



dapaanz

fostering excellence in addiction practice

ADDICTION STANDARD

Summer edition 2017

*Tuhia ki te rangi
Tuhia ki te whenua
Tuhia ki te ngakau o nga tangata
Ko te mea nui
He tangata, he tangata, he tangata
Tihei Mauri Ora*

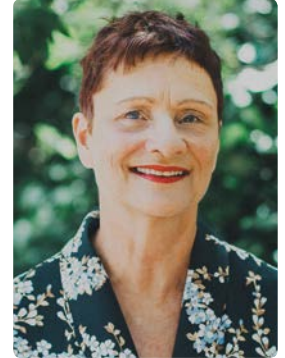
Welcome to the first edition of the Addiction Standard the renamed Bulletin. We are committed to providing a place where your voices are heard, issues raised, controversy embraced, and your excellent work and recovery stories celebrated.

We have just entered an exciting era. On the 19th of October a new coalition Government was formed creating a massive shift in the political environment. A commitment to increased addiction treatment, a sought-after review of the mental health and addiction systems and a referendum on drug law are all crucially important to the addiction sector. So, what does this mean for us? The opportunities for growing the treatment sector have arguably never been greater. It is time to make hay while the sun shines. A high priority for dapaanz is to work with the Government to grow the sector, and specifically, argue for better remuneration and resourcing. Look at our briefing to new Ministers published in this Addiction Standard and on our website.

As drug law change is a hot topic, we have three articles that examine drug law reform from slightly different perspectives. We welcome meaningful dialogue and robust debate on this important topic.

Cutting Edge this year was a resounding success with over 500 attendees. We are really pleased that the visibility of peer support continues to grow and this year with the help of sponsorships from NCAT (12),

HPA (7) we were able to provide 19 scholarships and dapaanz was able to provide a further 11 complementary registrations (the vast majority of the 30 scholarships/complementary registrations were for people with lived experience at different stages of their recovery journey). A big thanks to NCAT and HPA for their generous support! We have some very good articles on some of the keynotes in this edition (and on the videos on our website).



We are really chuffed to be able to announce (though the cat was out of the bag for this year's Cutting Edge attendees), that we have confirmed Johann Hari (author of Chasing the Scream), as a keynote for the 2018 conference in Rotorua.

Thank you to all who have contributed to the first edition of the addiction standard. Particularly those who have courageously opened their lives up to influence better practice such as Briar Scragg. We love to publish real stories of real people who have been through treatment and are on a recovery journey. It is so important to keep lived experience, the person and their whānau front of mind. We really thank you Briar and others for your vulnerability.

If you would like to submit anything in the Addiction Standard please send to sue@dapaanz.org.nz with 'addiction standard' in the subject line or contact me on 04 282 1809 to discuss.

As this is the first and last edition this year, we wish you a very warm and wonderful Christmas!

**Nga mihi
Sue**

Riana Potaka a member of the Te Ha Oranga Ngati Whatua Trust's He Timataga Hou New Beginnings AOD kapa haka group- He Waka Eke Noa- and recipient of a Cutting Edge Scholarship had the following to say about her experience at the conference:

'It was really quite overwhelming. It was the first time ever I've been to a conference. I got so much from it, it was just so cool to hear about different services and it really inspired me to keep going with the goals I have in working towards a career in addiction treatment.'

Briefing to New Government – Increasing Access to Addiction Treatment in Aotearoa

November 2017

Dapaanz is heartened the 2017 Coalition Government accepts the solution to addiction lies in the improvement of access to treatment rather than the current emphasis on enforcement.

Dapaanz looks forward to partnering with the new Government to develop workable solutions that will bring our drug policy in line with many other countries reducing the impacts of addiction for individuals, families/whānau and their communities. As the peak addiction sector body, we have the required knowledge and expertise to help.

In Aotearoa/New Zealand the cost of addiction to society is estimated at \$1.8 billion annually yet we spend around \$150 million each year on treatment. This makes little sense and dapaanz contends spending a little more to increase addiction treatment will save much more in health, social and justice costs.

One of the biggest problems is a disincentivised workforce

The problem is that increasing treatment options and making them more widely available cannot work without increasing the qualified, highly-skilled practitioner workforce. Under current conditions it is a workforce that will be difficult to grow.

Starting salaries for addiction practitioners can be well below \$40,000 and even qualified and experienced practitioners earn significantly less than their peers in the health and other allied sectors. Also, practitioners working in NGOs doing the same or similar work earn 10-20 percent less than their counterparts working in DHBs.

We need to attract and retain qualified practitioners to ensure a better future for those impacted by addiction. To achieve this dapaanz believes pay inequity must be resolved.

Addiction practitioners must be valued more highly

This is about professionalisation. Addiction practitioners have a minimum applied bachelor degree. They do extremely valuable and important work resulting in positive outcomes for individuals, families/whānau, and their communities.

The work of treatment practitioners:

- has a dramatic impact on the wellbeing of communities
- helps turn antisocial behaviour into prosocial behaviour
- makes an incredible difference in the lives of people with addiction and their families/whānau



- reduces health and welfare costs, and the need for prison beds
- reduces crime and its impact on communities.

And, we expect them to do all this for very poor wages. Meanwhile, the impacts of drugs like methamphetamine and synthetic cannabinoids mean practitioners are increasingly faced with clients who have complex needs including psychosis. Caseloads are also burgeoning in work environments that are fraught with complex issues around new substances.

These problems are only going to get worse, and if it weren't for the dedication and compassion of our current addiction practitioners, no one would be doing this work. It is simply wrong that we continue to rely on practitioners' going the extra mile for inadequate remuneration.

Solutions are not difficult or radical

There is a big pool of workforce potential the addiction treatment sector can draw on with little fuss. People can become registered as fully competent addiction practitioners and get jobs in addiction services if they are qualified in one of the allied professions (e.g. nursing, counselling and/or social work, etc).

Attracting just 100 people from the allied workforce would change the face of addiction treatment in New Zealand. Therefore, dapaanz sees great benefit in the Government re-allocating some funding to support allied workers wanting to move to the addiction sector.

We need to increase our range of treatment options

It is crucial to increase and retain the workforce, so we can increase the range of treatment options because one size does not fit all. Having more qualified addiction practitioners will reduce waiting lists so that treatment providers respond more quickly to people in need and

people's problems do not escalate.

- Resources must be increased towards early identification/intervention and treatment.
- People should be assessed for addiction through appropriate social services, doctors' surgeries, or wherever they go for help.
- Increased availability of services would make it easier for people to get help early before they resort to crime.
- Waiting list times must be eliminated so people receive help when they ask for it. When clients wait months for treatment their problems do escalate.
- Currently a person with a methamphetamine addiction could wait four months before being admitted to a residential programme.

About dapaanz

Dapaanz is the member association representing the professional interests of people working in the addiction treatment sector and has more than 1500 members. We:

- exist to support our members
- foster and maintain ethical and competent addiction practice
- manage endorsement and registration processes
- promote professional development
- advocate for the workforce and people affected by addictions.

Find out more at www.dapaanz.org.nz.

Executive Director: Sue Paton

Tel: 04 282 1809, 021 187 4311,

Email: sue@dapaanz.org.nz

Healthy Drug Policy Must Reduce Harm

By Natalie Bould

For a long time now, New Zealanders have tried to convince themselves that making drugs illegal is the best way to prevent harm. New Zealand Drug Foundation thinks we've got it all wrong, and have designed a new model to reduce harm. They think it's the most responsible way forward.

Forty-two years ago, New Zealand passed a law which was supposed to curb drug use – but instead, it's been used to punish and criminalise vulnerable people who are using drugs.

Since then, the Misuse of Drugs Act 1975 has been used to convict thousands upon thousands of people, who really need our help and support. These convictions have had a heavy toll on our society - on health, employment, family wellbeing and intergenerational poverty.

The biggest impact has been on Māori communities. Māori suffer disproportionate harm from drugs – and they suffer disproportionate harm from our drug laws. They are more than twice as likely to experience a substance use disorder in their lifetime, and they're significantly more likely to report legal problems from cannabis use. Around 40 percent of those in prison for drugs are Māori.

Despite all this, New Zealand still has some of the highest rates of drug use in the world. As drug use increases, the cries of outrage get louder – we must crack down harder, punish more people. Politicians have responded, spending millions to address the problem, increasing police resources, cracking down on gangs, and building more prisons.

It just makes no sense, says Drug Foundation Senior Policy Adviser, Kali Mercier.

"We keep convicting people, thinking that somehow if we punish them hard enough we'll eventually make them stop using drugs. We now know that simply doesn't work."



Kali Mercier presenting the model drug law at the NZDF July symposium.

Kali believes that New Zealanders are ready to talk about drug law reform. "We decided it was time to move the debate on further, put a stake in the sand and say how we think a new drug law for NZ could look.

"We all agree that drugs can – and do – cause harm. So the key goal is to minimise that harm. We want to make sure that if people decide to use drugs, they start later and use less frequently. We particularly want to protect young people from harm, and make sure all people can access treatment and support when they need it."

There is a better way: A pathway forward

In July this year, the Drug Foundation released Whakawātea te Huarahi, a model drug law which aims to replace conviction with treatment, and prohibition with regulation.

'Whakawātea' means to clear, free up, cleanse or purify spiritually, while 'huarahi' is a pathway, road or track. It signifies a fresh start for the debate on drug policy and a sense of movement towards a better future.

Under this model, all drugs would be decriminalised. Cannabis would be strictly regulated, and government spending on drug education and treatment increased.

Whakawātea te Huarahi was released during the Foundation's symposium on healthy drug law in July, at which local and international experts spoke strongly and passionately in favour of reform. Intense media interest gave the symposium plenty of fuel to ignite public debate, but we need to keep up the momentum. We invite anyone with an interest in the matter to read, comment, endorse and share our model drug law. You can find it on our website, nzdrug.org/drug-law-2020.

Whakawātea te Huarahi explained

Decriminalise use

The first part of the model drug law is based on the NZ Law Commission's 2011 recommendations and are similar to the Portuguese system. Portugal decriminalised the use of drugs in 2001, and invested heavily in prevention, treatment and harm reduction. This approach has seen decreased drug use among young people, led to fewer people in jail, and dramatically reduced HIV infections and overdoses.

A new law, administered by the Ministry of Health, would see Police issuing a cautionary notice to people found with drugs, and supplying information about help, treatment, and how to stay safe.

A case study

We want to make sure that people who do need help get it, and that others are kept out of the system as much as possible.

It works like this. A person – we'll call him Bob - is found by police with some methamphetamine in his possession. Police give him some brochures with health information and legal advice. They follow this up by issuing a 'caution' and refer him to a brief intervention session at a community alcohol and drug service. After a short chat it's pretty clear that Bob is struggling with regular methamphetamine use and it's badly affecting his family and work life. So he's offered a range of treatment options.

Bob's outcome is very positive. He seeks help, in time he reduces his use and is able to get his life back under control. He doesn't have a conviction, and he has a much better life outcome.

