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## FOR YOUR INFORMATION - SERVICES & AGENCY REFERRAL PROCESS

### PAI AKE SOLUTIONS SERVICES

**Alcohol & Drug Counselling** - Interventions for individuals and families affected by Alcohol and Drug use. These are facilitated by qualified and experienced alcohol and drug counsellors.

**Co-existing Mental Health and Substance Use Intervention/Therapy** – Interventions for individuals and families affected by Alcohol and Drug use and co-occurring mental illness. These are facilitated by qualified and experienced staff with backgrounds in counselling, psychology and social work within mental health and drug and alcohol fields. This involves assertive outreach, individual and family/whanau sessions, including home visiting where appropriate and necessary.

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### Pai Ake Solutions provide a range of groups to support people in their recovery from alcohol and issues. These are:

**AODE – Alcohol and Other Drug Education Group** is a six session programme offering education on substance and behavioural addictions, why they occur and choices we have about moving beyond them. This program is based upon a philosophy that knowledge is power. Through expanded knowledge the individual, family or community can be intentional in making positive change. **MORRINSVILLE ONLY**

**Te Hikoi O Nga Tane - the Men's Walk** is a 15 week interactive experience for men, guiding them through a range of issues focusing on increasing wellbeing, roles as men and future directions. Te Hikoi O Nga Tane will create an opportunity to share, pick up new skills and learn from the experience of others. Group participants can expect to gain some education, fellowship and peer support.

**Te Ara Wahine – the Women's Journey** is a 15 week interactive personal experience for women, addressing issues specific to women, their wellbeing, their roles within families and positive future growth. Te Ara Wahine has been developed to run alongside Te Hikoi O Nga Tane to ensure a more consistent and supportive learning experience within families. **HAMILTON ONLY – Next group 2012**

**Whanake** is a 10 week flexible strength based programme for rangatahi between the ages of 12 - 17 years of age, that promotes WHANAUNGATANGA as a model of wellbeing, which incorporates self (AU), relationships with family and significant others (WHANAU), and developing skills and support necessary to participate within a community while creating the confidence to direct their own journey (WHANAUNGATANGA). **CURRENTLY UNAVAILABLE DUE TO FUNDING RESTRICTIONS.**

## AGENCY REFERRAL PROCESS

1. **CONTACT** - Contact made by referrer with Pai Ake Solutions to determine/discuss client eligibility to access services:
  - a. Phone 0800 724 253 or 07 847 2351
  - b. Email [referrals@paiake.co.nz](mailto:referrals@paiake.co.nz)
2. **ELIGIBILITY** - Our services are available to adults and youth of any race, sex, financial situation and occupation, that are significantly affected by current alcohol and/or other drug use and/or co-occurring mental illness.
3. **FILL OUT REFERRAL & SCREENING TOOLS** - Referral form requested/accessed via:
  - a. Website [www.paiake.co.nz](http://www.paiake.co.nz)
  - b. Email [referrals@paiake.co.nz](mailto:referrals@paiake.co.nz) or [info@paiake.co.nz](mailto:info@paiake.co.nz)
  - c. The screening tools, AUDIT (Alcohol Use Disorder Identification Tool) and a DUDIT (Drug Use Disorder Identification Tool), are **required** to be completed and presented **signed by the client** as part of this process.
4. **RETURN REFERRAL & SCREENING TOOLS** - Referral completed in **full** and returned to Pai Ake Solutions to:
  - a. Email [referrals@paiake.co.nz](mailto:referrals@paiake.co.nz)
  - b. Fax 07 847 2355
  - c. Post Pai Ake Solutions  
PO Box 5631  
Frankton  
Hamilton 3242
5. **RECEIPT OF REFERRAL** – Once we have received your referral, we will acknowledge we have received it via automated email, phone call or letter within 5 working days. We will also be able to advise you of an approximate wait time, if any.
6. **REFERRAL** – If a referral does not meet our eligibility criteria, this will be acknowledged by an email, phone call or letter within 5 working days and your referral will be closed.
7. **TRIAGE APPOINTMENT** - Initial triage appointments will be made with the referee. This appointment is to identify needs; determine an approach to addressing issues; and manage risk during the waiting period. Referrers and clients will notified of this appointment via phone call or letter.  
*\*Please note that a triage appointment may not be required, dependant on individual circumstances.*
8. **ALLOCATION TO SERVICE / THERAPIST** – Therapists/Facilitators will send out letters of appointment to engage in group and individual interventions. Any further contact will then be managed between the client, the referrer (if requested) and the clinician.

