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

Our clocks have been put back, the firewood's been stacked, we've got the slow cooker out and we're sure you have too! We hope everyone had a safe and happy Easter weekend with friends and whanau and trust you're back doing incredible work with those in recovery.

We are very pleased to introduce a new member of the dapaanz team, Karen Meintjes.

Karen and her husband recently immigrated to New Zealand from South Africa, the wind did not put them off settling in Wellington which suits us just fine. Karen has a background in IT and administration and is now the official Registrar. Welcome Karen!

Due to the success of the Whanganui and Kerikeri workshops last November, we have decided to run additional workshops in Whanganui, Auckland, and Wellington. For more information see the notice board or go to the Events Calendar on the dapaanz website to register, as spaces are limited. If you have a specific training need in your region and have at least 15 people who would be interested in attending, please email sue@dapaanz.org.nz with 'regional workshop' is the subject line.

Karen Meintjes

Please see the 'notice board' for other important dapaanz updates. 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. We are committed to providing a place where your voices are heard, where issues are raised, where controversy is explored and your excellent work celebrated. Don't forget if you are in Wellington – pop in and see us at Level 5, 342 Lambton Quay (in the AMI Plaza).

Nga mihi
Sue

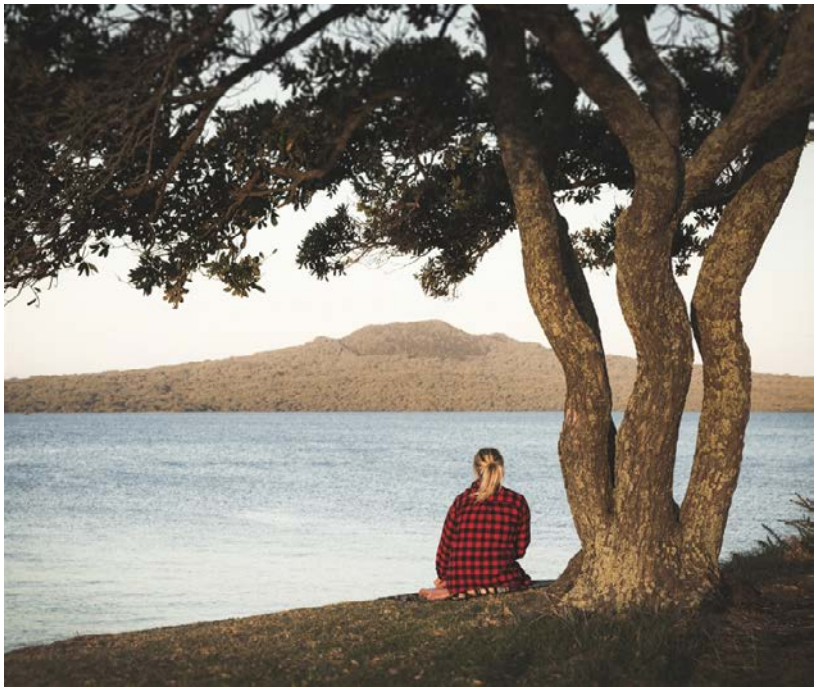
Consumer Story

My Story

I would like to start where I have worked very hard to be... Living in recovery, happy, mothering my smart and handsome boys, fulfilled in my life, working in CADS Pregnancy and Parental service (PPS) as a Peer Support Worker, supporting other women in recovery and (mostly) free from the self-limiting and destructive thoughts, feelings and behaviours that plagued me my whole life. Life sure is good!

But it has been a long and torturous path to get here! At no stage in my life did I dream of a future being a drug addict or alcoholic; it was never my life's ambition to destroy myself, to sit at home crying, distraught at how tragic my life had turned out. I did not goal plan to be in a detox unit shaking and shivering with physical withdrawal, emotional depletion and paralysing fear of what was going to happen next. I worked excruciatingly hard to be a functional addict, and I failed. Some people talk about a rock bottom, some describe being sick and tired of being sick and tired, some discuss a moment of clarity, a window of opportunity for a change; I had them all in a lump of deep soul-felt failure, that I was unable to live a good (perfect) life and be a good (perfect) mother. I knew my life was a mess, I knew I was letting myself and my kids down, that I was clinging on to the teeny bit of sanity I had left with my fingernails, yet I could not stop using substances. This is the grip of addiction, you know you need to stop, you want and try to stop, but you just can't stop.

I couldn't see a way out, so one was made for me. As a client of PPS, they gently challenged me on my denial (I was still trying to portray that I had my life together and things weren't as bad as they might sound), they challenged me on the effects my substance use was having on my children, and supported me to find ways of



doing things differently. When I finally realised my toxic relationship was destroying me, my sons were taken off me, when I had almost lost that last slither of sanity, I saw the light and admitted defeat. I asked for help, and I got it. Alongside being a client of PPS, I entered medical detox, then social detox and then attended 12 Step meetings and CADS Abstinence/Intensive Outpatient programme.

