Template 1: Budget Initiative template

Overview and context

Key Question/area	Comment/answer
Portfolio of lead Minister	Hon Dr David Clark, Minister of Health
Portfolio(s) of other Ministers involved (if this is a joint initiative)	N/A
Votes impacted	Vote Health, Vote Corrections
Initiative title	**Responding to pressures on AOD addiction services, including the Substance Addiction (Compulsory Assessment and Treatment) Act 2017**
Initiative description	This funding will respond to pressures and gaps in the existing model of care for Alcohol and Other Drug (AOD) addiction treatment, ensuring adequate and immediate services are available, supporting a step-up/step-down approach to care as people move from community to residential and back again, and providing for an increase in capacity.
Type of initiative	**Priority aligning**

If this initiative relates to a priority, please outline the specific priority/ies it contributes to	The Government priorities that this initiative relates to are:
	• Supporting mental wellbeing for all New Zealanders, with a special focus on under 24s
	• Improving the wellbeing of New Zealanders and their families
	  ○ Provide better access to affordable quality healthcare and better health outcomes for everyone
	• Reducing child poverty and improving child wellbeing
	• Supporting safer communities
	  ○ Reduce family and sexual violence
	• Lifting Māori and Pacific income, skills and opportunities

Does this initiative relate to a commitment in the Coalition Agreement, Confidence and Supply Agreement, or the Speech from the Throne?	**Yes** – referred to in the Speech from the Throne 2018 – Addressing child poverty and increasing funding for alcohol and drug addiction – *"Funding for alcohol and drug addiction services will increase, and drug addiction will be treated as a health issue…."* And the priority of children *"This government will address the social deficit in this country and it will start with children. About 290,000 children live in poverty in New Zealand, in many cases without adequate food, healthcare and housing…"*
Agency contact	Name: Maree Roberts, Acting Deputy Director-General, Mental Health and Addiction Agency: Ministry of Health Email address: maree_roberts@moh.govt.nz Phone number: s 9(2)(a)
Responsible Vote Analyst	[redacted]

Funding

Funding Sought ($m)	2019/20	2020/21	2021/22	2022/23 & outyears	TOTAL
Operating	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Funding Sought ($m)	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	TOTAL
Capital	-	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

1. Executive Summary

1.1 EXECUTIVE SUMMARY

A. Short summary of the proposed initiative and expected outcomes.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction calls for a transformation of New Zealand's approach to mental health and addiction. This initiative forms part of wider cross-sector and Vote Health mental wellbeing investment that builds the foundations for a transformed approach, while relieving significant pressures being borne by our sector partners. Addiction treatment services need to respond in new ways in the face of increasing demand for services from people with increasingly high and complex needs.

The Government is exploring changes in drug policy, particularly through the referendum on the legalisation of cannabis, and acknowledged that it is necessary to increase funding for AOD services both ahead of and alongside those changes. Cabinet decisions in December 2018 mandated Police applying discretion regarding personal possession of drugs where a therapeutic approach would be beneficial or there is no public interest in prosecution. At the same time, Cabinet committed funding for an Acute Drug Harm Discretionary Fund, establishing a Drug Early Warning System, developing and delivering 'Addiction 101' training (particularly in communities experiencing harm from synthetic drugs), and funding other Ministry of Health-led AOD initiatives that take a health approach to substance harm. The Cabinet decision also acknowledged that significant investment is required to address gaps at the acute end of the spectrum of care, and signalled the need for $9.550 million to begin to shore up services.

This bid seeks that investment – s 9(2)(f)(iv) [redacted] and the addition of $0.5 million for Vote Corrections – to ease the as a first step towards transformative change. New funding is required to manage cost pressures and strengthen the addiction treatment sector, including through provision of increased detoxification, residential care and supported accommodation. This initiative aims to strengthen capacity to ensure that updated models of care for alcohol and other drug (AOD) treatment provide immediate engagement with services and continuing care to support recovery.

