dapaanz
fostering excellence in addiction practice

BULLETIN

Vol 17, No. 7 – August 2017

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

Here we are in the last month of winter, we hope you have kept warm and safe and made the most of hot soup and hearty winter dishes! Our aroha goes out to all of you who have been affected by storms and floods. It has been a tumultuous time and I hope spring will be more settled.

This edition of the bulletin has some excellent articles. Make sure you check out Maynard Gilgen's article in the 4K series on Korero, Nathan Frost's article on drug treatment in Portugal and Paul Schreuder's controversial korero on whether business is becoming the addiction or driver in the addiction sector. We have also published Takurua Tawera's excellent background paper for the dapaanz Treaty of Waitangi policy (also found in the board policy document).

It is very interesting what has been happening in our sector. The New Zealand Drug Foundation held a very well attended and important Drug Strategy Symposium at Parliament in early July (hosted by Minister Dunne). Most of us agree that the current system is not working to reduce addiction-related harm and that this particularly true for Māori. However, the devil is in the detail and there is still some debate about what needs to happen to have the most positive impact. Decriminalisation? Legalisation? The take home message for me was that the issues are highly complex and resolution of the years of systemic bias are not likely to be resolved by simplistic measures, or without the voice of those most affected by the policy change.

It has been two years since the last dapaanz board was elected – it is time to vote for your representatives on the 2017-2019 board. Voting is your chance to ensure your interests are well represented. You will find the bios and why nominees want to be on the board in the bulletin. Also inserted are the voting instructions and form. Please complete and return to us no later than 6 September (return details are found on the voting paper).

Cutting Edge – Addiction is Everybody's Business is almost upon us and is shaping up to be one of the best yet. We hope to see you there. This year Cutting Edge will host keynote speakers from America, Australia, Samoa, and our own backyard. We have also increased the awards presented at the Oscarz Awards Dinner and have organised excellent entertainment by Unity Wara and an inspirational guest speaker.

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're in Wellington, pop in and see us at Level 5, 342 Lambton Quay (in the AMI Plaza)

Nga mihi
Sue

Topical

NOT POT

By Nathan Frost

'Not Pot' - is it killing users?

A spate of deaths in Auckland last month have been linked to synthetic cannabis use. At the time of writing this article, police have claimed eight deaths have occurred over the last month and have warned that further people will die unless a solution to the crisis is found. New Zealand Drug Foundation have disputed that these deaths have taken place only over the last few weeks, and are calling for more information relating to cause of death to be released by the police. The jury is out in terms of whether the police account or the Drug Foundation's account of the time-period is correct.

In each fatality, the person was believed to have recently used synthetic cannabis (known on the street as not-pot and synnie), or were found with the drug in their possession. However, coronial enquires are ongoing and the final causes of death are yet to be established.

The sudden string of deaths has thrust synthetic

cannabis back into the media spotlight with speculation and rumours of deadly new toxic substances now tainting the product. Under increased media scrutiny, reports of significant numbers of non-fatal cases, (often involving seizures and hospitalisation), have surfaced. Dapaanz sources working within the addictions treatment sector said people having seizures were not a new phenomenon, with recorded ED admissions dating back to when 'not pot' first appeared in an emerging unregulated New Zealand legal highs market.

Some of the legal highs being sold were causing problems (and would continue to do so in an unregulated market). In 2011, Minister Dunne put legislation through Parliament allowing bans of up to two years on psychoactive substances considered either dangerous, or containing illegal substances. Under this legislation, 43 substances and other product combinations were banned between 2011 and 2013. However, the pace with which psychoactive analogues were now being produced meant it was too difficult to keep ahead of the game.

In 2013 the Psychoactive Substances Act (the Act) was introduced to regulate psychoactive substances. The Act placed the onus on licenced manufacturers to prove their products were of minimal risk to users, before being permitted to sell them in a regulated market. Less than 50 products (out of around 200), were considered low-risk and left on the shelf (without testing). Reports of adverse effects from some products, public outcry, the testimony of users and issues relating to the Psychoactive Substances Amendment Act (which banned the testing of recreational drugs on animals), resulted in the government capitulating and removing all products. The psychoactive industry has yet to submit any product for testing.

One source working in residential rehab claims as many as a quarter of all of clients are presenting with dependency issues primarily related to 'not-pot' use. A common sentiment expressed by clients, (many of whom have long dependency issues with other substances like

alcohol and methamphetamine) is that things didn't start getting really bad until they started using synthetic pot.

Clients report that seizures are common amongst 'not-pot' users and that many have video footage on smart phones of fellow users having fits. Entering catatonic states is cited as another common side effect of the drug.

Not all synthetic cannabis is equal, with clients stating the stuff sold on the black-market today is an inferior and unpredictable product to what they were purchasing from dairies in 2013. But it is cheap, with a plastic KFC spoon, (the type you get to eat your potato and gravy with), the measure of choice for a ten-dollar bag deal.

Clients believe 'not-pot' is a problem that exists wide out in the open, yet it's impact remains invisible. Part of this relates to changing priorities in prohibition and enforcement. 'Not-pot' currently occupies a place in no-man's-land between significantly relaxed attitudes towards cannabis enforcement and an almost exclusive focus on Methamphetamine, (universally seen as a scourge to society).

This recent spate of deaths may change all of that. One thing is certain, as we grapple to understand the 'not pot' phenomenon, it is crucial that we listen to the voices most affected by synthetic cannabis; those using it, previous users, family members and the people working with them.

Treatment for hepatitis C saves lives

By Sue Paton

The Hepatitis Foundation estimates there are around 50,000 New Zealanders with hepatitis C (hep C) and only half these people know they have the virus. Twenty percent of those infected develop cirrhosis and 3 percent develop hepatoma or liver cancer. Therefore, hep C is potentially fatal in a significant proportion of those infected. This makes the diagnosis and treatment of hep C a priority for the addiction treatment sector.