I didn't need help understanding why addiction got a grip on me. I knew why, I had a shitty start to life and no one around me had the skills to take care of me properly or teach me healthy ways to be in the world. No one around me had the emotional skills to live life well so I didn't learn them either. I was bumbling along in my inadequate coping, raw uncomfortability of living in my skin, distraction and dissociation, until I found stuff that made me feel better and numbed my internal pain. That stuff was alcohol and at 14, I was ready for anything to take me away from being me. By 15 I was living out of home and consuming alcohol regularly. By 16 I was out of school, had a job and drinking Thursday to Sunday. Blackouts were a regular occurrence and this lead to waking up in places I didn't remember getting too, with people I didn't know. Every time I drank, I tried to not black out, but who can stop a freight train? After a while the nightlife in my city was too small for me and I moved to a bigger city, Auckland. I discovered drugs in Auckland and was so happy to discover the solution to my blacking out problem, I could just stay awake! Or take certain drugs and not need copious amounts of alcohol. But, as you may have heard before, the good times and the drugs only worked for a while, before they stopped working and I was left with my emotional pain (plus extra doses of regret, shame, self-loathing), dodgy friends, no money and a comedown! I would try to sort my life out, re-build with what I had left, promise myself I would not do drugs again, and try my hardest to 'stay good'. I could never stop everything though, just the hard drugs that were especially damaging. And I would try really hard... like really, really hard. But I could not maintain the change for long. I would have one night of use and that would release the beast again and I would be off on another binge; each time getting worse results, worse consequences and worse self-loathing. Why could I not get my shit together? How do other people know how to do life and I don't? What's wrong with me?

After years of using, trying not to use, and working really hard to build and maintain a life, the yo-yo-ing was exhausting. I was tired of living as I was. As I stepped out of the world of chaos and into recovery, I learned I have the disease of addiction; it wants to control me and destroy me. My antidote/medicine is recovery, a self-designed system of good supports/beliefs/choices that enable me to live a fulfilling life with love. This has taken a great deal of effort, commitment, surrender and acceptance. Surrendering to a life without substances, to trying different ways of doing things, to listening to other people's advice and guidance (instead of thinking I know what's best). Acceptance that I am wired differently to others, that I cannot use mind or mood altering substances and have a quality life, acceptance that I am a human being with a normal range of emotions and can learn to feel them and cope with them. And a great deal of effort in being gentle with myself as I learn a new and healthier way to live.

The transformation goes further and my painful past now serves a purpose in my Peer Support work. I am employed by the service I was a client in, which I feel really proud about and this also models to current clients how unique and accepting the PPS service is. I am privileged to work alongside other Mums as they navigate their recovery journey and it is an honour to share our experiences, strengths and challenges.

The 4K Model: Cultural Competency and Working with Māori

By Maynard Gilgen

Kaumātua

"Ko au, ko koe, ko koe, ko au"

Nā Mita Mohi[1]

Tēnā koutou katoa e te whānau. We meet again for me to shed light on the second "K" of this kaupapa, the word *Kaumātua*.

In light of koro Mita Hikairo Mohi's recent passing away, this kōrero is dedicated to him for the tireless mahi he and his whānau did in organising, facilitating and the running of taiaha wānanga in the South and North Islands since the late 1970s. *He tohu aroha tēnei ki a Koro Mita Mohi*.

This kōrero is not an in-depth piece of work on kaumātua, but rather an introductory paper on the fundamentals of what this term means and represent, including:

1. What is a kaumātua?
   - Definitions
   - Context and background
   - Health and wealth of kaumātua
2. What do kaumātua do?
3. How can kaumātua help us?

1. What is a kaumātua?

Definitions:

One defintion states that kaumātua (verb) (-tia) means:[2]

1. *v. To grow old, grow up.*

As a noun,

2. *n. adult, elder, elderly man, elderly woman, old man*

As an adjective,

3. *a. be elderly, old, aged*[3]

Barlow[4], reported that today a kaumātua refered to male tribal leaders who acted as a spokesperson on marae,

> "...and who are keepers of the knowledge and traditions of the family, sub-tribe, or tribe."[5]

Mead[6] also reported that,

> "Older individuals generally have a greater familiarity with and knowledge about tikanga because they have participated in tikanga, have observed interpretations of the tikanga at home and other tribal areas. The kaumātua and kuia, the elders, are often the guardians of tikanga. They are expected to know. Tikanga should not be new to them, but for many reasons this is not necessarily the case. Experience is definitely helpful in knowing what to do.[7]"

The main themes that hold true about kaumātua is that they are usually elderly, they lead, and carry knowledge about their whānau, hapū, iwi and tikanga. However, as Mead reported this does not always hold true; some individuals will be referred to as kaumātua but who have no special knowledge or leadership role.

Context and Background

To fully understand the concept of kaumātua today, we need to understand the context and background our kaumātua have come from. The role of kaumātua increasingly came to be seen as that of preserver of tradition, and as a maintainer of culture, even as the very institutions of tikanga and te reo were being lost. That role and the burdens upon modern kaumātua can only really be understood in view of the loss experienced by Māori people as a whole.

Historical overview

Prior to when the tables turned for hapū and iwi Māori and the wheels of colonisation shifted into high gear, some tīpuna Māori were prosperous for a brief period (1840 - 1850s)[8]. Economic expansion was taken advantage of by many hapū, this being due to warfare with the Crown and inter-tribal feuding declining[9]. Māori became competitive entrepreneurs and business people; Waikato, for example, exported kai and goods to Australia and California[10]. However, within 50 - 60 years huge tracts of whenua (land) had been sold or confiscated, with laws implemented to take more,[11] Pākehā settlement soared while the Māori population shrunk to an all-time low.[12] However, kaumātua along with their whānau, hapū, and iwi battled on using varied kaupapa Māori responses, such as the Kotahitanga, Kīngitanga and Prophet movements of Taranaki (Tohu Kākahi and Te Whiti-o-Rongomai), and leaders, such as, Te Kooti Arikirangi Te Turuki, who were then followed by Rua Kēnana, Wiremu Tahupōtiki Rātana and others.[13] Other Māori who came to prominence in the early to the mid-20th century were the likes of Apirana Ngata, Te Rangi Hīroa (Peter Buck), and Māui Pōmare[14]. Likewise, Te Puea Hērangi, who re-established the former capital of the Kīngitanga at Tūrangawaewae, Ngāruawāhia, in the 1920s, also played a significant role during this period for Waikato and iwi Māori throughout the country[15]. All these leaders received counsel, guidance and advice from kaumātua connected to them during their upbringing and work they did for their people.

