dapaanz

fostering excellence in addiction practice

BULLETIN

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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

As I have gathered in the stories and articles for this bulletin, I have been struck again by what an amazing workforce we have. In this edition we are privileged to have the personal stories of three people with lived experience. I hope their stories inspire you as much as they did me. I am committed to raising the experience of the consumer for two main reasons: it is important that we celebrate transformation, and stories of transformation inspires us in our mahi.

Please, feel free to contact me if you would like to do an article or tell your story in the bulletin or have ideas about other contributions. It is a great vehicle to tell stories from both a practitioner and consumer experience, to grapple with issues, and to publish relevant articles. As previously said, the views expressed are not necessarily the views of the dapaanz Executive Board, but we are committed to providing a place for you to have a voice, raise relevant issues, and to celebrate your excellent work. If you would like to submit anything in the bulletin please send to sue@dapaanz.org.nz with bulletin in the subject line, or contact me on 04 282 1809 to discuss.

This is our first bulletin with our new look. I hope you enjoy the look and feel and the articles and stories.

Remember to register for the School of Addiction, Christchurch 9-10 March 2016. Find more information and register at dapaanz.org.nz/school-of-addiction/

If you are in downtown Wellington, come and have a coffee with us at Level 5, 342 Lambton Quay (in the AMI Plaza).

Nga mihi
Sue

Consumer stories – *Wings trust*

Bob (not real name)

Years of addiction had taken almost everything from me. A once successful and happy family man, now just an empty shell, full of fear and loneliness, entrenched in a dark life of crime, violence and isolation, feeling no empathy for those I hurt and expecting warmth from no one.

I gave up hope and resigned to the fact that I would die in my misery. Then in an instant, my life changed forever, I was arrested on major charges and a sense of relief came over me, I didn't have to live that way anymore.

I entered a treatment centre, and as the fog cleared I regained hope for myself. I began to take responsibility and I started to get my family back.

I graduated treatment and moved to Wings Trust. I was still full of fear and anxiety, I didn't know how to have healthy relationships with people, and I was still facing a lengthy prison sentence. Slowly with the loving kindness of all those around me, I began to find peace and acceptance in whatever lay ahead for me. I became heavily involved in service and worked through the 12 steps. The wings community nurtured me to wellness and to a serenity that I had never experienced before. At my sentencing the Judge commended me on the changes I had made and acknowledged all the support I now have. I am now serving a community based sentence and remain very much involved with Wings Trust I am forever grateful for the second chance I have been given to better live my life and for the network of peers who I draw strength from through every moment of my day.

Blair

I am an alcoholic and today thanks to rehabilitation, support and much hard searching, I am grateful beyond words and “proud” of it.

I worked my whole life building my career, family, financial stability, respect, all the things “normal” people do, and I succeeded. What I failed to realise was that I also built blame, guilt, selfishness, resentments, ego, bitterness, pent up frustration, denial, the list goes on.

About 6 years ago this lifetime of unresolved issues became apparent and escalated through my drinking. I knew something was wrong but couldn't identify it. All I knew was that I was more and more reliant on alcohol to ease my mixed bag of emotions, feelings and pain; a sedative and a crutch I came to use and abuse to the limit and beyond.

My first definitive realisation things were wrong was driving drunk into two parked cars, writing off all three. In my drunken insanity I apparently managed to drive my car up the road when it just stopped. Witnesses accused me of trying to flee the scene, I then got out of the car with a part bottle of vodka and sat drinking on the side of the road, waiting for the police to arrive.

They did and I blew 5 times over the legal limit, they said clinically I should have been dead but I wasn't, however in hindsight I was dead in every other way.

But I was smart and cunning I hired a good lawyer and two years later the case was dismissed on a technicality.

Not so smart was in that two years I continued to drink uncontrollably, was forced into an alcohol rehab by my family, and sure enough I came out the same person as went in, only sober. My wife left me, my drinking and my unresolved issues spiralled to a new low, I was diagnosed with depression and alcoholism. In my insanity I isolated and drank my days and nights away.

I went into rehab again two years ago, this time on my own referral. It was different but I still did it for everyone else and not for myself. I got sober again but left with all the underlying problems unresolved.

I had numerous visits to the hospital, 27 in four years, 6 visits to detox. I was further diagnosed with acute liver cirrhosis, pancreatitis and other alcohol related illnesses. I acquired two DIC's and this time convicted for both, 400 hours community service work, loss of licence with ongoing conditions and restrictions. I drove my family away with all the lying, deception and my own denial.

The pattern continued, and I drank my way into a pit

One year ago, I had flat out hit rock bottom, emotionally, mentally, financially, physically and spiritually. The crash was painful in every way imaginable and I finally had two choices, die or face myself brutally, painfully and honestly.

I went into rehab again, this time to save myself, selfishly I went. Perhaps for the first time, I began to accept full responsibility for all the outcomes in my life. I saw that blaming was futile, that complaining was silly and that making excuses was hopeless. I realised it was me who created all the good and all the bad in my life and only I could make the initial move to pull myself out of the dark hole I had dug for myself.

Something this time was different. My disempowering patterns and behaviours became glaringly obvious and the triggers that kept me repeating these behaviours came into focus. I started to realise hitting rock bottom was not only inevitable but necessary, I became open and aware that I had been playing the same role, drama and dynamics over and over. This time round I was doing this for me, open to whatever could break the mould and start me on a journey back to my true self, the one I had been a long time ago.

After two months of rehab and a lot of education, self-discovery, humility and counselling I had a good foundation to work on in theory, putting this into practice made me take another approach. PATIENCE AND TIME, I realised I wasn't ready to go out and jump into this new life without some practice first, it had been largely theory to date.