Many of our clients are injecting drug users (IDUs) or have a history of intravenous (IV) drug use. People born 1945-1965 are a particularly high-risk group (even if not IDUs), as is anyone with a history of injecting drug use, whether regular or recreational. Other risk factors include a history of imprisonment, tattoos, transfusions prior to 1991, haemophilia and immigration from higher risk countries such as East Asia.

Injecting carries its own particular stigma and, as such, there is an increased likelihood of non-disclosure of historic IV use. There have also been barriers for current and past IV users accessing treatment for hep C – some, perhaps, related to discrimination or stigma. Anecdotally, many people with hep C, both here and globally, report experiencing stigma and discrimination. This leads to shame and further compounds the effects of the virus itself.

Stigma includes: misconceptions about how it is contracted; discrimination in the workplace' family members buying paper plates or not swimming with someone who is infected; and social isolation (cited in Tony Farrell 2016).

The stigma relating to having hep C can cause low self-esteem, diminished mental health and reduced access to medical care through fear of disclosing the disease. Conversely, stigma may contribute to a discriminatory hesitancy on the part of some medical providers and dentists to treat people infected with it.

However, with the advent of new, exciting medications it has been very pleasing to see the rates of treatment

uptake in primary care where the majority of infections can be cured. These new treatments are very effective and most who need them can take them.

On 12 June 2017 PHARMAC announced that the funding criteria for cirrhotic hep C treatment drug Harvoni would be widened starting immediately. This is wonderful news and will save lives and unnecessary suffering. While inequitable access for those with genotype 3 hep C remains, it appears there is now more willingness to break down barriers to treatment.

About a year earlier, on 1 July 2016, PHARMAC had announced the approval of three antiviral drugs for treating hep C (Harvoni, Viekira Pak and Viekira Pak-RBV). These drugs were the new direct acting anti-viral medications (DAAVs) but the variations of these approved were only suitable for treating people with genotype 1a or 1b, or those with decompensated cirrhosis.

There are six major hep C genotypes and 43 percent of New Zealanders with the disease have a genotype other than 1a or 1b meaning a lot of people did not have access to funded treatment unless they had severe liver disease (Pharmac June 2016).

Both changes PHARMAC has made are a significant step forward. However, the threshold for meeting the criteria, while lower than it was 12 months ago, is still high. In effect, it means around 100 people will now receive treatment each year – an increase from 40.

Before 1 July 2016 some people were treated with DAAVs accessed via trials, but the majority were treated with interferon which is injected and tends to have severe and unpleasant side effects including nausea, diarrhoea, itchy skin rashes, insomnia and severe depression. This lead to poor compliance and many felt their effects made treatment worse than the disease itself. To top it all off, their success rate was only around 40 percent. No wonder some people with hep C chose not to 'take the cure' when these were the only options.

Viekira Pak and HARVONI, by contrast, are taken in simple pill form once or twice daily, don't have debilitating side effects and have a 96-99 percent cure rate after just 12-16 weeks. This is great because if we have full access to treatment for all genotypes we will be able to cure this virus and eradicate it in New Zealand. The majority of liver transplants are hep C related, so the reduction in suffering and health costs will be considerable.

Our liver cancer rates are also rising dramatically (with a median survival rate of less than three months once a person is diagnosed). Those infected are often not aware of when they became hep C positive. This means many of the 50,000 or with hep C became infected in their late teens or early 20s but didn't come to be diagnosed until much later in life. Meanwhile the damage has been quietly done, especially in males over 40 and those who consume alcohol and eat fatty food.

Most people in New Zealand who are infected became so through IV drug use. There is now a lot of collaboration with needle exchanges and opioid substitution treatment to engage users into testing, fibro-scanning and treatment. Liver biopsies are a thing of the past as a GP or specialist only needs a liver function test, a genotype and a fibro-scan to have enough information to decide on suitable treatment.

We are entering a "treatment is prevention" paradigm, and that is why antiviral drugs like Harvoni are such a breakthrough. The challenge will be engaging past and present IDUs as many are not currently in treatment. Needle exchanges are gearing up to provide peer support, fibro-scans and non-judgemental privacy-assured access to treatment.

It is great PHARMAC has extended funding – but have they gone far enough?

Out of PHARMAC's hands is the exorbitant price set by Gilead – $1000 a pill for crying out loud! The actual estimated production cost is $1 per pill, and it is difficult to understand how profit drivers can completely override making access to lifesaving treatment a reality. PHARMAC has shown a real commitment in these two decisions to extend the reach of this effective treatment and are waiting for better prices of newer DAAVs so that the health dollar is spread further.

In November 2016, Naomi Wickens wrote an article for the dapaanz bulletin that raised these issues and promoted the Fix HepC Buyers Club as an alternative for those who don't qualify for funding though PHARMAC.

New Zealand has done well in the fight against HIV/AIDS to the point that few people here die of it any more. We've achieved that through better screening and medication and, importantly, through education and reducing stigma. Meanwhile, the rates of people dying of hep C have climbed exponentially. This is due to greater numbers of people in a highly stigmatised area that we haven't dedicated a proportional amount of research, advocacy and investment to.

Let's hope the PHARMAC announcement is a sign that the times are a-changing and that fear in whatever form will no longer be a barrier to those wanting help with either their disease or their addiction.

For those who don't qualify under PHARMAC's criteria, the Fix HepC Buyers Club provides a viable alternative to more affordable and safe generic drugs sourced in India and Bangladesh. The New Zealand Hepatitis Foundation endorses these.

If you do not qualify for the currently funded medications the http://fixhepc.com/ website will lead you through a step-by-step process on how you can talk to your GP. There is also information on the website for GPs who, through the Fix HepC Buyers Club, will be able to help you access generics in a safe and legal manner.

