

Alcohol and other drug outcome measure (ADOM)

Report three

For period July 2016 to June 2017

Published December 2017



Te Pou o te
Whakaaro Nui

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Glossary

AOD	Alcohol and Other Drug (services).
Matched pairs	Two collections, in this case treatment start and treatment end collections.
Episode of care	Where multiple referrals for a person are overlapping or within 14 days they have been condensed to one episode of care using the first referral and last discharge.
PRIMHD	Programme for the Integration of Mental Health Data.
Tāngata whai ora, Tāngata whai ora	Term encompassing, client, service user, consumer, people that access services. (plural uses macron).

Executive summary

This is the third national ADOM report, covering the period July 2016 to June 2017. Data used in this report is from PRIMHD and supplied by the Ministry of Health. It was extracted on 4 October 2017. The analysis period is for July 2016 to June 2017¹. This report has a focus on those people reporting alcohol or amphetamine-type substances as their primary substance of concern, as these are the two highest substances reported². This report includes:

- ADOM data in PRIMHD
- ADOM treatment start collections information
- ADOM treatment start and treatment end (matched pairs) analysis with a focus on alcohol and amphetamine-type substances reported as main substance of concern.

Treatment start collections indicate that amphetamine-type stimulants use is increasing, in terms of reported main substance of concern. People that state amphetamine-type substances as main substance of concern present with higher levels of daily mental health issues and are engaged less in work and other meaningful activities than alcohol users (graphs 15 to 18). It should be noted that amphetamine-type stimulants, as specified in the ADOM, does not differentiate between amphetamine powders, pills³ containing amphetamine, or methamphetamine.

There are 1,100 matched pairs (treatment start and treatment end) analysed in this report. Matched pairs show a reduction in substances used between treatment start and treatment end for alcohol and amphetamine-type stimulants (Table 1) with a medium to large effect. Further analysis will be possible as more matched pairs are collected and the number of collections rise. Large District Health Boards (DHBs) that are not yet submitting ADOM collections may have a significant impact on those numbers.

Table 1: Average days of substance use amongst those with use at treatment start, by ADOM treatment start, treatment end and outcome, matched pairs, July 2016 to June 2017

Question	Start mean	End mean	Outcome (Start minus end mean)	Cohen's d (effect size with 95% CI)	Effect of treatment
Q1: Alcohol days of use	9.7 (n=729)	4.1 (n=728)	5.6	0.74 (0.64-0.85)	Medium
Q2: Alcohol number of standard drinks consumed in a typical days use	11.0 (n=721)	4.8 (n=711)	6.1	0.70 (0.59-0.81)	Medium
Q4: Amphetamine-type stimulant number of days	10.0 (n=160)	1.6 (n=159)	8.4	1.25 (1.01-1.49)	Large

Notes: Cohen (1992)⁴ reports the following intervals for d: .2 to .5: small effect; .5 to .8: medium effect; .8 and higher: large effect.

¹ Please see appendix 1 for method (business rules).

² ADOM collections detailed in this report do not represent the whole population, only tāngata whai ora engaged with ADOM mandated services who complete ADOMs.

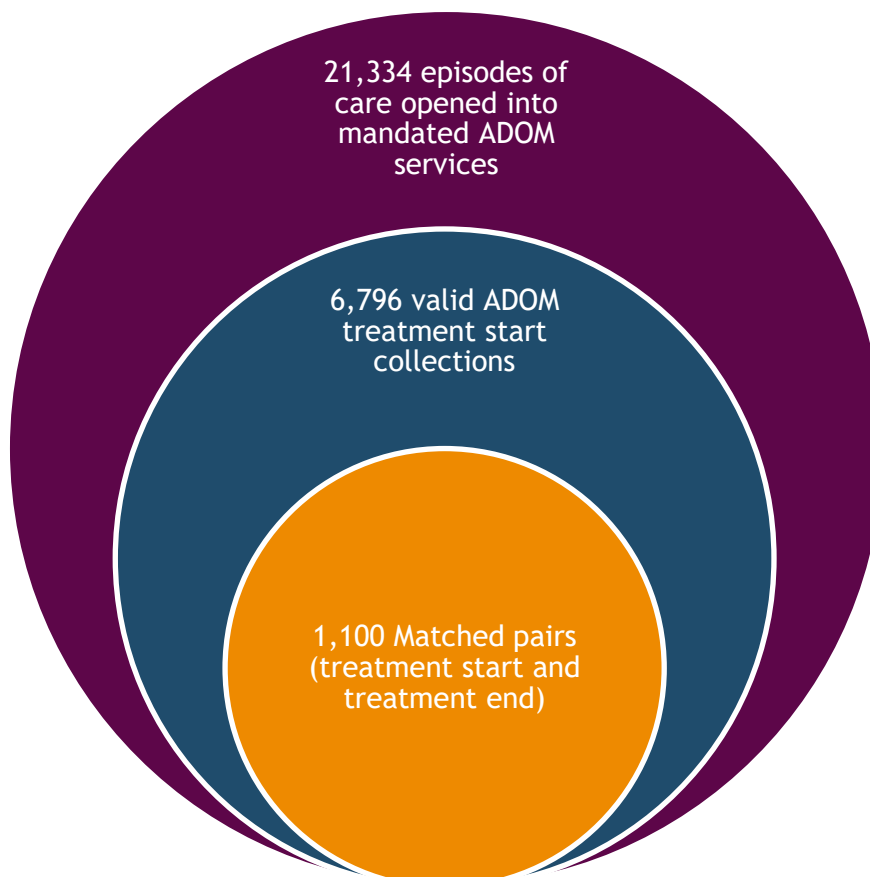
³ For example. Dexedrine, ProCentra, Dextrostat, Ritalin, Concerta, Vyvanse.

⁴ Cohen, J (1992) A Power Primer, Quantitative Methods in Psychology, *Psychologic Bulletin* Vol 112, No.1 155-159.

Part 1: ADOM in PRIMHD

- 21,334 - The total number of episodes of care opened into PRIMHD from **mandated services**; both DHB and Non-government organisation (NGO), between 1 July 2016 and 30 June 2017.
- 6,796 - The total number of valid ADOM **treatment start collections**.
- 1,100 - The total number of matched pairs - those ADOM collections that have *both* a treatment start and treatment end. Treatment end is in the period.

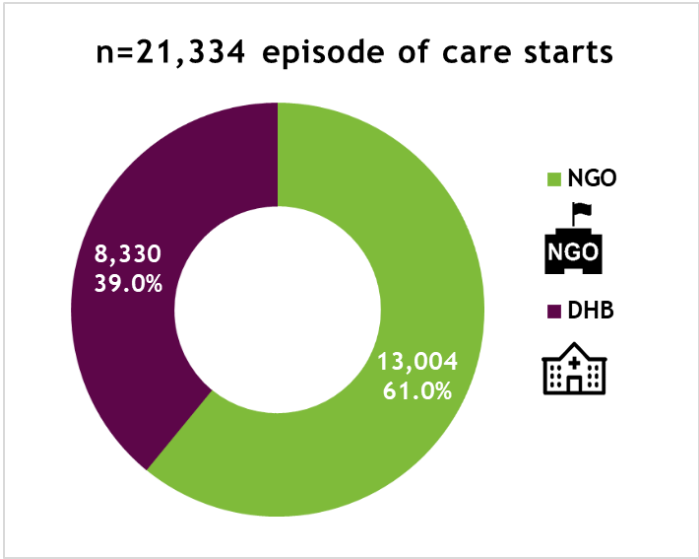
Graph 1: Total number of AOD episodes of care entered into mandated services, ADOM treatment start, and ADOM matched treatment start and end pairs, July 2016 to June 2017



Please note, when interpreting this report it is important to bear in mind the figures above. **Analysis on small numbers does not lead to effective population level interpretation.** Of all AOD referrals into PRIMHD, a smaller number are valid in mandated services, smaller numbers still have an ADOM collection at treatment start. Only 1,100 people have both a corresponding collection at treatment end (matched pairs).

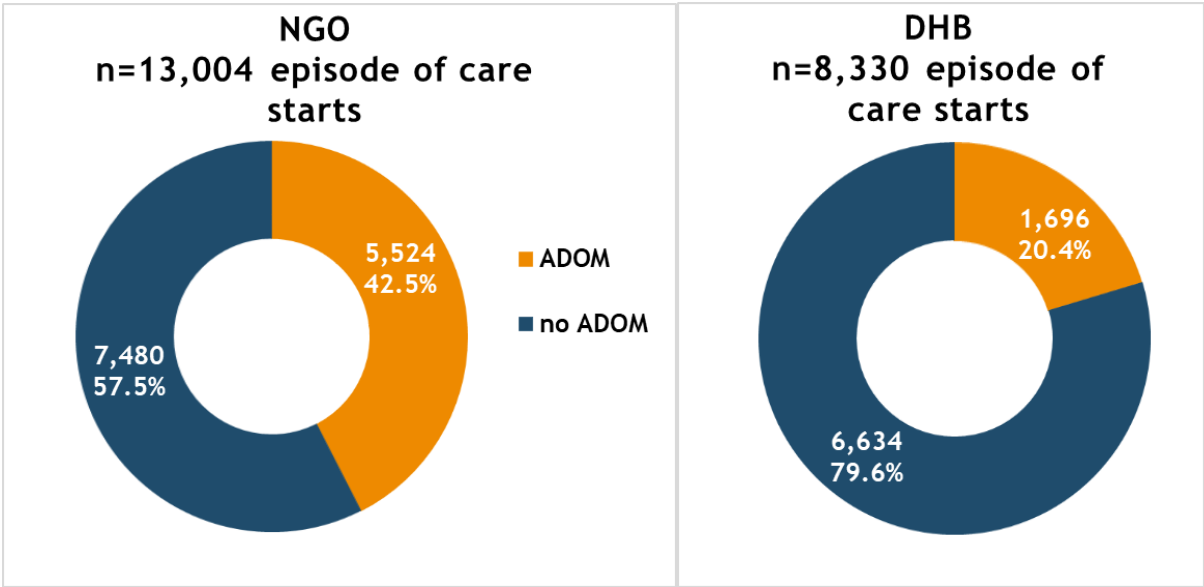
Graph 2 shows the number and percentage of episodes of care into ADOM mandated AOD services by NGOs and DHBs.

Graph 2: AOD episode of care into ADOM mandated services, by organisation type (NGO and DHB), July 2016 to June 2017



Graph 3 shows the percentage of at least one ADOM collection (treatment start or assessment only) against episodes of care in DHBs and NGOs. Over time the percentage of ADOM collections against episodes of care is expected to rise for both NGOs and DHBs.

Graph 3: AOD episode of care with at least one ADOM Collection (treatment start or assessment only) by organisation type (NGO and DHB), July 2016 to June 2017



Graph 4 shows episodes of care with at least one ADOM (treatment start) collection by NGOs and DHBs in each DHB area⁵. Some DHBs show no ADOM collections (reported to PRIMHD). This is largely due to IT system issues and does not indicate that ADOM is *not* being used in these DHBs.

NGO collections by highest percentage of treatment start collections against episodes of care are highlighted in table 2.

