Submission to the Mental Health Inquiry

dapaanz

fosterina excellence in addiction practice

June **2018**

Thank you for the opportunity to comment on this important kaupapa. Dapaanz is the association representing the interests of the Aotearoa/New Zealand addiction treatment workforce.

We have more than **1500 members** and are pleased to see the emphasis that this inquiry has placed on addiction.

This submission has been informed by two surveys we conducted with our members (the addiction workforce) and within our networks of those with lived experience[1]. Almost **a third of our membership** (mostly addiction practitioners) **responded** (ie, 465) and **we received 200 responses** from those with **lived experience**. Given the response rate we feel confident that our submission largely reflects the views of our members and those with lived experience.

[1] Individuals either in treatment, or early or longterm recovery, or family members who were currently or previously affected by a family member's addiction.

The survey feedback together with our experience in the sector, and knowledge of other countries success in reducing addiction suggests that **To better meet the needs of New Zealanders experiencing addiction:**

A paradigm and systematic shift from a punitive justice focus to a health and recovery approach is required.

The system requires more than just tweaks and increased funding.

We need to build a system that Supports wellbeing and recovery; provides a wide range of help options; and enables early and timely access to professional help.

We are currently seeing about **50,000** people of the estimated **150,000** to **200,000** people who would benefit from an intervention.

We need a diverse workforce that can meet current demand and deliver a more holistic approach.

This will require different types of professionals to provide the range of options required. Addiction practitioners will be a core group, and others, such as peer workers, social workers, and primary care workers will each have a role to play in a system that is focused on wellbeing and recovery. **Dapaanz can support this by playing a key role in overseeing the registration of addiction practitioners, endorsement or peer workers and supporting the allied workforce.**

We require clear and consistent leadership and up-to-date data. This would best be achieved by:

- establishing a Ministerial Council of relevant Ministers[2] to drive and oversee changes to the addictions system, supported by a cross-agency leadership group of Chief Executives from the health, social and justice sectors to: oversee the implementation process; ensure agencies are working in partnership; and report regularly to Ministers on progress
- re-establishing the Mental Health and Addictions Directorate in Ministry of Health to ensure a seamless interface between policy and implementation, and to ensure that funding mechanisms support a system focused on wellbeing and recovery
- conducting a national consumer survey and reactivating Te Rau Hinengaro (the NZ Mental Health Survey) and the Youth 2000 survey series.

Our submission provides more context and detail to the first three of these points and highlights other recommendations and possible solutions for addressing key issues raised by the sector. We have also asked to speak directly with the panel to expand on this kōrero and discuss how we may best be able to assist in establishing a health system that works for those with addictions moving forward.

[2] Including, as a starting point, the Ministers of Health, Justice, Corrections, Housing, and Social Development.

The broader picture

"It's time to abandon the illusion (delusion?) that it's possible to deliver effective mental health and/or addiction services using an inhumane 'market forces' economic model driven by a profit-is- paramount mentality. Neoliberalist policies force health services to act as if as they are corporations in competition with other corporations for 'market share.' This is a criminal squandering of resources, which results in a frantic 'race to the bottom'. We are not selling soap powder, we are trying to alleviate suffering!"

Comment from a member

Addiction is a symptom of our society – a society that is predominantly based on Western norms and values and driven by a neoliberal ideology. It would naturally follow therefore that the longer- term and more preventative solution to addressing addiction and mental health problems in this country lies in transforming our socio-economic philosophy and practices and moving toward a more wellbeing and holistic-based one. We are therefore pleased that the focus of this inquiry is purposely broad and that you are also interested in addressing a range of social determinants, including trauma and discrimination.

Many people with addictions typically experience trauma, and often many layers of it. This was clearly evidenced by a number of our survey respondents with lived experience, as the following quote denotes:

> "Addiction is more than just about using drugs; it's about looking at the emotional wounds, the inability to cope with life, childhood trauma and all those "things" which causes one's addiction problem in the first place."

For Māori, who continue to experience the effects of colonisation (such as systemic bias), the levels of trauma are possibly even greater and are reflected in the poorer and more inequitable socio-economic outcomes that Māori experience compared to non-Māori. As one survey respondent mentioned:

> "It's sad that mainstream models continue to be used on Māori by practitioners/ clinicians that don't work, the Department of Corrections being a prime example of where this happens. Their models are "clinician" focused, not "whānau" focussed. If training programmes continue to relegate Māori psychological models as being inferior to mainstream - being called those "cultural" ways of working (as if mainstream has no culture), things will continue to get worse, as they have. Being focused on individualism doesn't serve Māori. More investment and resourcing needs to occur in rehabilitation that are kaupapa Māori based and are connected to their whānau and vocational/tertiary training programmes. It's bizarre that our youth residence doesn't also provide comprehensive pathways to upskill the youth in their programmes to learn trades, professions...Support is paramount for both them and their whānau. Hence, whānau ora mahi needs to be happening in these communities too, rather than just providing therapy for their youth inside... psychological models focused on the client need to expand to include the whānau and their wellbeing too, eg, accommodation, kai, support, manaaki."