To make it simple, GPs can follow leading expert Professor Ed Gane's[1] step by step guidelines at www.hepatitisfoundation.org.nz/wp-content/uploads/2016/10/edarticlepdf.pdf

While there are challenges ahead, the main message is that hep C is curable, the majority of hep C patients can be treated now, and we look forward to the day when all patients have access to treatment and the virus is successfully eradicated.

1 Dr. Gane is Professor of Medicine at the University of Auckland, New Zealand and Chief Hepatologist, Transplant Physician and Deputy Director of the New Zealand Liver Transplant Unit at Auckland City Hospital.

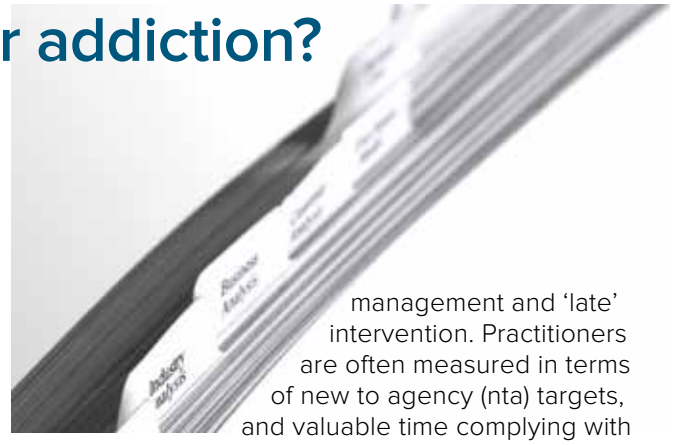
Is business becoming our addiction?

By Paul Schreuder, Senior Lecturer in Addiction studies, Wellington Institute of Technology

This year's Cutting Edge theme is about addiction being everybody's business. This got me thinking about how business has to some degree, become everybody's addiction. With many years of neoliberal politics behind us in Aotearoa, the nation has become educated into the market driven ethos and the ubiquitous 'user pays' mantra. Fiscal responsibility, downsizing, or lately the even more repugnant dehumanising term 'right sizing' have become part of a dominant discourse amongst business and government. Equally disturbing, is the use of terminology such as collateral damage and 'friendly fire' when describing job losses or treatment failures as business outputs are privileged over human outcomes. Health and educational services have not been immune to the economic rationalism that influences the day to day goings on in human service providers. There is of course nothing wrong with efficiency and maximisation of resources when it comes to getting the best value for clients coming to human services. But calling individuals clients, seems to be a rhetorical tool to somehow insinuate that the person has some choice or status as a recipient of client centred services. People who claim their entitlement at ACC are no longer called claimants but are now called clients under the banner of well-meaning mission statements. In actuality, they have little real choice of services.

In the education field, students are known as units of funding, or customers of the education industry. Indeed, successive government ministers of education have focused on the economic statistics of various schools and institutions, with less mention of the all-important student outcomes and long-term benefits of programmes. As private institutions ruthlessly compete for the education dollar, operational decisions made by highly paid managers are often made whilst pedagogical considerations are subjugated.

In the addictions field, market forces and contracting practices have also mirrored the practices that have evolved in the corporate world. Ironically, many folks who require the services offered by addiction agencies have enormous problems with instant gratification, yet shorter term interventions have replaced many of the long term residential programmes. Fixed term contracts are the norm and providers are required to compete for contracts often putting a lot of energy and resources into corporate business practices that could have been utilised for coal face service provision. KPIs (key performance indicators) have become commonplace in agencies and this can lead to practitioners who are interacting with the clients/patients/consumers focusing more on short-term outputs at the expense of long term outcomes. Indeed, relapse prevention and after care, as well as primary prevention initiatives often cannot be provided because the key focus is on crisis



management and 'late' intervention. Practitioners are often measured in terms of new to agency (nta) targets, and valuable time complying with business practice seems to be eating into face to face client interaction. Investment in technology to deliver cost effective service and maintaining a competitive edge appears also at times to strip resources at the human coal face. Branding of services has also become a big part of the 'caring industry' - including addiction services – and these services are becoming more franchised and corporatised. I wonder if some clients actually feel intimidated walking into some of these agencies that look less like places of healing and more like business offices?

In the short and seemingly swift twenty-five years that I have been part of the addiction field as a counsellor, facilitator, educator presenter and clinical supervisor I have often felt that business practices and bums on seats equations have been the centre of attention. In a field full of passionate souls, working with vulnerable people, who often are put on waiting lists and offered one hour a week of help with problems that consume them and their loved ones one hundred and sixty-eight hours a week, the constant stretching of resources, must create frustrations. Thankfully there are of course exceptions to this practice but with the closure of many inpatient facilities and Milieu therapy options people with complex addiction and other life problems are allocated an extraordinarily short time to address them with the help of a professional. Who dreamed up the idea the one hour a week formula? I doubt very much that this practice was started by practitioners who actually interact with clients.

Practitioners themselves often begin their employment in the field, loaded up with student debt on a salary that has not reflected the huge responsibility and years of study under their belt, and in a job market acquiescent to the conditions drawn up in board rooms and meetings with accountants and business managers.

I have also noted that over the years, the field has become more accepting of incorporating twelve step fellowships into their menu of options. Whilst personally I welcome this acceptance, I suspect that this free option serves more as a safety net than an integrated component of intervention planning. It was not so long ago that these fellowships were treated as opposition to mainstream 'evidence-based' service provision and quite often condemned in public and private. These fellowships have outlasted hundreds of professional agencies and short-lived corporatised treatment providers that

have either been taken over by larger organisations or replaced in a competitive contracting round that has left workers without jobs. It is commonplace for practitioners to be put into a position of reapplying for their restructured position in a more streamlined lean structure. CEOs, managing directors, regional managers, team leaders seem to change at an alarming rate and it is not uncommon to hear that such and such agency has undergone a new management restructure or is currently reviewing their operational practices.