Graph 4: Percentage of AOD episode of care into mandated services with at least one treatment start ADOM collection by organisation type and DHB area⁶, July 2016 to June 2017

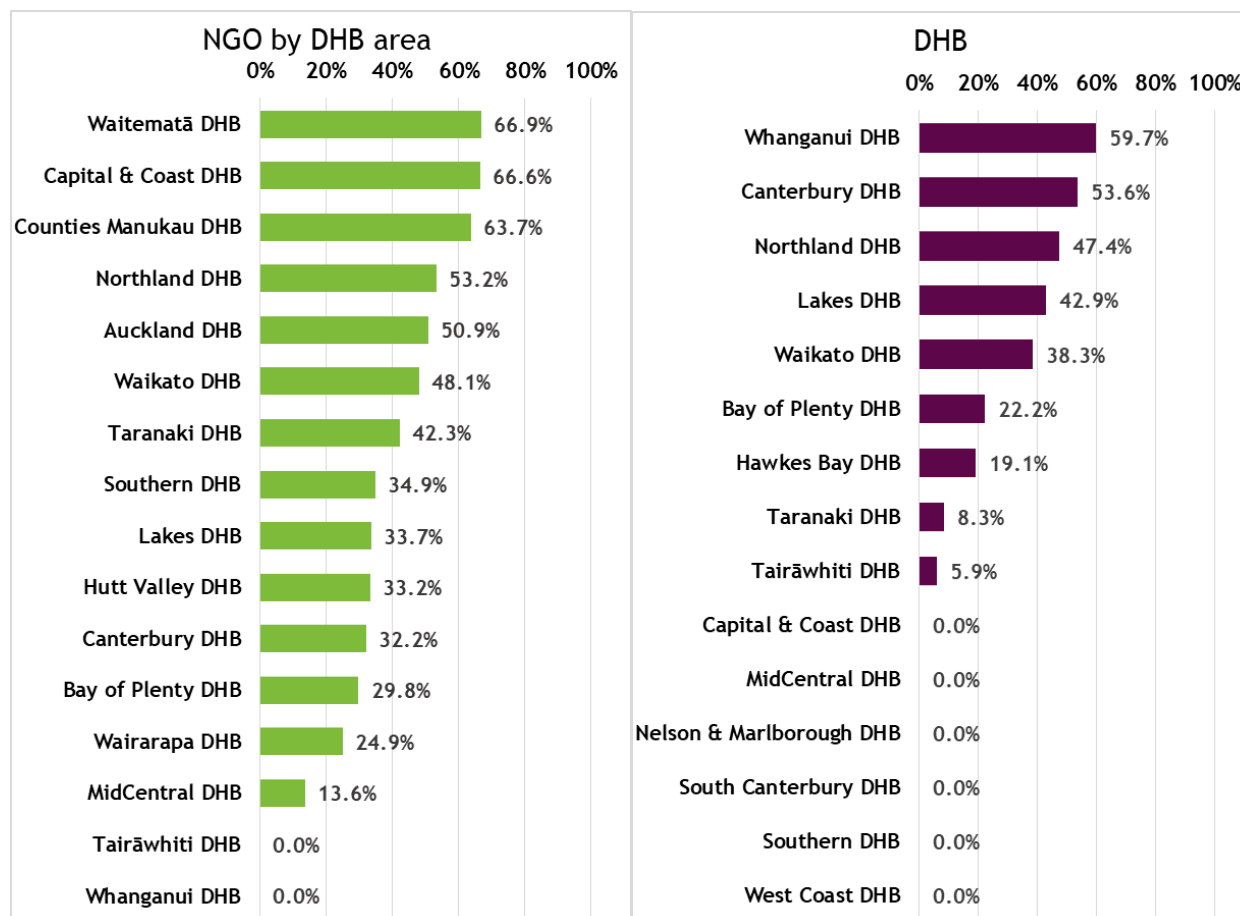


Table 2: NGOs with highest percentages of treatment start collections ADOM against episode of care, July 2016 to June 2017

NGO	Percentage	Number of episodes of care
Piritahi Hau Ora Trust	98%	48
Raukura Hauora O Tainui Trust	95%	138
Gore & Districts Community Counselling Centre Incorporated	84%	124
Te Puna Hauora Ki Tauranga Moana Trust	81%	43
Odyssey House Trust	79%	458

⁵ Waitematā DHB (providing regional AOD services for Auckland and Counties Manukau DHBs) have significant collections (outside of this report) using their own tool, Visual ADOM-R.

⁶ There are no eligible NGOs currently in the Nelson Marlborough, Hawkes Bay, West Coast and South Canterbury DHB area that have alcohol and other drug teams. It is not possible at this point to disaggregate AOD tāngata whai ora in integrated mental health teams from the following DHBs: Hutt Valley, Wairarapa.

ADOM collections by reason for collection

Graph 5 shows the total ADOM collections by reason for collection (RFC): assessment, start, review or treatment end. NGO services show more treatment starts and treatment end collections; a higher proportion of reviews are undertaken in DHB services.

Graph 5: Number valid ADOM collection by reason for collection and organisation type, July 2016 to June 2017

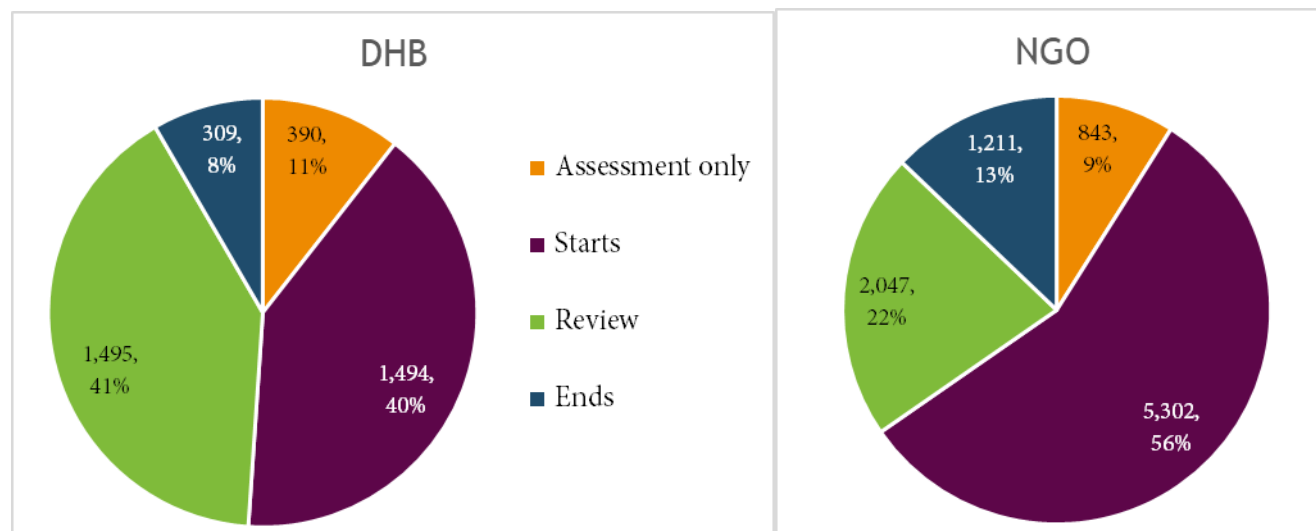


Table 3 illustrates how many collections were included in the analysis due to meeting the report building business rules, such as four or less missing items.

Table 3: Number of ADOM collection valid and not valid, by reason for collection, July 2016 - June 2017

Reason for collection	Valid	Not valid	Total	% valid
Assessment only	1,233	160	1,393	89%
Start	6,796	222	7,018	97%
Review	3,542	400	3,942	90%
End	1,520	353	1,873	81%

Note: Valid is when there is four or less items missing from the ADOM collection.

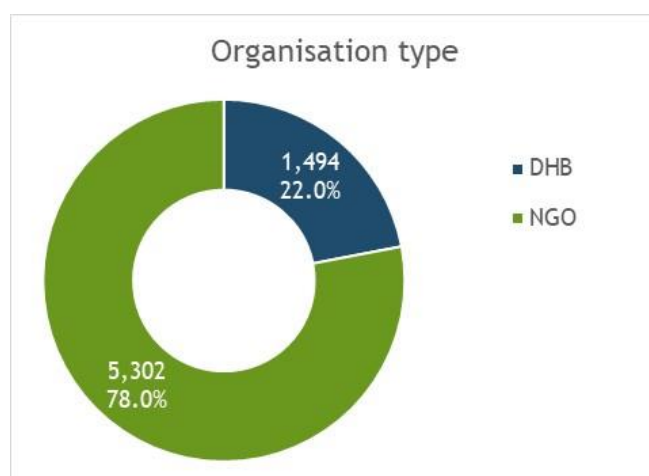
Part 2: ADOM treatment starts

The following section describes ADOM treatment start information. This provides an overview of the demographics, substance, and health and wellbeing of tāngata whai ora attending services at a national and DHB area level.

6,796 
valid ADOM treatment starts

Graph 6 shows ADOM treatment start collections by DHB and NGO, with percentages.

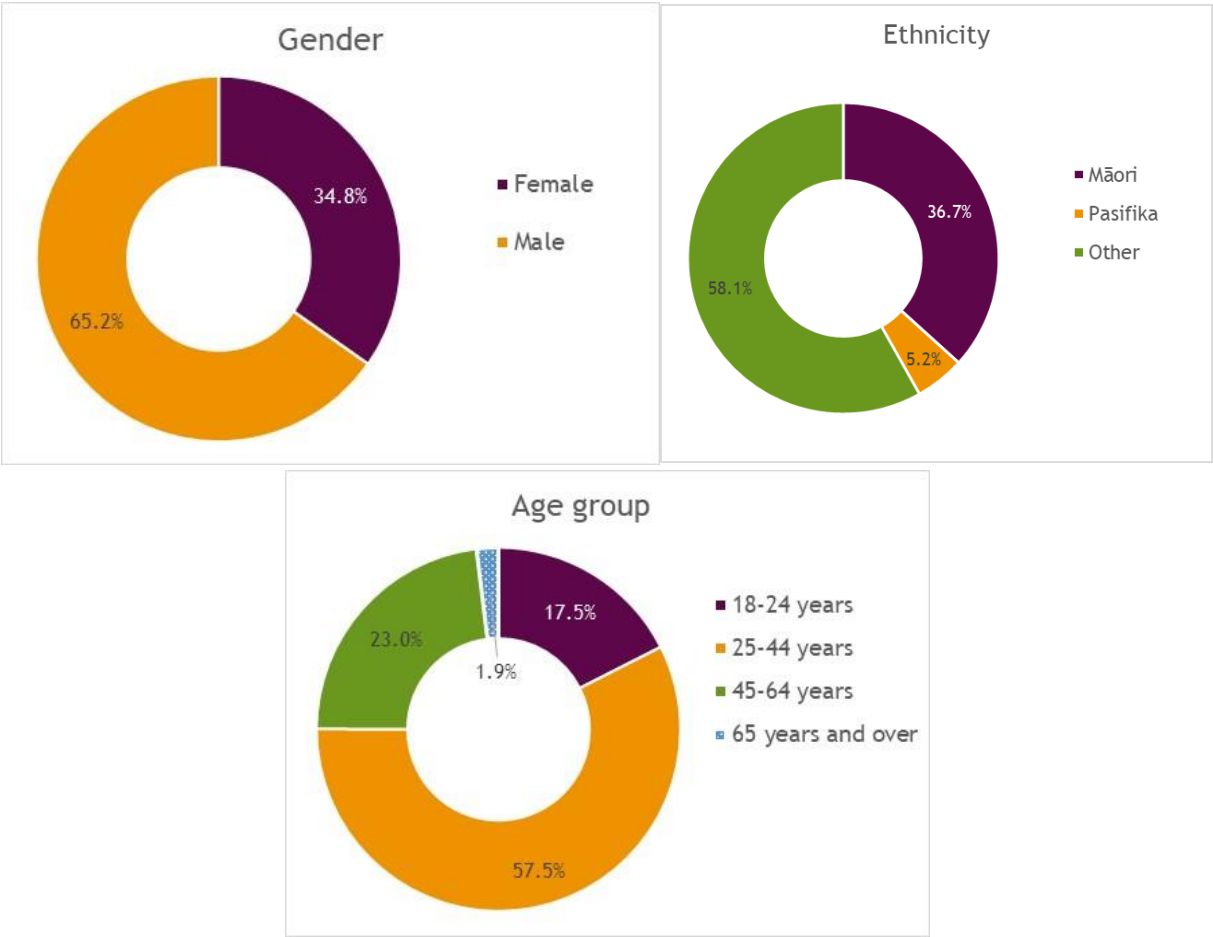
Graph 6: ADOM treatment start collection by organisation type, July 2016 to June 2017



Graph 7 shows the demographic profiles of treatment start ADOM collections. The gender distribution is in line with those accessing AOD services. Māori people make up 36.7 per cent, and are over represented in this data when compared to the general Māori population of 15 per cent⁷. The largest age group, at 57.5 per cent, are 25 to 44 year olds. According to 2013 census only 34 per cent of the general population make up this age group.