Of course, this is just one scenario. If it's clear that Bob is not experiencing harm from his use, he'll be given health advice, information on how to seek help if he needs it, and then he can get on with his life.

Regulate cannabis

While the majority of people who use cannabis do so without serious harm, we know that a proportion experience some form of negative impact, including



The five goals of the model drug law

respiratory disease and magnifying pre-existing mental illnesses. The longer the use, the greater the risks. And those risks are higher for young people.

It's vital that we limit the potential for a free commercial model like there is for alcohol, with industry giants wielding undue pressure on the market.

For these reasons, our model would see cannabis highly regulated, with public health as the central focus. Regulation gives us the best chance of minimising harm and restricting access to young people, so there would be strict controls around age, where cannabis could be consumed, where sales could take place and who could grow plants. Health warnings would be mandatory, and products would be taxed according to their level of potency.

Shops would be prohibited from setting up within a certain distance of an alcohol outlet, or anywhere near a school, kindergarten or church, and there would be no advertising allowed to glamorise the products.

Another of our goals for a regulated market is that it should promote community development. One part of this is removing barriers so that small-scale growers could become licensed. The employment and income opportunities this would create could go part way to redressing those communities that have suffered under the prohibitionist approach.

Individuals would be permitted to grow up to three plants at home for their own use.

Māori equity

Māori equity is a key area of concern for us. The model law would benefit Māori by reducing harm from drug use and drastically reducing the number of drug convictions. We also want to actively promote equity by ensuring that Māori communities can make choices about their role in a regulated cannabis market.

What to Do About Illegal Drugs in New Zealand, Especially Cannabis

By Doug Sellman

Professor of Psychiatry & Addiction Medicine
University of Otago, Christchurch

The New Zealand Drug Foundation (NZDF) has demonstrated leadership in proposing bold changes to the way currently prohibited drugs in New Zealand are managed; essentially advocating for a Portugal-type decriminalization of all illegal drugs and a regulated market for cannabis.

Let's begin with the Portugal-type decriminalisation. Given the positive outcomes found in Portugal over the past 16 years since decriminalisation was enacted, this proposal is virtually a no-brainer. There was great concern at the time that drug use would escalate amongst the young and drug-related harm would increase. In fact the opposite has occurred. This is in large part due to the shift of resources away from the justice system and into the health system, so that drug users are viewed across the population as in need of help rather than deserving of punishment. This help is readily available now in Portugal, which is in contrast to the punishment readily available for drug users in New Zealand especially if you are not Caucasian.

So congratulations to the NZDF for not only publicizing this measure and providing the background evidence for its effectiveness, but also for successful lobbying of the previous Associate Minister of Health responsible for drug policy to the point that he declared in his final moments in that role that he had advocated for this policy for many years.

Of course, under decriminalization, the supply and sale of drugs would remain illegal in a continuing Prohibition environment, which runs the risk of maintaining an enormous black market for illegal drugs and the loss of huge amounts of potential revenue for public goods, such as health, education and social care.

After alcohol, cannabis remains the most important recreational drug in New Zealand. The NZDF has proposed that New Zealand adopts a regulated market for cannabis. They envisage this involving small-scale growing enterprises and a series of small community-based private retail businesses dedicated to the selling of cannabis utensils and product, separated from schools and liquor outlets, with no promotion, the provision of health and treatment information, and legally accessible to 18 year olds and over.

There are two aspects of this model that I think are mistaken and asking for trouble. The first is the development of a new set of private businesses dedicated to drug-dealing. Although the envisaged model valiantly proposes a set of non-descript cannabis outlets that don't glamourize the use of cannabis, nevertheless the owners will be business people who own or rent the buildings, pay rates, hire staff etc and whose primary incentive will be to make a living, a very good living, from running a legal drug-dealing operation. The incentive will be to grow their businesses and



Professor Doug Sellman

move as much product as possible; that is what private businesses are all about in a capitalist market economy. There is no incentive in such a private business model to limit the sale of cannabis to the public. Cannabis retail businesses will not be responsible for the harms that will inevitably accrue from their cannabis sales. It will be the State (the public) that picks up the tab for those costs.

State-owned enterprises for alcohol have been demonstrated to be effective in reducing alcohol-related harm. A comparable model could also be effective for cannabis. The Scandinavian state-owned liquor outlets look very similar to what is being promoted by the NZDF for cannabis – lack of glamour, absence of advertising, and provision of health information at the entrance. However, the Scandinavian liquor outlets also have restricted hours and relatively high prices, through the absence of discounting for the purposes of growing the customer base. Being owned by the State (which also pays for the harm) builds in an incentive to NOT excessively grow the business.

A final aspect of the Scandinavia model is an adult purchase age of 20 rather than a teenage purchase age of 18, as suggested by the NZDF. This is the second troubling aspect of the NZDF model.

NZDF advocates have argued their proposals are “evidence-based”, which they mainly are, but on the point of the proposed purchase age the NZDF has resorted to repeating the mantric utterances of the alcohol industry and their apologists, who have for years and years lobbied extremely successfully for firstly reducing the purchase age of alcohol from 20 years to 18 years (enacted in 1999) and to retain it there despite two subsequent attempts in Parliament to raise it back to 20. One of the standard lines goes something like this: “if you're old enough to vote and fight for your country, you should be allowed to buy a beer”, which will presumably become “...have a beer and a bong”. The obvious retort to this nonsense is that we don't send our 18 year old soldiers off to war or our 18 year old voters off to vote without supervision. They don't fight or vote independently, but rather are exposed to a considerable amount of adult influence and guidance in their killing and voting. A purchase age of 18 encourages an independent youth drinking culture to thrive, as would be the case for cannabis under a legal regulated

market. Another standard line trotted out is that 18 is the consistent age that has been established as the beginning of adulthood in our country. This is nonsense too; we accept 16 as the consent age for sexual intercourse, while at the same time do not allow anyone under the age of 20 to enter a casino.

There is very little informative literature on the purchase age of cannabis. However, there is a rich alcohol literature on age, which is arguably the best guide for thinking about the purchase age for cannabis. Purchase age is one of the most effective ways of reducing

alcohol-related harm, and there is a substantial literature showing the damage to young people from reducing the age of purchase from 20 to 18 years.

In conclusion, I want to say bravo! once again to the NZDF for putting out there some progressive proposals on the controversial and complex area of illegal drugs. I agree with much of what is being proposed; but I am not convinced that a private enterprise model is the best scheme for a regulated cannabis market, and I am very concerned about the proposal for a legal purchase age of 18 years.

Opinion

Political Traction Necessary for Drug Policy Change

By Nathan Frost

Only months after then Prime Minister Bill English's assertion that drugs should remain illegal, a change of government has put drug policy reform firmly back on the table in Aotearoa New Zealand.

English's depressing political stance - in response to a New Zealand Drug Foundation symposium where experts from around the globe espoused the benefits of decriminalisation - highlighted an unfortunate fact for lobby groups enamoured with the good-sense of their policy aims.

We live in a world of political traction, not good sense.

It's a sentiment shared by Dr João Castel-Branco Goulão a former family GP and now the man widely known as the architect of Portugal's 2001 drug policy reforms. Dr

Goulão told me during an interview in Portugal earlier this year that if the Portuguese government were trying to get the same level of decriminalisation across the line today they would fail.

He believed the (then radical) new solutions proposed in response to Portugal's failing prohibitionist drug policies - which became legally effective in July 2001 - only gained the legislative momentum needed to pass into law due of the widespread negative impacts of a nationwide heroin epidemic affecting Portuguese citizens and families across all social strata.

The current post election exuberance stemming from our recent change in Government is partially fuelled by public perception that stale conservative baby boomer politicians have been ousted and Aotearoa New Zealand can look forward to a fresh brand of legislation driven by millennial concerns. However, it still remains to be seen whether the winds of change currently blowing will be enough to create the political traction needed for an overhaul of our long outdated drug policies.

Things really do need to change. Prohibition hasn't worked and initiatives based purely on criminal justice measures to reduce harm have been ineffective. Despite the previous government's Meth Action Plan, there is a glut of cheaper than ever amphetamines available NZ-wide and inadequate funding and treatment options for an increasing number of people needing help.

The rapidly changing face of the drug scene, not to mention the unprecedented pace with which new synthetic drugs are appearing, means now more than ever, a comprehensive policy that places the health and welfare of Kiwi's first must be decided upon and a course of legislative action committed to.

Aotearoa New Zealand has a poor record of accepting that illicit drug use in society is a fact of life and that prohibition has done little to reduce their sale and consumption. In this head in the sand environment, silver tongued snake-oil salesmen from profit driven industries spotted opportunities to capitalise on political compromise, and managed to lobby politicians into really dubious courses of legislative action, while maintaining



Dr João Castel-Branco Goulão and Nathan Frost in Lisbon earlier this year.

they cared about public health and Kiwi lives marred by criminal convictions.

Rather than entertaining a world where the drugs that we know a thing or two about because they've been around for more than a second were decriminalized, or dare I say it- regulated for sale, the government enacted the Psychoactive Substances Act because the idea of a regulated market for 'real drugs' like cannabis, involved a paradigm shift that was politically unpalatable.

This poorly considered legislation allowed an unscrupulous profit driven industry a sustained period of time to create market awareness of synthetic drug alternatives and build a consumer base, before a governmental U-turn left us in the mess we find ourselves in now, with too many headlines telling us of yet another life lost to black market synthetic drugs.

Twenty five countries have now enacted some form of drug decriminalisation and there is world-wide political momentum in favour of disbanding prohibitionist policies increasingly seen as socially harmful.

Aotearoa New Zealand has a long and proud history of political innovation on the world stage yet sadly we are lagging behind many nations in adopting new approaches to drug policy. Now more than ever an

opportunity exists in Aotearoa New Zealand to try something new.

With illicit drugs cheaper and more widely available than ever, and a lack of treatment options for Kiwi's whose rates of drug use are some of the highest in the world, the new coalition government has a responsibility to do better. The grim realities of where a prohibitionist path has led us, coupled with an underfunded addiction treatment sector and the recent spate of deaths may well provide the political traction necessary to forge a new path forward.

While interviewing Dr Goulão earlier this year I noticed a side cabinet in his office overflowing with a variety of statuettes, award knick-knacks, and portrait photos of Dr Goulão posing with a raft of various politicians and celebrities (Bono in one shot, Pope Francis in another). Among the many items and photos on display a glass Kiwi caught my eye. When I enquired as to the origin of the Kiwi, Dr Goulão tells me it was presented to him a month earlier by a visiting delegate from the New Zealand Police Association. That the association of those charged with the enforcement of outdated policies are visiting the man widely viewed as a global expert in drug decriminalisation speaks volumes of the crossroads Aotearoa finds itself at.

Feature

Synnie Deaths Tip of Iceberg Says Former Importer

By Nathan Frost

A former importer of synthetic drugs who wishes to remain anonymous has warned that the recent spate of deaths linked to AMB-Fubinaca is just the tip of the iceberg.

Potent synthetic drugs are being sourced in bulk online by Kiwi drug dealers to sell offline and the profits are enormous,' he said.