I did some investigation towards the end of rehab and was referred to WINGS Trust, a not for profit, Health Board affiliated provider of supportive community based therapy and abstinence based living. I never knew such a place existed.

I went in with fear and trepidation, but it was a healthy feeling, I was open to everything the programme had to offer and that was key. I now knew this was about me working the program and not the program failing me.

I have gained such a valuable education from Wings in their approach to groups, professional honest counselling, AA meetings and the 12 steps. Wings is a unique organisation with a unique service for those identifying with addiction in any form as problematic in their life.

I hit rock bottom and found a springboard from which to realise myself, my potential and a fresh start.

My sincerest gratitude to Wings.

Sally (not real name)

I was introduced to meth at the age of 22; I had it every now and then when my kids went to their fathers for the weekend. My partner at the time was an abusive alcoholic who drank heavily in the weekends. I didn't drink but I found meth was great for our relationship. He drank less and we fought less when we were high, which meant less dramas. If he was happy, we could all be happy. But meth didn't keep us together, the love of my life left me for someone else. I was 24, alone for the first time, financially struggling, I was broken. Having no education or work experience and really low self-esteem saw me prostituting to pay the bills. I needed the money, and drugs made my broken heart and degrading job bearable. I lived two lives; a functioning addict/mother by day and hooker by night. Nobody could know, I was so embarrassed - I hated my job. Eventually through working I met someone, he offered me drugs to sell. This meant I didn't have to sell my body anymore, so I changed occupation and meth totally consumed my life, every day and every night. I felt needed, somewhat powerful, meth gave me a purpose to make money, I socialized, and I was respected. Feelings I hadn't felt before. How could this be so wrong when it felt sooo good?

I had money, I had friends and for the first time I didn't need a man, I actually thought I was being a good mother as I could buy

nice things for my kids, I paid for babysitters so they were being looked after and they had everything they needed and wanted.

Eventually the dramas of dealing drugs found their way to my home, my life got dangerous real quick and I had to choose which life I wanted. I chose the money and the bag over my family and made the biggest mistake of my life, I gave my kids aged 7 and 8 to their father thinking I would outgrow this drug phase, and had every intention of having my kids back within the year.

That phase lasted 10 years...

I wheeled and dealed, lived in and out of motels, rolled and got bowled over and over again! I lost my license but kept driving, I didn't trust anyone to drive for me, high speed chases, police raids, continuous court appearances, Home D, Community D even jail didn't stop me, I was hooked. The courts sent me to "The Bridge" but I wasn't ready for treatment as I went straight back to the problem. As my using increased I saw my kids less and less, they moved to Napier which had me seeing them once or twice a year. I became like Santa Claus during the one or two visits a year I saw them, as they lived so far away. I was always sorry they could never get hold of me because I changed my phone number and addresses so much. I made promises each visit that I would see them more, but broke those promises every time, I didn't mean to, I just did. I was too busy or stuck on sentence. I was paranoid and in drug induced psychosis, everyone was after me, I was being watched, I knew I would eventually get caught and put in jail for a long time, as it was not a matter of IF, it was a matter of WHEN I would get caught. So when an associate paid an interest in me I thought it would be a great idea to commit to having a relationship with him, as he had money, and he had drugs. I could have the things I wanted without having to engage in criminal activity. It made perfect sense at the time.

Having easy access to drugs with no bills saw me blasting up to a gram a day, I didn't need that much but I had to keep up with my man, I didn't want to miss out. My psychosis and paranoia had me isolating at home too scared to go out. My man was hardly ever home, he left me with my "Shut Up" bag and took off for days sometimes weeks at a time. I spent most of my time waiting for him to come home, wondering where he was, what he was doing and who he was doing. He became my addiction, I hated him for how he treated me, and sabotage mode would kick in. I wrecked his things, became rude to his friends, even my friends, I trusted no one as loyalty would always lie with the biggest bag. I hated the crazy person I had become, the things I was doing, what I was saying I was rude and manic. I couldn't even trust my family and they had never touched drugs in their life! Everyone was in conspiracy!

I spent 4 years in this relationship and towards the end I was such an embarrassment to myself I had completely isolated. My kids now 16 and 17 had lost all respect for me telling me I loved my man and my drugs more than them. They didn't care about my gifts anymore, they didn't care if they had me in their lives or not.
My son told me "Go stick another needle in your arm, you're nothing but a junkie!"

How dare he talk to me like that? I'm his mother! Who does he think he is? I was furious! But he was right. And that's exactly what I did.

One night back at home all alone I figured the damage I had done to my family was too big, I would be doing everyone a favor if I disappeared. I wanted to end my life, so I took all my left over oxicontin, oxinorms, and the tramadol I got when I broke my leg on a stupid 2am mission 18months earlier. I didn't know what I was doing, but I had hoped to slowly and painlessly drift off to sleep and look down upon my body and see if my man even cared that I was gone, see if he would shed a tear for me. But that's not what happened. I got really sick. I don't remember much, just that he got home 2 days later, I was asleep in my own vomit, the house was a mess, I woke up to his words "What the f**k? No more for you!" He didn't care of my attempts, I felt pathetic a total failure, I couldn't even get that right. I was desperate, I craved a life worth living. It was then that I decided I needed treatment. Everything happened rather fast from that point, I left the only life I'd known for the last 12 years, I left my hometown, my man and my friends as soon as I could get into detox. My mum drove me to Auckland. I said goodbye to no one, as I didn't want a reason to stay. I had dreamed about this day for years, however never thought I would actually get there.

Detox was hard I feared what lay ahead for me, I knew no one. Staff at Wings came into detox for my assessment, I broke down. They understood my desperation and gave me hope for my future. I came into the care of Wings for 5 weeks and was prepped for going into rehab for 4 ½ months, which really helped me adjust to going into the intense treatment facility.
I graduated that program, and am now back at Wings. I am working really hard to get my family back into my life. Things aren't perfect but my kids are talking to me, they're proud of me!