**CHANGE OF CIRCUMSTANCES** - We encourage referrers and whānau to let us know immediately if there is any change in their circumstances i.e. change of address, not wanting to use our service.

**MISSED APPOINTMENT POLICY** – We understand there is a range of valid reasons for cancelling an appointment. In order to be consistent with all clients and providing a quality service, Pai Ake Solutions retains the right to deny further service if the client does not attend **two** sessions in a row without at least 24 hours notice prior.

**CLEAN ENGAGEMENT POLICY** – Pai Ake Solutions has a strong belief that whānau need to be in a well space to participate effectively in group and individual sessions. Clients are to be alcohol and drug free when attending sessions. Pai Ake Solutions retains the right to discontinue the session or refuse entrance to the premises, if clients are found to be under the influence.

## AGENCY REFERRAL FORM

Revised August 2011

- **PLEASE NOTE** that Pai Ake Solutions provides services to those that are significantly affected by **current** alcohol and/or other drug use and/or co-occurring mental illness.
- Please complete and provide **all** information requested. If incomplete, it may affect the outcome of your referral.
- An NHI (National Health Index number) is **required** for our files. If you are unable to provide this, please ensure that the name of the referee is correct and birth date is provided to avoid delays in the processing of this referral.
- The Alcohol Use Identification Test and the Drug Use Identification Test are standard screening tools that assists Pai Ake Solutions understand whether a substance use problem is present and the level of severity of the problem. This will form one part of the decision making process when reviewing whether a client meets entry requirements for our services. The other information that forms this decision making process is based on the level of information provided within this referral form.

<b>Date:</b>		<b>ADMIN ONLY</b>
<b>NHI Number</b>		<b>TRIAGE COMPLETED? Y / N</b>
<b>Database Code: (ADMIN ONLY)</b>		<b>DATE</b>
		<b>CLINICAN</b>
<b>First Name:</b>		<b>SERVICE 1</b>
<b>Last Name:</b>		<b>SERVICE 2</b>
<b>Date Of Birth</b>		<b>SERVICE 3</b>
<b>Gender:</b>		<b>NOTES</b>
<b>Ethnicity</b>		
<b>Iwi:</b>		
<b>Address:</b>		
<b>Phone No's: Mobile/ Home or Work</b>		
<b>The client is aware that this referral has been made?</b>		<b>YES NO</b>
<b>The client has transport to attend appointments?</b>		<b>YES NO</b>

## REFERRER DETAILS

<b>Relationship/role to the referee:</b>	
<b>Name:</b>	
<b>Organisation:</b>	
<b>Address:</b>	
<b>Phone No.:</b>	
<b>Email:</b>	

## PRESENTING ISSUES OF CLIENT

<b>Please complete the following areas</b>
<b>PSYCHIATRIC: Diagnoses, present symptoms, and medication (including name, dose, and frequency):</b>
<b>MEDICAL: Health issues/complications, history of Traumatic Brain Injury, and current medication (including name, dose, and frequency):</b>
<b>OFFENDING HISTORY: Offence type, date of offences, and incarceration periods</b>
<b>SOCIAL FACTORS: Including children/dependents, accommodation, finances, peer group, gang affiliation etc..</b>

**CULTURAL FACTORS:** Please identify any issues that are reflective of referees culture, ethnicity, whakapapa, whānau. Whānau support is encouraged. Please indicate if kaumatua support is requested.