'For those buying wholesale amounts, the price of one gram of AMB fubinaca can be as low as 1 USD and be used to make four ounces of synthetic product with a street value of up to \$2000,' he said.

Internet technologies developed over the last decade are facilitating the ease with which synthetic drugs can be purchased leading to a rapid global expansion in online marketing for new psychoactive substances driven by free-market trade and greed.

'It's never been cheaper or easier to import into New Zealand,' he said.

'Research chemical companies based in either China or the EU are providing product worldwide for the synthetic black market utilising either the internet or crypto-market transactions through the dark-web.'

'These companies employ effective concealment methods of either powders or liquids and guarantee



importers refund of money in the event of border seizures,' he said

'A lot of Chinese companies will send with a guarantee that you'll receive their product and will put your money in escrow so they don't receive your money until you've signed for it. They offer a 100% guarantee on delivery and a high purity level that is regulated via an online peer based rating system.'

'Like everything (drugs) sent from overseas it's sent in Mylar- a material used to bounce back light to reflect x-rays. If its packaged right and in a box with something else in the side of the box you won't see it because the Mylar will deflect the x-ray,' he said.

'Now that people vape everyone is importing vape juice and people get the research chemical powders broken down into liquid form, either in solvents or water and then baked back off once it arrives at its destination. There's no smell because the bottles are sealed with

rubber seals and cleaned with solvent before being covered in plastic packaging over the top.'

'Basically, any substance that can be concealed as a powder or liquefied, can be easily smuggled into New Zealand,' he said.

'There's other tricks to importation as well, the weight of a package can alter the amount of border scrutiny it receives, and certain overseas mail services and cut out countries are employed to minimise risk too.'

It's not just the compounds linked to synthetic products that New Zealanders should be worried about either.

'High potency synthetic analogues mimicking the effects of opiate, psychedelic and stimulant drugs have all been developed and in many cases the psychoactive impact of these drugs on human brain receptors is unknown because they've never been subject to any form of testing,' he said.

'Any person engaging in recreational drug use is potentially at risk.'

'Just one gram of ABM Fubinaca is sufficient to produce four ounces of average strength synthetic cannabis but if you decide to take that one gram and make one ounce then you've got some really explosive strength synnie that's going rock peoples' world.'

'The people who are bringing in kilos are aren't going to make four thousand ounces they're going to be making one thousand ounces, it's going to be super strong and it's going to send users into a catatonic state,' he said.

The extreme potency of synthetic compounds coupled with New Zealand's home cooked number eight wire drug culture has been a contributing factor in the spate of deaths.

'I think the deaths have been caused by back yard chemists mixing ABM Fubinaca or MMB Chminaca at a high dose before putting it in a spray bottle and randomly spraying it on the plant material unevenly. Because of the strength of the compounds uneven distribution can mean the difference between a dose that gets you high and a dose that kills you,' he said.

'A person who is onto it will use a pressure cooker to evenly distribute the compounds while allowing the flammable vapours to escape away from the heat source. Anything that can be evaporated can be used but predominantly people will use acetone or isopropyl alcohol because they're easy to get, have high rates of evaporation and don't leave behind much residue on the plant material.'

'All this talk in the media about toxic materials like fly spray, weed killer or petrol being used is a bit farfetched, the toxicity is linked to the strength of the dose not some random toxic substance,' he said.

Another issue with synthetic products is that often more than one compound is used.

'The more synthetic compounds people dissolve into solution to distribute onto plant material, the more it's going to mess you up. Each synthetic cannabinoid had a different hit to it from mild relaxation to extreme hallucinations to a couch sloth feeling. It's like mixing heroin with crack cocaine and methamphetamine all in one and smoking that. You're going to go up, you're going to go down, you're going to go sideways. You're going to get completely twisted.'

'Those receptors you're hitting are going to get overloaded and send your brain into a catatonic state and you're going to be useless sitting there with your mouth open. I've seen it happen, people having a bucket bong and afterwards they've got a bag in one hand and a lighter in the other and all of a sudden, their mouths will open like the open-mouthed clown at the side shows you pop the ping pong balls in and they'll drop everything and just sit out there and be absolutely useless and often have seizures too. They can have some idea of what is going on around them but they can't do anything about it. There's no sitting there and getting paranoid, it's more of an out of body experience, you're in your head but you can't feel any physical sensations you're just trying to hold your body up- it's a strange feeling,' he said.

With the issues relating to the psychoactive industry's inability to prove synthetic compounds are safe without animal testing, elements of the industry have reverted to online operations outside of NZ and products once available on NZ shelves can still be purchased online with buyers using international cut out addresses via you-shop type services.

Some of these companies are re-labelling their products as zero percent nicotine vape juice.

That dealers can provide an extremely strong and cheap product while making enormous profits means synthetics are being aggressively marketed by unscrupulous criminals.

The ease with which synthetic drugs can be imported into the country means a prohibitionist approach to control is unlikely to have any lasting impact.

The New Zealand Government is currently reviewing the Methamphetamine Action Plan in an attempt to develop a comprehensive approach to reduce harms from methamphetamine use. Given that synthetic drugs have been linked to 20 deaths it would be prudent to include all psychoactive substances in this plan. When one substance is given prominence and considered in isolation, it just makes room for other substances - some of which are potentially even more harmful, to fly under the radar. A robust and comprehensive approach that has recovery for individuals and families affected by substances at its core is necessary.

So far, those most affected by the spate of deaths have been young people, those living rough, those suffering from mental illness and other marginalised groups. We need to act before we see more deaths and suffering.

Sexual Abuse & Recovery- Briar's Story #metoo

By Nathan Frost

Hundreds of thousands of women and some men took to social media recently to share their stories of sexual harassment and assault in response to allegations of sexual misconduct against a Hollywood power broker.

Hashtag #metoo has illustrated the depressing regularity that women, men and (those unable to express their voices on social media) children face unwanted attention from perpetrators of sexual abuse.

For people in recovery from addictions, the magnitude of sexual abuse is a well known yet little talked about fact of life.

Upbringings marred by such heinous breaches of adult trust seem to be the rule rather than the exception within recovery communities.

Acts of childhood sexual violation cast long shadows over victim's lives and complicate the process of recovery from addictive and self-destructive behaviour.

Disclosing episodes of childhood sexual abuse can be so overwhelming and intense that many residential alcohol and drug treatment services have a policy of avoiding sexual trauma therapy during treatment.

Services believe they are doing their clients a disservice in picking the scab off a wound they have inadequate time or resources to heal.

Yet for sexual abuse survivor Briar Scragg, the process of disclosure began while she was a client at a residential alcohol and drug treatment service.

Ms Scragg, now a counsellor working with clients affected by sexual abuse and trauma, maintains that without the support she received from therapists as a resident at an alcohol and drug treatment program (including an extension of her stay from 8 to 16 weeks) she would still be trapped in drug addiction.

In 2012, Ms Scragg's abuser was sentenced to 9 years' jail for offenses committed over a sustained period of her childhood.

In his sentencing summary, the judge noted physical, mental and emotional distress caused by the sexual violation Ms Scragg had suffered including Chronic Fatigue Syndrome and drug abuse.

Ms Scragg, has decided to share her story in the hope it will help addictions practitioners better understand the issues and challenges disclosure presents for them and their clients.

On the day of our interview I'm greeted by Ms Scragg at the front door of her home, a vibrant young woman basking in the glow of her second pregnancy with a delightful two-year-old clinging underfoot.

It's not the first time we've met and I'm struck by the contrast of this meeting and the first time I met Ms Scragg eight years earlier.

I'd been sitting staring out the window of the group therapy room in rehab when a fragile looking waif had staggered around the corner of the administration building engaged in a seemingly precarious balancing act on high-heel-boot-clad stilt like legs.

With obvious dark clouds brooding overhead, Ms Scragg looked like she'd stepped off the cover of a fashion magazine at the worst heights of heroin chic.

That I'm met by this healthy young mother today and not the withered husk of potential I first encountered all those years ago is testament to Ms Scragg's therapeutic journey.

It's been a protracted and extremely tough process with a lot of support needed along the way, yet it's resulted in the unshackling of a burden Ms Scragg says was never hers to carry.

“ It's actually quite easy to own it because I've worked out that the shame that I have with it needs to be shame that he carries, not that I carry. ”

Here is her story.

Why is it important to tell your story?

'I started thinking people could get hope from my story. I was working with a few different clients dealing with abuse and it was seeming quite hopeless and I was umming and ahing with my colleagues about whether or not I disclosed my experience and someone I work with said they had heard Janella Bird (a narrative therapist) say, "in the counselling room share the personal but not the private".

'So I started wondering, is the sexual abuse that had happened to me something personal or private? Up until now I've been keeping it really private, still quite secretive and I thought to myself if I could move it from the private to the personal then that would be really healing.'

'It's actually quite easy to own it because I've worked out that the shame that I have with it needs to be shame that he carries, not that I carry. So after processing this I thought yip, it can be a personal story but it doesn't have to be a really private story. It's a part of me- a little part of me - and by being open about it perhaps helps make it less big in a way?'

'I also think that counsellors working with people in the addictions field, need to be informed on the dynamics of abuse and best practice when working with people who have been sexually harmed. When I was in rehab, if they couldn't hold me in a safe space when it started pouring out then it would've been really harmful and I

would never have been able to stay clean. I seriously believe if I hadn't been able to do the healing around the abuse I'd be a shell of the woman I am and I'd still be trapped in the daily grind of using drugs. One of the positive outcomes from this horrible experience is the opportunity to educate others, and if I can find a gem from this horror, I can live with it easier.'

Did you feel like the therapists at the rehab you attended had the expertise and understanding needed to help you when the abuse came up?

'Yes, they were really educated about what that might look like, they helped me understand what to expect and helped pace me through the process so that nothing became too overwhelming or completely unbearable because



“ If I hadn't received that care, I'd have never stayed clean. Rehab would've all been surface stuff for me if I hadn't done the deep therapy.”

there were times when it did become rough. If I hadn't received that care, I'd have never stayed clean. Rehab would've all been surface stuff for me if I hadn't done the deep therapy.'

So what is your story?

'Um..., where to start though? My dad died when I'd just turned four. He was really loving and a really good man but he died suddenly and mum was left with three kids. She reunited with one of her old friends and he became my step dad.'

'He sexually abused me from then until I was thirteen. He was someone who was really looked up to in the community. In our little town he was really well respected and had so much mana. He was deputy principle of a high school. I saw everyone just love him and under no circumstances did I consider saying anything to anyone.'

“ How can someone harm you in such a serious way and you still love them? How can someone hurt you so much and also treat you well some of the time? ”

'There were no warning signs for other members of my family because I was always just a good little girl. I was good academically and full of character. I seemed fine and I seemed to love him and I think a part of me did love him because he was good to me in many ways. This added to the confusion I experienced both as a child and as an adult. How can someone harm you in such a serious way and you still love them? How can someone hurt you so much and also treat you well some of the time?'