The prison programmes also seem to be delivered mainly on the basis of strict economic indicators and audited more and more on service delivery and contract obligations rather than the long-term outcomes of participants. Perhaps I am being harsh and a little cynical here, but I too find myself in the organisation that I work for, often complying with ticking the various boxes dreamed up by managers, when I would rather be giving my time collaborating with a living breathing human being – whether a student or client- who needs empathy, understanding, kindness and a helping hand with their solution to other complex life problems. In the long term, it has been empirically demonstrated in many studies that every dollar spent towards successful therapeutic outcomes, actually save several dollars more. Indeed, Professor Best, at last year's Cutting Edge presented yet again that rehabilitation benefits the individual and society not only in terms of health and safety but fiscally.

Addiction is everyone's business, so why are we becoming so dependent on business practices? It seems to me that tolerance is building for this habit, and we may be in danger of finding ourselves in an environment where business executives cause passionate workers with a calling for helping those in need, to withdraw their services? Competition rather than cooperation is evident, as we are forced to compete for the treatment dollar as educationalists and service deliverers. We who serve the field may need to take more of a stand and take responsibility for our inability to respond holistically to the needs of many clients coming for help. Before I hop off my soap box I propose that the first step may be to admit that we are never powerless to resist being addicted to business, and that we can resist the dependency on outputs over outcomes.

Article

Opioid Substitution Treatment in Lisbon City, Portugal

By Nathan Frost

In recent editions of the Bulletin I've set out to present the experiences of consumers receiving opioid substitution treatment (OST) in New Zealand because, as a former OST recipient, I believe consumers provide an extremely valuable (experience-based) perspective that should influence and inform critical thinking around best practise. Earlier this year I visited Portugal on a fact-finding mission examining the impact of their now 16-year-old drug policy reforms and was lucky enough to spend time with non-government organisation Ares do Pinhal's low threshold mobile methadone units in Lisbon.

In 2001, roughly 1% of Portugal's population were heroin dependent. This statistic - grossly disproportionate to the rest of Europe at the time - meant practically every Portuguese family, regardless of social standing, found themselves affected by addiction. In addition to this, drug-related deaths and transmission rates of blood borne viruses like HIV and Hepatitis C were well above the European average and soaring. It was obvious that prohibition wasn't working and radical solutions were needed at the legislative level. Portugal was faced with hard decisions and amid much political debate, accusations it was flouting International Narcotics Control Board (INCB) conventions, and moral panics of impending narco-tourism, Portugal took the bold step of decriminalising the possession for 'personal use' of all drugs. In fact, they went a step further than purely changing the law. The Portuguese reforms effectively dismantled a punitive judicial system and replaced it with a pragmatic health-based system that viewed any state response to drug use and addiction as an issue of public health rather than an illegal act to be prosecuted under the law. The introduction of these reforms has resulted in reductions of intravenous drug use, opiate related deaths and infectious diseases to rates that now sit below the European average. For drug dependent individuals seeking help, this reorientation of the state's response to drug use removed fears of prosecution, reduced stigma, and provided more treatment options due to the reassignment of prohibition enforcement funds to health department coffers.

In 2009, American lawyer, journalist and author Glenn Greenwald (famous today for publishing a series of articles on covert global surveillance programmes based on classified documents provided by CIA whistle blower Edward Snowden), wrote a paper for American think tank, the Cato Institute, that thrust Portugal's policy reforms into the global spotlight. Greenwald's paper showed that eight years in, the numbers were stacking up strongly in favour of a decriminalised model. What had previously been viewed by most of the world as little more than a reckless social experiment, was now gaining acceptance in many quarters as an enlightened piece of social policy backed up by thorough legislative measures. Today, the INCB holds Portugal up as a global leader in drug control best practise.

The Portuguese are understandably very proud to find themselves as the instigators of a changing global landscape rapidly moving from prohibition to decriminalisation. In recent years a steady stream of writers and journalists have visited Portugal to write the latest piece of 'trendy, edgy' copy. This volume of interest has resulted in the Ministry of Health establishing an international relations department and, after making initial contact via an email, I'm impressed

by the coordinated and collaborative response of a slick machine that provides me with a visit and interview schedule connecting me to various agencies and individuals comprising a comprehensive array of service provision and policy roles within the Portuguese system. Yet, for the plethora of articles celebrating how wonderful all of this is, very little has been heard from those with the most at stake from these changes in policy - Portugal's opiate-using population.

A highway underpass in Praca de Espanha is one of five methadone dispensing locations

It's a cold day by Lisbon standards and a brisk wind funnels through the highway underpass where the two transit vans of Ares do Pinhal's Mobile Low Threshold Methadone Programme are parked in Lisbon's Praca de Espanha neighbourhood. A queue of more than 50 clients (a fraction of the 1,200 souls the two mobile units see during their twice daily 90-minute shifts in five drug-saturated Lisbon neighbourhoods), stand patiently chatting among themselves or with members of the Ares do Pinhal team while waiting for their methadone to be dispensed from a counter built into the side of the van. Those wanting clean injecting equipment can access this from a needle exchange counter at the back of the same van.

Needle exchange in the back of the methadone van

There is an obvious comradery and mutual affection on display here. Team members and clients know each other on a first name basis and, although the conversations are in a language I don't understand, it's obvious that the banter is warm-hearted as members of the team check in on the welfare of their clients. This setting strikes me as much more community orientated than the sterile clinical setting of chemist counters manned by wary pharmacists back home.