⁷ Information taken from <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/infographic-culture-identity.aspx>

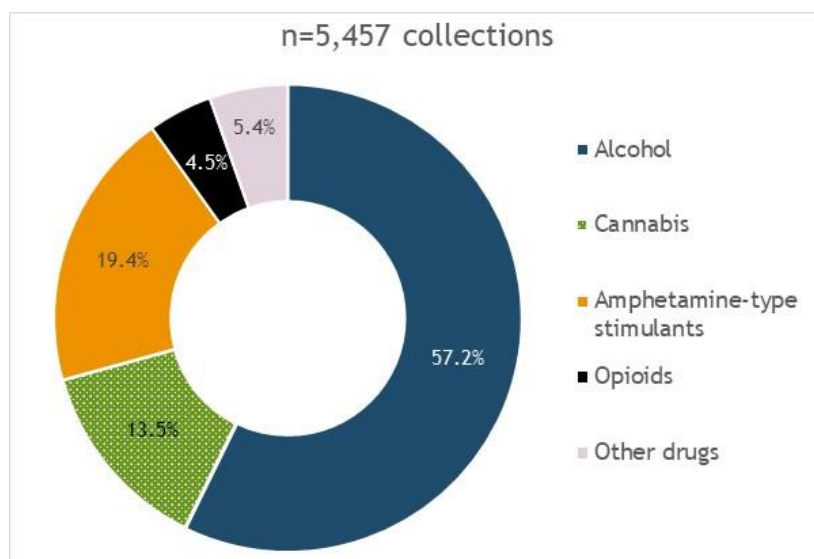
Graph 7: Profile of ADOM treatment start collection by gender, ethnicity and age group, July 2016 to June 2017



ADOM treatment start collections by substance of concern

Graph 8 shows stated main substance of concern among the 5,457 treatment start collections⁸.

Graph 8: Distribution of substance of main concern at ADOM treatment start collections, July 2016 to June 2017⁹



While we focus on primary substance of concern in this report, it was deemed useful to explore what secondary substance(s) of concern were stated, as people often use multiple substances. Where not reported as main substance of concern, alcohol features as a second substance of concern in all other categories. Likewise, amphetamine-type substances also feature where cannabis and alcohol are primary substances of concern. Analysis of this pattern will be followed over the next year of reports to feature as part of future reports.

Table 4: Second substance of concern by substance of main concern, July 2016 to June 2017

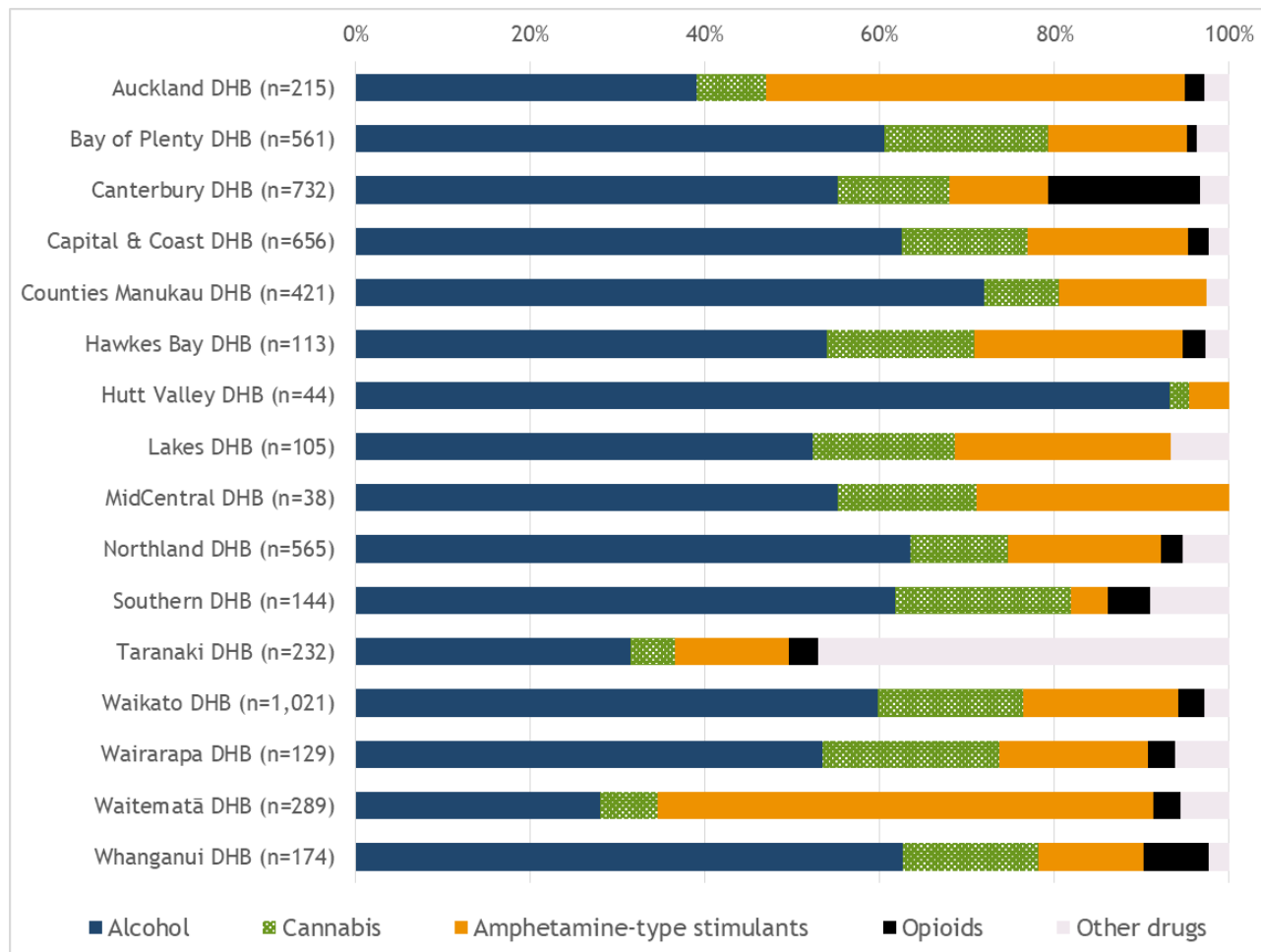
Substance of main concern	Second substance of concern
Alcohol (3,123)	Cannabis (628)
	Amphetamine-type stimulants (127)
	Other drug, unspecified (91)
Cannabis (738)	Alcohol (255)
	Amphetamine-type stimulants (98)
	Other drug, unspecified (27)
Amphetamine-type stimulants (1,057)	Cannabis (327)
	Alcohol (262)
	GHB (27)

⁸ Please note that ADOM is collected in service settings and not all 6,796 people specify a substance of concern at treatment start. Figures quoted here are not indicative of substance use in the general population, particularly, as not every person who has a substance use problem, accesses services.

⁹ There has been a rise from 15.9% of amphetamine type substances reported as main substance of concern (year to July 2016) 19.4% in the twelve months to June 2017.

Graph 9 shows stated main substance of concern by DHB area, including NGOs. Auckland and Waitematā (NGOs only) show much higher presentations of amphetamine-type stimulants than other DHB areas¹⁰. Taranaki shows a higher stated 'other' drugs, anecdotally the local NGO AOD service reports synthetics are a problem.

Graph 9: Distribution of substance of main concern at ADOM treatment start collections by DHB area, July 2016 to June 2017¹¹



Main substance of concern by gender

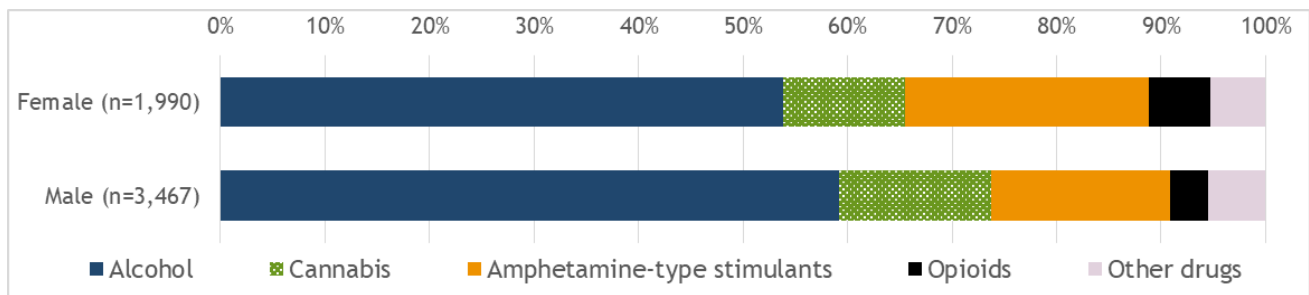
Graph 10 shows main stated substance of concern by gender. There is more alcohol and cannabis reported via ADOM in men and more amphetamine-type substance and opioids in women¹².

¹⁰ Though Waitematā DHB figures are not included, just NGO.

¹¹ Tairāwhiti DHBs have been excluded due to small numbers; South Canterbury, Nelson Marlborough and West Coast DHBs do not have any ADOM submissions.

¹² Not necessarily indicative of general population use.

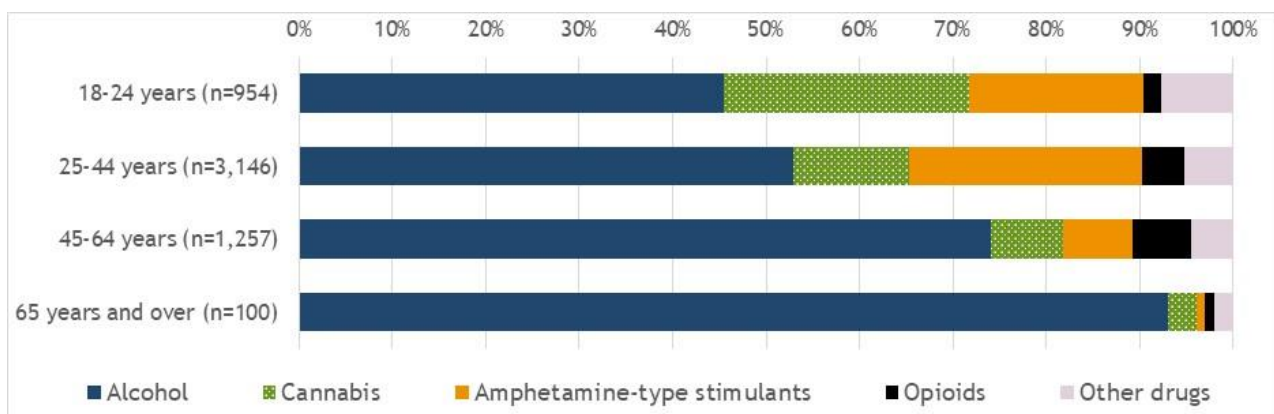
Graph 10: Distribution of substance of main concern at ADOM treatment start collections, by gender, July 2016 to July 2017



Main substance of concern by age group

Graph 11 shows main substance of concern by age and indicates a pattern of older people presenting to services with primarily alcohol problems. Cannabis features more in the youngest age group.