Current approaches tend to focus on the individual and have limited flexibility to incorporate that person's wider context. **We therefore encourage a greater variety of evidence-based models to be used, particularly those that include whānau or a supportive community (whānaungatanga-based approach)** as is demonstrated by the following survey respondent with lived experience:

> "Our roopu "He Waka Eke Noa"[3] has and still is working for me since I joined in March 2016. It's about having a whānau inside of recovery when my own whānau are still actively using. It's about finding my identity as a Māori woman who's come out of being an alcoholic for 30+ years. It's a place where we can gather every week and bring our tamariki along because they are a big part of our lives & our future. Whānaungatanga is what a lot of us never had but we do now within our roopu. Together we love, support, laugh, eat, bring our tamariki, find whānau connections, feed the wairua and hinengaro, haka, waiata etc...Nōu te rourou, nōku te rourou, ka ora e te iwi."

Taking a more holistic and wellbeing-based approach to addiction and mental health was also echoed by a number of our survey respondents, one of whom suggested that the government:

> "consider a service provision approach that prioritises physical, cultural and spiritual connectedness as an important factor in mental health and addiction recovery and health and wellbeing outcomes for ALL people of Aotearoa."

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[3] He Waka Eke Noa is an Auckland based service/roopu that comes under the umbrella of Te Rūnanga Ngāti Whātua, Te Ha Oranga health and wellbeing services.

Shifting from a punitive justice focus to a health and recovery approach

A person with an addiction has a health problem and should receive a health rather than justice response wherever possible. This was reflected in a number of comments made by survey respondents with lived experience. One respondent commented:

> "my son has spent years in prison...and no access to drug rehabilitation...he has an illness called drug addiction if he had cancer he would receive treatment. He needs to be punished for his crimes, but his crimes are driven by his illness. Many times, he has tried to get into rehabilitation but the gap between desire and it happening is too long so means that the relapse happens..."

When Philadelphia moved to a population health and recovery approach it went through three waves of evolution. The first essentially involved getting people 'into' the community through a process of deinstitutionalisation. The second wave focussed on improving quality of life by helping people to be 'part' of the community and the final wave was promoting healthy communities[4].Philadelphia's approach to transforming the system involved:

- adding peer and community-based recovery supports to the existing treatment system
- practice and administrative alignment in selected parts of the system and testing these through pilot projects
- cultural and values-based change driving practice, community, policy and fiscal transformation in all parts and levels of the system. Everything was essentially viewed through the lens of, and aligned with, recovery-oriented care[5].

We already have some services who are adapting their service models towards a recovery approach. For example, some community-based services support people to develop recovery capital by focusing on building hope and increasing social connectedness. Our residential services are working with community and peer groups to provide support before, during, and after a residential stay. Even our court system is trialling approaches to bring recovery into their processes. As one survey respondent commented:

> "The Drug Court system and concept is a very powerful way to address the root issues being the addictions, instead of simply punishing without addressing the cause."

Therapeutic treatment and recovery-focussed options

Dapaanz strongly advocates for the need to reallocate funding from building and maintaining prisons to increasing and enhancing treatment options for those experiencing addiction and increasing access to more recovery-focussed options, such as the Drug Courts, diversion, and a range of harm reduction choices.

The benefits of taking such an approach have been demonstrated and evidenced by Portugal who experienced substantial declines in addiction and resulting crime because people were receiving treatment instead of being locked up.

[4] Arthur C. Evans (2017) Population health framework for addressing addiction: the Philadelphia experience. A presentation at the Cutting Edge Conference.
[5] Arthur C. Evans (2017) Transforming systems how difficult could this be? A presentation at the Cutting Edge Conference.

A considerable number of survey respondents, both practitioners and those with lived experience, highlighted the importance of having more holistic (rather than purely diagnostic and medical) models of treatment and that there needs to be more rehabilitation and residential services across the country to meet the current need.