I lost many years with my kids but thanks to Wings and Treatment I have many more years ahead to look forward to.

Thank you so much Wings!

Maunga ki moana: *An alterNATIVE kōrero; healing, wellbeing and identity in addiction recovery.*

*Dr Reena Kainamu

*Dr. Kainamu Reg.Nurse PhD DAPAANZ Ngāpuhi/Ngāti Kahu/Pākehā is a mental health nurse and independent health researcher and, writer. At the time of writing she was an addictions clinician for the tribes. She acknowledges the healthcare whānAU/ahi kā, of whom she is but one member "we are a team".

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Paua
Turning rocks in shallow water
a paua glides
in search of solid rock
I recognise its flight
as my own.

Nā Marewa Glover (2001)

Transforming away from addictions involves a voyage to the core of self in meeting the person one longs to be; grounded in whānAU[1] mutuality as parent/partner/family member; rooted in social identity and, nurturing "village/community" purpose. (Re-) connection to whenua and whakapapa are intertwining vital knowledges, pou/signposts to health and well-being beyond reclamation of health status towards thriving. The symbiotic nutrients of whenua or home-places are: rongoa/healing among the hills; oranga ngākau/restoration in washing waters and; wairua amid the unseen and natural spaces. Central to wellbeing is the nexus between Papatūānuku and ahi kā/mana whenua; revisiting ancestral land and sea and its people is a journey of truth and authenticity, an intrepid passage of identity.

This is a beginning story of addicts, whānAU, their detoxication and recovery from methamphetamine (P/meth/ice) and tetrahydrocannabinol (THC/cannabis) usage. A kuia asked for these whānAU members to return to the tapu of marae and whenua, amid whakapapa and kinship. Socially, sexually, emotionally, financially, intellectually, mentally and physically - their addict lives in totality were regulated by substance dependence. Relationships, familial and non-kin, were linked to the illicit drug industry (production/selling/using). They chose to end the predictability of degradation and despair of a drug addiction lifestyle for the uncertainty in relocating away from all that they had known to live among ahi kā. They elected to change their lives.

They tally time, 30 days and nights, free from illicit substance usage. Intense emotions and irritability are inevitable and the whānAU are vulnerable, open to regret and easy to provoke. They find new ways to reign in tempers, to whakaiti themselves in the presence of grace and humility. When the sun pulls over the hills, they wake, greet the elders/ahi kā family members across the table. Patterns develop in the whare and in interacting with each other. Interdependency, obligations, manākitanga and tiakitanga are core values in kin relationships. They shift into tipuna-mokopuna type relationships, listening, being advised and learning. Practically and mentally their time is taken with the ordinary business of whānAU and community in undertakings for others, for the collective. Literally, they care for the walls and roof over their heads, hammer to nails, planks to struts.

Relationships are nurtured with the natural environment, the land, the sea and animals. They are excited to be a part of gathering kai-moana to serve hapū. Taste buds are stimulated by 'soul' food, they gain weight and appear less haggard. With lowering cortisol levels, their bodies rest, they relax, they trust, they have faith and hope…they smile. Night comes and where previously this signalled the start of their illicit trade/business, now their bodies and intellect quieten to circadian rhythms.

There are many layers to recovery, the appointments with AOD clinicians, therapists, GP's, kaimahi, literacy assessments and work and income services. The whānAU are open to religious experiences through others with similar journeys of addiction experiences and backgrounds. 44 and a half days clean and they are meeting new people in the health and wellbeing community. With increasing awareness of values empathy develops…how did we do this to others? Through awareness and understanding…they bust their own myths about methamphetamine usage…it is an addiction, an emotional distancing from healthy relationships within, between and across families and from their true cultural selves. It is a distancing from whenua and whakapapa.

They speak of transgenerational stories with its constant of marginalisation in the forms of poverty and underachievement against a background of dominance in forced disconnection from land, forced migrations and estrangement from indigenous culture. In the now, they seek approval from children raised by the other parent, they re-connect with 'non-using' people from their past and their souls open to hope and the possibilities of new ways of being. They share talk of close whānAU, the ones who reared them, and the ones who think about them on this journey to their true selves.

Ninety days clean…their confidence to remain drug-free increases and they are aware of situations that could pull them back through the door of dependency. A yen for an illicit 'rush' remains alluring in cellular memory. More recent re-membering evokes a thirst for caring

1. whānAU – the capitalisation of AU puts emphasis on the indigineity of self (AU) to family (whānau), the synergy between family and individual.

people and an attraction for benevolent reciprocity. Their stories change. They speak of family and community people. The substance in their talk is of self-belief in their own worth as members of whānAU and of new and kin communities. Their identities are transforming. The core values of people living on the whenua, within their own rohe become their values. Desires to re-enter into general society in search of legal incomes become realities and their futures include long-term plans around protecting, providing for and being family.

From self-interest to family and collective esteem, from drug dependence to interdependence with whakapapa and whenua; this is culture, dynamic, vibrant, perfect and flawed at the one time. An expedition of recovery begins with an epic journey about self, an exploration into whānAU wellbeing. WhānAU is everything.

Wellbeing is Identity.
Identity is WhānAU.
WhānAU is whakapapa.
Whakapapa is Whenua.
Maunga ki Moana.
Whenua is Wellbeing.

Opiate Substitution Therapy – Pathway to Change or Holding Pattern?