Ares do Pinhal team members dispensing methadone

Some of those standing in line wear surgical masks and I'm told that in addition to receiving methadone they will be treated on site with broad-spectrum intravenous antibiotics for a drug resistant strain of tuberculosis that has a high prevalence rate among Portugal's intravenous population. Antiviral medications for HIV and Hepatitis C (low threshold clients have seropositive rates of 70% and 20% respectively) are dispensed on site too. This pragmatic 'one stop' pharmaceutical dispensing is made possible through collaborative relationships Ares do Pinhal maintains with primary health care providers and enables a smooth referral process for client's various treatment needs to appropriate services. In fact, one of the two vans that make up the mobile unit exists as a mobile triage with a doctor on hand for health assessments and referrals.

A young man arrives wanting a place on the programme. He is given a small urine test pottle and retreats to the toilet in the triage van. The urine he produces is tested by a staff member using a test strip remarkably similar to pregnancy testers you buy here from the pharmacies. Two blue lines confirm the presence of heroin in his system and minutes later he receives his first dose of methadone.

Another man receives his dose and wanders over to introduce himself as Paolo in a surprisingly clear American-accented English. He proceeds to joke with the Ares do Pinhal team members about his position as their official translator. Paolo's face is a road map of long-term drug use. The grey pallor and deep creases of Paolo's skin and his slack mouthed set remind me of many opiate addicts I've chatted with over the years. Paolo's no slouch though, and his pale blue eyes (with pupils contracted to pin pricks), display intelligence and finely honed perceptive skills most of the world is blind to. In the often-chaotic world of scoring drugs on a daily basis, cutting through facades and reading people is a crucial skill necessary for survival. As Paolo approaches, I'm aware of his searching scrutiny in a way only one addict interacting with another will ever understand. Seasoned campaigners like Paolo can spot a fellow drug user on the street from 50 paces and, based on body language, assess within a nano-second the type of drugs the individual uses, the place on the scale between intoxication and withdrawal they currently occupy and consider what, if any, opportunities exist based on this

information. We get chatting and I tell him a little bit about my background - my many years of opiate dependence, the time I spent on OST programmes, the hard yards involved in counting down, withdrawal and the many lessons learnt navigating life opiate free. Realising I'm not just another rubber necking journalist Paolo proceeds to tell me his story, his voice a rasp of chain-smoked cigarettes washed down with methadone.

As a six-year-old Paolo emigrated with his family to the United States - his American-accented English makes sense to me now. Paolo's early 20s were lost in the haze of a cocaine honeymoon that spiralled into dependence and full-blown daily addiction. The wheels eventually fell off when Paolo was convicted for drug trafficking and sent to jail for 18 years. While incarcerated, 9/11 happened and legislation changes meant Paolo faced immediate deportation upon release back to Portugal, regardless of the fact he had spent the majority of his life in the U.S and his entire family resided there. Paolo returned to his native country a stranger in a strange land and without any real support. In the States, he'd only ever injected cocaine but once back in Portugal, Paolo was introduced to speedballs - a highly addictive intravenous mix of heroin and cocaine. The arrival of this potent mix spelt disaster for Paolo - he just couldn't get enough, his life quickly fell apart and he ended up on the street, unemployed and receiving treatment from the low threshold programme.

There's a deep-seated grief that emanates from Paolo as he describes the carnage of drug use in his life and the daily pain of being separated from family. As I listen to Paolo's story and hear his heartbreak it strikes me that among the many things children dream of becoming in adulthood, being trapped in the depressing daily grind of taking a substance - the absence of which precipitates the onset of brutal withdrawal - is not generally a desired life goal. When opiate dependant individuals find themselves receiving a treatment that restores some semblance of stability to life but ultimately does nothing to unlock the prison of being beholden to a substance, their emotional response is often equal parts relief and despair. This 'damned if you do damned if you don't' catch 22 is an issue overlooked by those who've never experienced the grip of addiction in their lives.

OST undoubtedly provides immediate relief from the chaotic and often life-threatening condition of opiate addiction unchecked. The gratitude and relief expressed by those for whom a measure of normalcy returns to their lives is a cause for celebration about the effectiveness and importance of maintenance programmes. However, one of the things common to the OST clients I have known over the years (and is true from my own experience), is that among OST consumers there are two distinct dialogues - one is the dialogue for the professionals working in the sector and the public, which centres on the rights and the benefits of OST. The other dialogue is more personal in nature and is what is shared among consumers – it focuses on the frustration of being shackled to the treatment (opiate) and the service. Perhaps with Portugal's low threshold there is less of a sense of that, but Paolo certainly communicated the frustration he feels at being stuck. It is this second (or arguably primary dialogue) that appears to be lacking acknowledgment. A sentiment I encounter time and again when talking to people receiving OST - even in those who acknowledge the positive benefits and stability OST has brought back to their lives - is one of resigned ensnarement and grief.

The Quinta do Lavrado housing estate home to Ares do Pinhal headquarters

Later that day I head to Lisbon's Quinta do Lavrado low income housing estate, a neighbourhood with high rates of drug use, unemployment and home to Ares do Pinhal's headquarters. A group of estate brats kicking a soccer ball in the hallway scatter as I approach the NGO's office door with Team Manager Hugo Faria. After knocking loudly for admission, Hugo laughing, tells me of the running battle they've been waging with the local kids who keep stealing their doorbell. A smiling staff member opens the door and I am ushered into a chaotic warren of former apartments (a gift from local government) turned into office space. This is truly a service embedded within the community they serve and I'm here to meet two Ares do Pinhal veterans with more than 50 years of experience working in Portugal's addictions treatment sector between them.

Things have certainly changed in the 20 years since Technical Director, Dr Elsa Belo, began her career as one of the first social workers to intervene in Casal Ventoso (a Lisbon shanty town known at the time as Europe's drug supermarket), where up to 5,000 people would gather daily to buy and consume heroin and cocaine. Photos of Casal Ventoso shacks - cobbled together from car crates, plastic sheeting and rusty tin - adorn Ares Do Pinhal's office walls. These gritty images tell a story of a time before drug policy reforms, OST programmes, or coordinated drug treatment services. Belo recalls there were close to a thousand souls squatting there and there was little she could do except hand out food and clothing or treat abscesses and skin diseases.

