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AT THE HEART OF THE MATTER, NZ DRUG FOUNDATION.
Te Tūāpapa Tarukino o Aotearoa

Transform treatment and support service delivery

This overview is part of the NZ Drug Foundation's acute drug harm community response guide. It makes recommendations on how health and social services can change to respond to acute drug harm. While insights are drawn from the most recent synthetic cannabinoids crisis, the recommendations are applicable to other substances.

People facing acute drug harm can fall through every gap in the system

The most recent synthetics crisis highlighted how the most vulnerable in our society could fall through almost every gap in our health and social system.

Harmful synthetic cannabinoid use was often linked with the other issues they were dealing with, such as homelessness, poor mental health, poverty, unemployment and general lack of social support. Their situations were often very complex and would benefit from a lot of support.

People using synthetic cannabinoids also weren't accessing traditional treatment services and services are not reaching out to them. Some of the reasons for this appear to be:

- Barriers and wait times: The window of opportunity to engage with some people using drugs can be very small. If someone is ready and motivated to go to treatment, they need access immediately. But the way current services are setup and long wait times stopped this from happening.
- Complex and co-existing problems: Services didn't have the expertise to provide the varied support people would need
- Threshold of need: Services said people were 'falling between the cracks' by being too "high needs" for one service, and not high enough for another
- Service rigidity: Traditional service delivery often wasn't suitable for them because current treatment models only work for those who can handle rigidity and expectations. There were too many barriers for them to overcome[1]
- Negative attitudes: People had negative experiences with health and social services previously.

This latest crisis echoes other cases of acute drug harm, like huffing and the ongoing methamphetamine problem. We need to transform the way treatment and support services are delivered.

[1] Barriers include a long minimum treatment programme of 8 weeks, lengthy intake and assessment processes, a requirement to be sober before accessing services, a staged referral process and an artificial separation of mental health and addiction services.

WE NEED TO CHANGE HOW SERVICES WORK

Provide wraparound support

People facing acute drug harm should be able to able access a single service they trust where they can get a range of support including addiction treatment, mental health, social workers, housing and/or employment support, and peer support.

Wraparound care can work with clients where they are at and if they are in crisis. They can support clients to get a range of support, like housing or social detox. These services need to be people-centred and work with clients on what is most important to them right now. Wraparound care can help build positive support structures and help people build a new purpose to help in their recovery.

The delivery of wraparound care will depend on community resources and services. But there are number of possible modes of delivery:

- **Co-located services:** Multiple services can be housed in the same building so the client doesn't need to go to different locations.
- **Satellite sites within existing services:** Satellite teams can be stationed at places frequented by people facing acute drug harm.
- **A single service holds a range of contracts**: A service can be contracted to deliver multidisciplinary support, like a youth one-stop-shop
- **Navigators:** Providing support workers and/or caseworkers to make sure clients stay engaged and get the specific support they need.

Many treatment and frontline services want to deliver more wraparound support but they were constrained by DHB contracts, resources and staffing. Flexible funding and contracts are crucial to enable this and wraparound services need to be able to trial different service delivery models and quickly adapt to client needs.

Make services low threshold

Low threshold services (or one-stop-shops) are open to anyone who requests support, with no entry criteria. Any door is the right door. These services and are essentially walk-ins – no sign-ups, no need to fill in multiple forms. These services can immediately work with clients in some capacity with no requirement on their level of engagement. Homelessness services are a great example of low-threshold services.

Low threshold services can actively facilitate people getting access to longer-term addiction services and other support while providing immediate help or relief from a crisis. This will be a crucial link in the health referrals system.

Low threshold can be achieved by:

- removing or lowering client criteria
- not having a goal of abstinence as a requirement for engaging
- allowing drop-ins (this could be during a dedicated time)
- supporting and facilitating peer support services and services that do not require a person to commit to a full 'programme' to access help.
- building peer support workforce to be able to facilitate intake when appropriate

Make sure detox services adapt for different substances

Detoxification services help people get through the effects of drug withdrawal. Social detox (no medication) will work for some people. But others using large amounts of some drugs will require medically supervised detoxification.