Te reo Māori and Tikanga

My mother's generation, who grew up in the 1920s through to the 1940s (who would be in their 70s-90s now), also grew up having been both physically assaulted and psychologically abused by their teachers at their respective schools for speaking te reo Māori[16]. One respondent in Edwards's[17] doctorate reported how their father was "...thrashed within an inch of his life for

speaking te reo Māori at school, and he never forgot it…" Sir James Henare also spoke about how he and his peers were sent into bush to cut down a supplejack with which they would be beaten with if any of them spoke te reo Māori[18]. A kuia also in the same forum told of how, as an infant, when she asked if she would go to the toilet in te reo Māori her teacher punished her, a memory still vivid to her, after many years.[19] Although the Department of Education at the time had no such official policy, battering Māori children for speaking te reo Māori was common practice.[20] Sir James Henare remembered how an Educational Inspector told him and his fellow pupils that, "*English is the bread-and-butter language, and if you want to earn your bread and butter you must speak English*".[21]

Migration to the cities

During the period from the 1950s - 1960s kaumātua and whānau left their whenua (tribal lands), as their lands became unproductive and the cities needed a labour workforce, subsequently, Māori streamed into the cities[22]. Within 25 years after WWII approximately 80 percent of Māori had relocated from their whenua to the cities[23]. Whānau did so with their native-speaking parents who then, as reported, no longer spoke te reo Māori to their tamariki and mokopuna, as they now had the view that it was vital for their tamariki to speak English as it was viewed English was the language of the future.

Second class citizens

During this period Māori veterans from WWII were treated as second-class citizens. Racist practices, such as, barring Māori veterans from drinking in hotel bars or allowing them to purchase alcohol was the norm. The late respected Tūhoe kaumātua, John Rangihau, reported he and his Māori WWII veterans would have to get Polynesians or Indians to buy alcohol for them[24]. In 1959 Dr. Henry Bennett who was the senior medical officer at Kingseat Hospital was not served at a local Papakura hotel because he was Māori[25]. My mother also recalled being made to sit in the poorer seats at the Pukekohe cinema, as well as being made to sit in the rear seats of buses[26]. David Ausubel, a visiting psychologist from America in the 1950s also observed how Māori were also barred from barbershops and banks in Pukekohe during the same period[27] John Rangihau also spoke about the racial prejudiced he experienced when he sought rental accommodation in New Zealand towns during the 1950s – 1970s, this was common experience for many Māori when they moved into urban areas.[28]

Assimilation

The Hunn Report of 1961 continued to promote the idea that Māori should become assimilated with Pākehā and their "mainstream" way of doing things, hence, belittling "Māori" ways of behaving and thinking, as Pākehā believed such ways were inferior, uncivilized and primitive.[29]

Consequently, just as Māori, growing older in the cities struggled to learn and use te reo Māori, we have also struggled to be able to value Māori ways of doing things, and have those ways acknowledged and valued by others. Further, poor health and economic disparity for Māori communities have set up further threats for kaumātua of this modern era.

Health & Wealth

Edwards in his research on kaumātua stated that Māori overall continue to "*experience a compromised quality of life and reduced life span relative to non-Māori*"[30]. He reported that the leading health causes for kaumātua include dialysis, cardiovascular disease, respiratory disease and digestive system diseases, which are at much higher rates among Māori than non-Māori[31]. Kaumātua have also been assessed to have higher rates of disadvantage, poverty and material hardship at rates 3-4 times that of non-Māori, hence, kaumātua often do not have much wealth to pass on to their tamariki, mokopuna, and whānau whānui (family and extended family).[32]

Whakarāpopoto (Summary)

To discuss kaumātua without highlighting what they've endured as a consequence of colonisation, is inadequate. Fortunately, as a result of those kaumātua who supported from both the front and behind, while also carrying the tikanga and mana of hard decisions made by their whānau in the 1970s, whenua has been returned that was stolen, our language is formally recognised as being another language of our country, and dozens of settlements have been reached with the Crown. Māori schools from kohanga reo to wānanga exist, and the Treaty is integral to our country. However, when considering what kaumātua often grew up in, we are fortunate that Koro Mita Mohi and others continued to manaaki their whānau, hapū and iwi and community, while also upholding and sharing tikanga that was taught to them.