Improved capacity will help ensure:

- People are able to access services sooner with shorter or no waiting time
- People are accessed in the community through outreach services
- People receive a comprehensive service that addresses not only their AOD issues but also other issues contributing to, or exacerbated by, their substance use
- Following a period of clinical treatment people are supported to maintain their recovery
- Recruitment and retention issues for the workforce are alleviated.

This initiative complements the proposed Vote Health package to expand access and choice of primary and community mental health and addiction responses, balancing the need to improve support for people with mild to moderate mental health and addiction needs, without losing focus on responding to those with more severe mental health and addiction needs.

2. The Investment Proposal

2.1 Description of the initiative and problem definition

What is this initiative seeking funding for?

Funding of s 9(2)(f)(iv) is sought to strengthen the addiction treatment sector and relieve significant capacity pressures through investment in:

- residential care
- detoxification services
- supported accommodation

The quantum per annum has increased since Cabinet decisions in December 2018 to allow for an additional $0.5 million per annum for Vote Corrections, [redacted] Funding has been calculated based on information gathered by the Ministry in preparation for the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (where DHBs were asked to develop costings to enhance their model of care at a regional level) and through work on joint procurement for AOD residential care with the Department of Corrections.

The Government Inquiry into Mental Health and Addiction has recommended transformative change for the wider mental health and addiction sector. For the addiction treatment sector, the immediate demand is to address current funding shortfalls in areas such as detoxification services, residential care and supported accommodation. It is envisaged that this funding bid is an initial step [redacted]

By addressing capacity issues, this funding will support AOD services to better manage the increase in complex clients, improve waiting times to allow faster access to help for people in crisis. The aim is not to necessarily to increase in any significant way the number of people able to be seen, however it is expected that the increase in supported accommodation will result in some increase in access to other care, such as residential and community care. The flow on effect of this will also be to support capacity in non-acute AOD services and in the community, strengthening the current model of care in advance of larger scale change.

With the introduction of Substance Addiction (Compulsory Assessment and Treatment) Act 2017, investment was made from within Ministry of Health baseline for the establishment of a treatment centre. [redacted]

Without additional funding, services will struggle to meet existing demand let alone unmet demand, outcomes will be limited for those that do access treatment, people will continue to re-circulate through the system, staff recruitment and retention will be adversely affected, s 9(2)(g)(i) [redacted], adding further pressure on the overall system.

Why is it required?

More than 50,000 people access addiction treatment services each year. Of these, almost all are treated in intensive outpatient services, but around 2,200 also access residential care and medical or social detoxification services. As well as treating the substance use, services are having to address co-existing health issues, eg trauma, self-harm, and depression, as well as social issues eg safety from abusive relationships, child welfare, physical health, housing, and employment.

In its recent report, *Estimating the Impact of Drug Policy Options*, (2018) the NZ Drug Foundation quotes that the number of people presenting to mental health and addiction services has increased by 73% in the last three years, while funding has increased by 40% (original reference from the Mental Health Commission). The report estimates that there are nearly 50,000 AOD users every year who want treatment but do not receive it. There are significant pressures across the existing model of care, and a number of gaps that likely contribute to high relapse rates.