'And so I remember when I got six or seven awards at a prize giving in my first year of high school - so I guess I was 13 and the abuse had stopped - and I thought to

myself I'm sweet, this hasn't even bothered me. I must just be one of the really strong ones because I'd gotten all of these awards and I was happy.'

'I think I'd just buried it so deeply that I just didn't really think about it. I never thought about what was happening when it wasn't actually happening. And then time ticked on and I got chronic fatigue syndrome which had me absolutely exhausted.'

'This was at the end of high school and I found myself stuck in bed for about twenty hours a day with exhaustion and pain, just totally shattered. No one really knew why or what had triggered it. It wasn't until I was in rehab that I discovered how my body remembered the abuse, the chronic fatigue was my body reacting to trauma.'

'It was through doing some bioenergetics therapy that I made that discovery. I didn't realise I was carrying all this repressed anger that was manifesting in physical symptoms until I did that work. The therapist said to me, "you're really angry aren't you"? And I said, "no no I'm over it" but once I got in touch with that anger I regained some power.'

“ Not long after that I found meth. And I was like I'm not tired anymore and I genuinely believed that I wasn't bothered by being sexually abused- that was one of the things meth did for me. ”

'Anyway he was still in the family home and mum and him seemingly still had a good relationship but then he got found out for child pornography. So then he lost his job and people started telling me "ah he's still a good man" "he'd never do it to a real person" "he was just looking at it on the computer". And I thought that's bullshit.'

'I actually went to see the same psychologist that he had previously seen due a court order resulting from his child pornography conviction. This psychologist had started believing that his offending only related to the child porn and started telling mum that he was definitely safe around kids.'

'So I ended up seeing the same psychologist and I said "actually you're wrong, he did this this and this to me" and the psychologist said, "if you tell anyone

there's going to be a suicide in your family, your mum's happiness depends on you keeping this secret". I'd known that anyway but it just helped me decide to keep it secret for a little while longer. I look back now and think, what a terribly unethical professional!

'Not long after that I found meth. And I was like I'm not tired anymore and I genuinely believed that I wasn't bothered by being sexually abused- that was one of the things meth did for me.'

'I remember looking in the mirror and being like I'm so alone in the world and that's exactly how I want it and I was full of energy and that was so nice you know after a few years of just feeling like I was walking through mud.'

'While I was on meth I didn't think about or was bothered at all by my childhood- so it served a good purpose, it helped me keep a lid on it when it was starting to bubble up. Then it caused its own problems obviously and time ticked by and I thought to myself I've got to sort my shit out and get clean!'

'During that time I'd told my partner what happened and he'd said to me "you're not going to ever get off drugs or ever get over chronic fatigue unless you tell your mum" because I was still keeping up the smiling face. And so- to cut a long story short- I found myself in rehab and I decided to tell.'

'The deciding to tell is a vivid moment for me. He knew that I was going to tell, I had told him I was going to be real in rehab, I told him I had no intention of telling mum, but that I was telling the therapists.'

“ He was driving and I looked over at his fat hands and had an intense flashback to him abusing me and in that moment I felt like a scared seven-year-old, and that feeling of internal grubbiness returned. ”

What did he say when you told him your intentions?

'The conversation got quite heated because he was really angry that I'd told my boyfriend. He said, "not a day goes by when I don't think about it, I'm so sorry I'll kill myself tomorrow if you tell mum. I don't mind, I know my life is over".

'So he apologised in a way and acknowledged what he'd done, which was nice because years earlier I'd tried to get him to do that and I'd confronted him and he had dismissed it. I'd gone to rehab thinking he had apologised and it wasn't until we were sitting in the group room and you said "if an apology is mixed with a threat, is it a genuine apology"? And I was like well that's true because he threatened suicide if I told. So he knew what was coming.'

'The moment that I knew I had to tell and not keep the secret from my family came when I went on a weekend leave with him and mum. He was driving and I looked over at his fat hands and had an intense flashback to him abusing me and in that moment I felt like a scared seven-year-old, and that feeling of internal grubbiness returned.'

'My whole life up until rehab I'd be able to be in the room with him, hug him, and it be fine but I looked over at his hands and I had the worst flashback. When the flashback passed I thought to myself f*** I can't do this anymore, I've got to tell! So that was the moment I made my decision. And then I got back and I was like yip, start planning a family meeting.'

How was that for you?

'I was so nervous! The therapist got me to write letters to myself to remind myself of why I wanted to tell and why it was so important to me to bring it into the light. I'd said it feels like I'm dropping a bomb on the family and one of the therapists was like "yes it is like dropping a bomb on the family but its not your bomb. It's going to drop - you're just choosing the timing".

'That was another thing that helped me, it wasn't actually me and it wasn't my fault that I had to break this shitty news but it was still a really hard meeting - I could barely find my words!'

How did you experience your mother and brothers' reactions?

'They believed me. I never doubted that my mum would believe because she was a good mum. I mean the home I was raised in was a middle class home, it was the kind of home that made others at school envious of my privileged life.

'My mum is a highly educated, loving and reasonable woman. I mean I had lots of reasons to tell, lots of reasons that made it safe enough for me to tell but I still didn't or couldn't. I don't want to talk for my mum but I think there might have been a wondering about why I couldn't tell even though she understood how hard it was, people don't get why you don't tell.'

'I have seen it at work many times, people in chaotic homes with no decent parental or family support have so many reasons not to tell. I knew I'd be believed and supported and it was still incredibly hard enough to break the silence.'

'Then my mum had to go back to work. It's a small town Gisborne and everyone seemed to know which was hard on my family I think. It's just really shit how sexual abuse infects a whole family, you get different gender, ages, ways of coping in the mix and it makes for a difficult time for even the most solid of families.

“ If you look at why disclosure has been a success in my life, one of the contributing factors was that I was believed. I was reassured when it did come out ”

'I still just wanted to stay in my protector role. I'd taken on that protector role of keeping it a secret and protecting them from the truth, and then after they knew the truth I still wanted to protect them from feeling that anger and hurt or whatever from it.'

So you had been carrying that burden for years?

'Yep, and he didn't say anything to me. He didn't say words to me like that its your fault, you need to be

ashamed about this or anything. When the abuse was happening he never used threats to keep me silent yet I still took it on as my burden. It was an unspoken thing I just automatically assumed the responsibility of that burden.'

Did you ever doubt that you'd made the right choice?

'No because it felt so f**king nice not carrying the secret anymore that the relief overwhelmed the doubt. Mum and my brothers reassured me that they were glad I'd told you know they said to me it was good that I told.'

'So she was able to give me that reassurance that I'd made the right decision. If you look at why disclosure has been a success in my life, one of the contributing factors was that I was believed. I was reassured when it did come out.'

“ When I worked through the damaged goods feeling and the self-sabotage cycle that comes with that I started attracting good things in my life ”

'I can't recall - not for any big amount of time - that I wished I hadn't disclosed. It was nice not having to face him! So then our family sort of just started to figure out a new life without him and then a year or so went by (I think - I'm not very good on the exact timing) and then it started to niggle again after feeling quite a lot of peace.'

'The burden of the secret had been lifted but then it started niggling again because I knew he was a pedophile in denial who was still a risk in the community and I hadn't done everything I could to stop that risk.'

So the initial disclosure was only about telling the family?

'Yeah once I'd disclosed to the family I thought right that's enough, I won't put family through the court stuff, I don't need that. I'd thought the disclosure was enough but after that initial relief it started to niggle again. And so I went to the HELP foundation in Wellington who deal with sexual abuse and they supported me to go to the police.'

Can you tell me a little bit more about what it was like going to the police?

'They were good. I met with them just to see what it might look like if I did go down that road and the detective clearly said that I was likely to get not guilty and warned me it would be a long process. He didn't sugar coat it but he listened and said yeah that he'd support me. And I thought right, give it a go I suppose. I did therapy each week through the HELP foundation and worked through the shame and the guilt and my low self-esteem - which were the biggies.'

'When I worked through the damaged goods feeling and the self-sabotage cycle that comes with that I started attracting good things in my life and started doing things that were good for me because I felt like I deserved them all of a sudden.'

'If I'm not worthy of good things and see myself as just damaged goods, then I'm not going to get what I want

out of life. I'm not going to have the sex I want because its not going to be about me or I'm not going to be treated well in the work place because its only me a damaged person, you know? Its all of that kind of stuff. That's why sexual abuse survivors end up with f**ked lives I reckon because they just believe they're not as worthy of the good life as other people are in the world.'

'So those were the things I worked through in therapy. I got to a place where no matter what the verdict was, I was still going to be walking away feeling peace. No matter what the outcome, it was going to be a success for me. So the success of the court process didn't hang on the verdict it hung on me articulating my truth and facing him and being a strong woman in that court room.'

'And so eighteen months after I first did the evidential I went to court. He went not guilty which I was gutted about. I was still hopeful that he might start living as an honest man and so I had to work through that too because I was gutted and it meant so much more work.'

'It meant being questioned by the defense lawyer and the defense lawyer was an academic who looked exactly like my step dad..., well not exactly like him but he mirrored my step dad in that he was an educated white male of the same age.'

'My counselling training provided me with an awareness of transference and counter transference. So I had that awareness while being questioned by the defense lawyer in a position of power who looked similar to my step dad, articulating himself in a similar educated white middle class manner to my step father - all of that.'

'There was a risk I could have gone into the victim role quite easily but because I was aware of that I was able to stay in my adult self in the court room, which was essential. You know to be put through that and be accused of..., um..., he really worked on putting the blame on me.'

“ This is a picture of strength and empowerment but that so wasn't me a couple of years earlier when I was trying to get home from America I was so high on meth I couldn't even put my shoes on ”

'He asked me questions like "when you were six If you didn't like what was happening why didn't you leave the bed"? And that was only one of many questions of that sort of thing. If I hadn't of done a lot of therapy it would have seriously triggered me into not being able to stand my ground.'

'Instead I was able to remain calm and say, "well actually, I was a little girl that needed love and to leave the bed would have meant isolation and no one's going to choose isolation when you're six or seven". And, um, yeah..., so I just nailed it.'

'I stayed grounded with my cheesy little stones that I was holding and I was so well prepared and going to a 12 step support group all that time and going for a run each morning of the court case and tuning into my higher power.'

'This is a picture of strength and empowerment but that so wasn't me a couple of years earlier when I was trying to get home from America I was so high on meth I couldn't even put my shoes on. I mean I was such an empty shell of who I was I became completely hysterical because I couldn't manage to put my shoes on at the airport! I mean back then I couldn't even get out of bed before reaching for the pipe on my bedside table.'

So what kind of time line is involved in reaching out to the HELP foundation, approaching the police and going through the court proceedings for a ruling?

'When I went to the HELP foundation I was basically ready to go through with things. I met with the detective Gus and I think we spent a couple of days doing the evidential and getting all the facts down. Then that sat there for eighteen months while they gathered supporting evidence and built a case before he was formally charged.'

'The case itself lasted a week and I spent two days being questioned and some other people were also questioned including my first boyfriend who was the first person I'd ever told about the sexual abuse.'

