions to emergency departments. It can improve the motivation required for an individual to examine and change their behaviour. Having a person with skills and knowledge about alcohol and other drug use available for assessment in the police cells and emergency departments could improve the management of intoxicated persons in police cells.

Additionally there may be a contribution they could make through screening and assessment for onward referral, for example persons screened as dependent could be linked to medical detox services.

To develop these services within a Police setting would require careful consideration on what the expected outcomes would be. NZ Police has indicated that they would prefer intoxicated person to be treated in a social or health setting and it may therefore be more useful to provide this service in emergency departments.

Appendix 1

Reference Group

Robert Steenhuisen	Community Alcohol and Drug Services
Dimitri Germanov	Auckland City Mission
April O'Hanlon	Community Alcohol and Drug Services
Stuart Anderson	Higher Ground
Chris Kalin	Odyssey House
Betty MacLaren	Auckland City
Jenny Freedman – Hauge	Northland Mental Health and Addiction Services
Major Ian Huston	Salvation Army
Shane Lewis	Wings Trust
Jenny Boyle	Northern District Health Support Agency
Emma Wood	Northern District Health Support Agency
Gavin Stevens	Tranx

Appendix 2

Interviews and Meetings

Dimitri Germanov	Auckland City Mission
Colin Mc Pherson	New Zealand Police, Papakura Police Station
Mandi Hardie	New Zealand Police, Whangarei
Laurinda Howarth	New Zealand Police, North Shore, Waitakere and Rodney
Pam Burke	Auckland City
Elleen Swan and colleagues	Te Whetu Tawera, Auckland City Hospital
Sarah Harnisch	Absolute Quality
Chris Kalin and colleagues	Odyssey House
Ian Hutson	Salvation Army
Jenny Freeman-Hauge	Northland Health
Nick Argyle	Auckland District Health Board, Mental Health Services
Debbie Antcliffe	Auckland District Health Board, Mental Health Services
Roy Hunt,	Safe Waitakere, Alcohol Project
Christine Birrell	Safe Waitakere, Community Action on Youth and Drugs
Pam Armstrong	Nga Manga Puriri, Whangarei
Kirk Mariner	Pacific Mental Health and Alcohol Drugs Service
Alexis Nathan	Northland District Health Board
Shirley Allan	Auckland Central Community Action Youth and Drugs
Shane Lewis	Wings Trust
Stuart Anderson	Higher Ground
Toni Bowley,	Community Alcohol and Drugs Service, Dual Diagnosis
Brian Hayward	ALAC, Northern Region
Alexis Nathan	Northland Health
Shirleyanne Brown	Northland District Health Board
Betty MacLaren	Safer Auckland City
Gilli Sinclair	Counties Manukau District Health Board
Donna Steele	Auckland City Hospital, Emergency Department
Gavin Stevens	Tranx
Jan Hall and colleagues	Psychiatric Liaison, Auckland City Hospital
Michael Webb	New Zealand Police
Terry Huriwai	Ministry of Health
Noelene Webb	Bridge Project,
Paula Parsonage	HSD
Vicki Kiddell	Northland DHB Consumer Service
Brian Vickers	Northland DHB Consumer Service
Helen Wood	Waitemata DHB District Mental Health Service
Peter McColl	Waitemata DHB Rodney Mental Health Service
Randy Brazie	Waitemata DHB District Mental Health Service
Helen Warren	University of Auckland
Michele Yeoman	Community Alcohol and Drug Services
Ian Scott	Community Alcohol and Drugs Service
April O'Hanlon	Community Alcohol and Drugs Services

Appendix 3

ICD Code	Description
9200200	Alcohol rehabilitation
9200300	Alcohol detoxification
9200400	Alcohol rehabilitation and detoxification
9200800	Combined alcohol and drug rehabilitation
9200900	Combined alcohol and drug detoxification
9201000	Combined alcohol and drug rehabilitation and detoxification
9603400	Alcohol and other drug assessment
F100	Mental and behavioural disorders due to use of alcohol, acute intoxication
F101	Mental and behavioural disorders due to use of alcohol, harmful use
F102	Mental and behavioural disorders due to use of alcohol, dependence syndrome
F103	Mental and behavioural disorders due to use of alcohol, withdrawal state
F104	Mental and behavioural disorders due to use of alcohol, withdrawal state with delirium
F105	Mental and behavioural disorders due to use of alcohol, psychotic disorder
F106	Mental and behavioural disorders due to use of alcohol, amnesic syndrome
F107	Mental and behavioural disorders due to use of alcohol, residual and late-onset psychotic disorder
F108	Mental and behavioural disorders due to use of alcohol, other mental and behavioural disorders
F109	Mental and behavioural disorders due to use of alcohol, unspecified mental and behavioural disorder
T519	Alcohol, unspecified
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent
Y1500	Poisoning by and exposure to alcohol
Y910	Mild alcohol intoxication
Y911	Moderate alcohol intoxication
Y912	Severe alcohol intoxication
Y913	Very severe alcohol intoxication
Y919	Alcohol involvement, not otherwise specified

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