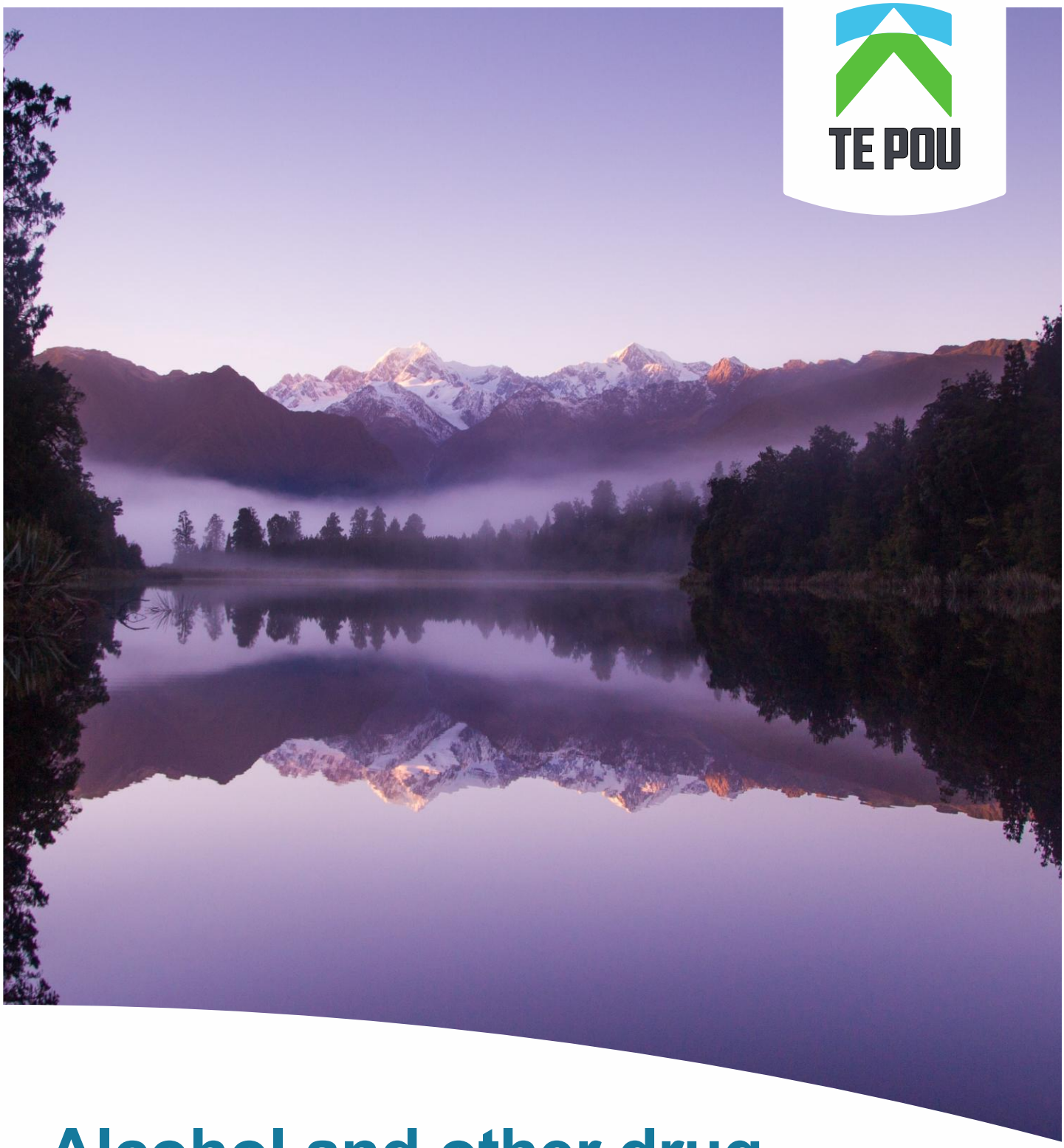

Alcohol and other drug outcome measure (ADOM)

Report 18: NGO and Te Whatu Ora ADOM collections, October 2021 to September 2024

tepou.co.nz

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Acknowledgements

This report was prepared by Sandra Baxendine (information analyst), Maria Basabas (researcher), Angela Jury (research manager), Selina Elkington (programme manager addiction), and Mark Smith (principal advisor – outcomes & information) of Te Pou. We also thank Simon Katz and Memo Musa from Atamira Platform for their review.

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Glossary

Term	Definition
AOD	Alcohol and other drug (services).
Matched pairs	Two collections, in this case treatment start and routine 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.
Tangata whai ora, Tāngata whai ora	Person or people seeking wellness; refers to people accessing AOD services.

Executive summary

Non-government organisations (NGOs) play an important role in providing addiction services and support in Aotearoa New Zealand. Community NGOs work alongside publicly funded (Te Whatu Ora) addiction services to support people's recovery from harms caused by alcohol and other drugs (AOD).

This 18th national Alcohol and Other Drug Outcome Measure (ADOM) report provides an overview of tāngata whai ora accessing NGO community AOD services and their outcomes.[1] This report builds on previous ADOM reports by Te Pou summarising recent available data.[2]

This report analyses data from NGO and Te Whatu Ora services mandated to offer the ADOM to tāngata whai ora, people with valid ADOM collections at treatment start, and matched pairs (both treatment start and end).[3] It uses PRIMHD data supplied by Te Whatu Ora, Health New Zealand (extracted on 22 January 2025) for the period October 2021 to September 2024.

Appendix A summarises the method.

Note, as some NGOs and Te Whatu Ora districts are not yet submitting ADOM collections to PRIMHD, results may not represent all people attending community AOD services.

This report focuses on NGOs and has three parts.

- Part one provides an overview of ADOM collections for the analysis period.
- Part two summarises ADOM data at treatment start.
- Part three presents outcomes at treatment end for tāngata whai ora in substance use, lifestyle and wellbeing, and recovery progress.

Key findings

Between October 2021 and September 2024, over half (57 percent) of addiction episodes of care among services mandated to offer ADOM started in NGOs. The characteristics of people accessing NGO services, their treatment pathways, and support needs tend to vary to Te Whatu Ora services.

ADOM data was collected for around one-third of episodes at NGOs (35 percent), similar to Te Whatu Ora services (34 percent).[4]

At treatment start, NGOs tend to support tāngata whai ora with more complex needs, such as greater use of amphetamine-type stimulants, concurrent multiple substance use, and frequent problems with lifestyle and wellbeing. Key findings for NGO services at treatment start include:

- 40 percent of tāngata whai ora identify as Māori (compared to 30 percent in Te Whatu Ora services)[5]

[1] This report excludes residential, inpatient, and corrections-based AOD services.

[2] ADOM reports are published on the Te Pou website, https://www.tepou.co.nz/initiatives/alcohol-and-drug-outcome-measure

[3] Tāngata whai ora could potentially have multiple treatment starts. ADOM treatment end is within October 2021 to September 2024.

[4] Treatment starts and assessment only.

[5] Māori reflect 16.8 percent of the general population aged 18 to 64 years, see https://www.stats.govt.nz

- 39 percent of tāngata whai ora accessed another addiction service within 3 months prior to episode start[6] (compared to 14 percent in Te Whatu Ora services)
- the two most common substances of concern are alcohol (56 percent) and amphetamine-type stimulants (25 percent; compared to 64 and 15 percent respectively in Te Whatu Ora services)
- 39 percent report using more than one type of substance (33 percent Te Whatu Ora services)
- 14 percent use both alcohol and amphetamine-type stimulants (10 percent Te Whatu Ora services).

Finding amphetamine-type stimulants and concurrent use of multiple substances are more common in NGOs reflects the complex challenges people experience at treatment start. Despite this, people accessing NGOs experience similar improvements to those in Te Whatu Ora services. At the end of treatment people in NGOs show larger improvements on average in reducing amphetamine-type stimulant use and fewer problems with criminal activity. These findings highlight how community NGOs enhance people's wellbeing and recovery.

Despite showing improvements during treatment, many people continue to experience problems in various lifestyle and wellbeing domains at treatment end, particularly in their mental health and physical health. This signals the need to strengthen support for other areas of wellbeing throughout AOD service delivery to support people's recovery. This may include, for example, connecting people with local physical and mental health services in the community as part of AOD treatment and discharge plans.

To better understand outcomes for tāngata whai ora accessing AOD support in the community, there is a need to improve ADOM collection rates. About one-third of episodes of care in NGO and Te Whatu Ora services have had ADOM collected. Better data collection by NGOs will help address broader gaps in outcomes data, make NGOs more visible in PRIMHD, and contribute to a better understanding of the role NGOs have in providing AOD support. This reiterates the importance of continued investment in ADOM training and supporting implementation to ensure better outcomes for people accessing AOD services.

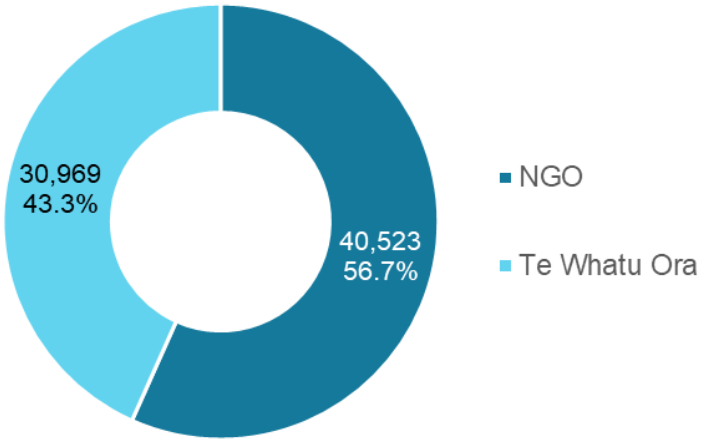
[6] Half of these were NGOs.

Introduction

In Aotearoa New Zealand non-government organisations (NGOs) play an important role in providing AOD support for tāngata whai ora (Atamira Platform Trust, 2025; Government Inquiry into Mental Health and Addiction., 2018). NGOs operate independently within and alongside a broader system of other health and social support services, including publicly funded Health New Zealand | Te Whatu Ora services (Bullock & Lavis, 2019).

NGOs provide a significant share of addiction services nationally. Figure 1 shows that between October 2021 and September 2024, more than half (57 percent) of all community addiction episodes of care started in NGOs.