“ Its his burden now, he can have that shame weigh him down cos its not weighing me down anymore. So yeah its definitely his burden, his shame and guilt to sit with, not mine ”

'So he gave evidence and mum, my brother, I'm not sure who else. Oh Jenny the therapist from rehab was called and was on hold that week but our side decided they didn't need her so she didn't come but she was all ready to go.'

'And then there were other written ones and he had a couple of people. And then he spoke and he showed himself clearly to be lying, he got tripped up big time. And we were just sitting there nervously watching the truth come to light. It was quite a beautiful moment.'

I guess you feel like you got some justice?

'Yeah I do! The beautiful sunny days I get to be here, I mean I get to go to the beach with my beautiful family and sometimes when I'm cooking a meal I think I get to choose what I'm cooking tonight and that's nice.'

'And I'm not like full of hate or anything but it is nice if I'm really honest knowing that I'm here and he's there and he doesn't get to.... I don't know I don't know.... Its his burden now, he can have that shame weigh him down cos its not weighing me down anymore. So yeah its definitely his burden, his shame and guilt to sit with, not mine!'

'I was sitting with a client the other day and she was getting the feelings out on the page (because I do quite a lot of interactive drawing therapy) and she named it just the way that I'd named it years before and it reminded me of that dirty feeling and that has f**king sat with me for so many years.'

'It's so hard to describe it to anyone who hasn't felt it but its like an internal dirtiness, it's like he made me not as

pure as I could have been. And, it's almost like not as sexy as I could have been? So yeah there's that - you get rid of that. I've had to work at getting rid of that dirty feeling and it sometimes lingers.'

What are the ongoing impacts- both positive and negative- that you deal with today?

'What area of my life hasn't this impacted? I can't name one. It's affected my work, its affected me as a counsellor in ways that are positive but that can also be really difficult. In relation to work If I'm grounded and in a space where I can totally park things I can bring a hell of a lot of understanding and empathy to bear in working with clients because I share with them a deep knowing but it's not always easy.'

'In the lead up to the parole hearing I became really ungrounded because I had moved myself into the victim role again to be able to voice how it's affected me at the parole hearing. In the week of the last parole hearing I was with a client who was the mother of a young person who had just disclosed sexual abuse and the mother was in full on blame mode of the little girl for not saying anything or going to the police. I found it really difficult to come from a de-centered position as a therapist in that session and did a fair bit of work with my supervisor around the influence my experiences have on my practice.'

As a parent, as a partner, as a friend, as a woman in the world. Its made me feel more unsafe than my friends who are walking down the street. Not everyone feels safe walking down the street. Some professionals reading this will be men and I know that some men don't get how vulnerable woman can feel in the world.'

'So yeah, I can't find an area that it hasn't impacted in some way. The healthy, loving relationship I have now hasn't come easy. I've had to really work at not having a world view, a core belief that men are all harmful and deceitful. He was my number one man in my life, my main person in my life as a little five-year-old so he taught me what men are like and he taught me mistrust and so yeah that's pretty sad.'

“ I guess my hope is that therapists working with survivors of abuse see the wisdom and strength in the person in front of them and hold the hope for them and their healing when the survivor can't see it for themselves yet ”

So you went to rehab for Methamphetamine addiction- how has your recovery journey been?

'At the start mantras like "a day at a time" and sometimes "a minute at a time" helped me get through. I did whatever I needed to do to clock up some days clean and just get some distance between myself and the drugs. Now, it's not so much like that. When I learnt to sit with feelings that were utterly unbearable, those feelings I thought I needed to avoid at all costs, when I learnt to sit with them, the desperate need for meth went. The

desire for it has stayed, and maybe I'll always desire that drug, but that desperate need passed a long time ago. It's really nice not needing a substance anymore. I never thought it would be possible.'

What would you like to say to someone carrying these secrets around or people working with clients who are carrying these secrets?

'God that's such a hard question to answer because everyone is different so I would say different things to different people.'

'I guess my hope is that therapists working with survivors of abuse see the wisdom and strength in the person in front of them and hold the hope for them and their healing when the survivor can't see it for themselves yet. I hope practitioners see the value in just making sure the client is currently safe and trusting them with timing around going to the police. For me, it worked in my favour to take my time, it was a subconscious decision and a wise decision to wait.'

“Once it all does start coming out then practitioners need to know that crisis emergency stage after clients get clean the emergency stage that follows it which can feel like an absolute crisis.”

'Because I got educated I got stronger and empowered to the point where I could articulate things in court really clearly and honestly - so sometimes it's a good thing to wait! And, if you reframe waiting as just working to strengthen then that's really helpful.'

'I would say as I said before to remember whose shoulders does the blame belong on? Who deserves to be carrying that dirty feeling - Is it really you or is that the aftermath of it?'

'Once it all does start coming out then practitioners need to know that crisis emergency stage after clients get clean the emergency stage that follows it which can feel like an absolute crisis.'

'I remember in rehab collapsing on the field on the grass just howling so loud and my hands and my face and body got all wet from the grass. It was like six thirty in the morning or something and I was just wailing on the field; sobbing- hysterical because it was just so raw when it all started coming back.'

'Practitioners need to be aware of that I suppose...aware of the rawness people can feel when their numbing

mechanism is gone and even kind of honour why some people are using drugs, rather than than positioning ourselves as experts in the therapy room and labelling clients as resistant to change. People aren't resistant they just have big protectors.'

'But to people who've been abused I don't know what else to say because every person is different and I don't know the families they come from and whether they'll be believed like I was? I would maybe say, you might feel broken beyond repair but you're not, no one is, and a peaceful feeling is possible.'

'The HELP foundation is bloody good! And there's some good police people too. After we got the guilty verdict my mum asked the lawyer who was really good and the detective if they'd go around the corner and have a drink, "it's been a hell of a week, we'll shout you a drink" I think she said.'

'The lawyer said to her "I don't usually do that but yeah why not". She told us that normally her clients are so traumatised they can barely speak, that they get on the stand, quiver and can barely get a word out.'

'But I was different. So you know, always remember, it affects people differently and I had a lot of resources in my favour that made the guilty verdict happen. He didn't count on me growing up to be that strong, he would've been banking on me being less resilient.'

So, reflecting on Briar's story and given the prominence of sexual abuse in the lives of those affected by addiction, is enough being done to address the impacts of this trauma?

The hashtag #metoo campaign has given a voice to the many lives adversely affected by sexual abuse and is helping to normalise disclosure, however, how this greater openness is reflected in addressing the current structural failures within our society in supporting, treating, and providing justice for victims of sexual abuse remains to be seen.

Nowhere is the impact of sexual abuse and trauma more evident than in the lives of those affected by addiction.

Those in recovery already know that sexual abuse is widespread and endemic within our society, they're all too aware of its impacts on their peers, people they've used with, people struggling to get clean, and people still trapped in addiction.

Yet, Briar's story is a hopeful one. It shows that professionals can make a real difference in people's lives. It shows that by acknowledging and working through trauma, people can recover and find freedom in their lives.

Opiate Substitution Treatment and Disaster Management

By Nathan Frost

People on opiate substitution treatment (OST) represent a vulnerable population in times of disasters, Dr Denise Blake from the Joint Centre of Disaster Research at Massey University told 2017 Cutting Edge delegates in her presentation on OST and disaster management.

'Disasters create and exaggerate vulnerabilities while also exposing pre-existing inequalities.'

The more vulnerable the population, the worse the impact of disasters on that population can be,' she said.

Dr Blake interviewed OST consumers and a range of relevant health and emergency management professionals.

Her research found specific vulnerabilities for people on OST following a disaster.

'Without appropriate emergency management planning to ensure opioid medications are available after a disaster, people on OST suffer physical and emotional distress in situations already fraught with danger and chaos.'

'Disruptions to daily consuming will lead to physical symptoms of withdrawal such as nausea, muscle aches, diarrhoea and vomiting in already traumatic circumstances,' said Dr Blake.

Fear of withdrawal caused many OST consumers to live in a constant state of anxiety due to their reliance on a system they perceived as being punitive.

'It can be difficult to access OST medications in a disaster setting because opioids are highly regulated drugs and OST clients have little control over takeaway dosing. Many people on OST are required to consume their dose daily at an approved pharmacy or clinic.'

Previous research in the US demonstrated how people were unable to access their opioid medication for up to five days following hurricanes,' she said.

'There are stories from Hurricane Katrina that people were wandering around vomiting in the Louisiana Superdome, professionals thought they were sick but the emergency responders and allied professionals did not understand the effects of opiate withdrawals.'

People on OST programmes were eventually taken to clinics on buses, but as all records had been destroyed people were either left to hang out of given a minimal dose to tide them over,' she said.

The vulnerabilities and issues OST consumers face in times of disaster are not only restricted to physical withdrawal either.

Those being treated with OST also have to cope with the psychological and emotional distress linked to their anxiety over possible disruptions in obtaining meds.



OST consumers interviewed for Dr Blake's research spoke of panic attacks, anxiety, depression and fear.

'Not only do OST consumers face the stress and anxiety of being powerless in a disaster, on top of that, they have to worry about access to their meds,' she said.

OST case workers interviewed for her research said consumers weren't going to die from withdrawal and that their clients knew that, however, Dr Blake maintains that in emergency situations, withdrawal could be a matter of life and death.

As one participant of Dr Blake's research put it,

'If you actually can't walk, or can't lift your children, or what you need to take with you to survive... or can't, get out of bed... because it really takes it out of you... it's not a case of someone just coming in and saying I need drugs, it's someone saying, I need a chance to survive.' (OST Client)

Those dispensing opioids to OST consumers also recognised the importance of ensuring access to meds in any disaster management planning.

We need to make sure that there's continuity of their medication supply because if you do that at least psychologically they will be fine, and mentally they'll be fine, if you don't give them that then they'll go into withdrawals and then you'll get the complexity and the effects of psychological issues like depression, stress—all those kinds of things. (Pharmacist)

Dr Blake believes disaster management plans must mitigate vulnerability and risks for OST clients by ensuring the accessibility and availability of opioid treatments in a post-disaster context.

'OST disaster management planning should emphasise service continuity and be flexible enough to meet the needs of this unique 'at risk' group.'

Alcohol and other drug and OST workers do understand

the specific needs of their clients, but unfortunately available resources to attend to disaster preparedness are limited,' she said.

At the time of her research - about 5 years after the Canterbury Earthquakes- all of the OST services

interviewed by Dr Blake were at various stages of completing their emergency management plans.

People with opioid dependency present a specific group that need to be considered in disaster planning and emergency management.'

Feature

Cutting Edge Street Art Project – Seeking Human Kindness

By Nathan Frost

For those working in addiction treatment who witness firsthand the negative impact an absence of love, kindness and consistency has in people's lives, the message of Wellington homeless man Kawana Pene's sign- Seeking Human Kindness- should resonate deeply.

I was lucky enough to spend some time getting to know Kawana Pene and other members of Wellington's homeless community during this year's Cutting Edge street art project.

Local Graffiti Artist Holly Rocc worked with Kawana to turn the poignant message of his sign into a billboard style piece of street art that was displayed during the conference in the expo area at Te Papa reminding delegates that addiction is indeed everybody's business.