Part Two – OST Perspectives

Nathan Frost
Special Projects Advisor

New Zealand Society on Alcohol & Drug Dependence

This series of articles provide an opportunity to have a robust debate on current OST practice in NZ. If you would like to do an interview for a future article, please email me at nathanfrost@nsad.org.nz

Methadone maintenance pioneers Vincent Dole and Marie Nyswander viewed opioid dependence as ‘a physiological disease characterised by a permanent metabolic deficiency’ which was best treated by administering ‘a sufficient amount of drug to stabilise the metabolic deficiency.’ (Dole & Nyswander, 1967) However, their view of treatment did not begin and end with the stabilisation of opiate dependent individuals through dosage. One of the key features of Dole and Nyswander’s treatment approach was in fact a holistic idea involving a pyscho/social treatment plan where those maintained on methadone took advantage of the rehabilitative services the programme offered to assist with reintegration back into mainstream society. Dole, Vincent P (MD); Nyswander, Marie E. (MD) (July 1967). ‘Heroin Addiction- A Metabolic Disease,’ New York Arch Intern Med –Vol 120

This issue we talk to Salvation Army Addictions, Supportive Accommodation and Reintegration Services National Consumer Advisor, Rhonda Robertson. Rhonda accessed various OST services across New Zealand over a 16 year timeframe and completed OST in 2010.

Dole and Nyswander believed effective methadone maintenance involved a psycho/social model of treatment. Do you believe enough is being invested in the social side of treatment here?

My belief is that generally I don’t think enough stuff is done on the social opportunities front. Let’s be clear, having a dose of methadone isn’t going to provide you with meaning and purpose in your life. It’s all that other stuff, the stuff that every human being strives for because at the end of the day people receiving OST are no different from anyone else, people are people and they have dreams and aspirations. I’ve always thought that when people first front up to an OST service they are initially really grateful and see the stability that OST offers as an opportunity to claim their lives back. So services need to make hay while the sun shines and create a treatment plan that thinks about connecting clients with opportunities in life that provide new skills, experiences and meaning, rather than have a treatment plan focussed purely around the dosing clinical medical side of OST.

So do you think OST as it stands today in NZ is a dispensing programme, and could provide people with wider horizons and life options?

Oh Absolutely! Information and life opportunities means your perspective changes; you develop a different focus. For me, even though I always had a plan of coming down the things that were of paramount importance in getting me off eventually were found in the work I did and the stable home that I lived in. I had animals to care for, that was paramount, those things were non-negotiable for me and they were important parts of my life. So when I think about it, the outcome was strongly in favour of being positive for me because I had other things in my life.

I think though what could have sped up the process for me was if OST had been able to provide connections to other services to learn some of those important things like the stages of change and some of the other common things that people who go to a residential treatment service or psycho-education groups offered in some outpatient services for example get exposed to. If the opportunity to learn more about myself had been offered in an outpatient setting, I would have jumped at it.

In what ways do you think that services could move to providing their clients with wider horizons and life options?

Well for a start services need to have a recovery orientated focus, and be geared up with staff who believe that not only is recovery possible but it is actually an expectation. And when I say recovery to me that means having a quality of life which I believe people can find through having a meaning and purpose in life. That is the context I'm talking about. That could mean that a person progresses along a line and eventually comes off but not necessarily because I always get nervous about a backlash against harm reduction approaches like what happened in the UK; probably because I come from a time back in the nineties when getting access to methadone was very hard. After all, it's about working with where the person is at, hence the need for a continuum of care.

So you're saying that somehow services need to instil a sense of hope in their clients?

Yes, that's right.

So when you got to the point of saying, ok I'm definitely coming off, did you feel supported by the service?

Yes, yes I did, but then you have to remember I had made my mind up and I always saw myself in control of my treatment, so if there were signals being sent that perhaps it wasn't a good idea, I might not have picked them up. I knew in my mind what I wanted, and that was that.

To me working with clients to achieve what they want is black and white. I understand from a clinical perspective the difficulties when someone says I've been dabbling and I'm still dabbling but I want to come off. I can understand why clinicians may be hesitant, however, to me they need to work with the client to support them in what they are asking for. And that's not only around coming off, that's around flexibility and scripting too. I often perceive some services to be very risk focussed and I believe one of the key ways of mitigating risk is by focussing on quality improvement and being client centred.

So you've received OST services in three different regions in NZ. Has that experience been a uniform one, or have you found they differed in their approaches to treatment.

No it has not been the same

Did any of these services ever talk to you about a time when you might come off the methadone, or was your sense of the programme one of indefinite maintenance dosage?

No never, however, in saying this I always fundamentally believed that it was my treatment, therefore I would direct what I needed. Right from the outset, I never had a desire to get up to a big dose, (in my head) because I thought what goes up has to come down. So for me it was never about getting on a big, big dose, I think from memory 90 mgs was as high as I ever got up to. I started reducing my dose around 2002, but I always had plans that I would come off, when that was, or how that would be, I wasn't sure I reduced my dose over a long period of time. For me it wasn't about how quickly I got there, but that when I got there I was ready. I didn't do it alone, I had a brilliant GP and an OST service that didn't put obstacles in my way.

You mentioned being treated under GP authority as well as through the OST.

I went on [methadone] with a G.P first, I went in through the back door. If you know the misuse of drugs act, then a GP writing methadone has to be authorised or gazetted, and that wasn't the case. However, because of the situation with the waiting list at the time, I think the GP tried to respond to the need that was coming through the door, and he wasn't the only one.

When I came off methadone, the GP who first scripted me was one of the first people I emailed, he'd put his career on the line to help me out and I've always been mindful of that.

So what was your experience going from your GP to an OST clinic?

I was beside myself!

What changed?