2. What do kaumātua do?

Koro Mita Mohi provides an extraordinary example of the duties and activities many kaumātua will engage in to some degree. Few people can alone embody such roles to the same degree, as Koro Mita did, but his example is a shining one of how age, wisdom, honed skills and experience could allow him to have an impact on so many people's lives as a kaumātua

(1) Pass on and preserve whakapapa and modelling tikanga

The impetus behind Koro Mita Mohi setting up his mau rākau wānanga was as a consequence of him being on board an organinsing committee in Ōtautahi (Christchurch) to prepare a pōwhiri for Matiu Rata in the 1970s.[33] They soon discovered that at the time they couldn't find anyone in Te Wai Pounamu who could do the wero. When one of the committee said they'd have to invite someone from the North Island to carry out this kaupapa, this was when Koro Mita told the committee he could carry out this duty, as his father had taught him how to do the wero, which he did.[34] Hence, Koro Mita spent decades passing on whakapapa and tikanga, according to his hapū, Ngāti Rangiwewehi, and iwi, Te Arawa, regarding the taiaha not only on Mokoia Island and in the Te Wai Pounamu (South Island) but also in prisons throughout the country.

(2) Provide wisdom on and work with their, whānau, hapū, iwi

Koro Mita also served on marae committees, performed and tutored kapa haka at a national and regional levels, was awarded an MBE in 1994 for his Mokoia Island taiaha

wānanga and was considered a kaumātua for not only for Ngāti Rangiwewehi but also Te Arawa.[35] He was also on school board trusts, the Parole Board, served on the local city council and was a kaumātua for the police.[36]

(3) Monitor and uphold tikanga and te reo Māori

Koro Mita was a native speaker of te reo Māori who grew up among his people in Awahou. He loved tikanga and never hesitated to bring manuhiri (guests) to either marae or Mokoia Island to pōwhiri them using kaiwero (taiaha exponents) he and his whānau had taught as part of this welcoming process (pōwhiri). Thus, along with others, Koro Mita ensured that tikanga and te reo was being consistently used and repeated, and not allowed to wither.

(4) Teach tikanga and mātauranga Māori

Koro Mita not only taught how to use the taiaha to the many thousands of tamariki tāne (youth), rangatahi (adolescent), pākeke (adults), mātua tāne (fathers), and koroua (grandfathers) he also taught the importance of manaakitanga, that is, to look after each other, our partners and loved ones, whānau, and others. He also had a passion for and taught waiata and kapa haka, in fact he'd tell the story of how he became so excited haka at the start of the World Rugby League match in France in 1972 for the New Zealand Kiwis he pulled his calf muscle and had to be replaced.[37]

(5) Modelling ways to deal informally with upset wairua, as well as issues such as addictions, poor mental health, and violence.

Koro Mita would always speak in the evenings in front of a huge bonfire to around 120-200 taiaha wānanga participants, besides being a natural comic, he also shared why he didn't consume alcohol, as he'd call to mind drunken whānau members who'd swear at each other and brutally fight each other when heavily intoxicated. He spoke about how traumatising this was for whānau and all involved. His example, which he also lived, as well as taught, allowed many other pākeke (adults) to share about challenges they'd had in their lives and also how they'd worked through and overcome abuse, violence, addictions, mental health issues, and trauma.

(6) Protecting and blessing

Koro Mita was a kaikarakia (one who carries out karakia). We always began and closed our taiaha training with karakia, and we'd always karakia our kai we'd have throughout the day. Further, he gave over karakia to specifically do with using the taiaha during the pōwhiri, these karakia are given to senior taiaha pracitioners.

(7) Expressing and inspiring aroha

Koro Mita, first and foremost, absolutely loved his sweetheart, nana Huka. In fact, as his whānau would say, the reason why he was able to host all the taiaha wānanga he did was because of his wife's impeccable management, advice, coordination, and support, she was often likened to a general[38], and a kaumātua in her own right. Koro's aroha he had for his tamariki and mokopuna, goes without saying. One of his mokopuna summed it up when he said, "...you know your koro is the best when John or Harry is saying that's his koro bro".[39]

Whakarāpopoto (Summary)

When looking at the attributes, roles and activities of a kaumātua, Koro Mita certainly epitomised these. However, the reader must also be aware that not all kaumātua carry similar attributes or knowledge as Koro Mita and other notable kaumātua. This being due to these kaumātua being part of the generation who were not given te reo Māori or taught tikanga as a consequence of the assismilationist policies and practices.[40] However, as John Rangihau recognised in the 1970s (cited in Rewi. 2016) that not a single person amongst them carried all aspects of Tūhoe tikanga and that they needed to 'pool their information' in order to consolidate their knowledge base.[41] Rangihau, similar to Koro Mita's experience, revitalised having, Kura Wānanga ā Tūhoe, for them to pass on their knowledge to their up and coming generations.[42] Tainui has also followed suit and gathered together their kaumātua to not only pool their knowledge of Tainui tikanga but to also begin teaching kaumātua who don't have this knowledge.[43] Other iwi, since the 1980s have followed suit.[44]

3. How can kaumātua help us?

To have therapeutic success with whānau Māori, it pays to either have the necessary knowledge of tikanga Māori, which includes having a command of te reo Māori and whakapapa connections and understanding of the tangata whenua (local tribe and community), and if you don't, it would pay to have access to either a kaumātua or Māori practitioner, who would be either able to assist or help you, or introduce you to a reputable kaumātua who can help you.

The following points are suggestions on how a practitioner or service might go about meeting kaumātua and how can kaumātua help them and/or their service.

Meet Kaumātua

These are several ways one can go about meeting kaumātua:

- Ask your service leadership which kaumātua they may use or have a working relationship with to deal with Māori;
- Call your local iwi your service resides in, for example, if I worked in Hamilton, I'd call Tainui. Another way to find out which iwi boundary you live can be found by looking on Google maps;
- Call your local District Health Board in regards to which kaumātua they use;
- Look up who might be the local kaupapa Māori addiction and mental health services in your area and ask them if they have kaumātua who work or are connected to them.