	At a national level, waiting times for counselling services of up to six weeks, and waiting times for residential care places but can be up to four to six months at peak times. There is also variability in where these services exist. For example, some DHBs, such as Tairawhiti and Bay of Plenty DHBs, do not have government-funded AOD residential care available in their districts, forcing individuals to leave their whānau and rohe to access support. In addition to residential care purchased by DHBs, the Ministry and the Department of Corrections directly purchase AOD residential care. The two agencies have initiated a collaborative procurement process for these services, which has revealed significant cost pressures due to the lack of cost of living adjustments and the increasing complexity of clients. There is also significant pressure on, and waiting times for, detoxification services. Tairawhiti DHB for example has only one medical detoxification bed available locally and no access to social detoxification. Supported accommodation is also variably available. For example, 21 beds are available in the Midland region, but are entirely based in Lakes and Waikato DHBs. Supported accommodation is a vital part of the step-up step-down model of care as it creates a bridge between residential care and care in the community. Addiction treatment services are starting from a deficit position nation-wide and additional investment over time has struggled to meet the rate of inflation or provide the minimal additional capacity, in light of demand. Funding constraints have resulted in district health boards not passing on cost of living adjustments to the NGO sector, which provides all AOD residential care across the country, and about half of all AOD services generally. Given recent Cabinet decisions to require Police to explore therapeutic options rather than criminal sanctions for personal possession of drugs, alongside the pressure placed on services by new synthetic drugs and ongoing concerns such as alcohol and methamphetamine, it is necessary to strengthen the addiction treatment system's ability to respond to alcohol and other drug (AOD) issues.

2.2 Options analysis and fit with existing activity

What other options were considered in addressing the problem or opportunity?

DHBs and NGOs continue to try to meet costs within baselines. The extent of cross-subsidisation to prop up services cannot be estimated.

The Ministry of Health contributed $2.0m in 2017/18 out of the addiction treatment baseline towards implementation of the new legislation, and is funding a range of initiatives such as the AOD Treatment Court pilot and the Pregnancy and Parenting Support Service. These commitments mean that additional funding at a national level is not available.

The Ministry has also sought funding through the Criminal Proceeds (Recovery) Act 2009, however this funding is by its nature one-off and therefore an unsustainable basis on which to fund essential services.

Old ways of working are being replaced with new models of care as services adapt to changing drug use, human complexities, and limited resources.

New models of care include:

- Changing the way addiction treatment is delivered, eg group counselling as an adjunct to one-to-one counselling, providing outreach services to marginalised groups rather than waiting for them to access services, and different ways of managing drug withdrawal services
- Working with families and not only individuals, addressing co-existing mental health and other health conditions, supporting children of parents with AOD issues
- Changing the mix of staff and providing workforce development to work in new ways, for example, employing peer support workers and social workers as well as addiction counsellors
- Addressing the period following treatment, when people need support to maintain what they have learned. For some, this will included ongoing community support. Without this, relapse is likely and services end up re-assessing and re-treating people that circulate through the health and justice systems.

However, without additional resource, this will not achieve lasting improvements.

What other similar initiatives or services are currently being delivered?	Addiction treatment services are well established across New Zealand. There is individual variation across the range of services available across DHBs. The proposal is to strengthen existing services that are under pressure, and where possible, fill gaps in local service provision.
What other, non-spending arrangements in pursuit of the same objective are also in place, or have been proposed?	Both ongoing work on the response to the Inquiry into Mental Health and Addiction and the Health and Disability System Review are considering changes to system settings (e.g. commissioning and funding models, accountability and governance arrangements, information sharing practices, etc.) that will support a transformed approach to mental health and wellbeing. This investment seeks to alleviate significant pressures on addiction treatment services, to enable the capacity and flexibility to embrace transformation.

Strategic alignment and Government's priorities/direction	The Government priorities that this initiative relates to are:
	• Improving the wellbeing of New Zealanders and their families
	  ○ Provide better access to affordable quality healthcare and better health outcomes for everyone
	• Supporting safer communities
	  ○ Reduce family and sexual violence
	• Supporting mental wellbeing for all New Zealanders, with a special focus on under 24s
	• Lifting Māori and Pacific income, skills and opportunities.
	
	This initiative also supports the Government's intention to improve the delivery of mental health and addiction treatment services and acknowledges the call in He Ara Oranga (the report from the Government's Inquiry into Mental Health and Addiction) for a significant increase in access to publicly-funded mental health and addiction services.
	