As I talked to Kawana and his street brethren a common narrative began to emerge around upbringings marred by parental alcohol and drug use. Kawana told me that at the age of four he was an expert at video games, and had this to say when I asked him to elaborate.

'My parents were partying all the time and I would get sat in front of the TV with the Sega console while they



Kawana Pene talks about life on the street to Dr Arthur Evans during the street art project.

carried on drinking and doing drugs. I'd clocked all of the games at the age of four. Sega was my babysitter.'

Drug and alcohol use is a fact of life on the streets Kawana's friend Aiden Hudson told me.

'We beg for money out here all day, every day. When I first came on the streets several years ago it was different, there were less of us, just the older ones and a few of us



Kawana Pene's heartfelt message from the street



Posing with the finished piece from left to right Kawana Pene, Aiden Hudson, Holly Rocc, and Tati Nightindale-Skelton

younger ones. Now it's changed, it's harder now.'

'The council move us on and the public seem to be sick of us. People don't even see me anymore; I mean it's been getting so bad I talk to myself sometimes. I try to address these people, try to smile and say hello but nothing, absolutely nothing. At best I get told to piss off and get a job.'

'You try sitting on a piece of cardboard out here for just a couple of hours begging for money and see how you feel, you're gonna want to get pissed or something too. If someone gives me fifty bucks I might just go and buy some weed, its tough out here you know, it's how it works.'

Accessing treatment options can be problematic for the homeless too. Unconventional routines including changes in sleeping locations and patterns can make keeping to appointment times problematic.

For those worrying about where they're going to sleep

next, where their next dollar is coming from, or where they can safely store their stuff, attending appointments or support groups isn't seen as important as meeting the basic requirements of survival.

With so many barriers to treatment and no real answers to be found in traditional service structures the challenge to the sector lies in finding a way forward to create meaningful engagements with homeless people.

The fact that people cared enough about Kawana and his message to organise an art project has restored his faith in humanity and helped him in his decision to transition from the streets into a house.

'It's humbling to have people who are willing to help me out, I'm just a homeless man. Its very powerful, I can't really explain it, very uplifting, my self esteem has gone really really high. Right now I feel happy about myself, that doesn't usually happen.'



Street artist Joseph Witana and project volunteer Tati Nightindale-Skelton chat



Graffiti Artist Holly Rocc hard at work.

The 22nd Cutting Edge Conference

This year's Cutting Edge conference, hosted by dapaanz, was held at Te Papa in Wellington, 7-9 September. The theme was 'Addiction is everybody's business' highlighting that we all have a role to play; whether we are an addiction practitioner, a manager, a peer support worker or are working in primary care. This theme focused on how we can create an integrated system that is responsive to people's circumstances, environment and their life stage.

Over 500 delegates attended from across the wide spectrum of addiction-based roles.

Framework for addressing addiction: The Philadelphia experience

The opening keynote address on Thursday 7 September was by Dr Arthur Evans who was recently appointed CEO of American Psychological Association.

Prior to that he was Commissioner of Philadelphia's Department of Behavioural Health and Intellectual Disability Services, a \$1b health care agency serving 100,000 people each year. Under his leadership the department underwent a systemwide transformation focusing on recovery, resilience and self-determination. This has improved access to services, led to fewer outpatient admissions and visits to crisis centres, and gained significant cost savings which the city has re-invested into community-based services and supports.

He said the issues we deal with in mental health and addiction are complex and suggested that our traditional systems and the way we have been trained are inadequate for that complexity. Our current approach is that we get people into treatment, we fix them and they leave well.

But there are several problems with what he called this "black box model". For example, frequent relapses mean people aren't necessarily fixed. Not everything that helps people comes from treatment providers; and waiting lists mean people often can't get to 'be fixed' anyway. Importantly our approach assumes we can treat everyone in much the same way, regardless of their context (family and circumstances etc).

"But we know people can recover and get better. There are probably people in this room who know the power of recovery."

"In Philadelphia we tried seeing people in context on the understanding that treatment is just one of many ways to help people. The biggest predictor of our health and wellbeing is social support," he said.

"Health care contributes to just 10-15 percent of what keeps us well. Most of what determines our health has to do with our behaviour, where we live, genetics and so on. In the US we spend trillions every year on that 10-15 percent of the sliver, almost ignoring all the other things. What if we started thinking about these other things as well as providing great health care?"

Three waves

He said the approach in Philadelphia took the form of three waves:

1. Building the foundation by getting people into the community to make connections
2. Helping people to be a part of their communities and have meaningful lives
3. Promoting health and wellness for the population.

He called this the "population health model" and said one important element of this was bringing in the expertise of people who have lived experience.

"We talk about peer culture, not just peer support. It's about more than just treating symptoms. What does it mean to live in a community context, and how do we help create an alternative community culture so people who have been using substances for many years can integrate?"

Seven conceptual shifts

Dr Evans spoke about seven conceptual shifts needed to start looking at a population health model rather than a black box model.

1. Working upstream (intervening earlier)

For example, he said the ACEs study showed childhood adverse experiences increase the risk of physical and mental health problems later. So, they introduced things like training people in mental health first aid to go into communities where there had been trauma, such as a shooting, to provide support and help people connect to services.

2. Broad set of strategies (beyond psychotherapy and medications)

The primary way we work with people is psychotherapy and medication but Dr Evans suggested there may be other things we can do. An example he gave was making a policy decision not to send children to residential care programmes that were away from their homes and families. They also decided to put a mental health professional in every courtroom where such decisions were being made, which made a huge difference and helped educate justice authorities.

3. Working with non-diagnosed populations

An example Dr Evans gave was approaching local Bhutanese and Burmese communities which had high trauma needs but that did not typically engage with services.

"So rather than come in and tell these communities how we were going to help them, we asked them to define



Dr Arthur Evans

what their problems were and their solutions, and offered to support them in that.”

4. Deliver health promotion interventions

Dr Evans said the absence of illness, which is the way we typically define health, is not actually health. “Can we do some things that actually promote health?” he asked.

One example was developing a Healthy Minds Philly website with lots of material aimed at health promotion rather than treating illness or fixing problems.

The website also included simple mental health screening because he said half the people who have a mental health challenge don’t come forward. The next step was to take screening out to the community and offer it at public places like libraries and railway stations, which also helped to normalise mental health and behavioural health issues.

5. Working in non-treatment settings

Dr Evans said there was a problem with homeless people that usually involved serious mental health problems or addiction. These are people who do not react well to suddenly being put in a structured environment so instead of the usual approach of connecting them to treatment and hoping to get them into housing, a Housing First approach was taken where people were treated as partners rather than people needing experts.

“The best way to work with people is to put them directly into housing and then support them. What do you want to work on? How can we design a programme that works for you?”

When they changed to that model Dr Evans said 90 percent of people stayed in provided housing for six to nine months instead of the typical one week, and then were in a position to be supported into their own homes.

He said dealing with a number of social determinants, including housing, made a huge difference for the people but also reduced average costs to the city from \$86 per person per day to \$28 per day.

6. Health activation and empowerment

In Philadelphia there were marginalised groups for whom the system didn’t work, such as men of colour (e.g. African American, Latino, Asian), so an approach was formulated to find alternative ways of engaging.

“For example, African American men don’t tend to talk about emotional issues so we worked with a professional story-telling organisation – a non-threatening strategy to help these men talk about topics they don’t traditionally mention.”

7. Working at the community level

“How do you go into a community and deliver strategies that engage lots of people?” Dr Evans asked

He showed a series of large murals that had been painted all over Philadelphia, created by artists in partnership with the community. The community comes up with the topic important to them that they want to create dialogue around and the artist reflects that in the mural.

“By letting the communities decide the issues we got engagement that continues to this day. This worked

much better than coming in and saying we wanted to talk to them about mental health.”

Dr Evans concluded by saying we work with the people society doesn’t want to deal with because they’re not worth our time or resources.

“But we know people can recover and get better. There are probably people in this room who know the power of recovery. We’ve tried to make sure that every single person in our community has that opportunity.”

Changing addiction systems: how difficult can it be?

On Friday 8 September Dr Evans spoke about transformational change; what was done in Philadelphia and what was learned along the way.

“Transformational change is different to incremental change which is just tweaking around the edges,” he said.

“We’re talking about having a vision of a very different world that addresses the challenges we’ve talked about in terms of the black box.”

Things that were able to move the system

Dr Evans outlined some of the things done in Philadelphia that contributed to transformational change. These included having many people who were engaged in the community around behavioural health issues and increasing cross-sector capacity. That means working with organisations like the police, fire department and schools so they were more aware and able to deal with addiction and mental health issues.

Greater stakeholder competencies meant spending a lot of resources and energy on things like mental health first aid and other kinds of training. Improved recovery rates for groups like the homeless and those stuck in inpatient settings with serious mental health issues relieved the burden on the system.

The efficiencies gained saved the city \$150m over 10 years which could be re-invested into services.

“Recovery means more than just giving a person a medallion at the end of their treatment and saying goodbye. In a truly recovery-oriented system relationships and support would continue.”

Lessons learned

Dr Evans then briefly summarised some of the lessons learned along the way.

1. Co-create a shared vision

“We could have come up with people and foisted ideas on them but a better approach is to share concepts and ask people for their thinking. We spent a year talking with people and building consensus on a shared vision. We wouldn’t have been able to make the big changes we wanted without doing this,” he said.

2. Build infrastructure for change

Dr Evans said that if an organisation is trying to shift how it’s working, there have to be people dedicated to building and doing the new things. As an example, he said that they were able to get 1000 homeless people

into their own homes, but this was something that couldn't have been done without a lot of supporting infrastructure.

"Who do we need to have in place? What sort of systems and committees? Those sorts of things turned out to be really important."

3. Develop conceptual clarity

Dr Evans said being clear about ideas was important, particularly for people in the addiction treatment sector who believed they were already recovery-focused in their work.

"So, we talked with them specifically about how recovery means more than just giving a person a medallion at the end of their treatment and saying goodbye. In a truly recovery-oriented system relationships and support would continue."

4. Celebrate the people and promote the work

Though anonymity is the 'name of the game', Dr Evans said they wanted to put a face on recovery so people would come to understand it better. A conference was organised by people in recovery to celebrate recovery. Registrations had to be stopped at 600.

"This told us people wanted to be engaged and a part of this movement that was burgeoning," Dr Evans said.

5. Use a big tent approach

Dr Evans said it was important to use as wide a scope as possible and that, as an example, they were very intentional about bringing in the faith community.

"Often when people have an addiction or mental health issue the first person they approach is their pastor, rabbi or imam, so we looked at areas with the highest crime and identified the religious leaders there and invited them and the service providers to meet for a short lecture on recovery, and then we'd connect the leaders to the providers."

Innovative Harm Reduction Approaches from Seattle

On Friday 8 September the Conference was privileged to hear from keynote speaker Dr Seema Clifasefi, who is an Associate Professor at the University of Washington-Harborview Medical Center in Seattle. Together with her colleague Dr Susan Collins she also co-directs the Harm Reduction Research and Treatment (HaRRT) Center which works collaboratively with substance users and their communities to co-develop, evaluate and disseminate evidenced-based harm reduction interventions and programming.