Figure 1. AOD episodes of care in ADOM mandated services by organisation type (October 2021 to September 2024)



There is an increasing focus on understanding how NGOs support the wellbeing of tāngata whai ora and communities (Atamira Platform Trust, 2025). However, less information is available about NGO service outcomes compared to publicly funded services. Information gathered through PRIMHD can be used to better understand the role NGOs play in providing AOD support.

This report provides an overview of ADOM data collected for NGO community AOD services between October 2021 and September 2024. It uses PRIMHD data supplied by Health New Zealand | Te Whatu Ora extracted on 22 January 2025 (see Appendix A for full method details). Findings are reported for services mandated to offer ADOM collections, tāngata whai ora with ADOM collections at treatment start, and matched pairs (people with valid ADOM collections at both treatment start and end).[7,8]

This report presents findings in three main sections.

- Part one: overview of ADOM collections for October 2021 to September 2024.
- Part two: overview of ADOM data at treatment start.
- Part three: changes during treatment (matched pairs).

[7] ADOM treatment end is within the October 2021 to September 2024 period.

[8] Valid collections are defined as ADOM collections with four or fewer missing items (excluding questions 7, 9, and 11).

It is important to consider the following when interpreting findings.

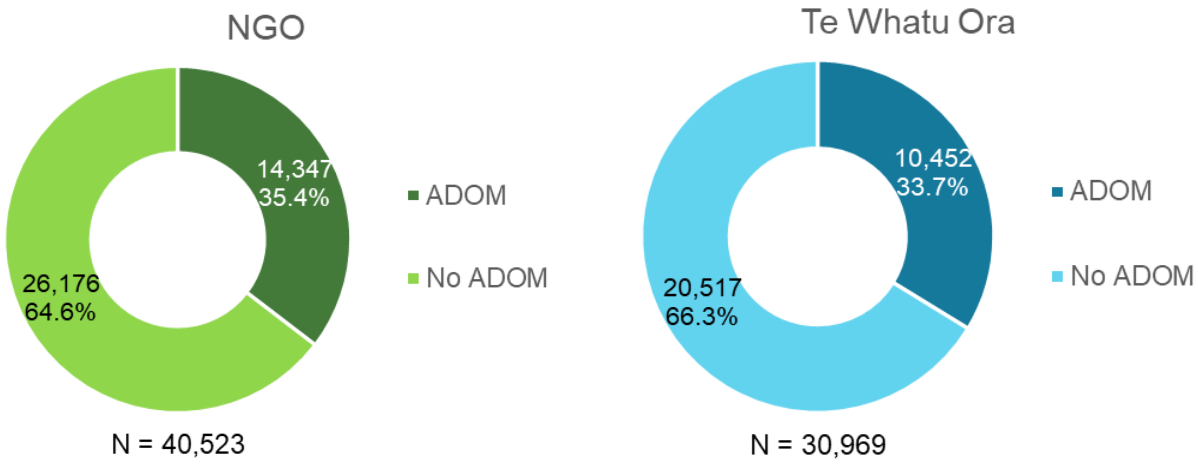
- Findings may not be generalisable to all people accessing AOD services as ADOM data has not been collected for all people accessing these services.
- Data cannot be used to estimate levels of problematic substance use in the general population.
- Findings in part three reflect outcomes for people who have had ADOM collected at both treatment start and end. Findings may not apply to others with different ADOM collections.

Part one: ADOM collections within PRIMHD

This section describes ADOM collections between October 2021 and September 2024 by service type and reasons for collection.

Figure 2 shows NGOs collected ADOM data for over one-third of episodes of care (35.4 percent), similar to Te Whatu Ora services (33.7 precent).

Figure 2. AOD episodes of care with ADOM collections (treatment start or assessment only) by organisation type (October 2021 to September 2024)



Reason for ADOM collection

Figure 3 shows reasons for ADOM collections by organisation type. NGOs are more likely to undertake assessment only and admission collections than Te Whatu Ora services. Conversely, Te Whatu Ora services had more treatment review and treatment end collections.

Figure 3. Reasons for valid ADOM collections by organisation type (October 2021 to September 2024)

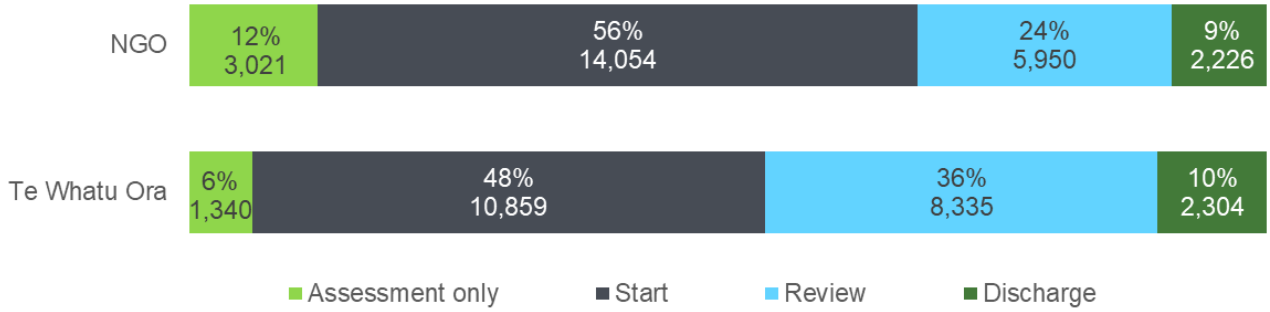


Table 1 shows the percentage of valid ADOM collections by reasons for collection. Overall, there is a large drop-off in valid collections between treatment start and end. At treatment start, review, and discharge, there were lower percentages of valid collections in NGOs than Te Whatu Ora services.

Table 1. Valid ADOM collections by reason for collection by organisation type (October 2021 to September 2024)

Reason for collection	NGO				Te Whatu Ora			
	Valid	Not valid	Total	%	Valid	Not valid	Total	%
Assessment only	3,021	142	3,163	96%	1,340	69	1,409	95%
Start	14,054	1,512	15,566	90%	10,859	592	11,451	95%
Review	5,950	1,223	7,173	83%	8,335	417	8,752	95%
Discharge	2,226	758	2,984	75%	2,304	363	2,667	86%

Part two: ADOM treatment start

This section describes ADOM data at treatment start including tāngata whai ora demographics, frequency of substance use, and lifestyle and wellbeing.

Figure 4 shows NGOs comprise 56 percent of ADOM collections at treatment start.

Figure 4. ADOM treatment start collections by organisation type (October 2021 to September 2024)

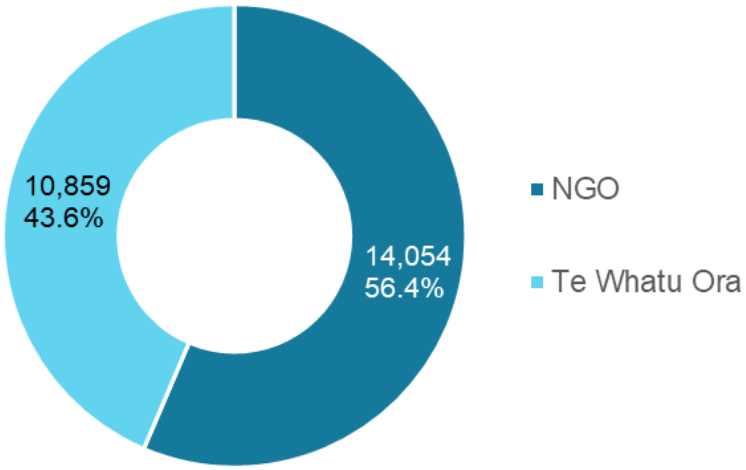


Table 2 indicates the demographic profile of tāngata whai ora with ADOM treatment start collections is similar to people accessing services overall. People aged 25 to 44 years are most likely to access NGO services. Māori make up a greater proportion of pepole accessing NGO services.

Table 2. Profile of ADOM treatment start collections and tāngata whai ora seen by organisation type and demographics (gender, ethnicity, age group) (October 2021 to September 2024)

	Number		Percentage		Tāngata whai ora seen	
Group	NGO	Te Whatu Ora	NGO	Te Whatu Ora	NGO	Te Whatu Ora
Gender						
Female	4,523	3,240	32.2%	29.8%	35.2%	33.5%
Male	9,521	7,611	67.7%	70.1%	64.7%	66.4%
Total	14,054	10,859	100.0%	100.0%	100.0%	100.0%
Ethnicity						
Māori	5,670	3,271	40.3%	30.1%	45.1%	32.2%
Pasifika	969	1,711	6.9%	15.8%	6.1%	11.3%
Other	7,415	5,877	52.8%	54.1%	48.8%	56.5%
Total	14,054	10,859	100.0%	100.0%	100.0%	100.0%
Age group						
18 to 24 years	1,534	1,467	10.9%	13.5%	14.0%	14.5%
25 to 44 years	8,669	6,090	61.7%	56.1%	60.7%	54.0%
45 to 64 years	3,533	2,996	25.1%	27.6%	23.3%	28.0%
65 years+	318	306	2.3%	2.8%	2.0%	3.5%
Total	14,054	10,859	100.0%	100.0%	100.0%	100.0%

Figure 5 summarises the proportion of people who accessed another addiction service in the 3 months before an ADOM treatment start collection. Among people with ADOM treatment start collections in NGOs, almost half accessed another addiction service prior; many were another NGO. Fewer people in Te Whatu Ora services had accessed another addiction service prior to treatment start.

Appendix B further shows prior addiction service access by ethnicity and gender.