A number of survey responses indicated live-in centres for at least a three-months were more successful for those with serious addictions than day programmes or residential programmes of less than three months. Several respondents shared their successful experiences of residential treatment:

> "I have been in recovery for nearly 26 years and have no doubt that residential treatment gave me the best possible chance to stay clean and sober. I would love to see more treatment centres available and especially have far more really experienced counselors who really understand addiction as I have seen so many people unable to get sober or relapse because they were told to 'cut down' on their using rather than make it clear total abstinence is essential for recovery."

> "...after 28 years sober and still living one day at a time as the AA principles tell us to do. I do not believe I would be where I am today without a live-in treatment center and the continued connection to like minded people."

> "My son has now been totally clean for about 5 years after several lapses but his time in rehab taught him so much about himself and his addiction and he was in a safe environment to want to change and get his life back that drugs had robbed him of."

The issue however is accessing residential treatment for those in need. Several our survey respondents conveyed accessing other less intensive options for those with problematic AOD use that aren't serious enough to warrant residential treatment or those that feel they are about to relapse. This points to an even greater need to invest in establishing and promoting a range of options to meet the needs of the people. People would be able to seek help earlier and access the best and most relevant option for their situation. How we present methamphetamine is a good example of what 'not' to do. We share the extremes of methamphetamine use and we present methamphetamine together with criminal activities by investing primarily in the justice and customs side of the equation. This has meant that the population see the two together, and residential treatment being the option that works. Residential centres are overflowing with people who have that presentation. However, we know that methamphetamine is not too hard to stop using but is very hard to stay off (with over one year of decreased cognitive functioning). We could have shifted the situation by having better supported withdrawal/home detox services, and long-term community-based support that involves high levels of activity (rather than relying on cognitive ability to recognise triggers and exit strategies). In other words, we could have supported a greater volume of people, much earlier in their journey.

Dapaanz recommends increasing access to residential treatment centres and Drug Courts so they are available to any person requiring this high-level of intervention in New Zealand, no matter where they live. We would also like to see addiction practitioners regularly attending courts to support people to use this avenue as an opportunity to change, and to advise on sentencing options where addiction is an issue.

This has been shown overseas to make a huge difference to someone's ability to re-integrate into their communities. In this regard...

we also recommend looking at and learning from countries, such as the Netherlands, who take a more rehabilitative rather than punitive approach to crime and drug-related offending. Learning from the methamphetamine example we would also like to see a greater investment in establishing and promoting a range of recovery-focused options.

In sum, reallocating funds from the justice system into health will save money and improve outcomes for individuals, whānau and communities.

Building a system that supports wellbeing and recovery

A system that supports wellbeing and recovery:

- helps people re-connect, engage in meaningful activities, and develop pro-social peer networks
- empowers and supports people to set their own treatment/wellbeing/recovery goals
- meets basic needs, such as housing, food and health care access, without pre-conditions such as sobriety or willingness to attend programmes
- supports family members
- increases peer support and community-based peer recovery supports to complement the treatment system, as well as consumer-informed services.

This is aptly summarised by two of our survey respondents as follows:

> "Addiction recovery should involve more than taking away what is "bad." It should focus on building something potent and positive to satisfy the unmet needs that caused the drug use, such as: connection to other people; positive affect; hope; autonomy; meaningful experiences; reduced suffering (mentally or physically); reduced self-awareness; to be a part of something bigger than themselves. Abstinence, in this sense, is the by-product of living a personally meaningful life. We need to build recovery groups into our society to achieve this." — Comment from a member

> "As a recovering meth addict, we need to help reprogram the addict, have more peer support people available to help and be recognised as a special tool for an addict or whanau...I know from experience that what is already out there...aren't working for the other thousands who are looking for help. The help they go to isn't what they are looking for. They need to be shown how to function again – back to basics. They must be shown what normal is again cos their normal was addiction...Learn to eat, routine and be able to trust again...they need understanding of the behaviours and so do the whānau. Both parties need to be educated on what to expect and what's going to happen next...both parties need to re-connect, repair their relationship. When an addict needs help and reaches out, they should be able to connect with a peer support person straight away cos at least they would understand what's going on for them. Referrals are a joke...because of the waiting time you have lost that person who was really needing the help..." — Comment from an individual with lived experience

Connection

> "The opposite of addiction is not sobriety it is human connection" ——— Johann Hari

The more connections and engagement one has with pro-social peers and community groups and time spent engaging in meaningful activities (such as education, training, employment or volunteer work) the greater the chances of recovering from addiction[6]. This was supported by a number of survey respondents, some of whom provided concrete examples of the success of this approach. For example, one respondent with lived experience commented that:

> "Loving connection was what worked and continues to work to help me stay abstinent."

People-centred services

As one of our survey respondents commented:

> "Recovery needs to be more understood and driven by compassionate services, which are prepared to do the long journey with people."