Once you have been given a contact telephone number of either a kaupapa Māori service who have kaumātua who work for them or made direct contact with a kaumātua, make sure when you speak with them that you are clear about your reason for coming to meet with them.

If a kaupapa Māori addiction and mental health service have kaumātua on staff or if a kaumātua invites you to meet them at their marae or service, which may have a marae, make sure that you:

- Inform them of how many people might be coming with you from your service and also make sure you let the service and/or the kaumātua know whether or not you will be bringing kaumātua with you who can kaikaranga and kōrero or not. Should a service or marae know that you don't have anyone to bring you onto their service or marae, then they will commonly provide one of their whānau to do this for you;
- Be prepared you could end up being welcomed formally (pōwhiri) on or undergo a mihi whakatau, depending where you will be welcomed, either a service or marae;
- Make sure to take kai (food) with you that is appropriate, for example, if it is near lunchtime, take suitable kai that could contribute for lunch (e.g., a cake, filled or sausage rolls, pāua);
- Be prepared to hongi (press noses) and/or kiss your hosts, the tangata whenua (home people) once speeches and waiata have been completed;
- Once the pōwhiri or mihi whakatau (formal greetings, greetings) are complete then you will be invited to share a cup of tea, coffee, or milo, with some kai (this is when bringing in your kai to share should occur). Make sure you don't begin to eat until karakia (blessing of the food) has happened. Plus, please don't sit on any tables as this is considered rude and offensive, as Māori believe tables are for kai not bottoms;
- Once kai and a cup has been had by all, everyone will again either go into the whānau room or wharenui to begin discussing the kaupapa at hand;
- Be prepared to listen what will be shared by kaumātua, as they will help to increase your understanding of Māori ways of thinking and doing.

How can kaumātua help?

Once you have completed going through the formal welcome proceedings, usually the next step is for people in the hui to introduce themselves. If possible have a brief kōrero prepared explaining where your parents are from, where you grew up, who your partner is, your children, what you do and what it is you want from the meeting. This process is commonly known as 'whakawhanaungatanga' (to make connections). This might be done through genealogical links, similarities how you grew up, and/or the challenges we all face when we become parents.

It can help the process if you are clear what it is you may want assistance with in your service, for example:

- How many tangata whai ora Māori and their whānau does your service or you see?
- Are tāngata whai ora Māori asking to see a kaumātua and/or a Māori practitioner? If so, what for?
- If tāngata whai ora and their whānau are asking to see a kaumātua is it because of matters to do with wairua (e.g., would they like their home blessed, has there been a tangihanga in the whānau, are there issues to do with mate Māori[45])?
- Would your service or you like to learn more about the local iwi, whenua, te reo Māori, waiata, or about tikanga, etc.? And,
- What might your service or your long term goal be in regards to having kaumātua involvement?

Kaumātua competency

It would be helpful to also know what knowledge and tikanga kaumātua carry, so they too can work within their levels of competency and skill. Commonly should there be matters concerning mate Māori, if they don't have the expertise to deal with such an issue, they will know kaumātua who can.

Whakamutunga (conclusion)

Having grown up with and worked with kaumātua all my life, I have come to recognise how important and relevant kaumātua are in working with tāngata whai ora and whānau in the field of addictions and mental health and us, as kaimahi (practitioners). There have also been some kaumātua who may hold tikanga, te reo, and mātauranga Māori, but who have abused their whānau and/or others, similar to what we've seen happen in some organisations, such as, clubs and churches. For this reason it is important to be cautious when building relationships with kaumātua, as it is with all new people who we allow into our whānau.

Pulling this paper together was challenging as it did make me realise and think more about the abuse and violence our tīpuna went through, which was repulsive and hideous, and that for those of us urban raised, we do have extra mahi hosted upon us as we go about re-connecting with our whānau, hapū, iwi; learn te reo Māori; let alone all the tikanga that comes with it. However, when you learn it from the likes of kaumātua, such as Koro Mita, it is a joy, reaffirming, and life changing - ask Cliff Curtis![46]

Nō rerira, tēnā koutou, tēnā koutou, tēnā koutou katoa,

Nā Maynard Gilgen
Matua Raki

References

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Article

Treat addiction, reduce crime

By Sue Paton, Executive Director, dapaanz

Reports from addiction services, feedback from our own member practitioners and the latest Arrestee Drug Use Monitor all suggest methamphetamine (meth) use is on the rise in some regions. At the very least is now more readily available, and more people are requesting help from services to deal with problem with meth use.

The Whanganui District Health Board, for example, reported a 25 percent increase in the number of people diagnosed with an amphetamine-related disorder in their catchment and issued an August 2016 media release warning about the dangers and destructiveness of the drug.

The release said meth is easy to get through social media, encrypted websites and international networks. And indeed, the number of people caught with meth has more than doubled in recent years nationwide and the amount seized by authorities has almost tripled.

This is despite meth having been identified as a law enforcement target and despite the Government's collaborative interagency action plan Tackling Methamphetamine. It's clear our efforts to address the use of meth are not going very well.

Hitherto our approach to curbing our burgeoning meth problem has included a significant focus on catching and punishing people who use it. It's the same old 'war on drugs' mentality that underpins our Misuse of Drugs Act.