Figure 5. Addiction activity in the 3 months before episode start for those with ADOM treatment start collections by organisation type (October 2021 to September 2024)

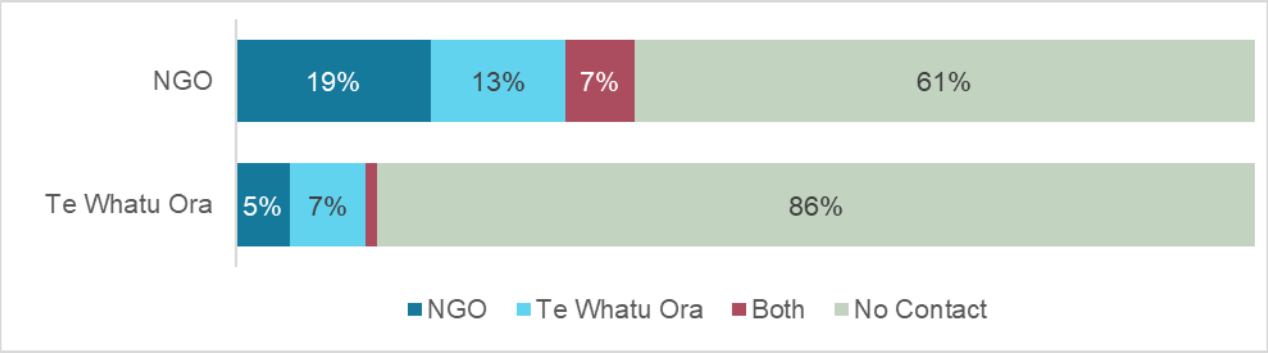


Table 3 shows average substance use in the last 28 days at treatment start by organisation type. Alcohol is the most commonly used substance across both NGO and Te Whatu Ora services.

NGOs show higher rates of amphetamine-type stimulant, cannabis, and cigarette/tobacco use.

Table 3. Substance use in the last 28 days at ADOM treatment start by organisation type (October 2021 to September 2024)

Substance	Average use (days)		Number		Percentage	
	NGO	Te Whatu Ora	NGO	Te Whatu Ora	NGO	Te Whatu Ora
Alcohol (days)	11.1	12.6	8,320	6,932	59.3%	64.0%
Alcohol (standard drinks)	12.1	12.0	8,185	6,810	59.6%	63.2%
Cannabis (days)	15.8	15.8	5,347	3,593	38.3%	33.2%
Amphetamine - type stimulants (days)	10.4	8.8	3,138	1,640	22.7%	15.3%
Opioids (days)	9.7	18.4	491	594	3.6%	5.6%
Sedatives/tranquilisers (days)	10.1	13.3	537	547	4.0%	5.2%
Cigarette/tobacco (cigarettes)	11.0	10.4	5,904	4,210	45.8%	41.5%
Injected drug (days)	9.3	13.4	460	379	3.6%	3.7%

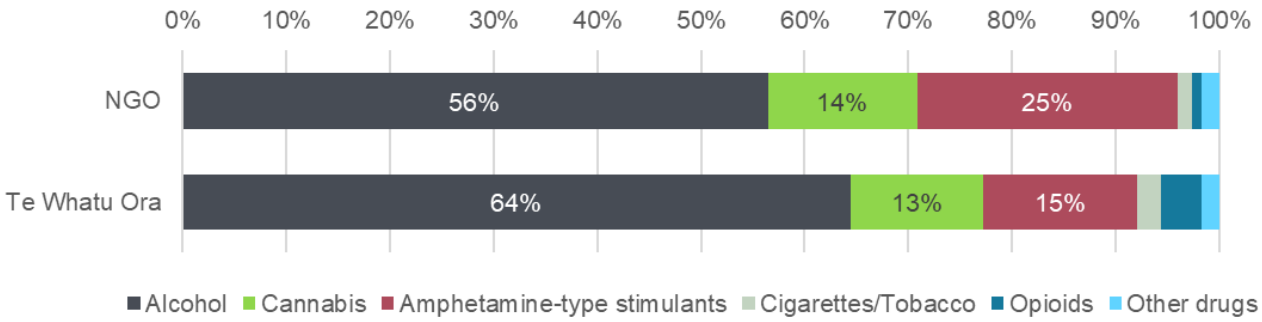
Main substance of concern at treatment start

When tāngata whai ora access services and complete their first ADOM collection, they are asked to report their main substance of concern. A main substance of concern reflects the substance people think is having the most impact on their lives. It may differ from the substance used most frequently.

A total of 19,952 people reported a main substance of concern at start of treatment (70 percent within NGOs and 93 percent in Te Whatu Ora services).

Figure 6 shows that one-quarter of people in NGOs reported amphetamine-type stimulants as their main substance of concern at treatment start.[9] Alcohol is the most common main substance of concern across both organisation types.

Figure 6. Main substance of concern at treatment start by organisation type (October 2021 to September 2024)



Note. Proportions of 5 percent or less not labelled.

Table 4 summarises secondary substance(s) of concern by organisation type. Alcohol and cannabis are common secondary concerns.

Among people accessing NGOs, secondary substances of concern were commonly:

- cannabis where alcohol or amphetamine-type stimulants were main substances of concern
- amphetamine-type stimulants where cannabis was the main substance of concern.

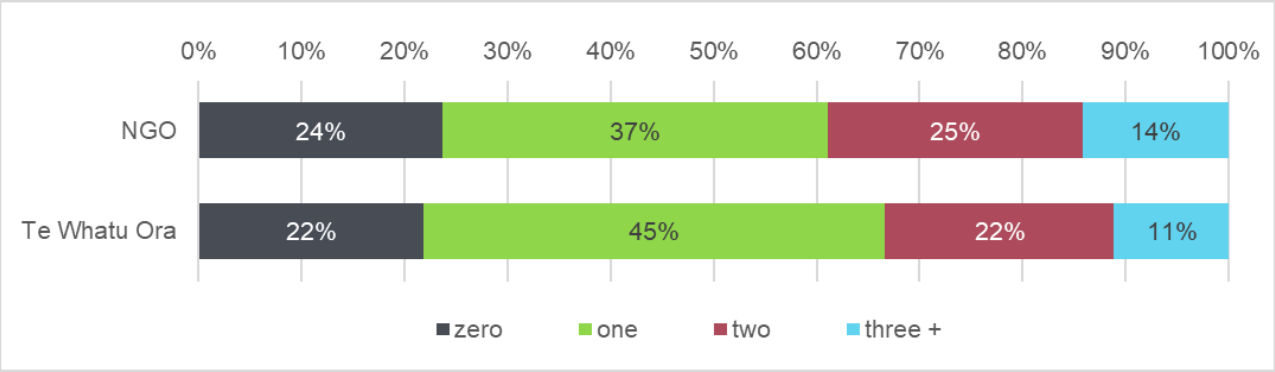
[9] Figures are not indicative of substances of concern for people not accessing services or accessing different AOD service settings such as residential and inpatient.

Table 4. Secondary substances of concern by main substance of concern by organisation type (October 2021 to September 2024)

Main substance of concern	Second substance of concern	NGO		Te Whatu Ora	
		Number	%	Number	%
Alcohol	Cannabis	1,185	21.4%	965	14.8%
	Cigarettes/Tobacco	640	11.5%	832	12.7%
	Amphetamine-type stimulants	382	6.9%	294	4.5%
Cannabis	Alcohol	432	30.4%	388	30.0%
	Amphetamine-type stimulants	265	18.6%	155	12.0%
	Cigarettes/Tobacco	134	9.4%	166	12.8%
Amphetamine-type stimulants	Cannabis	704	28.6%	439	29.2%
	Alcohol	548	22.3%	344	22.9%
	Cigarettes/Tobacco	120	4.9%	103	6.8%

Figure 7 shows how many types of substances people reported using in the last 28 days by organisation type. Among people at NGOs who reported using at least one substance, over half (51 percent) reported more than one. A lower proportion of people reported using more than one substance (42 percent) in Te Whatu Ora services.

Figure 7. Number of substances used in the last 28 days by organisation type (October 2021 to September 2024)



Note, excludes cigarettes/tobacco.

Table 5 looks at the various combinations of substance use by organisation type. In NGOs more people reported using a combination of substances involving both alcohol and amphetamine-type stimulants than in Te Whatu Ora services.[10]

[10] Including the 'Alcohol, amphetamine-type stimulants' and 'Alcohol, cannabis, amphetamine-type stimulants' groups.

Table 5. Combinations of substances used in the last 28 days by organisation type (October 2021 to September 2024)

Substances	NGO		Te Whatu Ora	
	Number	%	Number	%
No substance	3,327	23.7%	2,367	21.8%
Alcohol only	3,645	25.9%	3,822	35.2%
Alcohol, cannabis	2,358	16.8%	1,777	16.4%
Alcohol, cannabis, amphetamine-type stimulants	1,346	9.6%	691	6.4%
Alcohol, amphetamine-type stimulants	645	4.6%	350	3.2%
Alcohol and other	326	2.3%	292	2.7%
Cannabis	1,047	7.4%	813	7.5%
Cannabis, amphetamine-type stimulants	596	4.2%	312	2.9%
Amphetamine-type stimulants	551	3.9%	287	2.6%
Other drug	213	1.5%	148	1.4%
Total	14,054	100.0%	10,859	100.0%