Recovery is, and should be, determined by the person. Yet, recent research into consumer experiences of Opioid Substitution Treatment (OTS) services found that a number of the research participants who were attending or who had formerly attended an OST service reported challenges in being able to exit the programme or become opioid-free despite that being their explicit intention. For example, one person started on 40 mg of methadone and had increased to 100 mg within a few months. This person had originally entered the programme with the intent of coming off opioids. Others reported that they had to 'negotiate' or 'state their case' to be 'allowed' to come off OST or had received phone calls three months after exiting OST, that included an enquiry as to whether they would like to re-join OST despite their stated intention to the OST service to remain opioid-free[7]

Dapaanz would therefore like to see those experiencing addiction supported to choose whatever path they take to recovery and to change their recovery path overtime.

Basic needs

A successful component of Philadelphia's approach to recovery was meeting basic human needs. When Philadelphia changed to a housing first model, 90 percent of people with addictions stayed in provided housing for six to nine months instead of the typical one-week, and then were supported into their own homes. In dealing with a number of social determinants of health, including housing, Philadelphia experienced improved access to services, fewer outpatient admissions and visits to crisis centres, and significant cost-savings (ie, $8 million in savings over two years because of their permanent supportive housing initiative, which could then be re- invested into services)[8].

There is much that New Zealand could learn from the Philadelphia model in order to develop a similar recovery-orientated approach here, which involves meeting basic needs, such as housing, food and health care access. This should occur without pre-conditions such as sobriety or willingness to attend programmes.

Family support

A number of survey respondents raised the importance of needing more support for families of people with addictions, given that family formed an important part of the recovery process Therefore

a recovery model also needs to include support for family and whanau members, offering treatment for those seeking support in their own right, particularly those that are struggling to support their loved one who has an addiction.

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[6] David Best (2016) Recovery and social identity. A presentation at the Cutting Edge Conference.; David Best (2016) Recovery as an issue of social justice and social inclusion. A presentation at the Cutting Edge Conference.

[7] Allen & Clarke (2018). The consumer experience of Opioid Substitution Treatment (OTS) services: Qualitative research report.

[8] Arthur C. Evans (2017) Population health framework for addressing addiction: the Philadelphia experience. A presentation at the Cutting Edge Conference.

Peer support work

A key and complementary aspect of the recovery model is to connect people experiencing addictions with community or voluntary peer support groups (eg, Smart recovery group, 12 step programmes, cultural recovery groups, meth drop ins or other peer support groups) for ongoing support and to help re-connect them with their community and regain meaningful lives (eg, find accommodation). Survey respondents, particularly those with lived experience, provided a number of examples as to how successful peer support had been to their recovery and why it was successful, as one testimony demonstrates:

> "A peer support worker saved my life. Her lived experience was similar to mine but she made it very clear this journey was my own and she would stand by me. She showed no judgement towards me and had my back...best people to provide support to addicts are the recovered addicts themselves...they are not necessarily qualified professionals but their lived experience is valuable and relevant. Addiction is a community concern and the answers to the problem lies within the community itself. Just like it takes a village to raise a child not a group of qualified teachers...it should be so with addiction services."

Professor David Best, in his 2016 presentation at the national addiction conference Cutting Edge, highlighted research on the efficacy of peer delivered interventions, which suggested that peer models are successful because they provide the personal direction, encouragement and role modelling necessary to initiate engagement and support ongoing participation. According to Dr Arthur Evans, developing a peer culture involves:

- **considering ways to develop and empower informal peer leadership**
- **openly recruiting recovering persons as staff**
- **paying "peer specialists" to provide formalised support**
- **creating a sense of a community where recovering persons helping recovering persons is highly valued**
- **infusing peer self help throughout the service[9].**

This suggests

a qualified and regulated addiction practitioner workforce in a wide range of sectors, complemented by a less formalised community of help and peers with lived experience would provide the basis for a strong recovery model.

However, a number of survey respondents, while supporting peer support, also commented on how important it was to increase supervision for peer workers.

There is also a need for services to be consumer- informed.

[9] Arthur C. Evans (2017) Transforming systems how difficult could this be? A presentation at the Cutting Edge Conference

Early intervention and timely access to professional help is required

Recovery is intrinsically a social process where connecting and engaging in meaningful activity with pro-social peers. Having a safe place to live are the foundations of the model and therapeutic environments and interventions (including treatment) support change[10]. A recovery model therefore cannot work without a strong and flexible workforce and community of help. For example, increasing treatment options (eg, cultural approaches, various harm reduction options) and early intervention, as well as a making them more widely available and accessible, and reducing waiting lists[11] (which a large number of our survey respondents commented on) cannot work without growing and retaining qualified, highly-skilled practitioners.