The level of control and the scripting inflexibility. This inflexibility set me on a pathway really fuelled by a sense of resentment and injustice I guess you'd say. It would just send my anxiety levels through the roof because I had no control over any of that, and then I had an experience where one time in the weekend at work when I went to pick up my script they had stuffed it up. Just not having the ability to have any control over that, other than this is their rules, and for me that was like a red rag to a bull. I was never like oh well ok I should just grin and bear it and I should be grateful because I'd never wear that belief that I should be grateful. If I was going to a cardiologist with a heart problem for treatment, would I ever be told I should be grateful? So in my mind I shouldn't be any more grateful than any other health patient for any other health need and that's exactly the line I took. It's that 'deserving undeserving' thing I believed then, and I still believe today, that people with addiction problems deserve to be treated like anyone else.

So we have run out of time but before we go do you have any final thoughts you'd like to add on what OST could be doing better for its clients in NZ?

A service that only provides its clients with a dosing regimen misses an opportunity to provide its clients with other positive things for them to focus on and provide their lives with meaning. In the absence of this social component, where is the incentive for change and recovery?

Why don’t we do exposure training to prevent relapse?

Ian MacEwan
Registered practitioner and accredited supervisor

I’ve been working with a woman having panic attacks triggered by withdrawal from benzodiazepines. Sometimes she is terrified of being alone, sometimes of being trapped, sometimes of being suddenly incapacitated without any help available. No previous history before withdrawal. She has been bringing herself off benzodiazepines over the last year, guided by a programme she found on the internet. All went well apparently until these panic attacks started a few weeks ago. So we discussed options such as referral for assessment for prescribed anxiolytics, referral for psychotherapy but in the end agreed a course based upon graded exposure and core CBT to manage the feelings of panic. As you would expect, we formed a treatment alliance, worked together on increasing her sense of responsibility for the outcome, involved her husband and a close friend, notified her doctor. We started a programme of graded exposure to stressful situations and training in anxiety management. She has been doing well, with some early solid gains, a couple of slips, but real progress.

So why don’t we do graded exposure as a relapse prevention strategy for alcohol or drug dependence? I’m not talking controlled or reduced drinking programmes. Abstinence goals. We teach avoidance of drinking or drug situations, have done for as long as addiction treatment has been written about. It’s in our practitioner DNA to encourage avoidance as a critical relapse prevention strategy. Get rid of alcohol in the house, cross the road rather than pass pubs, give up cannabis-using friends, give drinking occasions a swerve and so on. Intuitively, capital A-Avoidance is important. But we do differently with agoraphobias, anxiety, social phobias, some personality disorders like borderline and passive aggressive. So, let’s be counter-intuitive for a moment. The CBT literature encourages the practitioner to assist the client to be in control of the causes of relapse, reducing feelings of dependence, helplessness and disability. Avoidance does not address relief from the anxiety of relapsing when faced with drinking situations or acquiring mastery over the occurrence of drinking situations.

There are a variety of precipitating factors leading to relapse from an abstinence goal but a common factor is being unprepared for dealing with a drinking or drug situation or alcohol or drug environment. Our advice, given from the safety of the counselling room, to “just say no”, remember why you need to be abstinent, remember your goals, remember how awful it all was before you stopped, remember the person/parent/partner/etc. you want to be, and their variants, given much more empathically and expertly than may be read here, can still be found wanting when exposed to the presence of alcohol or drugs. Alan Marlatt and Nick Heather have been leading applied researchers in graded exposure to relapse precipitants for alcohol and drug dependence. However, their promising findings seem unacknowledged and rarely transferred to treatment practice. I know it looks scary, but I am increasingly wondering why I don’t discuss graded exposure to my addiction clients. I happily did so with someone disabled by panic attacks.

Notice Board

“Our stories” – the impact of alcohol use on diverse communities

In 2011 the Health Promotion Agency brought together a diverse group of people to provide some insight into the issues that various communities in the Auckland area (whose voices are often never heard) typically face. In 2014 this group produced “Our Stories” - a compilation of personal stories about alcohol use and harm from the perspectives of their specific communities.

“Our Stories” provides a useful insight into the impact that alcohol use can have on new migrants, refugees, the physically disabled and rainbow communities. It can inform policy, be used as an educational tool in universities or schools, as an engagement tool for practitioners, as an inspiration for those struggling with problematic alcohol use, and to help break down stereotypes. It can be read or downloaded in a range of electronic formats at: http://www.alcohol.org.nz/resources-research/alcohol-resources/ebooks-and-guidelines/our-stories. For a limited time only, you can also order hard copies of “Our Stories” free of charge.

Addiction Research Bulletin

February 2016

Welcome to the Addiction Research Bulletin, February 2016

Welcome to 2016 and the February edition of Addiction Research Bulletin (ARB). Matua Raki brings you this resource, in conjunction with dapaanz, to offer some insights into recent addiction research activities that have relevance to New Zealand. This edition we have sought a number of resources and publications that highlight Kaupapa research and the process of engaging with Māori. We hope the ARB will help you be aware of, understand, appreciate, implement, utilise and critique addiction research. Please feel free to share it with others.

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A Kaupapa Māori research process

An indigenous process in mental health research

Within a health research context, indigenous people globally continue to demonstrate a commitment to provide their own solutions aligned to their specific world views. Māori, the indigenous people of Aotearoa New Zealand are no exception. They value relationships premised on the notion of respect and reciprocity, of giving and receiving. The practices and protocols within the pōwhiri process endorse these important approaches which operate between the tangata whenua (host) and manuwhiri (guest) to ensure successful encounters.

The pōwhiri process of engagement and participation is applicable to mental health research in that the employment of reciprocal relationships between the research participants (host) and researchers (guests) ensure positive engagement. Significant to this is that the research outcomes must directly benefit those being

Call for abstracts

Are you actively engaged in addiction research?