Dr Clifasefi began by reminding the audience that substance use is here to stay, and the sooner we accept this, the sooner we can work toward pragmatic and compassionate ways to address its harms.

"When we make addiction everybody's business, particularly the business of the person themselves, we are better able to have the wisdom that will help address issues in a culturally relevant and acceptable way."



Cutting Edge delegates and presenters sharing a light hearted moment

He said it was a great way of building relationships.

7. Create momentum

At the beginning there are usually fewer people on board when changes are happening, but Dr Evans said the number goes up over time.

"Start with the early adopters. We try to create policies to get those people to do what we would like, but the real trick is to work with the people who are already on board and try to create momentum from there."

8. Show me the data

In Philadelphia they broke out the ethnicity of those accessing services and found some groups were not getting the same rate as others.

"The best predictor explaining this was that we didn't have programmes in the areas in which some people lived, so we put out RFPs for those specific areas. The point is, if we hadn't examined the data we wouldn't have figured that out," Dr Evans said.

She said the war on drugs has failed and has had a devastating effect on our most marginalised and vulnerable populations in both the US and New Zealand.

"I believe we cannot talk about addiction in isolation of things like race, poverty and crime. They are all inextricably linked, which is precisely why addiction should be everybody's business," she said.

"When we make addiction everybody's business, particularly the business of the person themselves, we are better able to have the wisdom that will help address issues in a culturally relevant and acceptable way."

Dr Clifasefi spoke about harm reduction as a pragmatic and compassionate approach to minimising the harms or negative consequences/risks associated with substance use and maximising wellbeing and quality of life.

Housing first

Dr Clifasefi described the Housing First approach that had been adopted in Seattle.

Housing First has also been dubbed “harm reduction housing” and is based on the belief that housing is a basic human right; not a reward for good behaviour. It is permanent, low-barrier, supportive housing offered to individuals with histories of chronic homelessness, without preconditions such as abstinence or attending treatment.

The University of Washington was invited to evaluate the 1811 Eastlake (named after its address) Housing First programme which housed 75 individuals who were the highest users of publicly funded services. They found that for just these 75 people more than \$4m in tax-payer funds was saved in its first year of operation, and that there were significant decreases in hospital visits, jail days, emergency medical service use, as well as alcohol consumption and related problems, despite there being no requirement to stop or reduce substance use.

“But most importantly, Housing First was cited by residents as the thing that saved their lives,” she said.

LEAP®

After moving people into housing, the next step was to continue to reduce harms from substance use, and this led to the Life Enhancing Alcohol-management Programme (LEAP).

LEAP is a five-year study funded by the National Institute of Health and led by Dr Clifasefi. It’s a collaboration between academics, housing and health care providers and affected community members.

“We use a community-based participatory research framework to co-develop and evaluate programmes that reduce alcohol related harm and improve quality of life for residents living in Housing First settings,” she said.

“I think this is where we need to be directing our efforts. Science is telling us that harm reduction approaches are working.”

It’s a three-phased process

“First, we talked to the community to find out what they wanted to see happen,” Dr Clifasefi said.

“We then engaged the community and formed a community advisory board to develop and implement resident driven programmes. These fell into three broad categories: Leadership opportunities; Meaningful activities; and Recovery and healing pathways.

“The third phase was a controlled evaluation of LEAP as compared to Housing First as usual.”

Evaluation showed that LEAP participants had significantly higher scores on a measure of meaningful activity participation compared to control participants, and medium-sized reductions in peak alcohol use – along with a 24 percent reduction in alcohol-related harm – from before and six months after LEAP started.

“When we bring everybody to the table and make addiction everybody’s business, especially those affected by the problem, we are coming up with effective, acceptable, feasible and culturally relevant ways forward,” Dr Clifasefi said.

“I think this is where we need to be directing our efforts. Science is telling us that harm reduction approaches are working.”

LEAD®

Lastly Dr Clifasefi spoke about the LEAD® programme, launched in 2011, which she and her colleagues also evaluated.

LEAD is a police-driven programme that diverts low-level drug offenders and sex workers out of incarceration and prosecution and into harm reduction-oriented case management. It’s a collaboration between police, prosecutors, civil rights advocates, public defenders, political leaders, mental health and drug treatment providers, housing providers and other service agencies, as well as business and neighbourhood leaders.

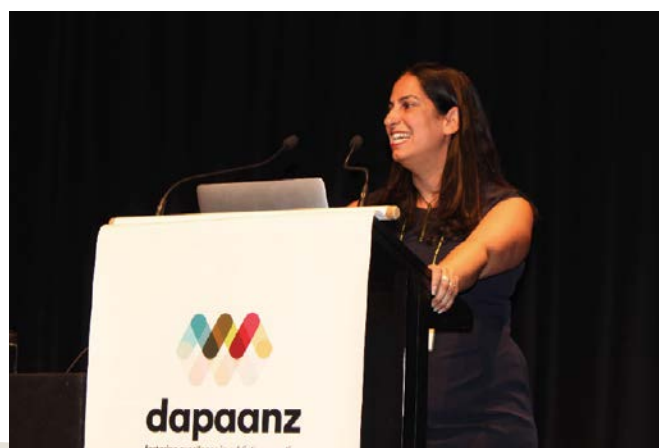
Some of the findings of the evaluation include that LEAD participants were:

- 58 percent less likely than people in the control group to be re-arrested.
- 87 percent less likely to have had at least one prison incarceration
- 40 percent more likely to procure housing or shelter during the follow up
- 46 percent more likely to be on the employment continuum at follow-up.

They were also found to cost the system \$3861 less per person compared to similar people not in the LEAD programme.

Dr Clifasefi concluded by saying New Zealand is a country with less bureaucracy and very progressive policies. It therefore could be a world leader around substances and substance users.

“If I can offer any advice based on the US experience, please don’t become another failed statistic. Trust me, it’s not fun to be on the wrong side of history and it plays out in ways that are coming to light in the current US landscape,” she said.



Dr Clifasefi is an Iranian American, married to a Kiwi. She initially trained as a cognitive experimental psychologist at Victoria University of Wellington, where she received her PhD in 2003.

Approaches to The Assessment of Cognition Within Addiction Services

On Thursday 7 September keynote speaker Dr Jamie Berry, Senior Clinical Neuropsychologist and Director at Advanced Neuropsychological Treatment Services (ANTS) in Sydney, spoke about cognitive impairment as it relates to addiction treatment.

He said the association between the two was strong, but that tools to identify cognitive impairment within addiction services are limited.

Cognitive impairment is a deficit in information processing in the brain. It differs from person to person but usually pertains to things like: memory; attention and concentration; visuo-spatial skills; language skills; and executive functions.

Dr Berry said brain injury is the leading cause of cognitive impairment – most commonly due to trauma to the head or stroke. However, long-term substance use can also result in cognitive impairment. Sometimes this is reversible; sometimes it is not.

“Hopefully we’ve now moved to a more recovery-focused therapeutic model to help people.”

Less intuitive causes can include mental illness, such as schizophrenia and psychosis, and learning disabilities (dyslexia, reading disorders) and other developmental conditions.

He said cognitive impairment is important to drug and alcohol services because it is one of the strongest predictors of relapse or failure to benefit from treatment.

But he said we need to be sure about why we choose to measure cognitive impairment. Traditionally the reason has been so we can do something to the patient to manage their behaviour.

“Hopefully we’ve now moved to a more recovery-focused therapeutic model to help people,” Dr Berry said.

“It could be simply that once the person knows their cognitive strengths and weaknesses, they’re empowered to do something about it. That doesn’t take much to achieve.”

Other reasons for employing cognitive impairment assessment might include cognitive rehabilitation using established tools and techniques – or it might be used to screen clients in or out of various programmes.

Lastly, he said there’s decision-making capacity which is relevant to New Zealand’s new Substance Addiction – Compulsory Assessment and Treatment legislation.

How do we assess cognition?

Dr Berry said performance-based tests are one way of assessing cognition, for example memory or mental tasks, and that these are pretty much the ‘gold standard’.

Another way he suggested was to simply ask people about their cognition and related variables.

“It’s a simple tweak you could make to your services and it’s a reliable way of gaining some information that is in line with a more collaborative approach.”



Dr Jamie Berry

Finally, he said just observing everyday behaviour can give you clues about what is going on at a cognitive level.

However, Dr Berry warned that, while cognitive testing is useful for measuring impairment, it’s not always great for predicting real world behaviour.

“With your filters on you may interpret behaviour in a certain way and attribute it to certain motivations – whereas it may just be the person is not processing information correctly,” he said.

“Being distracted and unfocused may not mean a person is unmotivated or disinterested. They may in fact be struggling with sustained attention. If we look at their history we may learn they have ADHD or brain injury or both. Just that knowledge can help shift our lens of interpretation.

“The disadvantages of observational assessment is that it is subjective, but it is a skill you can refine over time, and I would encourage you to work at that.”

The next level of detecting cognitive impairment Dr Berry spoke about was self-reporting, which can have two different components – self report about symptoms or about history.

He said it’s important that intake procedures include questions about things like head injury and loss of consciousness, but that they should also include asking about hospitalisation following head injury.

He said research he had done with We Help Ourselves (WHOS) suggested that, of a sample of 128 residential clients, 44 percent met criteria for significant cognitive impairment and half of these had had a head injury severe enough to warrant hospitalisation.

“So hospitalisation after loss of consciousness is a significant predictor of cognitive impairment and that’s good to know, so asking about that history is important.”

But he said clients can also be asked to self-report about symptoms, such as memory or thinking difficulties, though 86 percent will say yes to this, even some who don’t have an impairment.

He suggested using standard questionnaires such as the Cognitive Failures Questionnaire, which is free and in

the public domain, to be more precise about subjective complaints. The Self Control Scale (Brief) is very quick and easy to administer and other tools include the Behaviour Rating Inventory of Executive Functions – Adult (BRIEF-A), which requires the administrator to have a degree in psychology or similar discipline.

SACAT

Dr Berry said that under New Zealand's new Substance Addiction – Compulsory Assessment and Treatment legislation (SACAT), decision-making capacity must be assessed by an approved specialist.

"In an ideal world you would have a neuropsychological assessment every time you do a capacity assessment, but sometimes that's not appropriate, such as when someone is intoxicated," he said.

"So it's important you ask the right questions and use testing and behavioural observations to help determine the nature of impairment. When you know this you're in a much better position to help a person restore their capacity, which is one of the main aims of SACAT."

Minding My Own Business Is Not in My DNA

Keynote speaker Jeanette Grace, Dean Te Wananga Māori at Whitireia Community Polytechnic in Porirua, is no stranger to the mental health and addiction sector.

She says addiction really was her business when she participated in establishing Rangataua Mauriora in Porirua in 2000. It was a kaupapa Māori alcohol and other drugs service working with rangatahi, tamariki and their whānau.