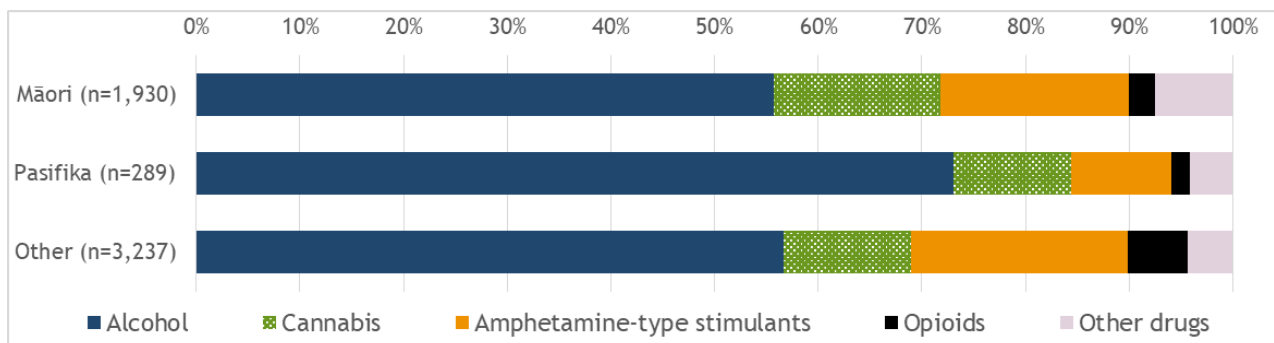
Graph 11: Distribution of substance of main concern at ADOM treatment start collections, by age group, July 2016 to July 2017



Main substance of concern by ethnicity

Graph 12 shows main substance of concern by ethnicity. More Pasifika people present with alcohol as substance of main concern than other ethnicities.

Graph 12: Distribution of substance of main concern at ADOM treatment start collections, by ethnicity, July 2016 to July 2017



ADOM treatment start collections by lifestyle and wellbeing

This section is focused on the lifestyle and wellbeing of people accessing services, based on the questions collected in Section 2 of the ADOM at treatment start.

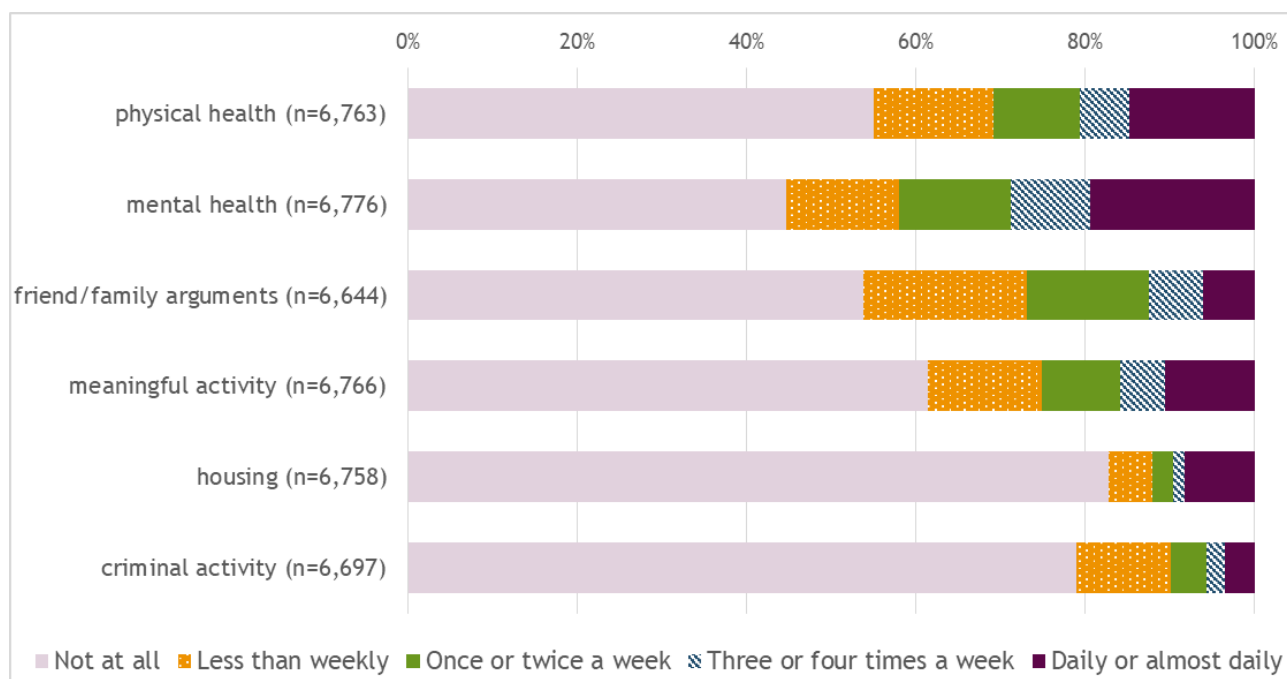
Lifestyle and wellbeing - all tāngata whai ora

Question key:
Q12 How often has your physical health caused problems in your daily life?
Q13 How often has your general mental health caused problems in your daily life?
Q14 How often has your alcohol or drug use led to problems or arguments with friends or family members?
Q15 How often has your alcohol or drug use caused problems with your work or other activities in any of the following: social, recreational, looking after children or other family members, study or other personal activities?
Q17 Have you had difficulties with housing or finding somewhere stable to live?
Q18 How often have you been involved in any criminal or illegal activity such as driving a motor vehicle under the influence of alcohol or drugs, assault, shoplifting, supplying an illicit substance to another person?

Graph 13 shows overall response distribution of tāngata whai ora to ADOM Section 2, lifestyle and wellbeing questions. Results indicate that the lifestyle and wellbeing of tāngata whai ora has been negatively impacted, regardless of their gender, age, ethnicity or the substance they used.

Results indicate nearly 31 per cent of tāngata whai ora experience at least some physical health problems each week, and nearly 42 per cent of people state they are affected by mental health problems each week. Around 10 per cent of tāngata whai ora state they are engaged in criminal activity at least weekly.

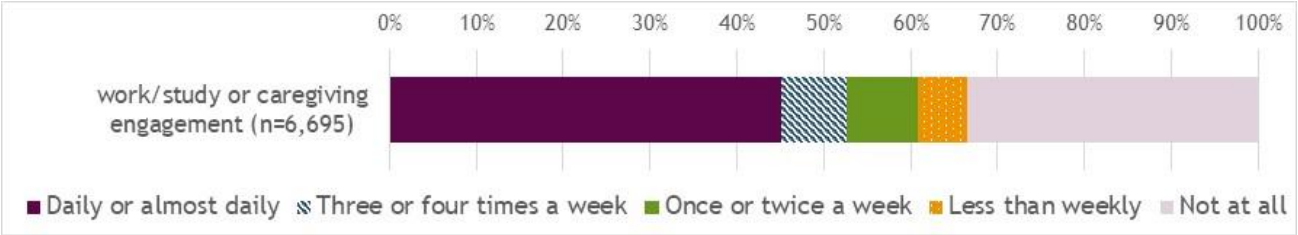
Graph 13: Distribution of lifestyle and wellbeing responses at ADOM treatment start collections, July 2016 to June 2017



Question key:
Q16 How often have you engaged in any of the following: paid work, voluntary work, study, looking after children or other caregiving activities?

Graph 14 shows engagement with work and other activities. The distribution on question 16 is presented separately as it is a reversed question in ADOM. The higher the number the better the engagement with work and other activities. Over 60 per cent of tāngata whai ora report being engaged in work, study or caregiving each week.

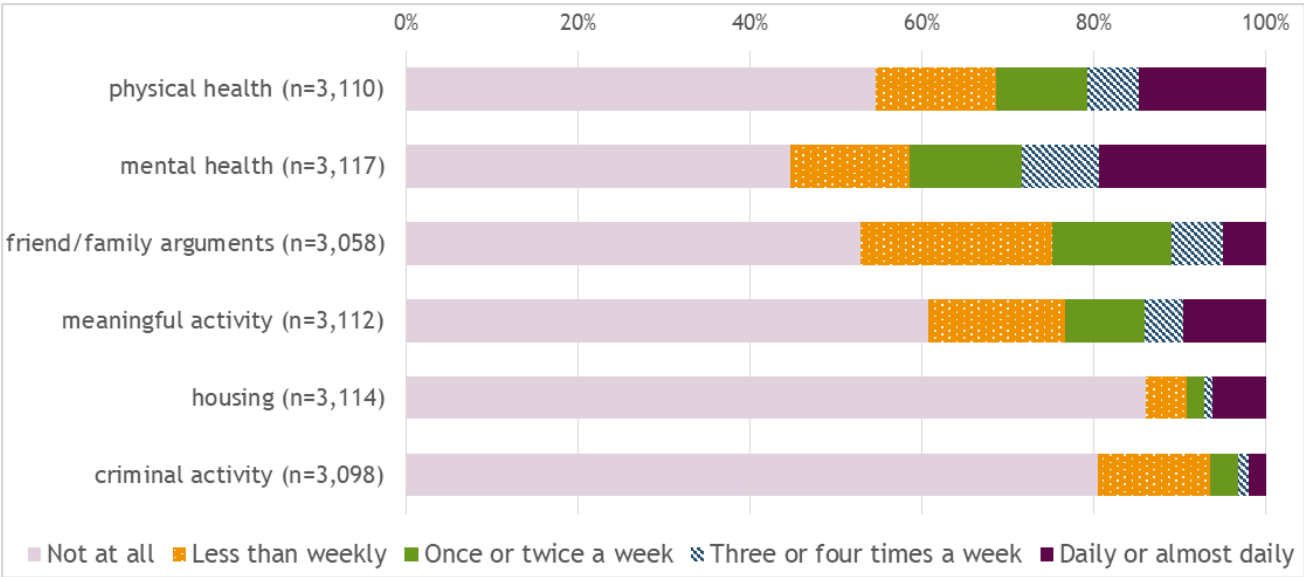
Graph 14: Distribution of lifestyle and wellbeing Q16 responses at ADOM treatment start collections, July 2016 to June 2017



Lifestyle and wellbeing - by main substance of concern

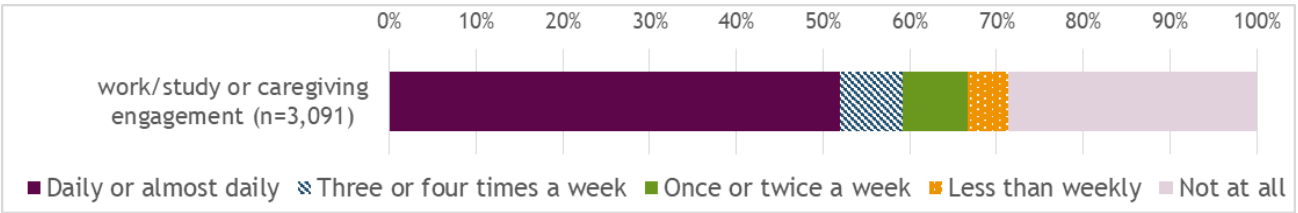
Graph 15 shows lifestyle and wellbeing response from tāngata whai ora that state alcohol as their main substance of concern, nearly 20 per cent of people report mental health problems daily or almost daily.

Graph 15: Distribution of lifestyle and wellbeing responses at ADOM treatment start collections, alcohol main substance of concern, July 2016 to June 2017



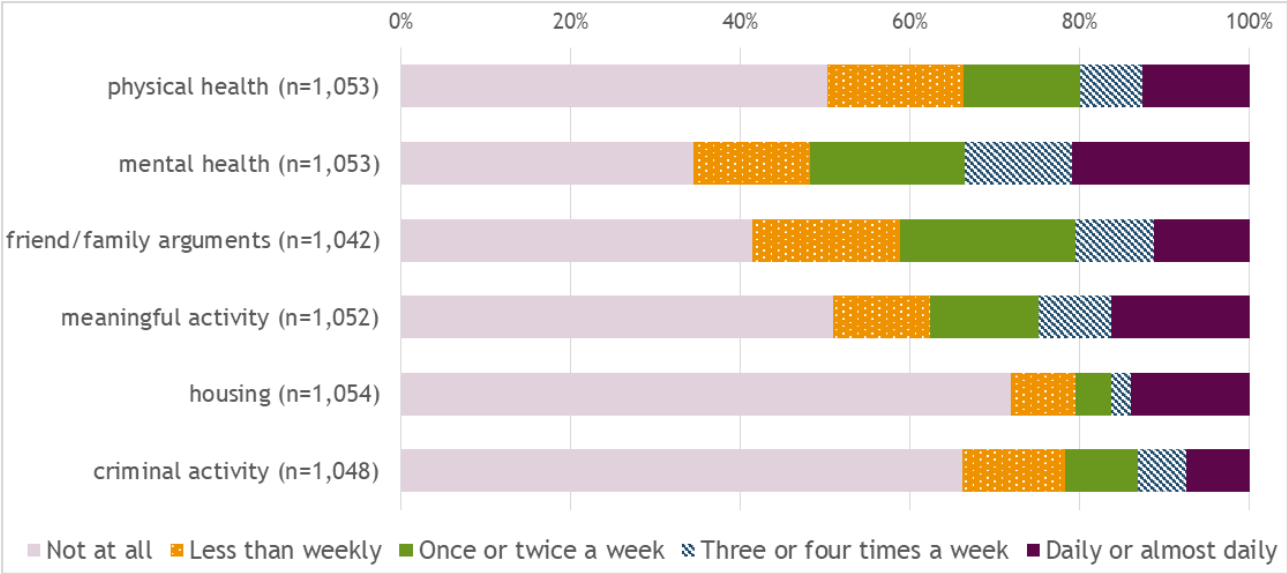
Graph 16 shows engagement in activities as responded by those that stated alcohol as primary substance of concern. Over 50 per cent of people were engaged in work, study or caregiving daily or almost daily.