The 7th Addiction Research Symposium will be held in Wellington at Victoria University in collaboration with the Universities of Auckland, Otago/Christchurch, Massey and Matua Raki on 29 April 2016. Abstracts for presentations on topics in the addiction field are welcome from all perspectives. The objectives of the Addiction Research Symposium are to:

- provide a forum for New Zealand addiction researchers from all disciplines to meet and share their work
- provide an opportunity for research students (PhD, Masters) to present and be supported by more experienced colleagues
- allow for focused discussions on issues of common interest to addiction researchers, including potential collaborations.

Researchers working in the areas of alcohol and other substances and behavioural addictions are invited to submit an abstract for presentation. Abstracts of no more than 300 words can be submitted to Bronwyn Kivell at Victoria University (bronwyn.kivell@vuw.ac.nz) or Klare Braye (klare.braye@matuaraki.org.nz) by 6 March 2015. Presentations will be approximately 20 minutes in length, with opportunity for discussion and feedback.

If you have any questions about submitting an abstract or about the symposium itself please email bronwyn.kivell@vuw.ac.nz or klare.braye@matuaraki.org.nz

Matua Raki

researched. The components of the pōwhiri process identified as most useful to research include karanga: the invitation to participate and the response; mihimihi: identifying the researchers, their intent and value of the research to participants; whaikōrero: the research proper; and koha: the reciprocal process of giving and receiving. The pōwhiri process provides a model of support to conduct research with Māori which may also be applicable to research with other indigenous cultures.

Citation: McClintock, K., Mellsop, G., Moeke-Maxwell, T., & Merry, S. (2010). Pōwhiri process in mental health research. International Journal of Social Psychiatry.

http://isp.sagepub.com/content/58/1/96.short

Guidelines for researchers on health research involving Māori (2010)

Health Research Council, 2010

The Māori Health Committee of the Health Research Council of New Zealand (HRC) has produced guidelines to assist researchers who intend undertaking biomedical, public health or clinical research involving Māori participants or research on issues relevant to Māori health. This includes projects focusing on Māori as a cohort and as part of the wider population being studied. The guidelines inform researchers about consultation and the processes involved in initiating consultation with Māori.

The purpose of any consultation is to ensure that research contributes to Māori health development whenever possible. This consultation is also the foundation for co-operative and collaborative working relationships between researchers and Māori organisations and groups.

These guidelines provide concise rationale about ‘why Māori are to be involved in health research’ and encourage us to think about some of the questions pertaining to involving Māori and the role of the researcher at a number of levels, both prior to and during the research process. They explain ‘why’, ‘when’ and ‘who’ to consult and provide a consultation checklist.

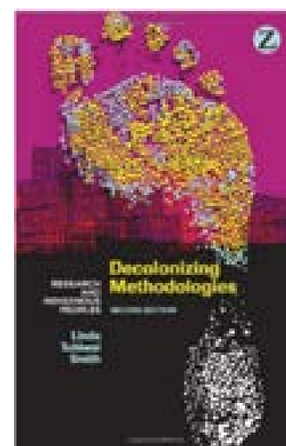
Te Ara Tika, Guidelines for Māori research ethics is also provided as a framework for addressing Māori ethical issues within the context of decision-making by ethics committee members. It draws on a foundation of tikanga Māori (Māori protocols and practices) and is useful for researchers, ethics committee members and those who engage in consultation or advice about Māori ethical issues from a local, regional, national or international perspective.

www.hrc.govt.nz/sites/default/files/Guidelines%20for%20HR%20on%20Maori-%20Jul10%20revised%20for%20Te%20Ara%20Tika%20v2%20FINAL%5B1%5D.pdf

Professor Linda Tuhiwai Smith – ‘Decolonising methodologies’

Maynard Gilgen provides his thoughts on the Keynote korero at Healing our Spirits Conference held in Kirikiriroa, November 2015.

I first met Linda and Graham in the mid to late 1980s as they were growing a kaupapa Māori education rōpū at the University of Auckland. I was interested to catch Linda’s pearls of wisdom since hearing her talk in the late 1980s at the New Zealand Psychological Society about eating kinas.



Since then Linda has gone on to become a professor, accomplished author and sought after speaker at indigenous and other conferences throughout the world. Her book *Decolonising methodologies* has made her a rock star in the realm of indigenous research and issues worldwide.

Linda’s presentation and style hasn’t changed. Her kōrero was tika, pono and delivered in a supportive way to an audience of predominantly Māori and Pacific Island whānau and other indigenous whānau from the four corners of the globe.

Part of Linda’s opening kōrero was: *“..the fraught concept of evidence in a world where stories matter”*. She stated how it is wonderful for us to hui and to be able to share our successes and “enjoy just being” with each other, as we often don’t have such an opportunity.

She highlighted the ongoing challenges, and ‘toxicity,’ that occur for Māori and other indigenous whānau who exist in mainstream environments. This is reflected in the mainstream language we predominantly use today that has been forced upon us in times gone by (my mother’s generation).

She stated how often the mainstream focus is about putting us, as Māori, in with them, and how our ideas are often homogenised, reworked and then dished up to us with a different intent to their original. For those of us working in the addiction arena, Linda acknowledged the work we are all doing, especially for us as Māori and our allies, and encouraged us not to be whakamā and look at putting our ideas, models and the way we do things out there through kōrero, wero, presenting papers, and being actively involved in policies and contracts.

Linda’s korero, along with those of other speakers, promoted the idea that using indigenous solutions and innovations for indigenous problems and issues is the way forward for us.

Research review

A selection of recently published research relevant to New Zealand

Improving health outcomes for indigenous peoples: What are the challenges?

Hayman, N., et al. (2015, August 6). *Cochrane Library*.