	The WAI 2527 claim being considered by the Waitangi Tribunal is likely to include a strong mention of the impact of alcohol and other drugs on Māori, in particular Māori women. This initiative will contribute to the Government's efforts to improve outcomes for Māori.
	
	Ensuring sufficient capacity of addiction treatment services is also aligned with the Government's broader policy agenda related to AOD, including the proposed Referendum on the legalisation of cannabis in 2020 and the Cabinet-agreed mandating of Police applying discretion regarding personal possession of drugs where a therapeutic approach would be beneficial or there is no public interest in prosecution.

2.3 Outcomes	
Overall outcomes expected from this initiative	Expected outcomes for this investment are: • Increased trust and confidence in mental health and addiction treatment services by service users • Improved social and economic outcomes for those people in the treatment system, their families and the wider community • Reduced costs to the health system, eg Emergency Departments, medical wards & mental health, and also to other sectors, eg Police, Justice, Oranga Tamariki. • Better utilisation of health services across the board by those who have not normally accessed primary care and tertiary services • Consistent implementation of the model of care for particular services such as detoxification, residential and community outreach services
2.4 Implementation, Monitoring and Evaluation	
How will the initiative be delivered?	Addiction treatment is not a single procedure, and can involve a process of assessment, withdrawal management, counselling (one to one, or in groups) as an out-patient, and in some circumstances residential treatment. Continuing care services can include a variety of services, including respite and relapse prevention. The range of such services is also reflected in the

	diversity of occupational groups that work in the sector. Attention to coexisting mental health and physical health conditions also adds to this complexity. Getting the combination of these services right, and the flow of patients through the system is a challenge for DHBs. While most DHBs fund and some also provide most of these services, it will be necessary for the Ministry and the DHBs to identify which services might need to be strengthened in each DHB and region, for example some DHBs have no residential treatment services within their boundaries, and some have limited withdrawal management services. The immediate focus will be on: 1) Residential Services 2) Detoxification services 3) Supported accommodation (as a bridge between treatment) In recent years, the DHBs have worked to develop their models of care. In some instance, those models have been implemented, eg Waikato DHB has implemented a new youth AOD treatment model of care; Canterbury DHB has a Central Coordination Service (CCS) to facilitate access to a range of treatment services. Regional planning forums have been established to identify priorities. Such forums will be instrumental in delivering the initiative. Through the course of joint agency work on AOD residential care, the Department of Corrections has indicated that it also faced cost pressures in this area. These have been accounted for in the bid. There are other potential impacts on other agencies, eg Corrections having a single point of entry service that then allocates referrals to appropriate treatment services, improved youth AOD treatment services support schools, university health services, and Oranga Tamariki.
How will the implementation of the initiative be monitored?	Monitoring and reporting on DHB performance is the role of the Ministry. Once implementation plans are developed they can be monitored as part of the existing framework.
Describe how the initiative will be evaluated	Evaluation would be made a requirement of the DHBs on accepting any funding particularly if milestones and outcomes are a part of the contract. The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 includes a specific requirement for an evaluation to be completed on after three years.