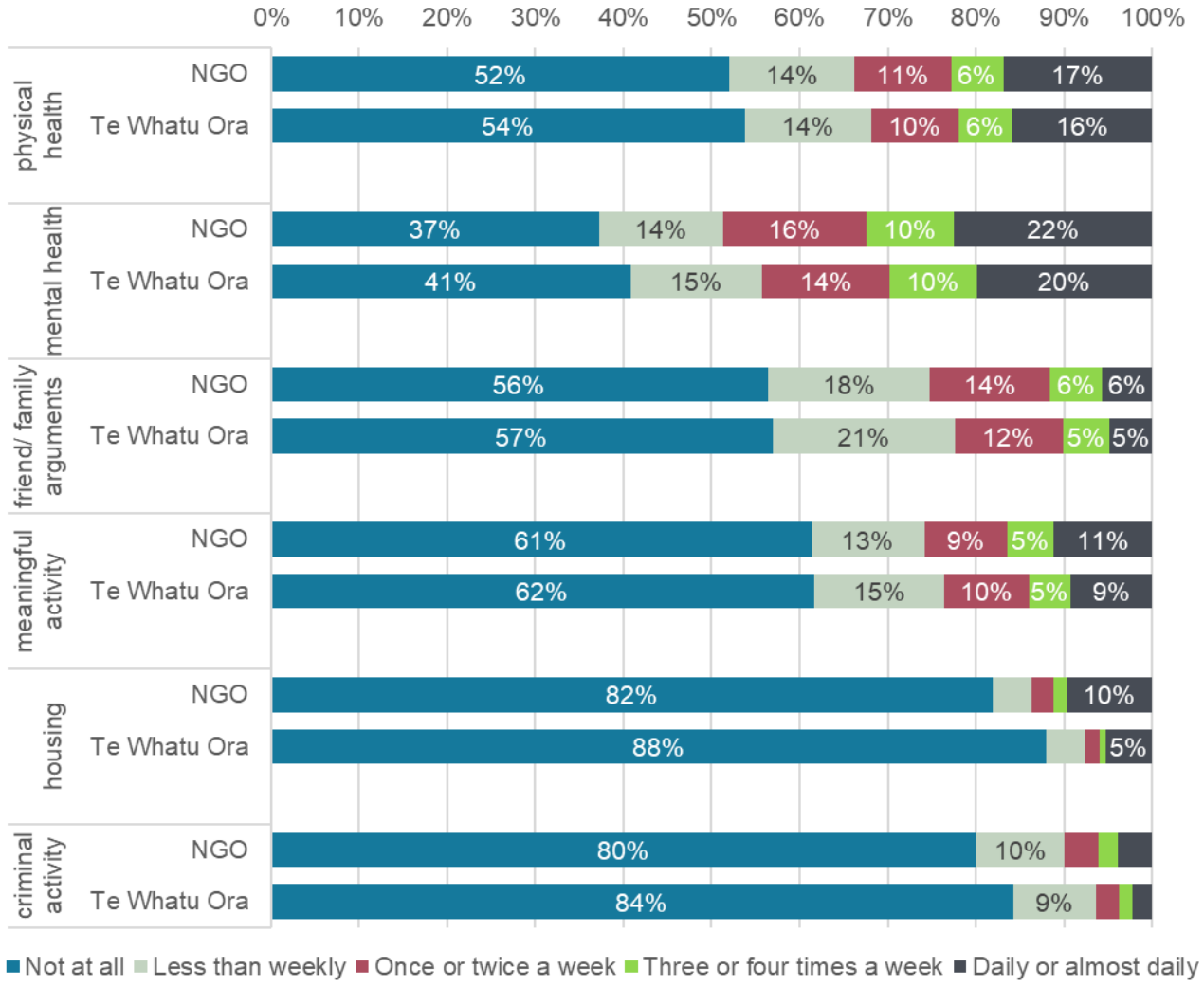
Lifestyle and wellbeing at treatment start

This section describes lifestyle and wellbeing domains for tāngata whai ora at treatment start based on ADOM section two questions (see Appendix C).[11]

Figure 8 shows the proportion of tāngata whai ora who experienced problems with lifestyle and wellbeing domains at treatment start within NGOs and Te Whatu Ora services. People in NGOs reported slightly more problems with mental health, housing, and criminal activity at treatment start.

[11] Table 7 in Appendix B provides the section two questions in full.

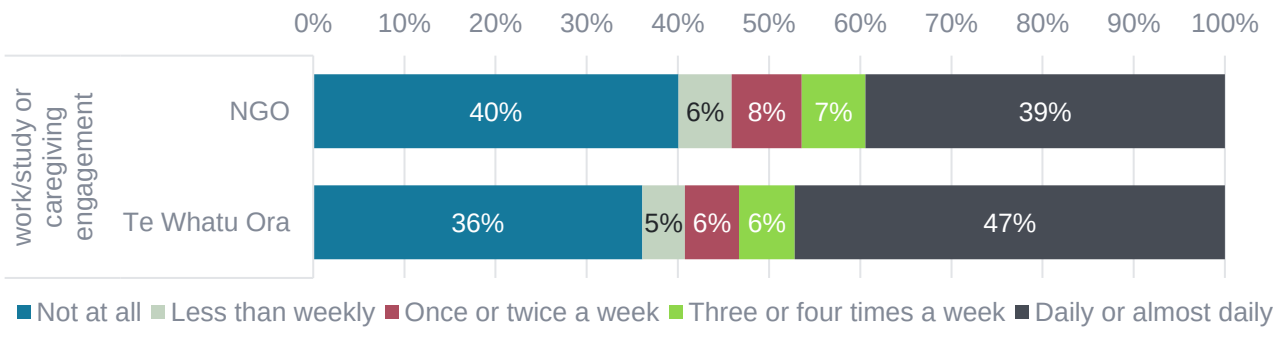
Figure 8. Lifestyle and wellbeing domains at ADOM treatment start by organisation type (October 2021 to September 2024)



Note. Proportions of 5 percent or less not labelled.

Figure 9 shows lower rates of engagement with work, study, or caregiving among people starting treatment at NGOs.

Figure 9. Engagement with work, study, or caregiving at ADOM treatment start by organisation type (October 2021 to September 2024)



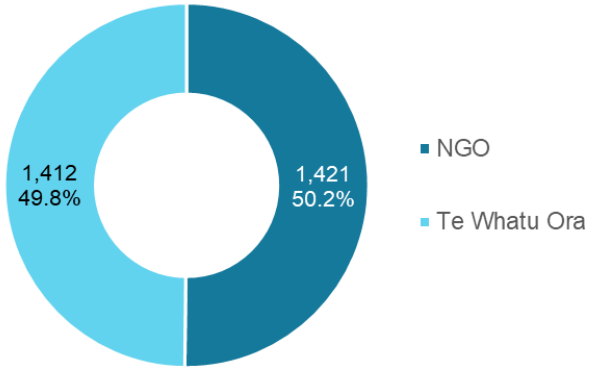
Part three: Outcomes (matched pairs)

This section describes outcomes for people accessing community AOD services where ADOM was collected at both treatment start and end (2,833 matched pairs).[12]

People who completed treatment after this period are not included in the following analyses.[13] A significant number of tāngata whai ora are missing valid ADOM treatment end collections and are therefore not included (see Appendix A for inclusion criteria).

Figure 10 shows NGOs make up just over half of matched pairs.

Figure 10. ADOM matched pairs by organisation type (October 2021 to September 2021)



Changes in substance use

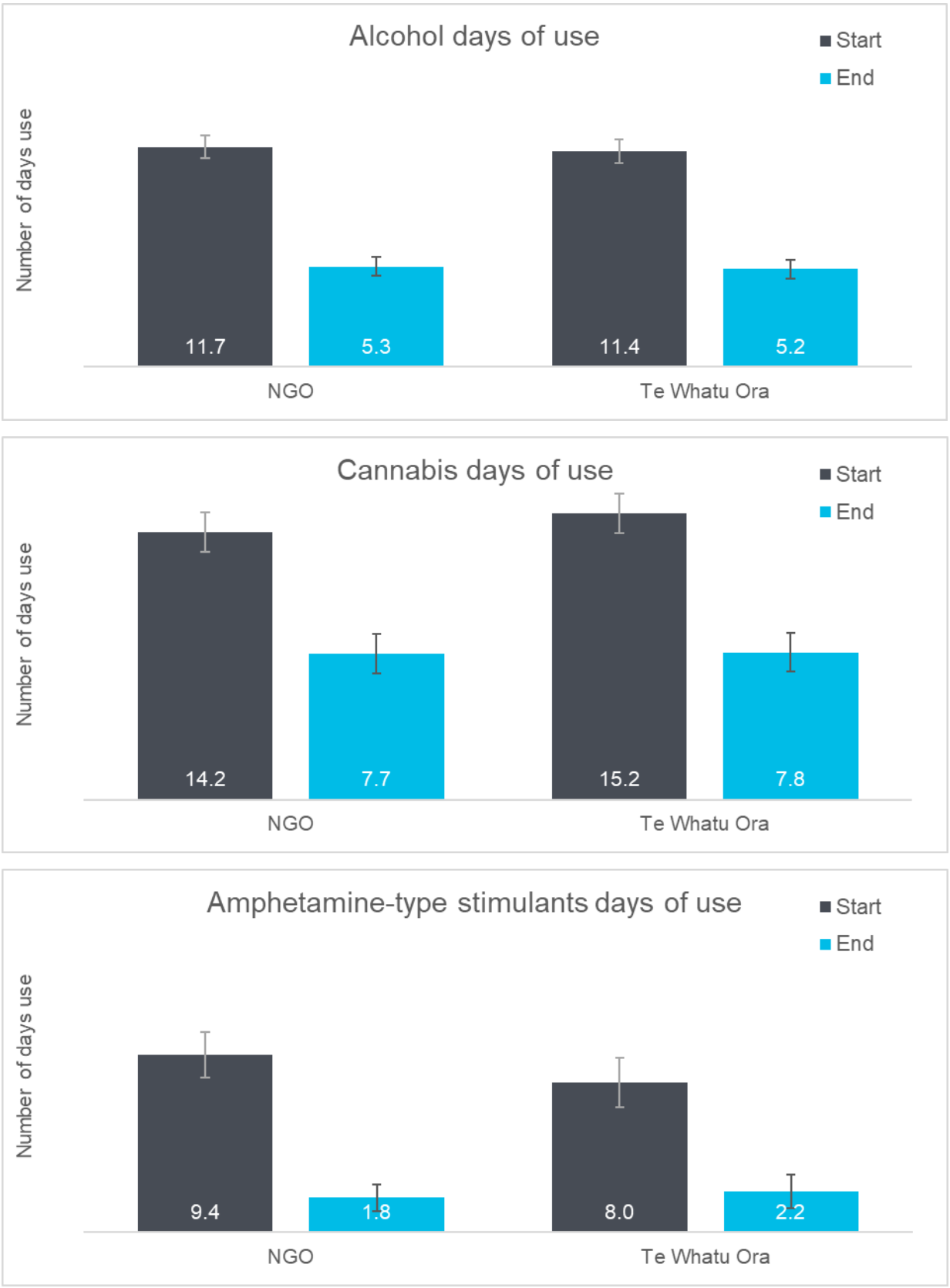
This section presents changes in people's substance use between treatment start and end. Analyses by main substance of concern are not undertaken due to the limited amount of data available. Appendix D contains effect size analyses informing results.

Figure 11 shows medium-to-large decreases in the frequency of substance use for tāngata whai ora across all substances between treatment start and end. NGOs show larger reductions in amphetamine-type stimulant use than Te Whatu Ora services.