Internationally, the health of indigenous people continues to be inequitable. The international working group on indigenous affairs reports that indigenous people remain on the margins of society: they are poorer, less educated, die younger, are much more likely to commit

suicide, and are generally in worse health than the rest of the population.

www.cochranelibrary.com/editorial/10.1002/14651858.ED000104

A literature review: Addressing indigenous parental substance use and child welfare in Aotearoa: A Whānau Ora framework

McLachlan, A., Levy, M., McClintock. K., & Tauroa, R. (2015), *Journal of Ethnicity in Substance Abuse* 14(1):96-109.

Parental substance use disorders (SUDs) for Māori, the indigenous people of Aotearoa New Zealand and an ethnic minority, are considered to be contributors to adverse effects on outcomes for their children. This article offers a review of international and Aotearoa literature in regard to key considerations for Māori parents with SUDs who present to an alcohol and drug (AOD) specialist for assessment and treatment.

Factors to increase positive outcomes for Māori children of parents with SUDs are promoted. Effective adult AOD services provide support to parents with SUDs through comprehensive assessment and intervention plans that consider both individual and familial risk and protective factors. In this context, it is imperative that possible child welfare issues are identified early to ensure prevention or intervention.

An AOD workforce that is effective with Māori must not only have the knowledge and skills to facilitate access to other relevant sectors, such as education, employment, and housing, but also have at least some basic knowledge and skills in Whānau Ora philosophy and whānau-centred best practice.

www.tandfonline.com/doi/abs/10.1080/15332640.2014.947460

The Design and relevance of a computerised gamified depression therapy program for indigenous Māori adolescents.

Shepherd, M., Fleming, T., Lucassen, M., Stasiak, K., Lambie, I., & Merry, S. N. (2015). JMIR Serious Games, 3:1

Depression is a major health issue among Māori indigenous adolescents, yet there has been little investigation into the relevance or effectiveness of psychological treatments for them, including for depression among indigenous communities. This studies explores the opinions of young people (taitamariki) and their families of a prototype computerised cognitive behavioural therapy (cCBT) programme called Smart, Positive, Active, Realistic, X-factor thoughts (SPARX). It's a free online computer game intended to help young persons with mild to moderate depression, who are feeling down, stressed or anxious. The results of this study were used to refine SPARX prior to it being delivered to taitamariki and non-Māori young people.

www.ncbi.nlm.nih.gov/pmc/articles/PMC4392467/

The burden of disease and injury attributable to alcohol in New Zealanders under 80 years of age: marked disparities by ethnicity and sex.

Connor, J., Kydd, R., Shield, K., & Rehm, J. (2015). *New Zealand Medical Journal*. 128:1409

This study reports on the estimates of morbidity and mortality due to alcohol consumption in New Zealand. An estimated 5.4 percent of all deaths under 80 years of age were attributable to alcohol in 2007 (802 deaths) and these represented 13,769 years of life lost (YLLs). Injuries accounted for 43 percent; cancer for 30 percent; and other diseases for 27 percent of deaths. Sex and ethnic disparities were marked, with twice as many deaths in men as women for both Māori and non Māori, and the age-standardised death rate for Māori two and a half times the rate for non-Māori.

The leading cause of alcohol related death in both Māori and non-Māori women was breast cancer. Alcohol consumption results in substantial loss of good health across the life course in New Zealand and contributes to Māori/non-Māori and male/female health disparities. High average consumption and heavy drinking occasions confer the greatest risk of harm to the drinker and others.

www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1409/6435

Research report: Patterns and dynamics of alcohol consumption during pregnancy in a recent New Zealand cohort of expectant mothers

Social Policy Evaluation and Research Unit. August 2015

Foetal alcohol exposure continues to present as a public health challenge. This report sheds light on the scale of the issue and increases the knowledge base about the women who drink alcohol while pregnant, how much they drink, and how their drinking behaviours change as the pregnancy progresses. The Growing Up in New Zealand study interviewed 6822 expectant mothers to obtain their personal information and experience during pregnancy. It included questions on the level of alcohol drinking before the women became aware that they were pregnant, during the first trimester, and after the first trimester.

www.superu.govt.nz/sites/default/files/Alcohol%20and%20Pregnancy%20Research%20Report.pdf

Māori Rangatahi and Addiction

KcClintock, K., Huriwai, T. & McClintock, R.

This review highlights substance use, abuse and dependence and related issues in regard to Māori (the indigenous people of Aotearoa/ New Zealand) with a key focus on rangatahi (youth). It has been argued that the health status of every population group is influenced by a range of interacting factors, including the effects of colonisation, socioeconomic deprivation and age structure.

www.matatini.co.nz/news/m%C4%81ori-rangatahi-and-addiction

Confidence and connectedness: indigenous Māori women's views on personal safety in the context of intimate partner violence

Wilson, D., Jackson, D., & Herd, R. (2015). *Health care for women international*.

Māori women, similar to women belonging to indigenous and minority groups globally, have high levels of lifetime abuse, assault and homicide, and are over-represented in events that compromise their safety. The authors

sought insights into how Māori women view safety. Twenty Māori women's narratives revealed safety as a holistic concept involving a number of different elements. The authors found women had developed an acute sense of the concept of safety. They had firm views and clear strategies to maintain their own safety and that of their female family and friends. These women also provided insights into their experiences of feeling unsafe.

www.ncbi.nlm.nih.gov/pubmed/26491900

Resources

He kai i ngā Rangatira He korero o nga whānau whaiora

This report explains what people with lived experiences think of being under the Compulsory Assessment and Treatment Mental Health Act and receiving care from acute mental health units.

http://matatini.co.nz/he-kai-i-te-rangatira-o-ngā-whaiora-whānau

What Works project

What Works is part of a host of sites run by Community Research. The What Works website is designed to address the needs of and help groups in the sector to evidence their outcomes. It is the first step in a larger What Works project, involving training and capacity building associated with the site. Priority audiences for this website are frontline workers, managers and governance members of small to medium sized community and not for profit organisations that receive public funding.

www.whatworks.org.nz

Events

Evidence to Action Conference 2016

5 April, Wellington

Organised by Superu, this full day event aims to deliver rich insights from international and local thought leaders on evidence-based decision making.