Pay inequity

Under current conditions, a qualified and experienced addiction practitioner earns significantly less than their peers in the health and other allied sectors thereby making it difficult for non-government organisations to retain highly qualified addiction practices. There is also disparity between what is paid to District Health Board employees and those working for non-government organisations.

> Pay inequity needs to be considered and resolved

and this was clearly evidenced by a number of our members who commented that they were so overworked and underpaid that they were now seriously considering leaving the profession. Some respondents also commented, unnecessary time was spent on administration tasks and documenting issues rather than providing them with the support they require.

The allied workforce and registration

There are also other ways to grow the addiction workforce by dipping into the large pool of potential addiction practitioners such as nurses, counselors and social workers who, if employed in addiction treatment and under the supervision of an addiction accredited supervisor, would qualify for provisional registration as addiction practitioners. To upskill as fully registered practitioners, people with an applied bachelor degree in allied sectors would only need to obtain a level 7 addiction-specific qualification to go to full registration.

> Dapaanz strongly supports a regulated addiction workforce.

This is because currently anyone can set themselves up as an addiction practitioner, or a service, even if they have no qualifications, skills or accountability. This is potentially high-risk for people accessing services (particularly private services), who may have a person working with them who does not have the skills or training to give them the support that will really help them.

> Compulsory registration would ensure addiction practitioners must meet certain training standards and would make them accountable in terms of ethics and competency. Dapaanz would be willing to work with the Government on achieving a regulated industry that would protect both addiction practitioners and the families and individuals they serve.

[10] David Best (2016) Recovery as an issue of social justice and social inclusion. A presentation at the Cutting Edge Conference.

[11] A number of survey respondents (both practitioners and those with lived experience) commented that it was not unusual to wait in excess of 12 months to access treatment services.

> Attracting just 100 people from the allied workforce would make a significant difference to addiction treatment in New Zealand. Therefore, dapaanz sees great benefit in the Government re-allocating some funding to support allied workers (eg, nurses, counselors, social workers) wanting to move to the addiction sector. We would also like to see organisations such as the police, fire department and schools trained and working with the treatment sector so they are better equipped to deal with the addiction and mental health problems they encounter so frequently. The addiction workforce could provide support for training professionals in other areas and more flexible delivery of services could mean that addiction practitioners are available in non-specialist settings.

A number of survey respondents also commented on the need for the addictions and mental health workforce (although noting that addiction is seen as an under-resourced sub-set of mental health) to collaborate more closely. They also expressed the need to ensure that effective responses to addiction were not watered down in the process of collaboration and that this could be achieved by practioners in mental health also being trained and skilled in responding to addiction and vice versa.

Early intervention

Identifying people with problematic AOD use early and connecting them with services (before reaching a crisis point) is an important part of a recovery approach. We received many comments from survey respondents, particularly those with lived experience on this. Growing the pool of qualified addiction practitioners means people could be assessed for addiction wherever they go for help (eg, social services, doctors' surgeries).

> Having qualified addiction practitioners working alongside medical and other staff is strongly preferable to a purely medical model, which we believe is not sufficient. Addiction treatment is a social model and recovery lives in the community.

Incentivising services and centralising resource development

> Dapaanz also supports the need to incentivise services that excel.

According to Dr Arthur Evans, by implementing a flat fee for services and then paying an additional fee for those services that eliminated wait times or met other specified objectives the worst performing services soon became the best.

> There is also a need for a centralised and co-ordinated approach to developing resources to support the sector.

Research undertaken with young people and AOD services last year concluded that centralised umbrella branding to market all help options across the country, which local communities can then pick up, tailor, and use to market within their own area, was identified as the best option for promoting and increasing help-seeking among young people[12].

[12] New Zealand Drug Foundation. (2018). Making it easy for New Zealanders to make changes and seek help for their alcohol use: an approach co-developed with young people. Wellington: NZ Drug Foundation.

Thank you once again for the opportunity to comment. With our extensive network of addiction practitioners and people with lived experience, dapaanz can easily tap into the required knowledge and expertise to support you to build a health and recovery system that will better meet the needs of New Zealanders experiencing addiction and reduce the impacts of addiction for individuals, families/whānau and their communities. We welcome the opportunity to further discuss how we could best support you to do this.

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Please contact our Executive Director of dapaanz, **Sue Paton** either by email at: **sue@dapaanz.org.nz** or by phone: **04 282 1809 / 021 187 4311.**

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