Graph 16: Distribution of lifestyle and wellbeing Q16 responses at ADOM treatment start collections, alcohol main substance of concern, July 2016 to June 2017



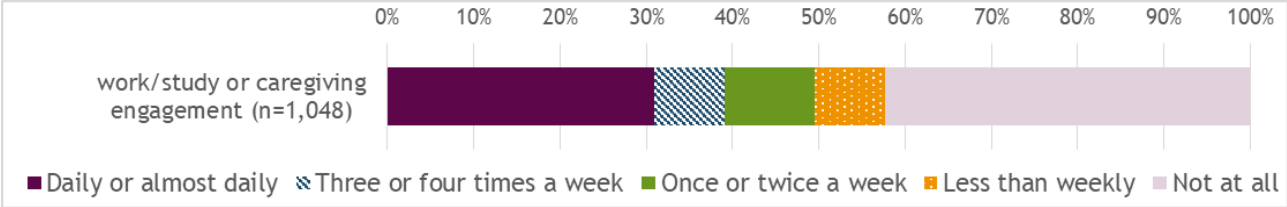
Graph 17 shows lifestyle and wellbeing response from tāngata whai ora that state amphetamine-type substances as their main substance of concern. Over 20 per cent of people report mental health problems daily or almost daily.

Graph 17: Distribution of lifestyle and wellbeing responses at ADOM treatment start collections, amphetamine-type stimulants main substance of concern, July 2016 to June 2017



Graph 18 shows engagement in activities as responded by those that stated amphetamine-type substances as primary substance of concern. Approximately 30 per cent of people were engaged in work, study or caregiving daily and almost daily.

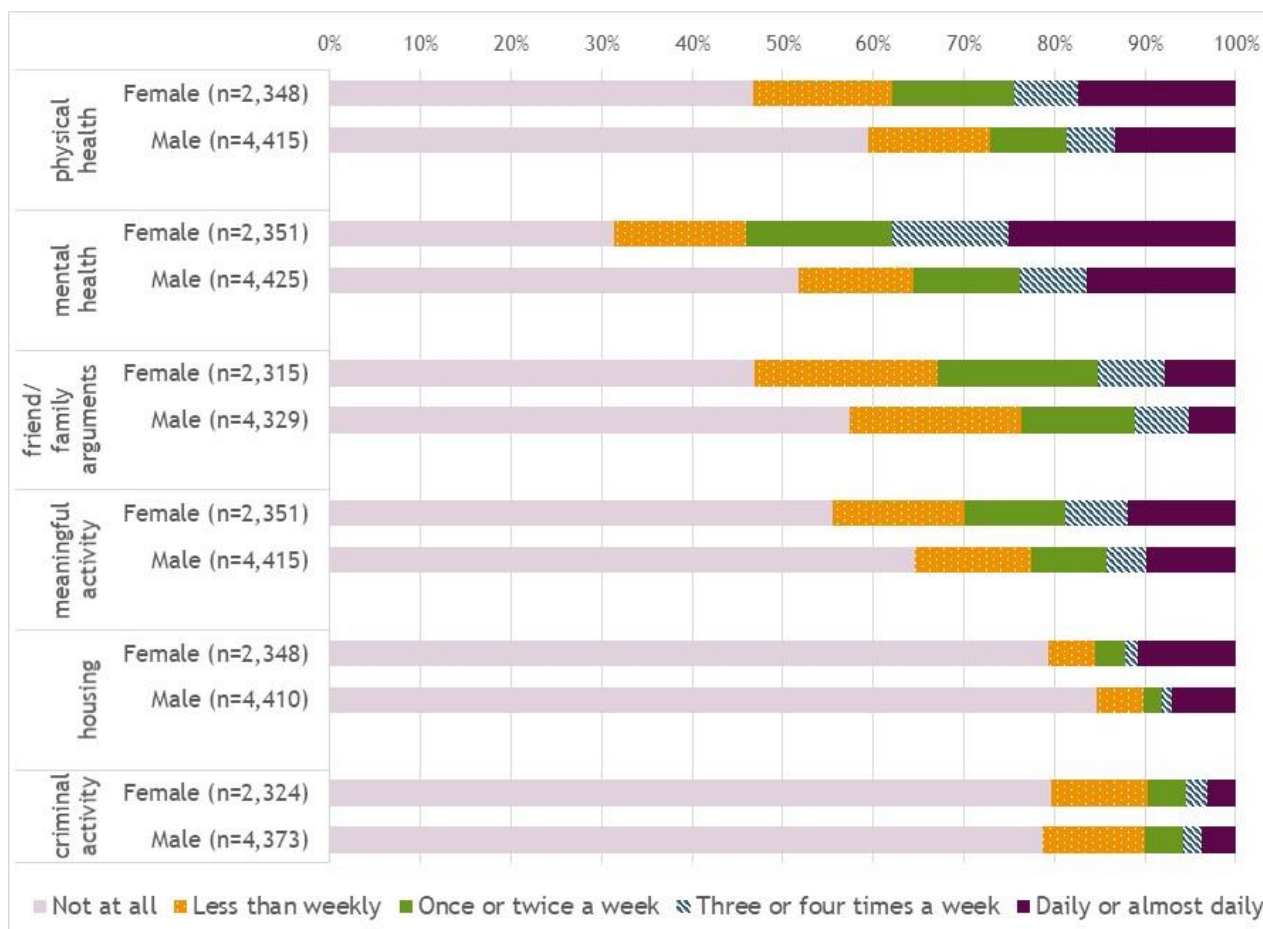
Graph 18: Distribution of lifestyle and wellbeing Q16 responses at ADOM treatment start collections, amphetamine-type stimulants main substance of concern, July 2016 to June 2017



Lifestyle and wellbeing - by gender and ethnicity

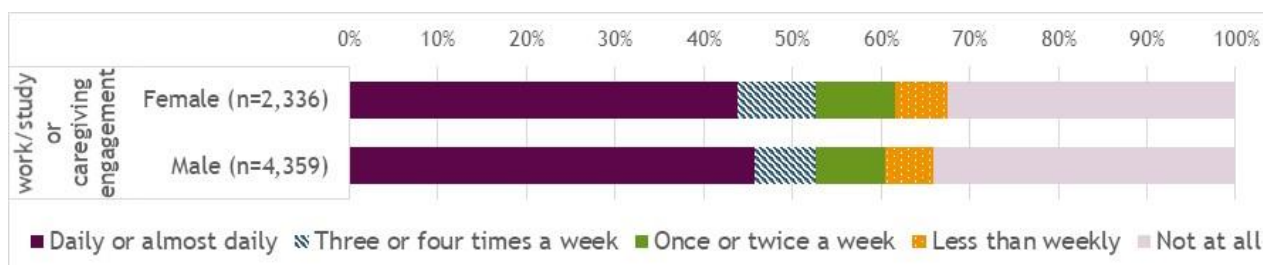
Graph 19 shows females are more likely to report lifestyle and wellbeing concerns, particularly in relation to mental and physical health.

Graph 19: Distribution of lifestyle and wellbeing responses at ADOM treatment start collections, by gender, July 2016 - June 2017



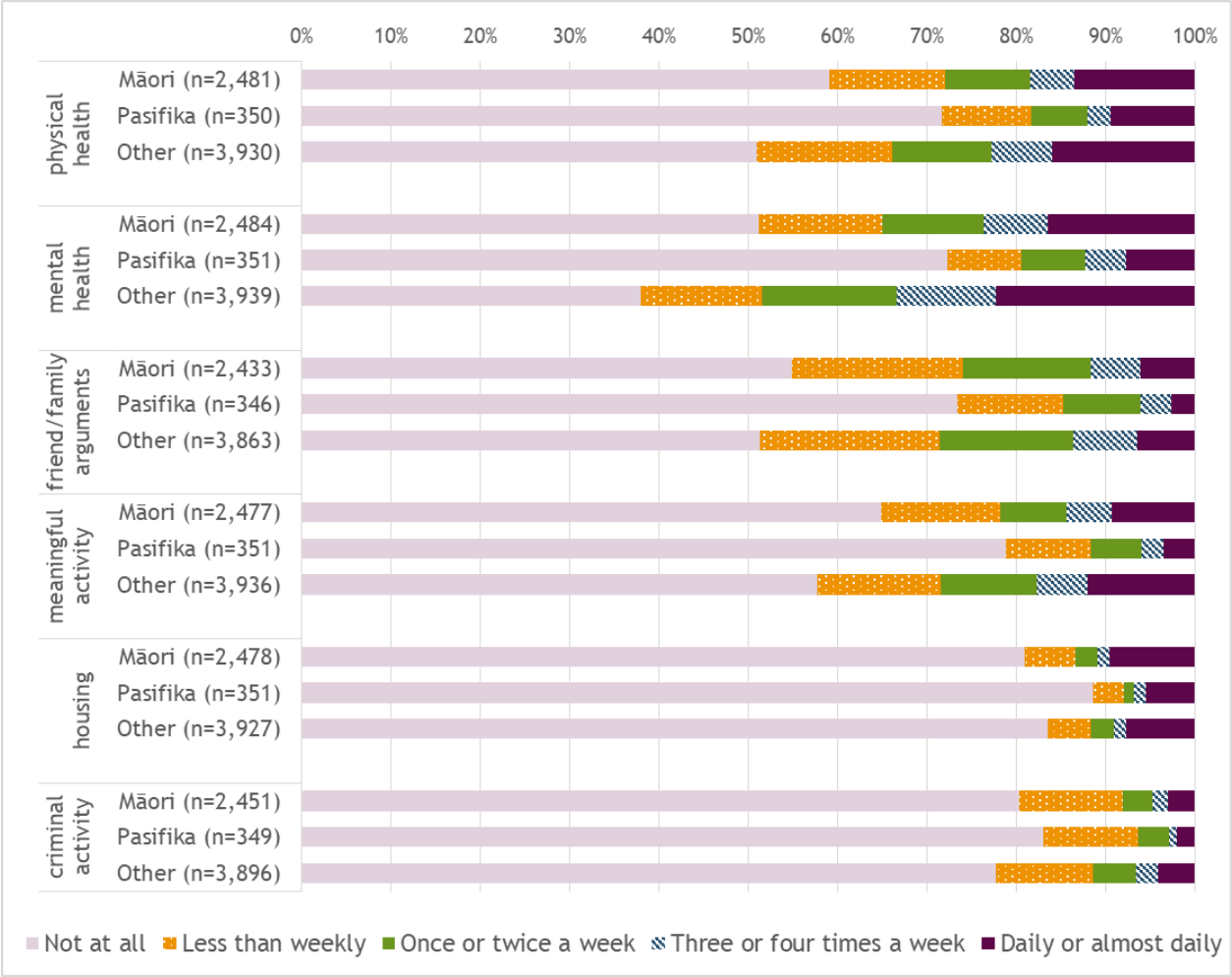
Graph 20 shows little difference between males and females regarding engagement with work, study or caregiving activities.