Some people will need to go through detox because they can engage in any other type of treatment. And where possible, residential options are important because removing people from their social context was often crucial to recovery.

Detox services need to adapt for different drugs. For example, most social detox programmes are only contracted for 5-7 days to cater for alcohol or opioid use. But the peak of synthetic cannabinoids withdrawal is 4-7 days with symptoms remaining up to 2 to 3 weeks after depending on the case. There is a very strong desire to use again. They may not need to be in a detox facility over this period and especially the latter half could be supervised at home but people need to be aware of the longer timeframe.

Detox can be transformed by:

- **Substance-specific detox protocols and treatment periods:** Change detox to be substance-specific, and where necessary, have longer treatment periods to account for new and emerging drug trends.
- **Supervised at-home detox for local communities and fast referral pathways:** Very small communities might not be able to have the capacity to provide local detox.

Establish outreach teams that can deal with complex needs

Street-based or mobile outreach teams is one of the best ways to build up rapport and start the process of engagement. This is especially important for people that don't access or have had previous bad experiences with traditional services.

There are several ways to do outreach:

- **Mobile outreach vans attached to services:** A van enables outreach workers to go right to where people are, offering a cup of tea and advice, and help make referrals if wanted.
- **All hours (24/7) outreach support:** Services should make sure someone is always available to help people struggling with their drug use. A support worker could take them away from the environment, help them find reasons to hope and sources of enjoyment, pleasure and achievement.
- **Drop-in spaces:** These spaces can be equipped with things that take care of some basic everyday needs, like food or something to do. People would have a safe space in the community where there is no stigma. Support workers can be onsite.
- **Community based activities:** Such as learning a new skill or volunteer work. These all provide opportunities for meaningful engagement.

These interventions are crucial and are often cheap to run.

People using drugs hazardously can be difficult to engage, or link into treatment, especially if they don't have secure housing. With some of the new psychoactive substances with 'hard and fast' withdrawal or where people's behaviour is more extreme, traditional outreach practices might not work well. Services need to be adaptive to the populations and drugs that are present in their communities.

Use multidisciplinary teams for people with complex needs

Multidisciplinary outreach teams are the best equipped to deal with people with co-existing problems. Expertise can come from mental health, addictions, homelessness services, peers, social and/or youth work services. The composition can be adapted according to the target populations in each community.

WE NEED TO BUILD UP THE WORKFORCE

Thread peer support through all services

Building up a network of peers with lived experience can help services engage people earlier. Peer workers would have to be well supported with resources, information, and high-quality supervision so that they can do the work well without it impacting their own wellbeing.

Grassroots action is already happening. One respondent set up a Facebook support group which currently has 39 members.

We recommend all services working with people using synthetic cannabinoids should have some form of peer support and advisory groups threaded through their service. Peer support can engage people much earlier in their recovery journey and provide expert advice on how services need to adapt to cater to these vulnerable populations.

Provide substance-specific training to frontline staff

The effects, harm and withdrawal from different drugs can be extremely varied, particularly synthetic drugs. The lack of understanding and knowledge in this area can be a barrier for health and social services to respond effectively.

Everyone should make use of the free 'Addictions 101' training offered by Matua Raki. But others will need more specialised knowledge.

Paramedics ED staff	Substance specific clinical best practice which details how to stabilise, treat and refer someone to get further support Harm reduction and brief intervention for clients who are not ready to stop, how to assist people into services, and how to support friend or family withdrawal. How to send off samples to be tested to work out what clients have taken[2]
Primary care practitioners Other clinical staff	General information on what different drugs are, how they affect the body and what to expect when engaging with someone who is using them Substance-specific clinical best practice Harm reduction and brief intervention for clients who are not ready to stop, how to assist people into services, and how to support friend or family withdrawal.
AOD practitioners Support workers (including peer support)	General information on what different drugs are, how they affect the body and what to expect when engaging with someone who is using them Substance-specific harm reduction and brief intervention Clinical best practice for new and emerging drug trends

[2] Most EDs have an MoU with ESR (government testing agency) to test samples for free.

This training and information can be provided by:

- Matua Raki
- NZ Drug Foundation
- Local AOD services
- Acute drug harm community of practice.