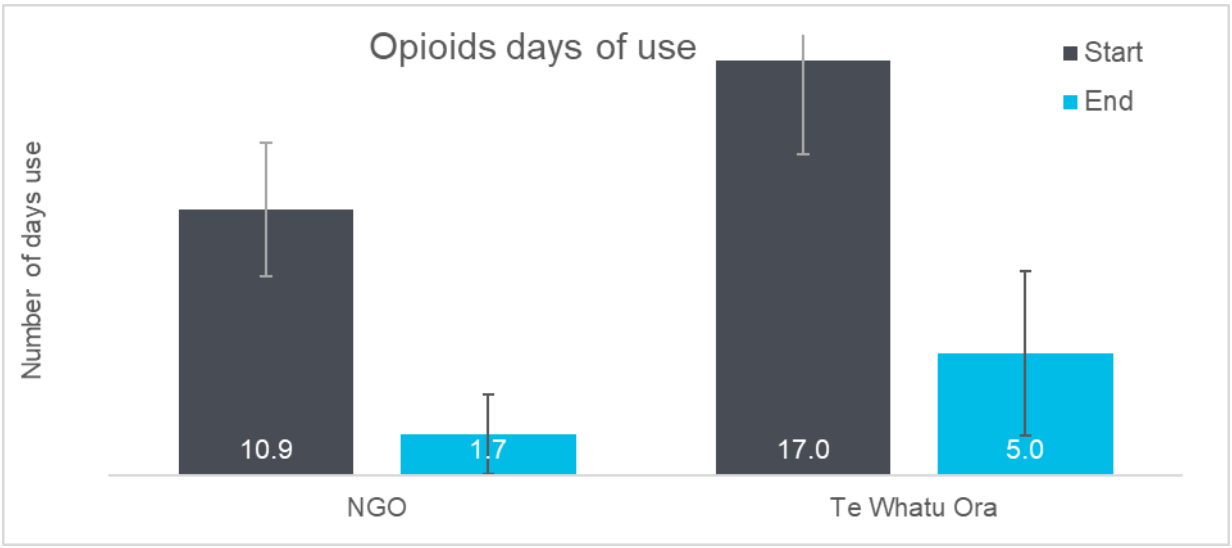
[12] The main substance of concern for people with matched pairs data is similar to that of all people who had ADOM collected at treatment start.

[13] Treatment for some substances (such as opioid substitution treatment) occurs over a long duration and are therefore less likely to be captured in matched pair analyses covering a short time period.

Figure 11. Change in average days of substance use in the past 28 days for matched pairs by organisation type (October 2021 to September 2024)[14]



[14] Matched pairs with reported substance use frequency at treatment start.



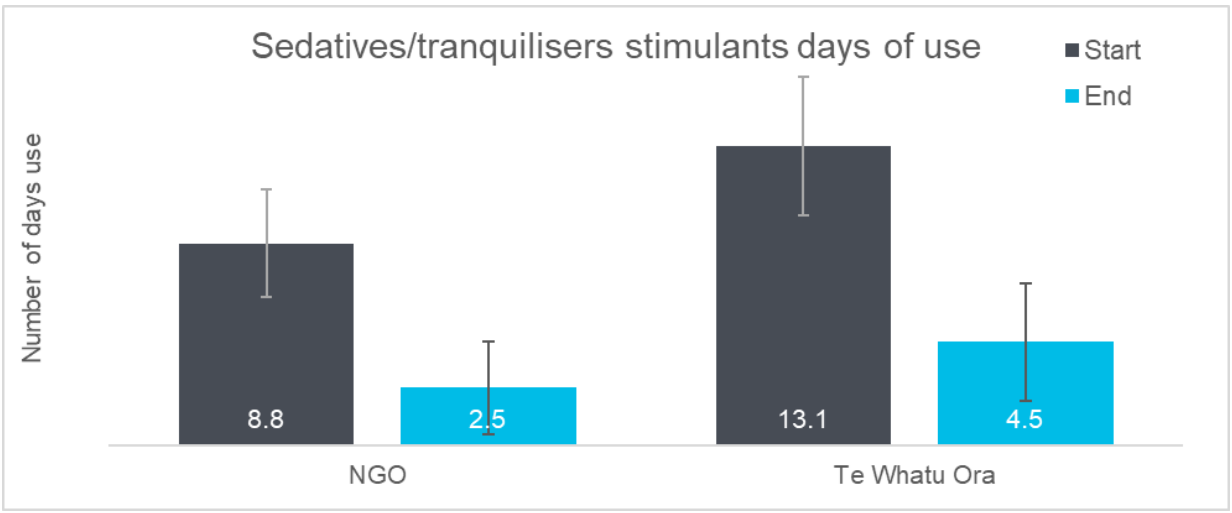


Figure 12 shows a reduction in the average number of standard drinks tāngata whai ora consume on a typical drinking day between the start and end of treatment.

Figure 12. Change in average standard drinks consumed in a typical drinking day for matched pairs by organisation type (October 2021 to September 2024)

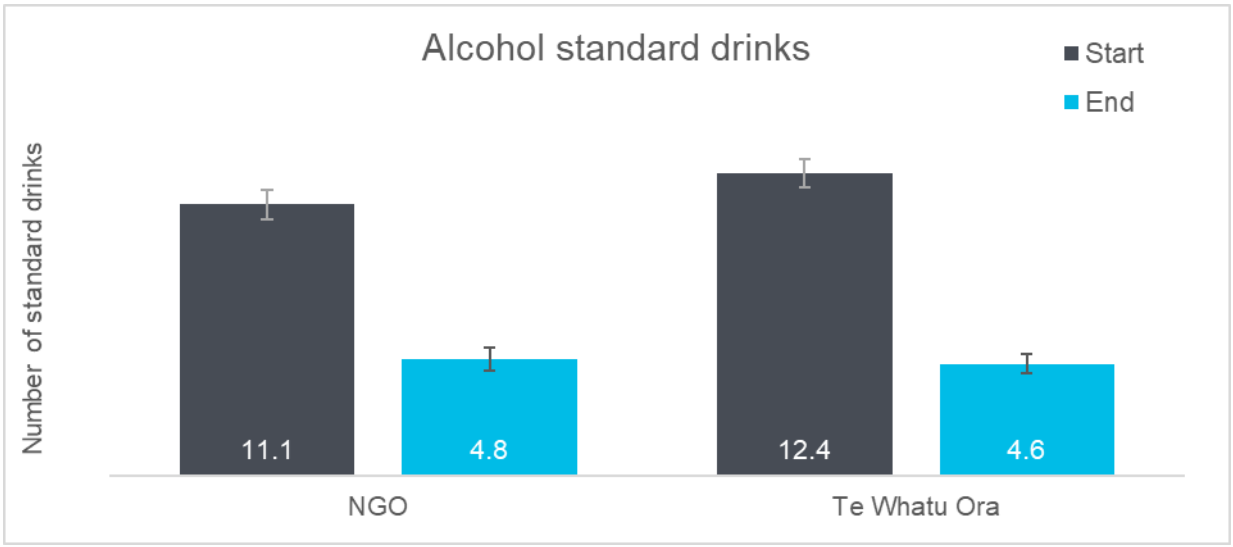
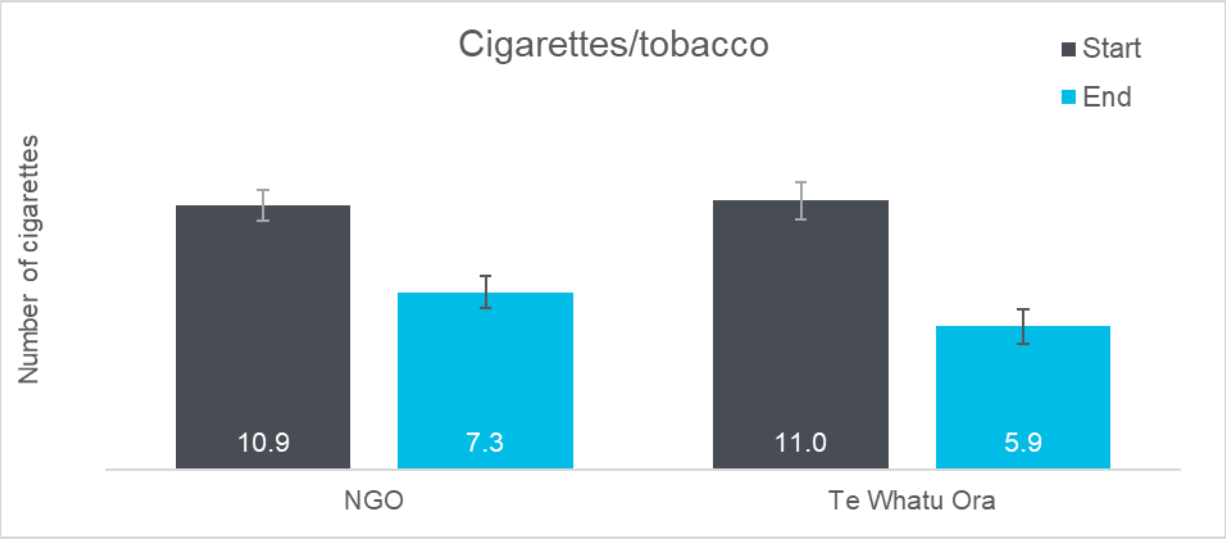


Figure 13 show that cigarettes/tobacco use reduces during treatment in both NGO and Te Whatu Ora services.