Graph 20: Distribution of lifestyle and wellbeing responses Q16 (engagement with work, study or care giving) at ADOM treatment start collections, by gender, July 2016 to June 2017



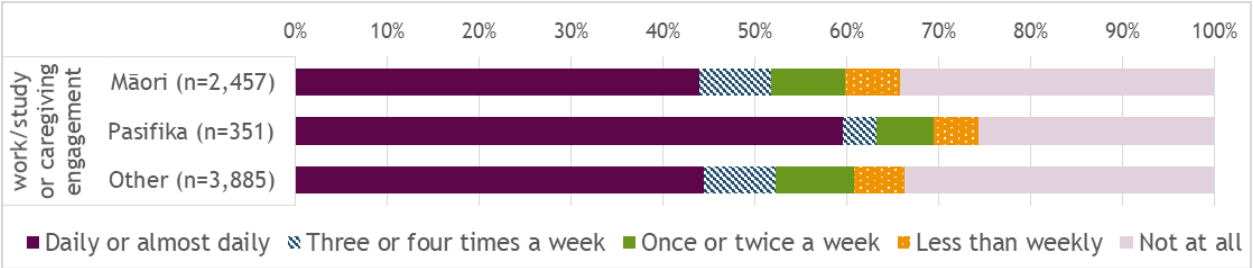
Graph 21 shows the response to Section 2 ADOM lifestyle and wellbeing questions by ethnic group. Māori and Pasifika people appear to have less lifestyle and wellbeing concerns compared to other ethnic groups. However, Māori have more concerns than Pasifika people, particularly in relation to mental and physical health.

Graph 21: Distribution of lifestyle and wellbeing responses at ADOM treatment start collections, by ethnicity, July 2016 to June 2017



Graph 22 indicates that Pasifika people tend to be engaged more with work, study or caregiving than tāngata whai ora in other ethnic groups.

Graph 22: Distribution of lifestyle and wellbeing responses Q16 (engagement with work, study or caregiving) at ADOM treatment start collections, by ethnicity, July 2016 to June 2017



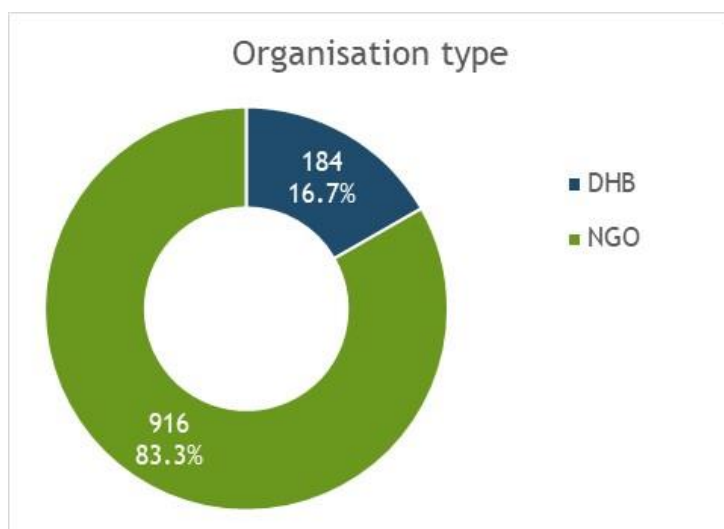
Part 3: Outcomes (matched pairs)

1,100 
Matched start and end pairs

There are 1,100 matched pairs of treatment start and treatment end ADOM collections. Please note that tāngata whai ora starting treatment during this year may still be in treatment and would not be included in matched pairs; also, did not attend (DNA) drop offs would exclude a significant number of potential pairs.

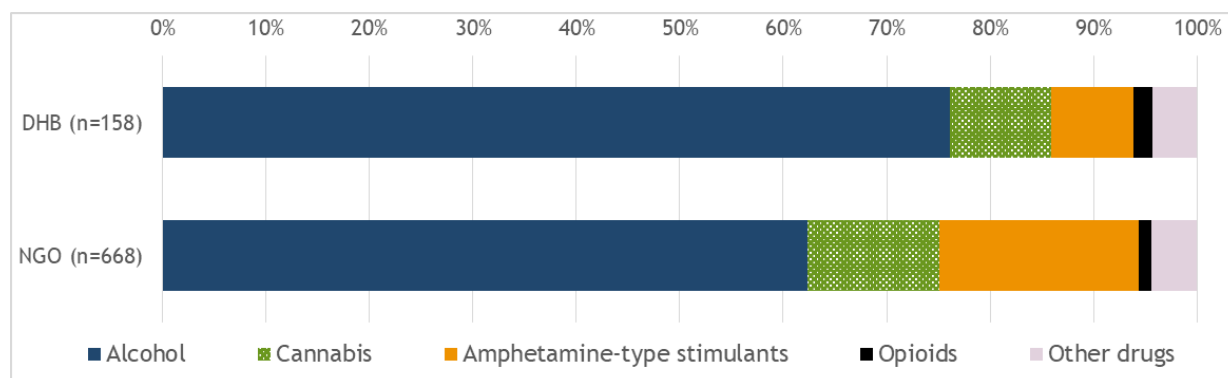
Graph 23 shows matched (treatment start and treatment end) pairs. NGOs have significantly more matched pairs than DHBs. District health boards may keep people in treatment longer than NGOs, perhaps due to case complexity¹³.

Graph 23: Percentage of ADOM matched pairs by organisation type, July 2016 to June 2017



Graph 24 shows the percentage of matched pairs by main substance of concern. Compared to all ADOM collections at treatment start, matched pairs were more likely to report alcohol as the main substance of concern, and less likely to report and amphetamine-type stimulants.

Graph 24: Percentage of ADOM matched pairs by main substance of concern, by organisation type, July 2016 to June 2017



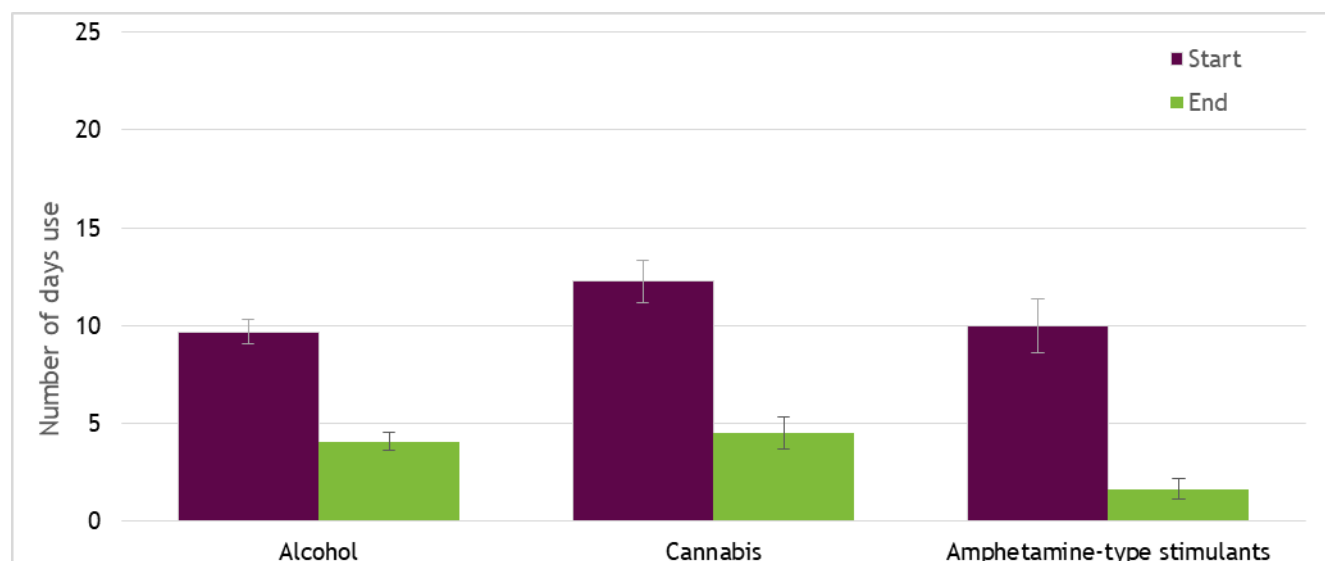
¹³ DHBs are often contracted to work with moderate to severe, where NGOs are often funded to work with mild to moderate complexity.

ADOM matched pairs by substance of concern

Due to the number of matched pairs currently available, treatment start and treatment end changes have been calculated for **any** substance use stated at treatment start, not specifically for main substance of concern. When more data is available, further analysis will be possible.

Graph 25 shows change in substance use between treatment start and treatment end. Results show a decrease in substance use between treatment start and treatment end. As an example, at treatment start the average number of days of alcohol use was 9.7 days compared to 4.1 days at treatment end. This indicates an average reduction in days of use by 5.6 days. [Table 5](#) provides a full list of changes in substance use.

Graph 25: Days of substance use in the past four weeks at ADOM treatment start and treatment end for those matched pairs with substance use as treatment start, July 2016 to June 2017



Graph 26 shows a reduction in the number of standard drinks used in a typical drinking day (from 11.0 to 4.8), by tāngata whai ora, from treatment start to treatment end.

Graph 26: Standard drinks used in a typical drinking day at ADOM treatment start and treatment end for those matched pairs with use at treatment start, July 2016 to June 2017

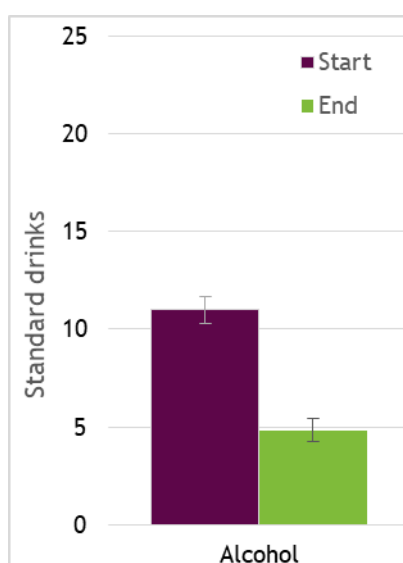


Table 5 provides analysis of the effect of treatment on substance use from treatment start to treatment end. Alcohol (days and amounts) and amphetamine-type stimulants all show significant improvement from treatment start to treatment end.