**CURRENT DRUG/ALCOHOL USE:**

Drugs used in the last 12-months

Complications of alcohol/drug use, including documented offending under the influence or in order to maintain use, health problems, poor employment performance, relationship problems. Please note when these occurred.

History of drug treatment (year and service)

**RISK ISSUES:** History of violence towards staff, history of violence towards others (please specify if violence has been towards any specific group/population), risk of harm to self, or risk of harm due to either vulnerability to harm from others or vulnerability due to poor self care.

Harm to self (history of suicide attempts, self harm, poor self care i.e. nutrition, hygiene etc,:

High risk behaviour i.e. driving, sexual practices:

Harm to others:

History of violence to others (please specify):

Harm from others i.e. vulnerable to suggestions from others, domestic violence etc:

## SIGNIFICANT OTHERS INVOLVED IN SUPPORTING THIS INDIVIDUAL

(Family, peers) Include contact details

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## OTHER AGENCIES CURRENTLY INVOLVED

<b>Name:</b>	
<b>Organisation:</b>	
<b>Address:</b>	
<b>Phone No.:</b>	
<b>Email:</b>	

<b>Name:</b>	
<b>Organisation:</b>	
<b>Address:</b>	
<b>Phone No.:</b>	
<b>Email:</b>	

## PAST INTERVENTIONS AND/OR ASSESSMENTS

<b>Name &amp; Agency</b>			
<b>Dates:</b>		<b>Reports attached:</b>	

<b>Name &amp; Agency</b>			
<b>Dates:</b>		<b>Reports attached :</b>	

<b>Please specify any areas you are seeking to be addressed by Pai Ake Solutions</b>

## SERVICE REQUIRED

<b>Please tick service required (See notes for description)</b>
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- |  |   |
|--|---|
| <input type="checkbox"/> Te Hikoi o Nga Tane (The Men's Walk)  | <input type="checkbox"/> Alcohol and Drug Counselling (Adult)                             |
| <input type="checkbox"/> Te Ara Wahine (The Womens Journey)<br><b>HAMILTON – next group March 2012</b> | <input type="checkbox"/> Alcohol and Drug Counselling (Youth)                             |
| <input type="checkbox"/> AODE – Alcohol and Other Drug Education Group<br><b>MORRINSVILLE ONLY</b>     | <input type="checkbox"/> Co-existing Mental Health and Substance Use Intervention/Therapy |

## ADMIN ONLY

<b>CLINICIAN PLEASE INDICATE BELOW</b>	
<input type="checkbox"/> Triage Completed/Notes Attached	<input type="checkbox"/> <b>AUDIT / DUDIT</b> Completed/Attached
<input type="checkbox"/> Assessment/s attached	<input type="checkbox"/> Other _____

## The Alcohol Use Disorders Identification Test (Compulsory)

Record answers carefully, place the correct answer number in the box at the right. (Please note that the client **must** sign the document.)

<b>1</b>	How often do you have a drink containing alcohol?	
0	Never [Skip to Qs 9-10]	
1	Monthly or less	
2	2 to 4 times a month	
3	2 to 3 times a week	<input type="text"/>
4	4 or more times a week	
<b>2</b>	How many drinks containing alcohol do you have on a typical day when you are drinking?	
0	1 or 2	
1	3 or 4	
2	5 or 6	
3	7, 8, or 9	<input type="text"/>
4	10 or more	
<b>3</b>	How often do you have six or more drinks on one occasion?	
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	<input type="text"/>
4	Daily or almost daily	
<b>4</b>	How often during the last year have you found that you were not able to stop drinking once you had started	
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	<input type="text"/>
4	Daily or almost daily	
<b>5</b>	How often during the last year have you failed to do what was normally expected from you because of drinking?	
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	<input type="text"/>
4	Daily or almost daily	
<b>(A) SUB TOTAL SCORE</b>		