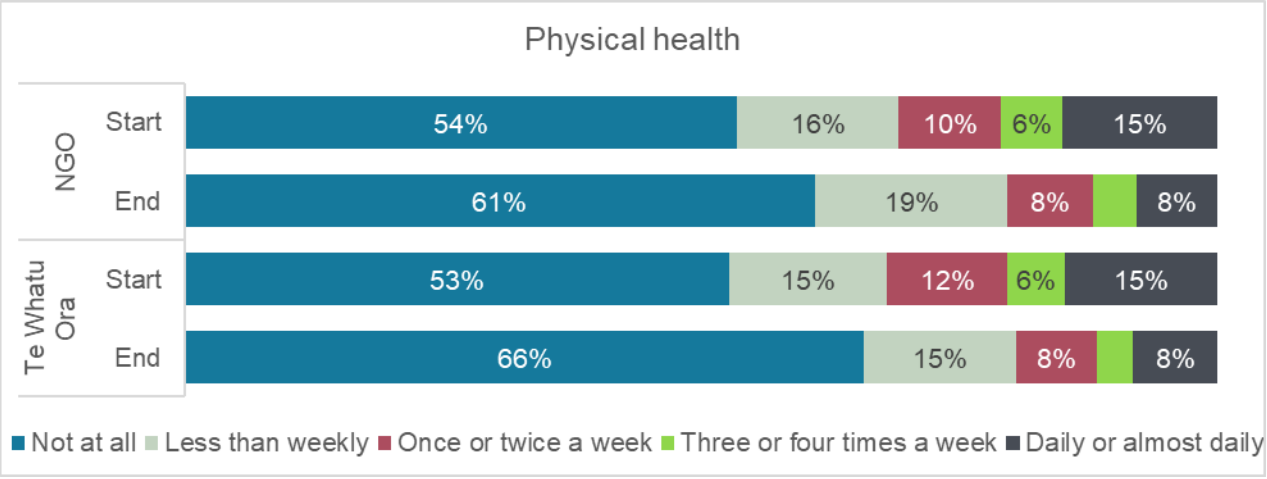
Figure 13. Change in cigarettes/tobacco consumed in a typical day for matched pairs by organisation type (October 2021 to September 2024)

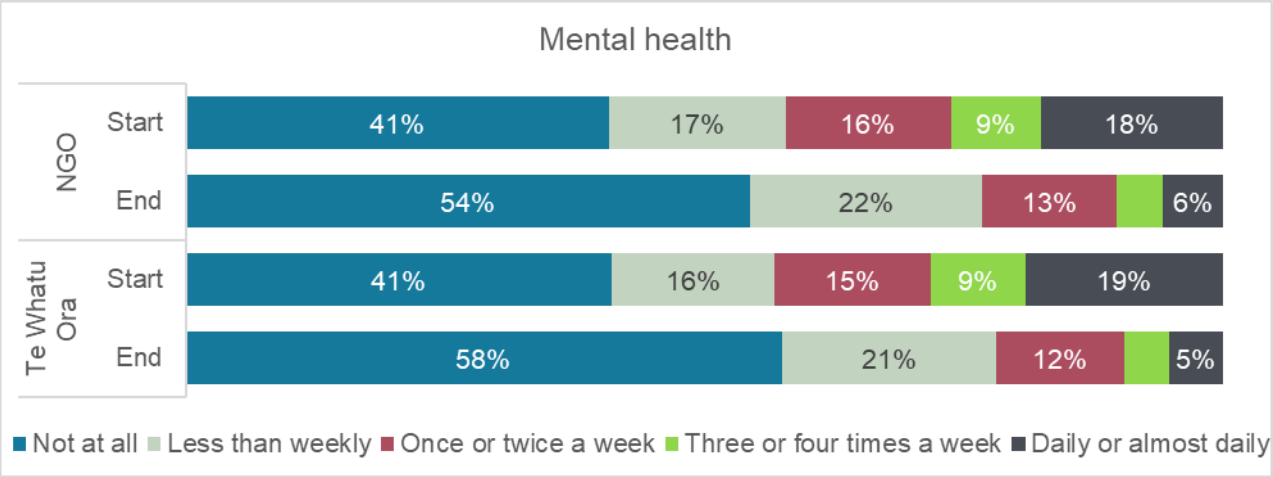


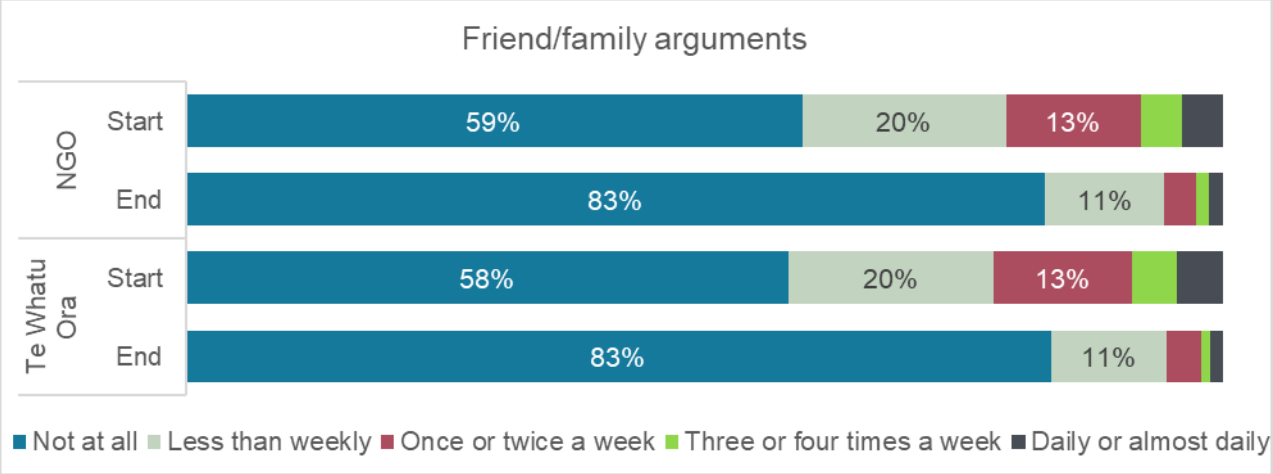
Changes in lifestyle and wellbeing

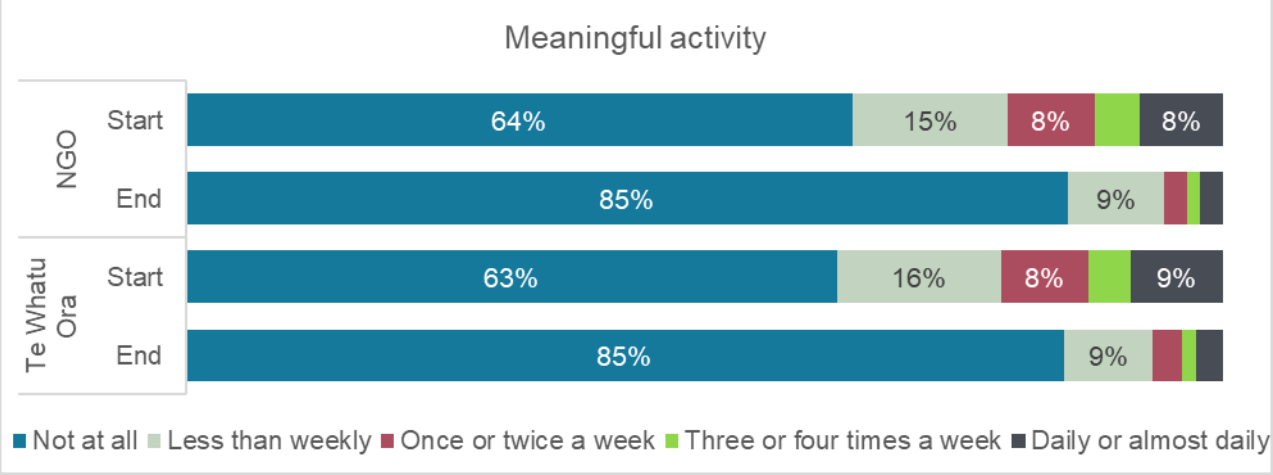
Figure 14 shows improvements in all areas of lifestyle and wellbeing between treatment start and end. People accessing NGOs report larger improvements in criminal activity problems and slightly smaller improvements in mental health and physical health than those at Te Whatu Ora services. Problems with housing show little change throughout treatment regardless of service type.

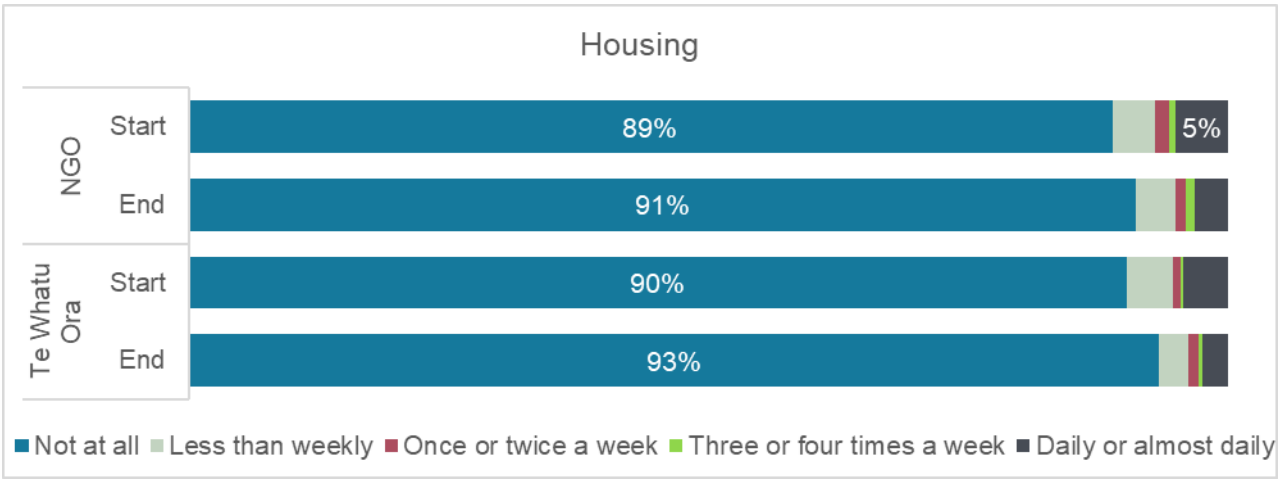
Figure 14. Changes in lifestyle and wellbeing domains for matched pairs by organisation type (October 2021 to September 2024)