7th Addiction Research Symposium

29 April, Victoria University, Wellington

The 7th Addiction Research Symposium will be held in Wellington as a collaboration between the Universities of Victoria, Auckland, Otago/Christchurch, Massey and Matua Raki. Abstracts for presentations on topics in the addiction field are welcome from all perspectives.

www.matuaraki.org.nz/events/7th-addiction-research-symposium/932

10th Annual Conference of the International Society for the Study of Drug Policy

New Zealand satellite conference, 11-12 May 2016, Auckland

The theme of the Auckland satellite conference, *Regulating drug use: Beyond prohibition and legalisation*, will explore innovative regulatory responses to new psychoactive substances ('legal highs') and cannabis which are in the middle ground between absolute prohibition at the one end and unregulated commercial markets at the other end. Abstract enquiries can be made from the link below.

http://www.issdp2016.com/#!satellites/c1wor

Hui Whakapiripiri

4-5 July 2016, Te Papa Tongarewa, Wellington

The Health Research Council will host Hui Whakapiripiri. The theme is Reflections of Māori health research - acknowledging, strengthening, extending. A call for abstracts will be made soon.

www.hrc.govt.nz/news-and-media/events/hui-whakapiripiri-2016-wellington

Australian and New Zealand Addiction Conference 2016

18-20 May, Gold Coast

The Conference, themed Alcohol – Other Drugs – Behavioural Addictions, Prevention, Treatment and Recovery and hosted by the Australian and New Zealand Mental Health Association, will include workshops, presentations and forums dedicated to sharing skills and understanding in the treatment of all addictive disorders, including alcohol and other drugs, behavioural addictions, and the emerging field of online compulsive behaviour in both adults and children.

www.addictionaustralia.org.au/

MHS Conference 2016

23-26 August 2016, Auckland

Auckland will be the setting for an exciting and vibrant TheMHS Conference 2016 – *People: authenticity starts in the heart*. It is people who act with integrity, are authentic, and combine heartfelt action with evidence-based practice who establish leadership cultures that truly resonate with other people. *People: authenticity starts in the heart* aims to focus attention on all the people involved in the system – people who access services and their families and whānau; people delivering services; people who help guide and shape these services; and people in our communities. Abstract submissions are now open.

http://www.themhs.org/pages/themhs-conference-2016.html

Cutting Edge Conference

7 -10 September 2016, Energy Event Centre, Rotorua

The Cutting Edge addictions conference is New Zealand's key addiction treatment gathering, providing an excellent opportunity for the addiction sector to get together, to network, and to learn about and embrace innovative thinking and practice. We are very excited to

announce that Dr David Best has been confirmed as a keynote speaker as has Dr Denise Blake. The theme of the conference, *Celebrating transformation*, lends itself to highlighting transformative practice for individuals and families, organisations and communities.

www.cmnzl.co.nz/cutting-edge-2016/

Useful research websites

Health and Disability Ethics Committees (HDEC)

HDEC's function is to secure the benefits of health and disability research by checking that it meets or exceeds established ethical standards. Find out more at http://ethics.health.govt.nz/.

Centre for Addiction Research (CFAR)

CFAR (University of Auckland) is dedicated to providing timely, relevant and independent research to help inform policy and practice in relation to substance misuse and the treatment of addictive consumptions. Research is available at www.fmhs.auckland.ac.nz/en/faculty/cfar/our-publications.html.

National Addiction Centre (NAC)

NAC (University of Otago) is involved in a number of funded projects. Find out more at www.otago.ac.nz/nationaladdictioncentre/research.html.

Social and Health Outcomes Research and Evaluation (SHORE) and Te Rōpū Whāriki (Whāriki)

SHORE and Whariki (Massey University) are multi-disciplinary research groups undertaking policy and community research and evaluation on a variety of health and social topics. Publications and current projects can be viewed online at www.shore.ac.nz/.

Gambling and Addictions Research Centre

The Gambling and Addictions Research Centre brings together research that improves New Zealanders' understanding of how gambling and addictions affect society, and enhances policy and professional practice. Find out more at www.niphmhr.aut.ac.nz/.

University of Otago

The Mental Health and Addiction Research Centre (MHARC) brings together the research activities of the Mental Health Clinical Research Unit, the National Addiction Centre and the Gene Structure and Function Laboratory. Find out more at http://spar.co.nz/research/centres/otago005628.html.

Community Research

Community Research gathers research about New Zealand's tangata whenua, community and voluntary sector, creates a hub to share ideas and advocates for good practice methods in community research. Find research, information about researchers and toolkits at their website: www.communityresearch.org.nz/.

Health Promotion Agency

Find a number of recent research publications at the Health Promotion Agency website: www.hpa.org.nz/research-library/research-publications.

National Register of Research and Implementation Projects

This Research Register is a comprehensive source of information on recent tertiary education research and implementation projects, currently conducted in New Zealand. Find out more at http://akoaotearoa.ac.nz/research-register.

The New Zealand Family Violence Clearinghouse

The New Zealand Family Violence Clearinghouse is a national centre for research and information on family and whānau violence in Aotearoa New Zealand. It is based at the School of Population Health, University of Auckland. More can be viewed at: https://nzfvc.org.nz/

Have your say!

We hope you find the Addiction Research Bulletin useful. We look forward to receiving your articles, feedback or suggestions for future editions. Is there something we've missed? Your views are important to us.

Email: klare.braye@matuaraki.org.nz or call 04 381 6473.