<b>6</b>	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	<input type="text"/>
4	Daily or almost daily	
<b>7</b>	How often during the last year have you had a feeling of guilt or remorse after drinking?	
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	<input type="text"/>
4	Daily or almost daily	
<b>8</b>	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	<input type="text"/>
4	Daily or almost daily	
<b>9</b>	Have you or someone else been injured as a result of your drinking?	
0	No	
2	Yes, but not in the last year	<input type="text"/>
4	Yes, during the last year	
<b>10</b>	Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?	
0	No	
2	Yes, but not in the last year	<input type="text"/>
4	Yes, during the last year	
<b>(B) SUB TOTAL SCORE</b>		
<b>(A) + (B) = TOTAL SCORE</b>		

Client Signature

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## The Drug Use Disorders Identification Test (Compulsory)

Here are a few questions about drugs. Please answer as correctly and honestly as possible by indicating which answer is right for you. (Please note that the client **must** sign the document.)

<b>1</b>	How often do you use drugs other than alcohol? (See list of drugs following.)
<input type="checkbox"/>	Never [Skip to Qs 9-10]
<input type="checkbox"/>	Monthly or less
<input type="checkbox"/>	2 to 4 times a month
<input type="checkbox"/>	2 to 3 times a week
<input type="checkbox"/>	4 or more times a week
<b>2</b>	Do you use more than one type of drug on the same occasion?
<input type="checkbox"/>	Never [Skip to Qs 9-10]
<input type="checkbox"/>	Monthly or less
<input type="checkbox"/>	2 to 4 times a month
<input type="checkbox"/>	2 to 3 times a week
<input type="checkbox"/>	4 or more times a week
<b>3</b>	How many times do you take drugs on a typical day when you use drugs?
<input type="checkbox"/>	0
<input type="checkbox"/>	1-2
<input type="checkbox"/>	3-4
<input type="checkbox"/>	5-6
<input type="checkbox"/>	7 or more
<b>4</b>	How often are you influenced heavily by drugs?
<input type="checkbox"/>	Never
<input type="checkbox"/>	Less often than once a month
<input type="checkbox"/>	Every month
<input type="checkbox"/>	Every week
<input type="checkbox"/>	Daily or almost every day
<b>5</b>	Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?
<input type="checkbox"/>	Never
<input type="checkbox"/>	Less often than once a month
<input type="checkbox"/>	Every month
<input type="checkbox"/>	Every week
<input type="checkbox"/>	Daily or almost every day

**Client Signature**

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<b>6</b>	Has it happened, over the past year, that you have not been able to stop taking drugs once you started?
<input type="checkbox"/>	Never
<input type="checkbox"/>	Less often than once a month
<input type="checkbox"/>	Every month
<input type="checkbox"/>	Every week
<input type="checkbox"/>	Daily or almost every day
<b>7</b>	How often over the past year have you taken drugs and then neglected to do something you should have done?
<input type="checkbox"/>	Never
<input type="checkbox"/>	Less often than once a month
<input type="checkbox"/>	Every month
<input type="checkbox"/>	Every week
<input type="checkbox"/>	Daily or almost every day
<b>8</b>	How often over the past year have you needed to take a drug the morning after heavy drug use the day before?
<input type="checkbox"/>	Never
<input type="checkbox"/>	Less often than once a month
<input type="checkbox"/>	Every month
<input type="checkbox"/>	Every week
<input type="checkbox"/>	Daily or almost every day
<b>9</b>	How often over the past year have you had guilt feelings or a bad conscience because you used drugs?
<input type="checkbox"/>	Never
<input type="checkbox"/>	Less often than once a month
<input type="checkbox"/>	Every month
<input type="checkbox"/>	Every week
<input type="checkbox"/>	Daily or almost every day
<b>10</b>	Have you or anyone else been hurt (mentally or physically) because you used drugs?
<input type="checkbox"/>	No
<input type="checkbox"/>	Yes, but not over the last year
<input type="checkbox"/>	Yes, over the last year
<b>10</b>	Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?
<input type="checkbox"/>	No
<input type="checkbox"/>	Yes, but not over the last year
<input type="checkbox"/>	Yes, over the last year