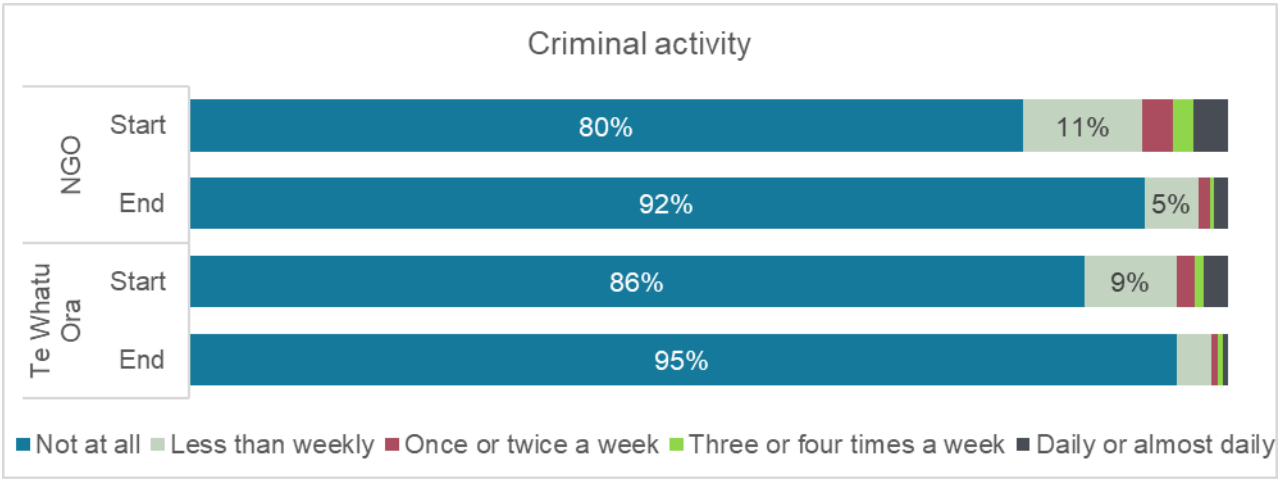



Mental health
NGO
Start
End
Te Whatu Ora
Start
End
41%
17%
16%
9%
18%
54%
22%
13%
6%
41%
16%
15%
9%
19%
58%
21%
12%
5%
Not at all
Less than weekly
Once or twice a week
Three or four times a week
Daily or almost daily


Friend/family arguments
NGO
Start
End
Te Whatu Ora
Start
End
59%
20%
13%
83%
11%
58%
20%
13%
83%
11%
Not at all
Less than weekly
Once or twice a week
Three or four times a week
Daily or almost daily


Meaningful activity
NGO
Start
End
Te Whatu Ora
Start
End
64%
15%
8%
8%
85%
9%
63%
16%
8%
9%
85%
9%
Not at all
Less than weekly
Once or twice a week
Three or four times a week
Daily or almost daily

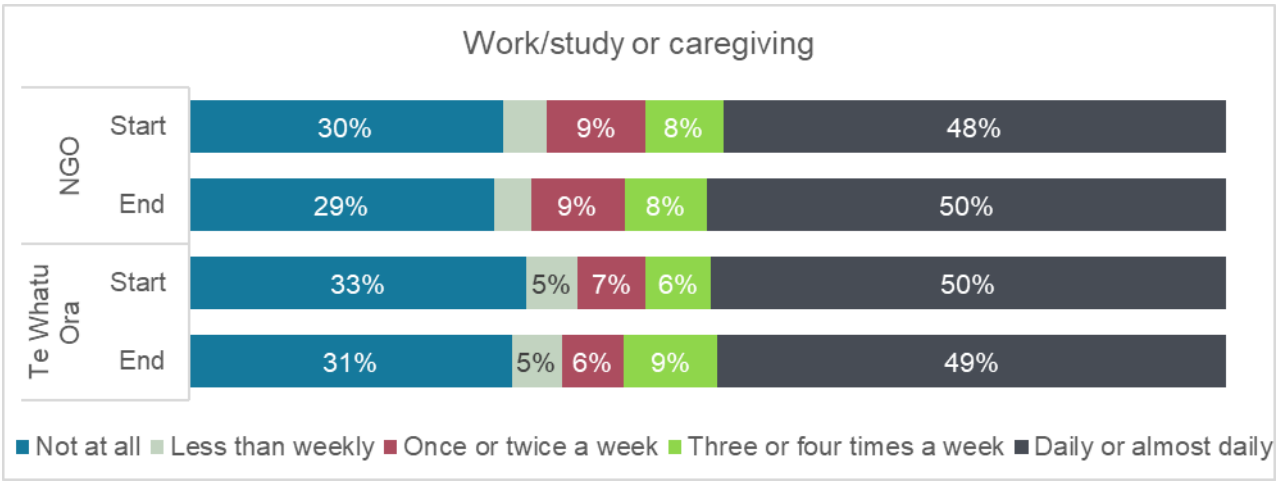




Note. Proportions of 5 percent or less not labelled.

Figure 15 shows slight improvements in engagement with work, study, or caregiving throughout treatment for both NGOs and Te Whatu Ora services.

Figure 15. Change in engagement with work/study or caregiving for matched pairs by organsiaton type (October 2021 to September 2024)



Note. Proportions of 5 percent or less not labelled.

Changes in perceptions of recovery progress

Figure 16 shows that on average, tāngata whai ora accessing both NGOs and Te Whatu Ora services tend to feel closer to where they want to be in their recovery at the end of treatment compared to the start.

Figure 16. Change in self-rated closeness to desired recovery for matched pairs by organisation type (October 2021 to September 2024)

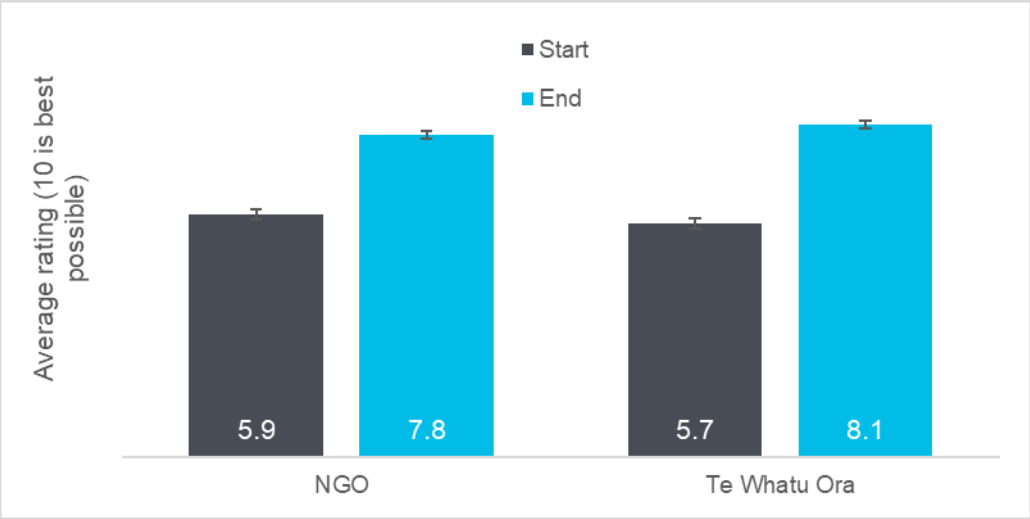
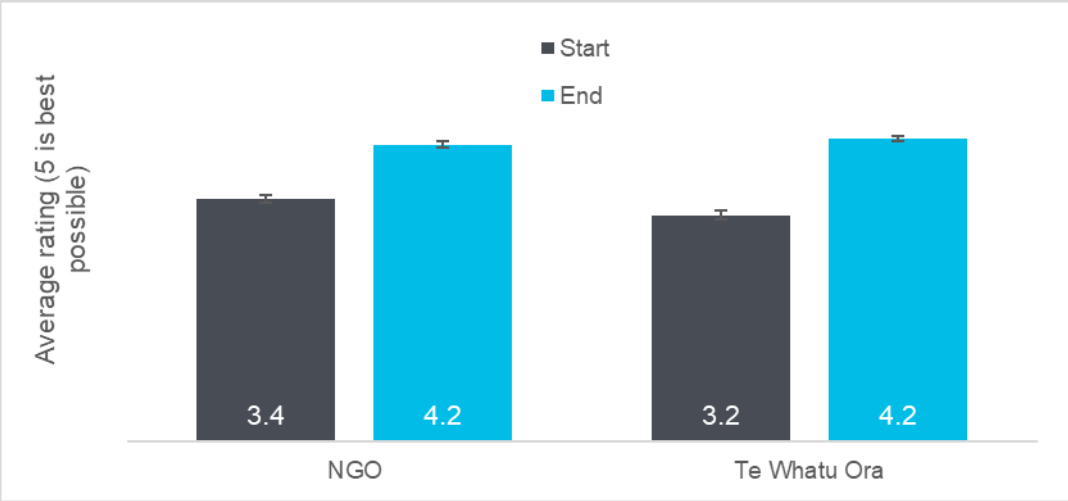


Figure 17 shows tāngata whai ora tend to feel more satisfied with their progress in achieving their recovery goals at the end of treatment compared to the start in both NGO and Te Whatu Ora services.

Figure 17. Change in self-rated satisfaction with recovery progress for matched pairs by main substance of concern (October 2021 to September 2024)



Discussion

This ADOM report focuses on the substance use, lifestyle and wellbeing, and recovery for people accessing NGO services using PRIMHD data for the period October 2021 to September 2024.

Alcohol and amphetamine-type stimulants are the most common substances of concern for people accessing NGOs

Tāngata whai ora accessing NGO services commonly report alcohol and amphetamine-type stimulants as their main substances of concern. A similar proportion of people in Te Whatu Ora services also identify these as their primary and secondary substances of concern. These findings align with recent evidence identifying alcohol and methamphetamine as the most harmful substances to individual and community wellbeing in Aotearoa New Zealand (Crossin et al., 2023).

Of particular concern is that people accessing NGOs tend to report higher use and greater concern around amphetamine-type stimulants. Amphetamine-type stimulants, including drugs like methamphetamine and cocaine, are linked with harms such as mental health challenges, cardiovascular illness, increased risk of HIV and hepatitis C infections, and social and financial problems (Farrell et al., 2019; Yasbek et al., 2022). Methamphetamine has particularly greater negative impacts on communities including rural and high-deprivation areas, and Māori who are criminalised for its use at higher rates and experience compounding harms compared to other groups (Yasbek et al., 2022).

NGOs support people with complex wellbeing needs

Many people accessing NGOs report concurrent use of both alcohol and amphetamine-type stimulants at rates higher than Te Whatu Ora Services. Use of amphetamine-type stimulants and alcohol together can increase people's risk of cardiovascular problems, injuries and accidents, and sudden death compared to using either substance alone (Farrell et al., 2019; Narayan et al., 2021; Singh, 2019).[15] It is important to consider and address the health and wellbeing impacts for tāngata whai ora.

Integrated physical and mental health support can further improve outcomes

People accessing NGOs tend to report slightly more problems in various lifestyle and wellbeing domains at treatment start, particularly in mental health, housing, and criminal activity than those at Te Whatu Ora services. Despite this, matched pairs data shows NGOs achieve similar improvements in substance use, lifestyle and wellbeing, and recovery progress as Te Whatu Ora services. Areas where NGOs show larger improvements include reductions in amphetamine-type stimulant use and fewer problems with criminal activity.