Casa Ventoso in the old days

Psychiatrist and Clinical Director, Dr Rodrigo Coutinho, was a young intern in a Lisbon general hospital when in 1987 he and other colleagues were asked to create a Ministry of Health-run additions treatment centre. Addiction treatment centres were practically non-existent at the time (only three nationwide). Rather than being run by the Health Department, they were administered exclusively by the Department of Justice. In the early days of addiction treatment, the only option for opiate addicts in Portugal was detox and abstinence. Coutinho remembers clients' relapse rates being 80% or higher during this period and, in some cases, those relapses resulted in death.

Dr Rodrigo Coutinho and Hugo Faria

Hearing stories such as these of the dark old days prior to adequate treatment services and policy reforms, it's easy to see why veterans such as Belo and Coutinho are such true believers in OST.

Internationally, the success of Portugal's drug policy reforms and enlightened addiction treatment services is a story presented through a lens that highlights measurable 'macro' societal outcomes at the expense of hidden microscopic impacts on those living addicted lives and those who love them. Graphs and pie charts highlighting the statistically positive outcomes of decriminalisation and harm reduction do little to inform readers of the daily realities of OST for the Paolos of this world. I think also of the young man receiving his first dose earlier today and I wonder where his journey leads from here.

It is with these thoughts on my mind that I ask my next question - what percentage of low threshold clients express a desire to count down and eventually discontinue OST? When I put this to Coutinho a brief look of discomfort passes across his face before he responds that all Portuguese addiction treatment services are client-led and that OST in Portugal is essentially a two-tiered system. What the client wants the client gets - period. The low threshold programme places no expectations on its clients to discontinue the use of any drugs. Coutinho views low threshold as a pragmatic approach to monitoring the personal health of an otherwise hard to reach population with a view to improve public health overall. Its main goal, he explains, is not to stop consumption of drugs but to stop their associated societal harms. Interestingly, low threshold OST programmes will only dispense methadone to their clients, alternative opiate substitutes such as Buprenorphine are not made available in low threshold programmes.

High threshold OST programmes come with some negotiated expectations for clients while on the programme. This can include agreements that other drugs are not to be consumed, mandatory engagement with appropriate health care providers, participation in an outpatient treatment programmes or residing within a therapeutic community - some of which are 12 step (have abstinence as a goal), where lengths of stay can be up to 18 months. Nationwide, Portugal has around 3,000 beds in therapeutic communities. Coutinho states that the no strings attached policy of the low threshold programme is the more popular of the two-tiered OST system (in Lisbon low threshold clients number 1,200 whereas high threshold recipients are less than 900).

So, what can OST programmes in New Zealand learn from Portugal? Allen and Clarke is currently undertaking some research commissioned by dapaanz to find out how OST consumers (or consumers who have recently exited OST) perceive the service they received. Preliminary findings of this qualitative research (a small sample from three services) found those who had exited OST programmes (five in total) all found exiting a challenging process. Participants stated that the message they received from OST staff was that the most appropriate course of action was to remain on the programme indefinitely - that coming off OST had few benefits and was unlikely to be successful. This stance seems at odds with Ministry of Health guidelines for OST practice that, "...strongly endorse a path that moves away from a maintenance-treatment model and towards client-led, recovery-focused treatment." (Ministry of Health. 2014. New Zealand Practice Guidelines for Opioid Substitution Treatment. Wellington: Ministry of Health).

Inadequate acknowledgment, encouragement and a lack of any real tangible support for clients seeking pathways leading away from maintenance fails to adhere to best practise guidelines. Services that discourage and ignore the wishes of their client's treatment goals are withholding the dignity and respect the recipients of health care in New Zealand deserve. Portugal's two-tiered OST programmes make access to maintenance treatment an incredibly easy 'no-strings attached' process. However, it is worthwhile noting that of the 2,100 clients receiving OST in Lisbon, 900 have voluntarily entered the high threshold programme, which operates with client-led expectations of recovery. The Portuguese two-tiered model actively supports OST client aspirations through service provision and infrastructure and, in doing so, provides clients with clear aspirational pathways. Kiwi OST recipients deserve no less.

The 4K Model: Cultural Competency and Working with Māori

By Maynard Gilgen

Kōrero

"Ko te kai a te rangaitira, he kōrero"[1]

Kia ora (greetings)

In 1984 my friend, Naida Glavish, was rebuked and on the verge of being sacked for saying those Māori words of greeting, as an Auckland toll operator. Although she contemplated taking her "medicine", so to speak, the response she received from her departed kuia as she was driving across the Auckland Harbour Bridge was, "Nui ake tēnei take i a koe" ("This is far greater than you"). Like most of us, her first reaction was to dismiss this kōrero (talk) coming from the other side and blame it on the wind coming through an opened car window. But after winding the window up, she again heard her deceased kuia repeat her message to her. The rest is history.[2] As Naida says, the matter went all the way to the top and Prime Minister Muldoon's response to it was simply to say that as far as he was concerned she could say "*...kee ora. Just as long as she doesn't wanna say Gidday Blue*"[3], and that was the end of that.

This story introduces my next kaupapa of the K4 model, the word Kōrero.

This kaupapa is an introduction to the fundamentals of what this term means and represents. It includes:

1. What is kōrero?
   - Definitions.
   - Context and background.
2. How can kōrero help us in working with tangata whai ora (clients) and whānau Māori in our mahi (clinical work)?

1. What is kōrero?

Definitions:

One definition states that kōrero (verb) (-hia,-ngia,-tia) means:[4]

1. v. To tell, say, speak, read, talk, address.