## LIST OF DRUGS (Note: Not alcohol!)

Cannabis	Hallucinogens	GHB and others	Solvents/inhalants	Amphetamines	Cocaine	Opiates
<ul style="list-style-type: none"> <li>• Marijuana</li> <li>• Hash</li> <li>• Hash oil</li> </ul>	<ul style="list-style-type: none"> <li>• Ecstasy</li> <li>• LSD (Lisergic acid)</li> <li>• Mescaline</li> <li>• Peyote</li> <li>• PCP, angel dust</li> <li>• (Phencyclidine)</li> <li>• Psilocybin</li> <li>• DMT</li> <li>• (Dimethyltryptamine)</li> </ul>	<ul style="list-style-type: none"> <li>• GHB</li> <li>• Anabolic steroids</li> <li>• Laughing gas</li> <li>• (Halothane)</li> <li>• Amyl nitrate</li> <li>• (Poppers)</li> <li>• Anticholinergic compounds</li> </ul>	<ul style="list-style-type: none"> <li>• Thinner</li> <li>• Trichlorethylene</li> <li>• Gasoline/petrol</li> <li>• Gas</li> <li>• Solution</li> <li>• Glue</li> </ul>	<ul style="list-style-type: none"> <li>• Methamphetamine</li> <li>• Phenmetraline</li> <li>• Khat</li> <li>• Betel nut</li> <li>• Ritaline</li> <li>• (Methylphenidate)</li> </ul>	<ul style="list-style-type: none"> <li>• Crack</li> <li>• Freebase</li> <li>• Coca leaves</li> </ul>	<ul style="list-style-type: none"> <li>• Smoked heroin</li> <li>• Heroin</li> </ul>

## PILLS – MEDICINES

Pills count as drugs when you take more of them or take them more often than the doctor has prescribed for you.

- pills because you want to have fun, feel good, get "high", or wonder what sort of effect they have on you
- pills that you have received from a relative or a friend
- pills that you have bought on the "black market" or stolen

SLEEPING PILLS/SEDATIVES			PAINKILLERS		
Alprazolam	Glutethimide	Rohypnol	Actiq	Durogesic	OxyNorm
Amobarbital	Halcion	Secobarbital	Cocclana-Etyfin	Fentanyl	Panocod
Apodorm	Heminevrin	Sobril	Citodon	Ketodur	Panocod forte
Apozepam	Iktorivil	Sonata	Citodon forte	Ketogan	Paraflex comp
Aprobarbital	Imovane	Stesolid	Dexodon	Kodein	Somadril
Butabarbital	Mephobarbital	Stilnoct	Depolan	Maxidon	Spasmofen
Butalbital	Meprobamate	Talbutal	Dexofen	Metadon	Subutex
Chloral hydrate	Methaqualone	Temesta	Dilaudid	Morfin	Temgesic
Diazepam	Methohexital	Thiamyl	Distalgesic	Nobligan	Tiparol
Dormicum	Mogadon	Thiopental	Dolcontin	Norflex	Tradolan
Ethchlorvynol	Nitrazepam	Triazolam	Doleron	Norgesic	Tramadul
Fenemal	Oxascand	Xanor	Dolotard	Opidol	Treo comp
Flunitrazepam	Pentobarbital	Zopiklon	Doloxene	OxyContin	
Fluscand	Phenobarbital				

Pills do NOT count as drugs if they have been prescribed by a doctor and you take them in the prescribed dosage.