Nevertheless, many people accessing both NGOs and Te Whatu Ora services report at least weekly problems with physical and mental health at the end of treatment. This reflects the multiple and

[15] Concurrent use of other combinations of drugs can also pose risks to individual and communities (Armoon et al., 2023; Crummy et al., 2020; Wang et al., 2017)

complex impacts addiction has on wellbeing and reiterates the importance of integrated support within and alongside AOD services. This may involve working more closely with physical and mental health services and practitioners, peer support, and whānau ora throughout AOD treatment. Connecting tāngata whai ora with local services and supports in the community, particularly at discharge point, may also be beneficial.

Improved data collection is needed to better understand outcomes for tāngata whai ora

There is a need to improve collection rates for ADOM in NGOs, as well as Te Whatu Ora services, to better understand outcomes for tāngata whai ora accessing AOD support in the community. Currently about one-third of episodes of care in NGO and Te Whatu Ora services have had ADOM data collected. This means the results reported here may not represent all people accessing services.

Improving ADOM collection rates in NGOs is important for addressing the broader gap in NGO outcomes data and continuing to make NGO data more visible in PRIMHD. This will help better understand the role NGOs have in providing AOD support. Improving collection rates is important for building an evidence base that is more reflective of people accessing services. Continued and improved ADOM collections, as well as training and implementation support for services, can enhance data quality and show measurable progress over time.

Conclusion

Routinely collected and available ADOM data reflects the positive outcomes NGO community AOD services achieve with tāngata whai ora. Findings align with broader concerns around the impacts of alcohol and amphetamine-type stimulants on individual and community wellbeing. These highlight the importance of integrating AOD support with other areas of wellbeing to further support recovery.

Appendix A: Method

Below is an overview of the inclusion and exclusion criteria for data used in this report. Please see full details for ADOM report building rules at https://www.tepou.co.nz/resources/adom-report-building-rules/775

Inclusion and exclusion criteria

AOD episode of care entering mandated services:

- includes teams mandated to collect ADOM[12]
- 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 referrals together to make an episode of care if they overlap or have 14 days or less between referral end and referral start date
- includes those episodes of care which start in the period of the report.

Treatment starts are within the episode of care: include only episodes of care with a treatment start ADOM collection including assessment only (RC13, RC14, RC15) in the 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 items[16]
- excludes RC19 – Treatment end – DNA and RC21 – Treatment end – other.

For treatment start ADOM collections (RC13, RC14) are 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.

Other notes

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

[16] Excluding question 7, 9, and 11.

Appendix B: Addiction service access prior to ADOM

Figure 18 shows addiction service access in the 3 months before an ADOM treatment start by ethnicity and organisation type. Within NGOs, people of Other ethnicities (predominantly New Zealand European) were more likely to access another addiction service prior to treatment start than other ethnic groups.

Figure 18. Addiction activity in the 3 months before ADOM treatment starts by organisation type and ethnicity (October 2021 to September 2024)

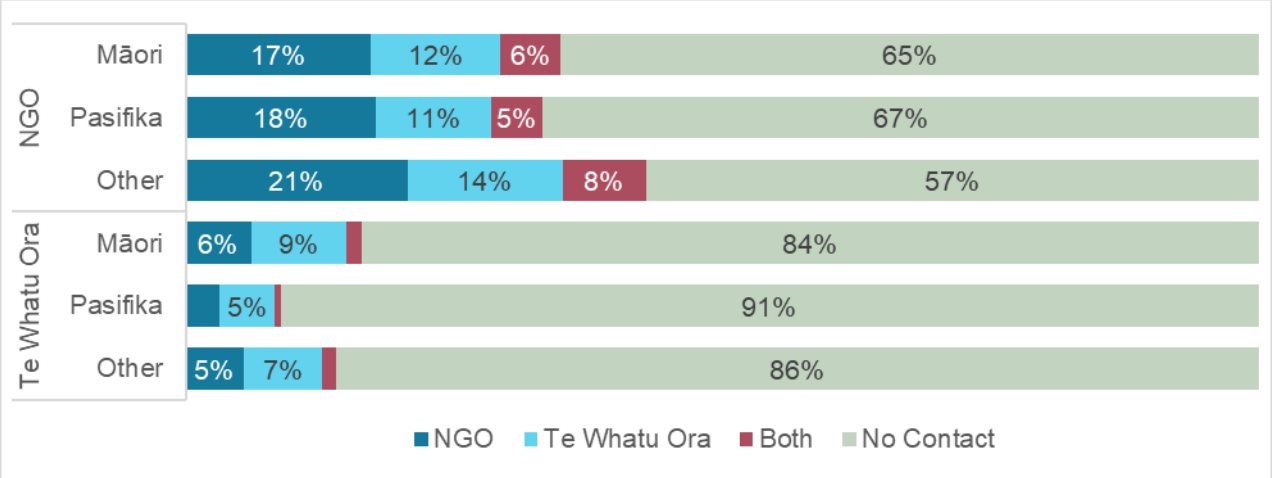
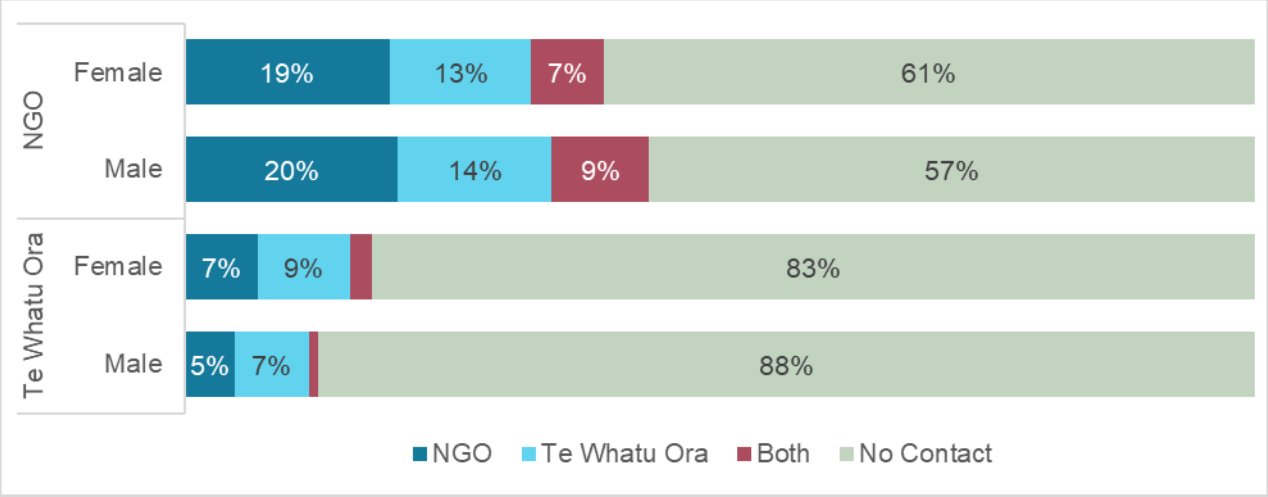


Figure 19 shows addiction service access in the 3 months before an ADOM treatment start by gender and organisation type. Prior service access is similar for men and women.

Figure 19. Addiction activity in the 3 months before ADOM treatment starts by organisation type and gender (October 2021 to September 2024)



Appendix C: ADOM Section 2 questions

Table 6. ADOM section two questions (lifestyle and wellbeing)

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

Appendix D: Effect size analysis

Table 6 shows effect sizes of changes in average days of substance use between treatment start and end for matched pairs. There were medium-to-large reductions in most types of substances used across both NGOs and Te Whatu Ora services. The only small reduction found was for cigarettes/tobacco in NGOs.

Table 7. Change in average days of substance use amongst matched pairs with substance use reported at treatment start, by organisation type (October 2021 to September 2024)

Question	Organisation type	Start mean	End mean	Outcome (Start minus end mean)	Cohen's *d* (effect size with 95% CI)	Effect size of treatment
Q1: Alcohol days of use	**NGO**	11.7 *(n=875)*	5.3 *(n=871)*	6.4	0.74 (0.65-0.84)	Medium
	Te Whatu Ora	11.4 *(n=927)*	5.2 (n=*927)*	6.2	0.70 (0.61-0.80)	Medium
Q2: Alcohol number of standard drinks consumed in a typical days use	**NGO**	11.1 *(n=872)*	4.8 *(n=852)*	6.3	0.80 (0.70-0.89)	Large
	Te Whatu Ora	12.4 *(n=911)*	4.6 (n=*907)*	7.8	1.02 (0.93-1.12)	Large
Q3: Cannabis days of use	**NGO**	14.2 *(n=411)*	7.7 *(n=409)*	6.5	0.60 (0.46-0.74)	Medium
	Te Whatu Ora	15.2 *(n=416)*	7.8 (n=*412)*	7.4	0.69 (0.55-0.83)	Medium
Q4: Amphetamine-type stimulant days of use	**NGO**	9.4 *(n=198)*	1.8 *(n=196)*	7.6	1.07 (0.86-1.28)	Large
	Te Whatu Ora	8.0 *(n=145)*	2.2 *(n=144)*	5.8	0.85 (0.61-1.09)	Large
Q5: Opioids days of use	**NGO**	10.9 *(n=56)*	1.7 *(n=52)*	9.2	1.08 (0.69-1.48)	Large
	Te Whatu Ora	17.0 *(n=35)*	5.0 *(n=35)*	12.0	1.13 (0.62-1.63)	Large
Q6: Sedatives/tranquilisers days of use	**NGO**	8.8 *(n=59)*	2.5 *(n=58)*	6.3	0.75 (0.37-1.12)	Medium
	Te Whatu Ora	13.1 *(n=55)*	4.5 *(n=55)*	8.6	0.82 (0.43-1.20)	Large
Q8: Cigarettes/tobacco amount used	**NGO**	10.9 *(n=585)*	7.3 *(n=564)*	3.6	0.46 (0.34-0.57)	Small
	Te Whatu Ora	11.0 (n=563)	5.9 (n=540)	5.2	0.59 (0.47-0.71)	Medium

Note: Cohen (1992)[17] reports the following intervals for *d*: .2 to .5: small effect; .5 to .8: medium effect; .8 and higher: large effect.

[17] Cohen, J. (1992). A power primer, quantitative methods in psychology. *Psychological Bulletin, 112*(1), 155-159.

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