Table 5: Average days of substance use amongst those with use at treatment start, by ADOM treatment start, treatment end and outcome, matched pairs, July 2016 to June 2017

Question	Start mean	End mean	Outcome (Start minus end mean)	Cohen's d (effect size with 95% CI)	Effect of treatment
Q1: Alcohol days of use	9.7 (n=729)	4.1 (n=728)	5.6	0.74 (0.64-0.85)	Medium
Q2: Alcohol number of standard drinks consumed in a typical days use	11.0 (n=721)	4.8 (n=711)	6.1	0.70 (0.59-0.81)	Medium
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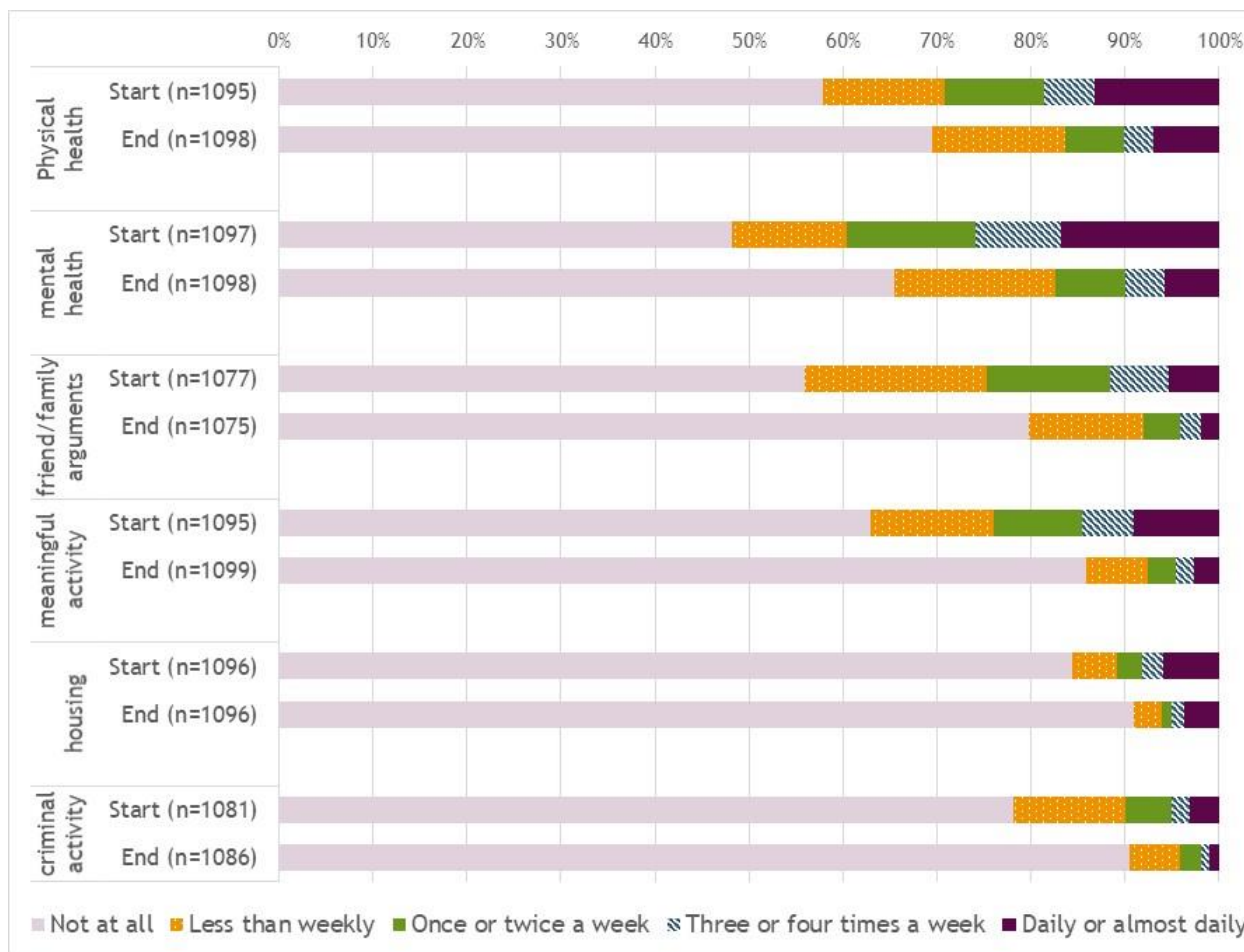
Notes: Cohen (1992)¹⁴ reports the following intervals for d: .2 to .5: small effect; .5 to .8: medium effect; .8 and higher: large effect.

¹⁴ Cohen, J (1992) A Power Primer, Quantitative Methods in Psychology, *Psychologic Bulletin* Vol 112, No.1 155-159.

ADOM matched pairs by lifestyle and wellbeing

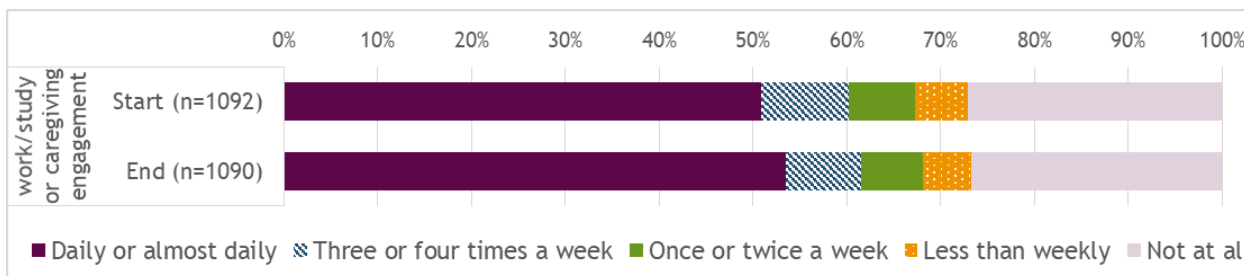
Graph 27 shows positive changes between treatment start and treatment end in lifestyle and wellbeing.

Graph 27: Distribution in lifestyle and wellbeing for ADOM treatment start and end for matched pairs, July 2016 to June 2017¹⁵



Graph 28 shows a small but positive change between treatment start and treatment end in employment, study and caregiving.

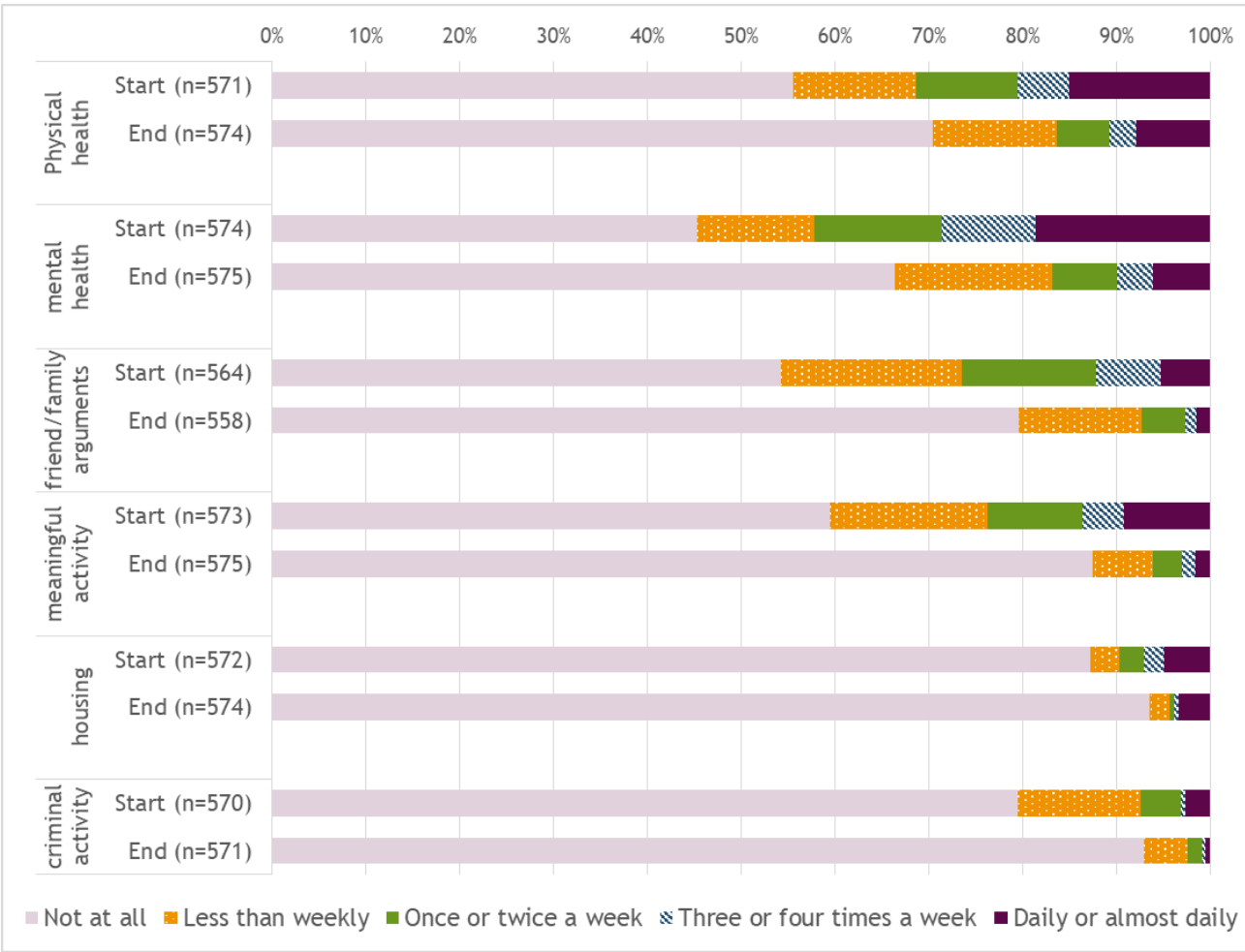
Graph 28: Distribution in lifestyle and wellbeing between ADOM treatment start and end for Q16 matched pairs, July 2016 to June 2017



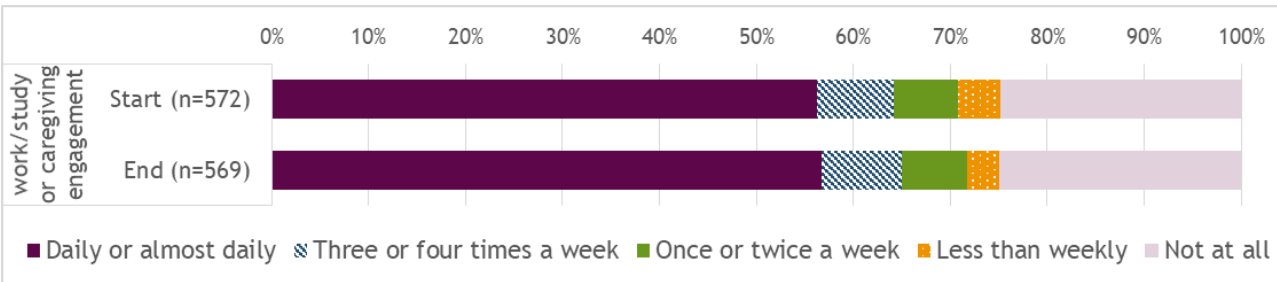
¹⁵ The matched pair total is 1,036. Some start, end figures and matched pair totals differ because a tangata whai ora may chose not to answer one of the questions at start or end, but still be within total data missing rules.

Graph 29 and 30 show changes in lifestyle and wellbeing scores where alcohol is the main substance of concern. While all domains showed improvement, the reduction in arguments by over half (at least weekly), and reduced problems in meaningful activity by a similar amount is positive.

Graph 29: Distribution in lifestyle and wellbeing for ADOM treatment start and end for matched pairs, alcohol main substance of concern at treatment start, July 2016 to June 2017