3. Wellbeing Impacts and Analysis

3.1 Wellbeing domains – People's experience of wellbeing over time

Domains List domains, using the key above, where there is an impact. Order domains by magnitude of impact, i.e. largest impact domain first.	**Impact(s) description** Identify the impacts, with a separate line for each impact relating to a specific domain	**Who are affected?** Individuals/families/government/etc? Be as specific as possible. Are there distributional differences?	**Magnitude of impact** Relative to the counterfactual key assumptions, quantified to extent possible, and where possible monetised	**How big?** High/ Moderate/ Low, or where possible present value	**Realised** in <5 / 5-10 / 10+ years	**Evidence base** Nature of evidence and key references	**Evidence quality** High/ Medium/ Low
Health	Improved outcomes for people seeking addiction treatment	Currently 51,000 people accessing treatment per year. • Low income and vulnerable individuals, families, • Māori/Pacific (and other ethnic groups) • Women/mothers and their children • People who are in the justice system with criminal records • Individuals with AOD and co-existing problems • Children of parent with AOD/CEP issues • NGOs and service providers • Addiction and Mental Health sector • Government agencies • District Health Boards	Relative to the counterfactual: People are able to access services sooner without having to wait People are accessed in the community through outreach services People receive a comprehensive service that addresses not only their AOD issues but also other issues contributing to, or exacerbated by, their substance use Following a period of clinical treatment people are supported to maintain their recovery Recruitment and retention issues for the workforce are alleviated.	High	< 5 years	Unmet need could be as high as a further 50,000 (NZ Drug Foundation).	Medium
	Alcohol and other drugs contribute to the costs of emergency departments, and to morbidities &.mortalities caused by cancers, cardio-vascular disease, and mental health disorders.	• Individuals • Families • Victims • DHBs and other agencies	Reduced waiting times for emergency departments as fewer drunk and drugged people are admitted following vehicle crash, accidental and intentional injury, and violence. Reduced medical, surgical, pharmaceutical costs associated with alcohol and other drug related diseases, eg liver cancer, throat cancer, and breast cancer.	High	< 5 years	447,000 people (14.45) of the population reported drinking 6 or more alcoholic drinks on one occasion - at least weekly (past-year drinkers) (*NZ Health survey 2018)* 31,000 people are estimated to have used amphetamines iin the past 12 months *(NZ Health Survey 2018)*. Scientific literature indicates that alcohol is a causative agent in at least seven different types of cancer including two of the commonest – breast and colorectal – but also including mouth, pharynx, larynx, oesophagus, and liver. The evidence is based on over 100 studies since 2007, and the risk is not simply associated with heavy drinking; quite moderate amounts of alcohol are associated with an increased risk of cancer.	High
Income and consumption	High levels of alcohol and drug use affect a person's ability to hold down a job, and income is spent on these, often ahead of other basic commodities.	• Individuals • Families • Communities	Starting work, or resuming work increases person's well-being and provides income for them and family. Positive role-model influence next generation. Individual households are better off.	Moderate	< 5 years	WINZ data would show number of beneficiaries with identified AOD issues	Medium
Jobs and earnings	High levels of alcohol and drug use affect a person's ability to hold down a job, and income is spent on these, often ahead of other basic commodities. Avoided	• Government agencies eg WINZ, IRD • Education providers • Potential employers				WINZ data would show number of beneficiaries with identified AOD issues	

Cultural identity	Māori are disproportionately affected by alcohol and other drugs.	• Individuals • Families • Communities	Mana-enhancing services can help restore mana to individuals and families. Recovery from alcohol and other drugs can improve cultural identity. Māori were traditionally alcohol and other drug free. The WAI 2527 claim being considered by the Waitangi Tribunal is likely to include a strong mention of the impact of these on Māori.	High	< 5 years	New Zealand Health Survey (2018) results show rates of hazardous drinking for Māori, Māori men; and Māori women are higher proportionate to wider NZ population.	High
Social connections	Use of illegal drugs tends to be secretive	• Individuals • Families • Communities	Improvements in physical health, mental health, friend/family arguments, meaningful activity, housing, and criminal activity are measured and show improvements.	High	< 5 years	The Alcohol and other Drug Outcome measure (ADOM) measures a range of psycho-social indicators of people in AOD treatment. For the period January to December 2017, participants indicated improvements in at least weekly issues with mental health (from 43% to 18%), physical health (from 36% to 19%), family and friend arguments (from 32% to 11%) and meaningful activity (from 25% to 10%), where alcohol was the main substance of concern. (Aclohol and other drug outcome measure – Report Four)., available at www.Tepou.co.org)	Medium