As we move into 2017, we're about to spend $1 billion to provide another 1800 prison beds to accommodate our growing muster – mainly imprisoned for drug offences – and a one-off $15 million has been set aside to combat meth. Most of this will go on police initiatives to catch offenders.

But, unfortunately, punishing drug use out of existence has never worked and never will. And, while it's fine to come down hard on those who manufacture and/or supply this drug for profit, and who prey upon the weakness of those who have become addicted, the sad reality is it will be the latter who make up the majority of the offenders caught.

Most of those who use meth (or any other drug) problematically in New Zealand are not bad people. They have become addicted and some commit crimes as a result.

We know this from the 2010-2015 Arrestee Drug Use Monitor, which was released by Police in late November 2016. It says 85 percent of detainees in 2015 said at least one problem had resulted from their substance use.

Problems included charges for assault, theft and/or wilful damage – along with life costs such as car accidents, job losses and overdoses.

The Monitor reports a "surge" in meth use and associated problems in some regions, and with those attributing their crime to meth having risen by as much as 29 percent since 2012 in some places. The proportion who felt dependent on meth increased from 22 percent in 2011 to 34 percent in 2015.

There will always be people who commit crimes, but we can see from this that if we removed addiction from the equation, crime figures would be much lower and drug-related harm to New Zealanders would be dramatically reduced.

So how do we address addiction and reduce the supply of meth and other drugs in New Zealand if the law 'putting the fear into them' doesn't work?

First, we have to recognise that addiction is primarily a health problem, not a criminal one. And then we need to provide services to deal with those problems before they worsen. We have to make it easier for people to get help when they need it and we need to get a whole lot better at identifying people with developing problems early so intervention can take place before their situation escalates into offending.

Wouldn't it be great, for example, if GPs and other health professionals and service providers regularly made screening for meth and other drug use a part of their interaction with patients or clients?

Wouldn't it be great if we spent more time with new arrestees and prisoners to work out whether an addiction is behind their offending and how that addiction could be addressed so they don't offend again?

Helping offenders (and others) overcome their addiction would not only reduce crime, it would also reduce demand for drugs –and this is one of the most effective ways to reduce supply. Take the market away and people will be less inclined to produce the drugs. A first-year economics student could tell you that.

We could learn from the Netherlands when it comes to this. There they've taken a new approach emphasising rehabilitation and working with incarcerated people in a therapeutic way to address the reasons for their offending, including addiction. In doing so they're enabling people to return to society sooner and reducing the likelihood of their reoffending.

While we're building more and more prisons, as many as 24 have been shut down in the Netherlands since 2015 because prisoner numbers have fallen so dramatically. It's not hard to imagine a similar approach working just as well here.

While our Government seems yet to have worked this out, the news is not all bad.

In August 2016 Waitemata police announced they had concluded their investigation into organised meth distribution and had taken five people into custody. But they also said they would follow up with the suppliers' clients, not to make further arrests, but to give them prevention advice and help them access support services.

Quoted in the media release, Detective Inspector Hayden Mander said, "Drug dealers constantly exploit those who are addicted and drive them to commit more crime to fund their habit."

He gets it, and this softened approach is a small but welcome start that could, if it became the norm, go a long way towards reducing New Zealand's meth and other drugs problem.

It's time for addiction treatment to stop being Health's poor cousin, which has left our services struggling to meet demands while funds are still being wasted on a punitive approach.

Treatment transforms lives that have been broken by addiction. And the earlier we can get to people who need it the better. When you consider that every dollar spent gets paid beck seven-fold in terms of reduced social costs, treatment and prevention are clearly good investments. A first-year economics student could tell you that too.

Research Review

By Klare Braye
Matua Raki

Welcome to the Addiction Research Bulletin (ARB) Research Review. Matua Raki brings you this resource, in conjunction with dapaanz, offering insights into recent research activities that have relevance to the addiction sector in New Zealand. We hope the ARB will increase your awareness, understanding, appreciation, implementation, utilisation and critiquing of addiction research. Please feel free to share it with others.

Globally, communicable diseases are on the decline, however, non-communicable and chronic diseases, including mental health are not. Data and trends typically reflect mortality rates, as a fairly 'cut and dry' measure, however, it is morbidity that has a significant cost and burden on society. About ten percent of GDP is spent on health care; over one third of which is currently spent on mental health. Whilst world health is changing, so too is the world of work, with manual and physical hazards typical of the past, largely being superseded by a new pattern of psychological and life satisfaction challenges. It is suggested that the word 'work' used be a verb, but is now better described as a noun, in which going to work is less of an action and more of thing of life. The workforce is also changing: it is aging, retirement is deferred, there is a baby boomer bulge, absences and recruitment are costly. The focus and costs of workplace 'injury and illness' used to be on injury, now it is illness, and there is a resulting shift in focus from injury prevention to wellness. For more information on these changes and an international perspective refer to the work of Litchfield, P., Cooper, C., Hancock, C., & Watt, P. (2016). Work and Wellbeing in the 21st Century (www.mdpi.com/1660-4601/13/11/1065/htm).

The World Health Organisation (WHO) has a significant role to play in the direction of health care. As early as 1948 a radical move saw a definition of health in its broadest sense as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity' (WHO, 1948, www.who.int/bulletin/archives/80(12)981.pdfWHO; Grad, 2002, www.who.int/governance/eb/who_constitution_en.pdf). Whilst criticised for the ambiguity over the term 'complete', and more dynamic alternatives since being offered, it did offer hope by readdressing the negative definition of health as the absence of disease and instead moved to address physical, mental, and social domains (BMJ, 2011, www.savenhshomeopathy.org/wp-content/uploads/2012/09/Huber-Definition-Health-BMJ-21.pdf).