As a noun,

2. n. speech, narrative, story, news, account, discussion, conversation, discourse, statement, information.

Barlow[5], opened his section on "Reo Māori" (Māori language) stating,

> *"Ko te reo te waka hei kawa i ngā whakaaro, tikanga, hiahia, tūmanako nawe, hītori, karakia, wawata, mātauranga, me ērā atu mea o te tangata. E kī nei tētahi, kāhore he mana o te iwi, mena ka ngaro o te reo.*
>
> *Nō reira, ko te reo Māori he reo tapu i homai e ngā atua ki ngā tūpuna, mā taua reo anō ka whakaatungia te hinengaro me te mana atua ki a rātou. He ihi tō te reo, he mana tō te reo, he tapu tō te reo. He wairua tō te reo, he mauri tō te reo. Mā te wairua ka rangona te reo, mā te mauri ka mana ai te reo..."*[6]
>
> *"Language is the vehicle by which thoughts, customs, desires, hopes, frustrations, history, mythology, prayers, dreams, and knowledge are communicated from one person to another. It has been said that a people without a language have no power or unique identity.*
>
> *According to Māori their language is sacred because it was given to their ancestors by the gods and it is by language that the Māori are able to know the will and mind and power of the gods. Language has a life force, a power, and a living vitality. Language has a spirit and also a mauri (that gives it its unique structure and function)..." (p. 114).*[7]

Therefore, Māori believe that their language was given to them by the Atua (Gods). The kaumātua, Eruera Stirling, upheld this idea when he said,

> *"...always remember your ancestors and the Māori way of life or you'll be nobody! Your mana comes down the descent line as a gift of power from Io-matua-kore, Tāne-nui-ā-rangi, Tū-matauenga and the lesser gods, and as a blessing from our father in heaven; it gives you the power to talk, the power to stand up at the marae, the power to deal with anything...If you don't have the mana or spiritual power, though, it doesn't matter how many degrees you've got, you'll go nowhere."*[8]

Context and Background:

Te Kaupunga Dewes stated,

> *"This language [te reo Māori] is still the most essential feature of Māori culture, which as a way of life continues to be dynamic. Oral proficiency in Māori should be the basic aim and should permeate*

1 "The food of chiefs is language".

2 Glavish, N. (2017). Naida Glavish: She wouldn't comply. In Wilson and Misa (Eds) (2017) The Best of E-Tangata. Wellington: Bridget Williams Books Ltd. (P.18).

3 Ibid, P.19.

4 Moorfield, J. C. (2012). Te whanake, Te Aka, Māori-English, English-Māori Dictionary and Index. Auckland: Pearson, p.64.

5 Barlow, C. (1991). Tikanga whakaaro: Key concepts in Māori culture. Auckland, Oxford University Press.

6 Ibid, p.112.

7 Ibid, p. 114.

8 Stirling, E, & Salmond, A. (1980). Eruera: The teachings of a Māori elder. Auckland: Oxford University Press. (P. 205).

all language and literature courses, because the bulk of our literature (history and music) is oral... Māori who are well grounded in their own culture, inclusive of Māori language, are more likely to do well and find a satisfactory lifestyle than those who are not. Their knowledge stimulates pride of race, self-respect and confidence".[9]

Mead[10] highlighted that although there are fewer people now who are "quite knowledgeable"[11],

"...the vast majority know little about the subject [tikanga Māori] and there are reasons why this so. Active suppression by agencies of the Crown over the last century is one reason. Another is the conversion to Christianity and its accompanying repudiation of culture. Another more obvious one was the general belief among both politicians and educationalists that progress and development meant turning away from Māori culture and accepting only 'proper knowledge' from the western world. Some of that sort of negative thinking is still present today."[12]

Naida's experience in the mid-1980s and Hinewehi Mohi's decision to sing the national anthem in te reo Māori at the Rugby World Cup in Twickenham, 1999, again showed how racism exists in Aotearoa. The backlash against Hinewehi, like Naida, was significant to the point. Many years later, Mohi is still hurt by the controversy.

"It is easy to get into a cocoon of thinking that everyone thinks our language and culture is fantastic and want to share it, but unfortunately it's not the reality," says Mohi. "There was very vocal opposition to the singing of the national anthem in Māori and I was really hurt by that. It has taken me most of the last 16 years to recover."[13]

In my last Bulletin article on Kaumātua[13] I gave a brief overview of te reo Māori and tikanga that gives some insights into how racism and violence was used to belittle the mana of te reo Māori and tikanga. If you want to explore this kaupapa (framework) in greater depth, especially focusing on what steps and actions Māori have taken to address te reo Māori, I refer you to Winitana's[14] and Anderson, Binney, and Harris' publications.[15]

This year is the 45th anniversary of the Māori Language Petition being presented to Parliament, and the emergence of Kohanga Reo and the reo Māori claim in 1985 that kicked off the Māori language renaissance.[16] The fight for te reo Māori to be recognised and used has been hard, gruelling, challenging and is ongoing. Only last week, Don Brash on the AM Show[17] again belittled the relevance of learning te reo Māori, but on this occasion he was challenged by the hosts of the show. While the same issues that Naida Glavish faced in 1984 still exist there is now far more tolerance and acceptance of te reo Māori as being a taonga belonging to all New Zealanders.

2. How can kōrero help us in working with tangata whai ora (clients) & whānau Māori in our mahi (clinical work)?

The initial aim of any counselling, psychotherapy and/or providing a psychological intervention is to develop rapport[18,19] with your tangata whai ora so kōrero can occur that can assist them to whakamana their whānau and them. Ironically, whenever I say what would any of us do if we go to work as counsellors, psychotherapists, or psychologists in Japan, the following comes to mind:

- Learn to speak and attempt to pronounce Japanese correctly.
- Consult with other counsellors, psychotherapists and psychologists about the ways Japanese greet, meet and communicate with each other.
- Learn about Japanese history, culture, religions, views and beliefs.
- What knowledge and behaviours do I need to be aware of so I am not disrespectful to my Japanese tangata whai ora and their whānau?
- Learn what counselling, psychotherapeutic and psychological models and frameworks work best for Japanese tangata whai ora and their whānau.