3.2 Wellbeing capitals – Sustainability for future wellbeing

Capitals	Describe the impact and its magnitude	Realised in <5 / 5-10 / 10+ years
Financial/Physical	**Increase**. The chronic use of alcohol and other drugs takes a heavy toll on the health of the person, and there are subsequent effects on close family members. These negative effects can be inter-generational. There are financial and physical harms to individuals associated with illegal drug behaviours. Standovers and "taxing" of individuals with drug debts, crime to manufacture, sell, distribute, obtain and use illegal drugs, are common. Such costs could be avoided with timely access to treatment. Alcohol and other drugs can contribute to increased family violence. Improved treatment of individuals can lead to increased safety and security for family members. Individual circumstances would improve. This would also make investment in some areas more attractive if there was less drug use/activity, for example in Northland. Improved investment in turn could lead to improved employment and social opportunities for people.	<5 years as the cost is immediate
Human	**Increase.** This initiative is focussed on improving individual health by promoting access to addiction treatment and recovery services. This helps to build the stock of human capital by increasing the quality of life for an individual, reducing health costs, social connections, reducing crime and victimisation, and promoting productivity.	<5 years as the cost is immediate
Natural	**Maintain**. This initiative has no impact on natural capital.	<5 years as the cost is immediate
Social	**Increase.** Reducing alcohol and drug use can improve social connection, reduce crime and reduced anti-social activity. People in recovery also tend to give back to the community. This impacts on social capital in a positive way.	<5 years as the cost is immediate

3.3 Risk and resilience narrative

Does the initiative respond to or build resilience?	This proposal will help to build resilience that will assist New Zealand to maintain or/and improve existing levels of wellbeing

4. Costing understanding and options

4.1 Detailed funding breakdown

Please provide a breakdown of the costs of this initiative

s 9(2)(f)(iv) [redacted]

The funding sought will purchase:

- Residential care. It will enable DHBs, the Ministry and the Department of Corrections to purchase AOD residential care from NGOs at increased rates that take into account the increased cost of living, and the increasing complexity of people they are treating (eg, trauma, comorbid issues)
- Detoxification services (social and medical)
- Supported accommodation. This is a vital bridge between residential care, detoxification, and care in the community as an outpatient.

The quantum per annum has increased since Cabinet decisions in December 2018 to allow for an additional $0.5 million per annum for Vote Corrections, [redacted] Funding has been calculated based on information gathered by the Ministry in preparation for the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (where DHBs were asked to develop costings to enhance their model of care at a regional level) and through work on joint procurement for AOD residential care with the Department of Corrections [redacted]

Workforce development has not been included in this bid. A key assumption used is that wherever possible and clinically appropriate, peer support and other allied health workers are employed to deliver any additional services funded through this bid. This is in line with recommendations from the Mental Health and Addiction Inquiry.

[redacted]

4.2 Options for scaling and phasing	
Scaling, phasing or deferring - including 75% and 50% scenarios	s 9(2)(f)(iv) [redacted]

5. Collaboration

5.1 Collaboration and evidence	
What type of cross-agency and/or cross-portfolio initiative is this?	This proposal is a cross-agency and/or cross-portfolio initiative where agencies have collective responsibility and are **jointly responsible** for delivery.
Agencies and Ministers that have been engaged in initiative development	The agencies following have been engaged in the development of this Budget bid: • Ministry of Health • Department of Corrections The following agencies have been informed of this bid's development through consultation on the December 2018 Cabinet paper on synthetic drugs, drug law reform and implications for services: • New Zealand Police • Ministry of Justice • New Zealand Customs • National Drug Intelligence Bureau • Ministry of Social Development.
Impact of cross-agency collaboration	Costs for the Department of Corrections has been included into the Bid to reflect the Department's cost pressures for AOD residential care.
Risks and challenges	The proposed funding will 'shore up' the existing system, and should be regarded as a first step towards transformative change for the wider mental health and addiction system. There is a risk that if no further additional funding is made available at a later stage, a transformed model of care will not be able to be funded, weakening linkages between the health sector and Police, both nationally and locally.