The prevalence of ill health in New Zealand is clearly documented. New Zealanders experience high rates of chronic conditions including obesity, diabetes, cardiovascular disease and some cancers. Two out of three adults in New Zealand experience a physical or mental illness lasting greater than six months (Ministry of Health, 2008). Sixty seven percent of New Zealanders are overweight or obese and 19 percent have a mood and/or anxiety disorder. The percentage of adults experiencing psychological distress decreases with age, notably over the age of 65 and Māori have poorer health and more unmet need for health care (Ministry of Health, 2016, www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/current-recent-surveys/new-zealand-health-survey).

This edition we will focus on wellbeing. Inspired by the article from David Best- The well-being of alcohol and other drug counsellors in Australia: Strengths, risks, and implications, (2016) who also presented at Cutting Edge in 2016 on Recovery as an issue of social justice and social inclusion (www.dapaanz.org.nz/vdb/document/70)and Recovery and social identity (www.dapaanz.org.nz/vdb/document/69), we were drawn to considering how our workforce are doing in terms of wellbeing. This venture has led us to interesting explorations and findings regarding the wellbeing of workforces and the activities or interventions that can support this (hyperlinks included).

Focusing specifically on the sub population of addiction workers, it is said that, 'our workers are our greatest resource'. Ensuring their health and wellbeing and maximising opportunities for them to perform at an optimal level is therefore essential (Skinner & Roche, 2005, www.nceta.flinders.edu.au/files/2412/5548/1890/EN114.pdf). The addiction sector is a growing workforce that crosses the domains of primary care, peer support, social services, justice, education, and public health. Whilst numbers of the wider workforce are not clear, we do know that there are almost 200 health funded services contracted to deliver addiction services across New Zealand Aotearoa, employing approximately 1,400 full time equivalent staff. Forty eight percent of the workforce is employed in District Health Board service and 52 percent in non-government organisations. Vacancy rates stand at around four percent; clinical roles make up 68 percent of the workforce, 22 percent of whom are reported to be Maori (Te Pou o Te Whakaaranui, (2015, www.matuaraki.org.nz/initiatives/workforce-data/165) .

An increasingly prevalent characteristic of addiction work (along with other sectors) is intensification, where more is expected of workers, but with fewer resources, reducing the time available for workforce development activities (Skinner & Roche, 2005) and placing particular pressures on those involved in emotionally demanding work, (Roche, Duraisingam, Trifonoff, & Tovell, 2013, www.ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1119&context=aprci ; Volker et al., 2010, www.onlinelibrary.wiley.com/doi/10.1002/smi.1276/full). Strategies and interventions to maintain and enhance the wellbeing of AOD workers are critically important,

not only for workers themselves, but for organisational functioning. They are also important for client engagement and outcomes (Landrum, Knight, & Flynn, 2012, www.ncbi.nlm.nih.gov/pmc/articles/PMC3268890/).

On average, adults spend at least one third of their life at work (WHO, 1999, www.who.int/occupational_health/regions/en/oehwproguidelines.pdf). The 2006 New Zealand census showed that 22 percent of employees work at least 50 hours per week (Fursman, 2009, www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj35/parents-long-work-hours.pdf). This makes the workplace an ideal environment to promote the health and wellbeing of the adult population and has been internationally recognised by the WHO as a space to promote and support healthy lifestyle changes to a large audience (WHO, 2011, www.who.int/occupational_health/topics/workplace/en/). In fact, organisations have legal responsibilities to ensure workplaces do not cause harm to the health of employees (The (New Zealand) Health and Safety at Work Act, 2015). More information can be found about this at the Health Promotion Agencies Wellplace: Your guide to workplace wellbeing site (www.wellplace.nz/facts-and-information/mental-wellbeing/legal-responsibilities/).

There is an increasing body of evidence referring to programmes and activities to enhance worker wellbeing that range in focus on the individual through to the organisational. Workplace health promotion policies and programmes are increasingly common (http://www.worksafe.govt.nz/worksafe/toolshed; www.wellplace.nz/; www.workwell.health.nz/workwell_home). There is evidence that resilience-promoting work environments can reduce the negative, and increase the positive outcomes stemming from working in potentially demanding environments (McCann et al., 2013, www.internationaljournalofwellbeing.org/ijow/index.php/ijow/article/view/153). The provision of quality clinical supervision has an important protective effect on AOD workers and links them more closely to the organisation and AOD treatment sector (Roche, Todd, & O'Connor, 2007, http://www.tandfonline.com/doi/abs/10.1080/09595230701247780). And the presence of positive workplace perceptions, arising from organisational management (Harter et al., 2002, www.media.gallup.com/documents/whitePaper--Well-BeingInTheWorkplace.pdf) are all shown to effectively enhance worker wellbeing.

This review has highlighted a selection of the literature pertaining to worker wellbeing, and informs the pending wellbeing of the workforce survey being conducted in New Zealand and New South Wales as a collaboration between Matua Raki, NADA and NCETA.

Notice Board

Cutting Edge 2017 – Addiction is Everybody's Business

Te Papa, Wellington 7-9 September

This year's theme is Addiction is Everybody's Business - 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 focuses on how we create an integrated system of care that is responsive to people's circumstances, environment and their life stage.