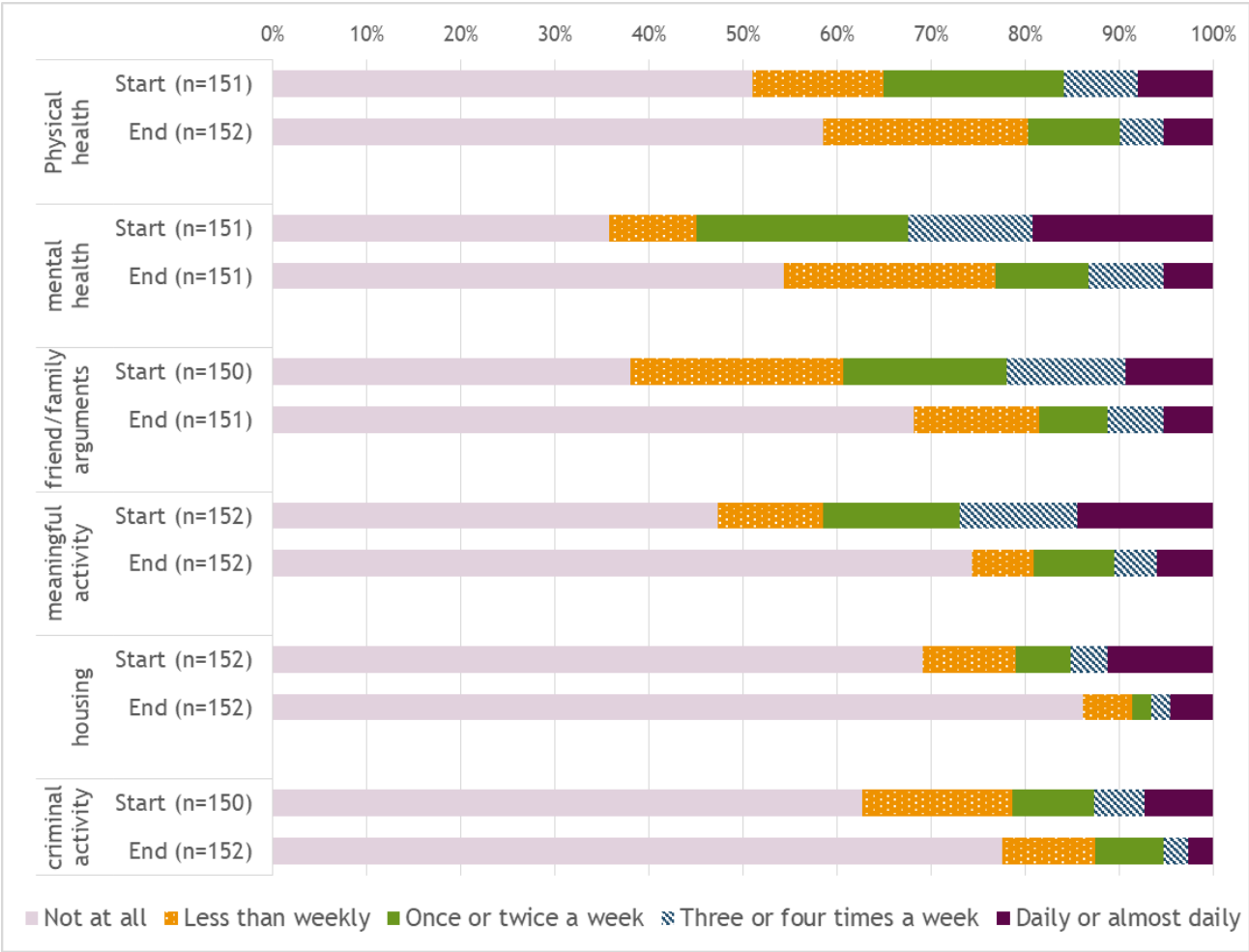


Graph 30: Distribution in lifestyle and wellbeing between ADOM treatment start and end for Q16 matched pairs, alcohol main substance of concern at treatment start, July 2016 to June 2017



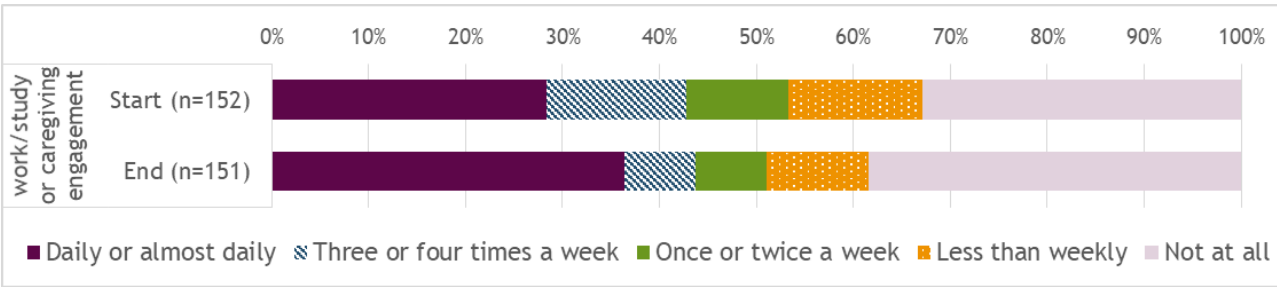
Graphs 31 and 32 show changes in lifestyle and wellbeing for those stating amphetamine-type stimulants as main substance of concern. All domains show significant reduction in problem areas. Perhaps the most striking that at treatment start some 19 per cent of tāngata whai ora reported mental health problems daily or almost daily, while at treatment end that had reduced to 5 per cent.

Graph 31: Distribution in lifestyle and wellbeing for ADOM treatment start and end for matched pairs, amphetamine-type stimulants main substance of concern at treatment start, July 2016 to June 2017



Graph 32 shows improvement at treatment end for those tāngata whai ora stating amphetamine-type substances as main substance of concern.

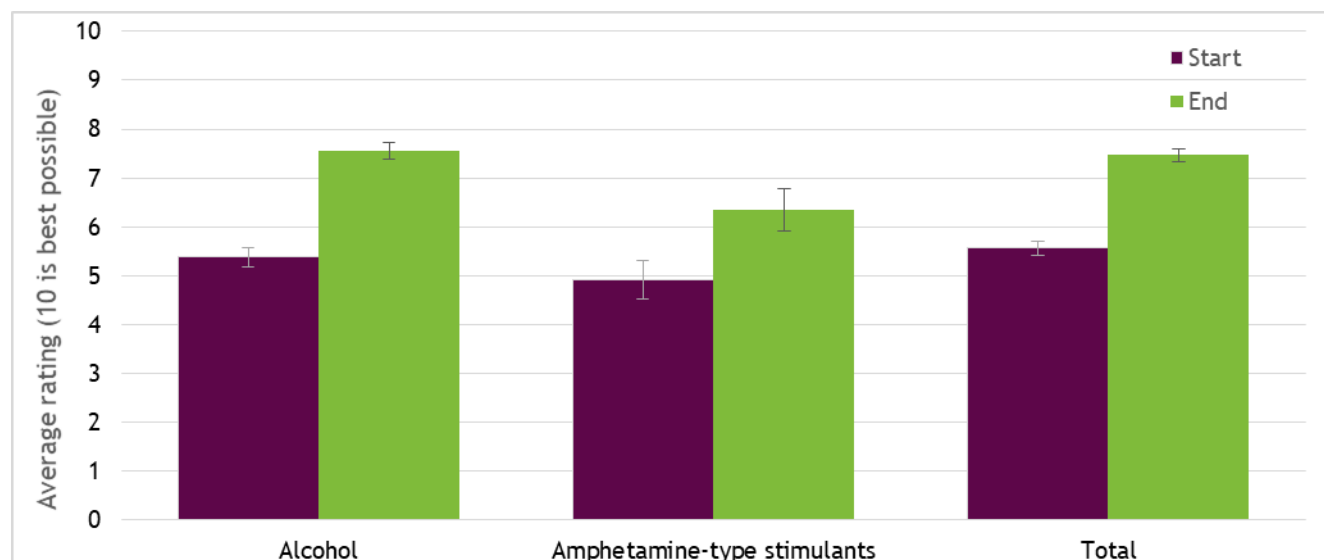
Graph 32: Distribution in lifestyle and wellbeing between ADOM treatment start and end for Q16 matched pairs, amphetamine-type stimulants main substance of concern at treatment start, July 2016 to June 2017



ADOM matched pairs by recovery

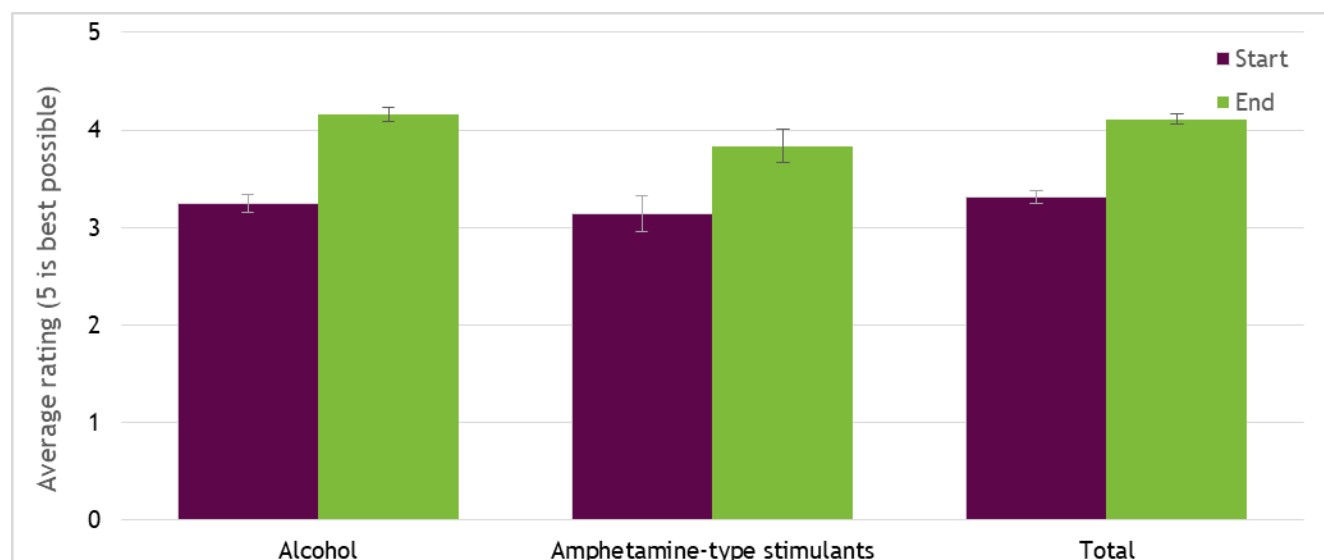
Graph 33 shows positive changes from treatment start to treatment end in how tāngata whai ora see themselves in relation in how close they are to where they want to be in their recovery.

Graph 33: Average self-rating of rates of closeness to desired recovery at ADOM treatment start and end collection, by selected substance of main concern, July 2016 to June 2017



Graph 34 shows positive change from treatment start to treatment end in how tāngata whai ora regard progress towards their recovery goals. Those using amphetamine-type stimulants show slightly less progress toward recovery goals at treatment start and treatment end than those using alcohol.

Graph 34: Average self-rating of how satisfied tāngata whai ora are with progress towards achieving their recovery goals at ADOM treatment start and end collection, by selected substance of main concern, July 2016 to June 2017



Appendix 1. Method¹⁶

Inclusion and exclusion criteria

AOD episode of care entering mandated services:

- includes teams mandated to collect ADOM¹⁷
- includes team type of alcohol and drug team or a co-existing team
- includes tāngata whai ora aged 18 years and over
- includes referrals with an in-scope contact. Excludes activity settings: WR, PH, SM, OM and exclude activity type: T08, T32, T35, T46, T47 and T49. The activity type is a contact
- join referral together to make an episode of care if they overlap or have 14 days or less between referral end and referral start.
- includes those episodes of care which start in the period of the report
- excludes Waitematā DHB from referrals and ADOM data as this DHB area uses a local outcome tool (Visual ADOM-R) which does not align with PRIMHD mapping requirements.

Treatment start with are within the episode of care: Include only episode of care with a treatment start ADOM collections including assessment only (RC13, RC14, RC15) in analysis.

ADOM collections analysis:

- includes teams recognised or identified as those mandated to collect ADOM
- includes tāngata whai ora are aged 18 years and over
- excludes ADOM collections with five or more missing items¹⁸
- excludes RC19 – Treatment end – DNA and RC21 – Treatment end – other
- excludes Waitematā DHB as the data uses local outcome tool (Visual ADOM-R) which does not align to PRIMHD mapping requirements.

For treatment start ADOM collections (RC13, RC14) is used.

ADOM matched pairs:

- based on ADOM collections above
- includes those for 28 days or longer
- uses the date of the end collection. Start collection can be outside the period but after 1 July 2015.

Opioid substitution services data:

- based on ADOM collections above
- includes tāngata whai ora in services who are coded as an opioid substitution team and/or those who receive contact T18 – Methadone treatment specialist service attendances or T19 – Methadone treatment specialist attendances (consumers of authorised GPs).

Other notes

‘Not specified’ answers to items are excluded for specific questions. For example, for substance of main concern there are a number of collections without a response to this question.

¹⁶ Please see ADOM report building rules for a full explanation of methodology, inclusion and exclusion of data in these reports.

¹⁷ Some teams in the list are excluded. This is because the team is coded as a community mental health team, and AOD only referrals cannot be differentiated.

¹⁸ This is excluding questions 7, 9 and 11.

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