"I was very clear at the time that my responsibility was not to deliver a service that replicated western systems and models," she said.

"I have an enduring pride in the use of waka ama as a therapeutic intervention because it touched the soul of our people and that is important to us. The restoration of grace, mana and order to whānau is what I am passionate about."

These comments set the tone for her keynote address on Thursday 7 September.

"If this sector is going to take tikanga Māori and apply it in service provision, then I want you to think about how you do that... That it's not superficial and subordinate to western methodologies."

Ms Grace spoke about her childhood growing up in her Māori culture of obligation, privilege, responsibility, service, love and nurturing, where tikanga was practised in the home. She was immersed in the culture of the marae and related a number of stories about the closeness, care and mutual support of her wider whānau and neighbourhood.

"Living as Māori enabled us to have faith and confidence in each other, to pool our resources, to protect our whakapapa," she said.

"That is tikanga Māori and tikanga is the way we practise



Jeanette Grace

what we believe. Everybody was our business. Things weren't our business. People were our business."

Ms Grace said the intention of Te Tiriti o Waitangi was that two cultures would live harmoniously in this land. However, she said she wanted to dispel any illusions about that; that the reality is Māori are afforded what Anne Milne called a 'touch of brown in the white space' in her doctoral thesis *Colouring in the White Spaces: Reclaiming Cultural Identity in Whiteman Schools*.

"This is not to denigrate the wonderful work that has been done by people in this room, by others in the addiction sector, and by those who have passed on. It is simply an observation that 'touches of brown' are a poor substitute for whakapapa, intergenerational whanaungatanga and kainga as we know them, she said.

"If this sector is going to take tikanga Māori and apply it in service provision, then I want you to think about how you do that, so the experience people have of it is like the experience I have described to you. That it's not superficial and subordinate to western methodologies."

She spoke of disparate incarceration rates, Māori children in state care and the number of Māori with mental health issues, and suggested that in the nine generations since contact with Pakehā, Māori have become removed from tikanga structures and are living according to western systems, social constructs and laws. She said this is a barrier to Māori wellbeing.

"Very few Māori experience a childhood and a life like the one I was privileged to have. Yet it is their birth right by whakapapa. Thinking about that, why do we keep doing what we do? Why do we continue to try and use a



system that has so spectacularly failed us for 120 years?"

She repeated that it is tikanga that provides the opportunity for the restoration of order, grace and mana to whānau, hapū and iwi, and that it must occur in ways that are authentic and not subordinated to western systems and frameworks.

"For Māori, everything we need resides in the tikanga we carry."

She said it is important that we hold the line, advocate for

tikanga as we know it and utterly reject the notion that tikanga is failing Māori.

"It is not failing our people. It is the application of tikanga out of context in a subordinate position that makes it difficult to get the outcomes we need.

"No matter what, the Māori heart will prevail. And I want to tell you that the Māori heart exists inside the bodies of people who think Māori, feel Māori, behave Māori, honour whakapapa, take care of future generations and love people."

It Takes a Village to Raise a Child – Samoa's AOD Court

On Friday 8 September Justice Mata Keli Tuatagaloa spoke about Samoa's Alcohol and Other Drug Court (ADC), which was established in February 2016, making Samoa just the second Pacific country to have such a court after New Zealand.

Justice Tuatagaloa is a graduate of the University of Waikato and of New South Wales. She is the first woman to be sworn in as a judge in Samoa and was appointed the first woman Supreme Court Judge in 2015. She has presided over Samoa's ADC since its establishment.

By way of background she said there is a high rate of alcohol- and drug-related offences in Samoa. However, custodial sentences have not solved the problem. In 2012 43 percent of offences were committed under the influence of alcohol or other drugs. By 2014 this had risen to 72 percent.

Samoa's ADC is fairly new so there isn't yet a lot of data, but numbers are growing. It started with 16 participants in 2016 and had a total of 35 participants in July 2017.

To be eligible an offender must plead guilty and not face charges of murder, manslaughter, sexual offending or serious drug dealing; or any offence that would result in more than three years imprisonment. It should also be likely that they committed the offence under the influence of or in pursuit of alcohol or other drugs.

"Community justice supervisors are the Samoan version of detox or monitoring bracelets because we don't have the resources for these things."

The aims of the court include identifying the extent of the alcohol or drug problem; identifying appropriate treatment; identifying other likely drivers of criminal behaviours; and working with the offender's family, church and village to strengthen their ties with their community.

"It's about harm reduction," Justice Tuatagaloa said.

"Reduced reoffending means safer communities and we believe safer communities are the responsibility of the whole community, not just the ADC. It is everybody's business."

It is Samoa's sense of community, of everyone looking after each other by knowing everything that goes on in the village, that the ADC taps into. Lives are shaped by village law that can vary from village to village. Some villages require everyone to attend church on Sundays



Justice Mata Keli Tuatagaloa

and some enforce alcohol bans. Penalties are imposed if rules are not adhered to.

So, she said, it is in this context that the ADC believes the village should be drawn back in to help those of their own who were nurtured there but have somehow lost their way.

The ADC works with community justice supervisors who could be village mayors, matais (family chiefs), village women representatives, and church ministers.

"Community justice supervisors are the Samoan version of detox or monitoring bracelets because we don't have the resources for these things," Justice Tuatagaloa said.

"They become the ears and eyes of the ADC in the community, and if something like breach of bail occurs, the community justice supervisors report it to the treatment team who report it to the court."

The involvement of family is essential so the ADC holds a family group conference before participants are accepted. This informs the family about what will happen and encourages the family's support. It's crucial the participant lives in a good and safe environment where there won't be any temptation to use substances while on the programme.

Sometimes the families don't want to accept the participant back to reside with them and when this happens Justice Tuatagaloa said participants are more likely to lapse and be exited from the programme for resentencing.

"It's surprising when that happens because Samoa is about family. But we usually find where the family is strong, the offender is accepted back and usually adapts easily."

There are two phases to the programme. Phase 1 consists of seven weeks of mainly psychoeducational programmes so the participant can come to understand the link between their alcohol or drug use and their offending. Phase 2 is 12 weeks of intensive treatment and one-on-one monitoring concentrating on relapse prevention. After this, participants are released back to their families and communities.

She said the ADC has a ripple effect.

“If the drivers of the offender’s behaviour are addressed the rate of reoffending should decrease. This means less violence upon women and children, which has a positive impact on health services, not to mention the health benefits to the participant themselves.

“It means safer communities and villages. If villages are safe, Samoa is safe.”

NZ Police & Northland DHB Te Ara Oranga Methamphetamine Demand Reduction Pilot

Representatives from the Northland DHB and New Zealand Police discussed an innovative approach to methamphetamine demand reduction with delegates at this year’s Cutting Edge in September.

The Te Ara Oranga Methamphetamine Demand Reduction pilot- made possible via a three million dollar fund through the Criminal Proceeds (Recovery) Act- is the first joint venture of its kind in New Zealand.

The pilot is trialing an integrated holistic model of police and health activity to reduce methamphetamine demand by enhancing treatment options and increasing service response and early interventions.

The collaborative model between the Police and Northland DHB has been developed in response to increased levels of harm from methamphetamine use in Northland communities, to whanau and children.

Methamphetamine admissions to Timatanga Hou, Northland DHB’s detox unit, are now second only to alcohol, and methamphetamine has become the second or third most common reason for referral to DHB Drug and Alcohol services in Tai Tokerau.

‘Those of us working in the Drug and Alcohol treatment sector have been seeing first hand an increase in negative impacts from methamphetamine use over the past few years,’ Jenny Freedman, NDHB Clinical Psychologist said.

‘It’s really exciting for those of us who do this work to have the opportunity to provide a timelier and more

comprehensive range of evidence based treatments for people who use methamphetamine and also support whanau affected by their drug use.’

In conjunction with greater access to treatment options, a dedicated squad of seven police officers has been formed to specifically focus on reducing methamphetamine harm and supply.

However, rather than focus exclusively on punitive measures for meth users, Acting Detective Inspector Mike Varnam told delegates police will offer those trapped in cycles of meth addiction support and access to treatment services.

Detective Inspector Varnam believes that the Te Ara Oranga initiative brings a fresh approach that will help to address the harms caused by methamphetamine in Northland.

‘I think this pilot represents an acknowledgement that we can’t just arrest our way out of this problem and that a more integrated health and harm reduction approach is needed.’

‘While supply control operations- including the targeting of large importations and high level dealers- have resulted in major recoveries of methamphetamine, supply chains are resilient and users are still able to access methamphetamine. An approach that offers support to users with increased access to treatment is needed to reduce the demand for the drug,’ he said.

Project Manager Jewel Reti told delegates the Te Ara Oranga model aims to enhance the entire treatment continuum, including four streams within its health component- screening, brief intervention and referral to treatment, treatment whanau/ community resources and evaluation.

‘Te Ara Oranga seeks community involvement and inclusion and includes the provision of resources for whanau members concerned about the impact of methamphetamine and their families and community,’ she said.



Celebrating Our Workforce Cutting Edge 2017



Celebrating Our Workforce Cutting Edge 2017





Notice Board

New board

Welcome to the new board - Ben Birks Ang, Selina Elkington, Debby Sutton, Anna Nelson, Dr Denise Blake, Annabel Prescott, Suzy Morrison, Takurua Tawera (Pou Whakarae) and Mike Kilioni (Pacific representative).

A special welcome to those new to the new board

Dr Denise Blake – Lecturer Massey University, Joint Centre for Disaster Research

Denise has engaged in the social justice sector as a consumer, health professional and researcher for over 20 years. She has a particular commitment to the welfare of vulnerable populations both within a disaster context and more generally.

Annabel Prescott – Real Youth Services

Annabel has been engaged in the addiction sector for the last 15 years as a practitioner, clinical supervisor, academic, research and was a previous dapaanz board member. She is currently undertaking her PhD looking at how schools develop and implement drug policies.

Paul Schreuder – Senior Lecturer Wellington Institute of Technology

Paul has over 25 years as an addiction practitioner and clinical supervisor, and lecturing in addiction studies. He was on the original dapaanz board and has an interest in gambling as well as substance addiction.

Mike Kilioni – Independent practitioner Wellington

Mike has worked in addictions and mental health for 15 years with extensive experience working in hospital settings. He is a founding member of DRUA – the Pacific Addictions Network and a member of the Pacific Advisory Group for Health Promotion Agency.

Workshops

Please let us know if you are interested in hosting a workshop in your area. We will be posting some workshops for the new year soon. As a heads-up, we have the world-renowned Valerie Mason John, the mindfulness-based addiction recovery guru delivering two two-day mindfulness workshops in 2018 (Auckland and Wellington). These will be up on our website soon.

Incomplete applications

We are receiving a lot of incomplete applications and renewals (missing the line manager or supervisor sign off, disclosure forms, or payments). This requires a lot of work for our registrar to chase up the bits that are missing. Can you please make sure you have all the paperwork required when submitting your renewal?

Annual survey

Thanks to those of you who filled out the annual survey. You can check out the results here <http://www.dapaanz.org.nz/annual-survey-2017>