Cutting Edge 2017 is shaping up to be the best yet. Join us for another 3 days together at Wellington's renowned Museum of New Zealand Te Papa Tongarewa as we hear from incredible international and local speakers, attend

plenary sessions, celebrate outstanding practice at the Oscarz Awards, make new connections in the sector, and gain fresh insight to enrich your professional practice.

Registrations Now Open

Early bird registrations are now open, register before July 31st and save $90.00

To Register go to www.cuttingedge.org.nz

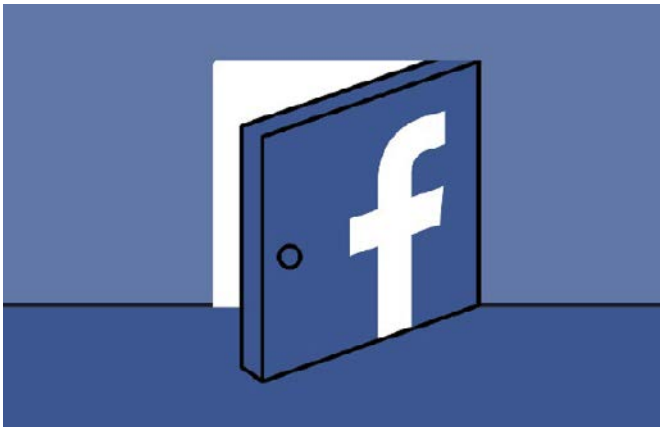
Call for Abstracts

There were incredibly high calibre submissions last year and we expect the same will be true for CE2017; with that in mind we warmly invite you to submit an abstract for the selection process. This year areas of interest include (but are not limited to) innovative approaches or what you are doing that works, person centred system responses, working with offenders, best practice in OST, community and primary care responses and working with offending populations.

Submissions close 5pm Friday May 26, for more information or to submit an abstract, go to www.cuttingedge.org.nz

We're in The Book!

We are now on Facebook. Stop on by and say hello or if you're feeling particularly generous you can Like our page. We would love to engage with you and hear your views on Addiction Sector news.



Regional Workshops

Following the success of the Whanganui and Kerikeri workshops run last November, we are now running workshops around the country throughout 2017. Be sure to register as spaces are limited.

Working with trauma Safely and Effectively with Psychologist Brett George

- Higher Ground, Auckland, Friday 28 April
- Wellington, Monday 1 May

Developing Mindful and Compassionate Practice with Counsellor Brent Cherry

- Thorndon Hotel, Wellington, Thursday 15 June

Ethics and Boundaries with Psychotherapist John Savage (two-day workshop)

- Wellington, Tuesday 4 & Wednesday 5 July
- Higher Ground, Auckland, Tuesday 23 & Wednesday 24 May
- Whanganui, Tuesday 6 & Wednesday 7 June

Transactional Analysis for Addiction Practitioners with Psychotherapist John Savage

- Auckland, Tuesday 7 November
- Wellington, Tuesday 28 November

To Register go to the Events Calendar at www.dapaanz.org.nz

Upcoming Research Events

National Addiction Research Symposium

May 5th 2017, Auckland

The National Addiction Research Symposium is collaborative venture between the Universities of Auckland, Otago, Massey, Victoria, AUT and Matua Raki, creating a supportive and collaborative networking environment and facilitating the sharing of ideas and initiatives among New Zealand researchers, clinicians, students and policy makers involved in the addiction field. www.matuaraki.org.nz/workforce-groups/addiction-research-symposia/163

Australian and New Zealand Addiction Conference

15-17 May 2017, Gold Coast

Covering topics around prevention, treatment and recovery. There will concurrent streams, poster presentations and workshops.

www.addictionaustralia.org.au/

Te Ritorito 2017: Towards whānau, hapū and iwi wellbeing

3-4 April 2017, Pipitea Marae,
55-59 Thorndon Quay, Wellington

This two-day forum will provide an opportunity for researchers, policymakers, advocates, and practitioners to discuss whānau, hapū and iwi wellbeing in our day-to-day practice and what the bigger picture means for both

Māori and Government. Te Ritorito is being jointly hosted by Te Puni Kōkiri and Superu.

http://www.superu.govt.nz/news-and-events/te-ritorito-2017

The MHS Conference

Embracing Change: Through Innovation and Lived Experience.

29 August - 1 September, 2017. Sydney, Australia www.themhs.org/pages/themhs-conference-2017.html

Cutting Edge 2017 Addiction is Everybody's Business

6-9 September, 2017. Te Papa Museum, wellington.

This key addiction treatment gathering provides opportunity for the addiction sector to get together, network, and learn about and embrace innovative thinking and practice. In encouraging the emerging addiction research workforce and recognising the value of evidence into practice, Matua Raki will again support the New and Emerging Researcher Award for an oral or poster presentation for a research initiative. www.cmnzl.co.nz/cutting-edge-2017/oscarz/#10233

5th International Conference of Te Ao Maramatanga-New Zealand College of Mental Health Nurses

10-11 October 2017. www.nzcmhn.org.nz/News-Events/News-Archive/2017-Conference

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

Cutting Edge 2017
Te toka tū moana

Addiction is Everybody's Business

Museum of New Zealand Te Papa Tongarewa, Wellington, New Zealand

6–9 September 2017

Invitation for abstracts from anyone working in the addiction sector are now open

Invitation to Attend

Key Partners

hpa health promotion agency

Matua Raki
National Addiction Workforce Development

Ministry of Health
Manatū Hauora