Yet, when looking at the bulk of therapeutic literature on counselling, psychotherapeutic and psychological treatment models and the main themes of tertiary courses in Aotearoa, very few of these programmes have the following:

- Staff and clinicians who are fluent in te reo Māori and tikanga and teach in a bilingual and bicultural way.
- Know how to greet, meet and communicate with tangata whai ora Māori and their whānau appropriately (formally and informally).
- Know Māori history, culture, religions, views, and beliefs,
- Have a close relationship with the tangata whenua and use local marae on a regular basis when working with tangata whai ora Māori and whānau.
- Are learned and fluid in Māori psychological models and frameworks.[20]

When examining Pākehā who went on to develop intimate and positive working relationships with Māori, such as Sister Suzanne Aubert[21], Jock McEwan[22], Michael

9 Dewes, T. (1975). The case for oral arts. In King (Ed) Te ao hurihuri: The world moves on. Auckland: Longman Paul. (P. 47).

10 Mead. H.M. (2003). Tikanga Māori: living by Māori values. Wellington: Huia Publishers.

11 Ibid, P. 2.

12 Ibid, pp. 2-3.

13 Gilgen, M.E. (2017). The 4K model: Cultural competency and working with Māori. Bulletin, Vol 16, No. 7, April 2017. http://www.dapaanz.org.nz/vdb/document/75

14 Winitana, C. (2011). My language, my inspiration. Wellington: Huia Publishers and Te Taura Whiri i te Reo.

15 Anderson, A, Binney, J., & Harris, A. (2014). Tangata whenua: An illustrated history. Wellington: Bridget Williams Books.

16 Winitana, C. (2011).

17 Bracewell-Worrall, A. (2017). 'We had a duty' – Auckland Grammar on introducing complulsory te reo Māori. Retrieved from http://www.newshub.co.nz/home/new-zealand/2017/07/we-had-a-duty-auckland-grammar-on-introducing-compulsory-te-reo-m-ori.html.

18 Castonguay, L.G., Constantino, M.J., & Holtforth, M.G. (2006). The working alliance: Where are we and where should we go? Psychotherapy: Theory, Research and Practice, 43, 271-179.

19 Norcross, J. (2010). The therapeutic relationship. In Duncan, B.L., Scott, D.M., Wampold, B.E., & Hubble, M.A. (Eds.). The heart and soul of change. (2nd ed.) pp. 113-142. London: American Psychological Association.

20 Levy, M.P. (2007). Indigenous psychology in Aotearoa: Realising Māori aspirations. (Doctor of Philospohy), Univeristy of Waikato, Hamilton, NZ.

King[23], and Joan Metge[24], there are common themes that can assist those of us who have had limited experience with Māori and te ao Māori (the Māori world) from their experiences that can provide us with examples we can apply in our own lives.

Tīmatanga - Introduction

Sister Suzanne Aubert's entry into te ao Māori was as a consequence of her becoming a Catholic nun with the purpose of coming from France to bring and share her faith with the people of Aotearoa, in particular, Māori. Hence, she boarded the Général Teste and came here with Bishop Pompallier and 23 of her colleagues in 1860.[25]

Jock McEwan reported that his entry into te ao Māori was as a consequence of his father becoming the headmaster of Taonui School at Aorangi.[26] Consequently, he attended a school where 40% of the pupils were Māori in 1920.[27]

Michael King reported that, although he'd grown up knowing some Māori families and individuals, it wasn't until he began working for the Hamilton Waikato Times in 1968 that he began being exposed to Māori issues and experiences.[28]

Joan Metge described growing up with teacher parents who taught in "small rural towns" and began developing her understanding of te ao Māori through Māori friends and their whānau.[29] Consequently, when she became qualified in the 1950s as a social anthropologist and connected with Māori mentors she began researching Māori living in Auckland city compared to my (the author's) wife's whānau and hapū who resided in Ahipara, Northland.[30]

Kōrero te Reo Māori - Speak Māori

Sister Suzanne Aubert's began learning te reo Māori as she travelled on the Général Teste to Aotearoa in 1860. This was because Bishop Pompallier

> *"was firm about the importance of knowing their language. To know the language was to know them [Māori] better: "Knowing something of a foreign language can sometimes give an educated and perceptive man certain insights into the nature of peoples, the origin of their race and their intellectual and moral capacities". Pompallier considered himself a good linguist and saw this as a simple prerequisite."*[31]

Sister Suzanne Aubert went on to write a Māori-French phrase book for Father Soulas[32], worked on an English-Māori dictionary[33], and wrote a Māori-English phrase

21 Munro, J. (1996). The story of Suzanne Aubert. Auckland: Auckland University Press & Bridget Williams Books.
22 McEwan, M. (2016). Te oka – Pākehā kaumātua: The life of Jock McEwan. Wellington: Reviresco Trust.
23 King, M. (1999). Being Pākehā now: Reflections and Recollections of a White nation. Auckland: Penguin Books.
24 Metge, J. (2015). Tauira: Māori methods of learning and teaching. Auckland: Auckland University Press
25 Munro, J. (1996), p.53.
26 McEwan, M. (2016), p.9.
27 Ibid.
28 King, M. (1999), p.75.
29 Metge, J. (2015), p.1.
30 Ibid.
31 Munro, J. (1996), p.63.
32 Ibid, p. 159.
33 Ibid, p. 160.

book in 1885.[34] Knowing how to kōrero te reo Māori and having an understanding of tikanga Māori, according to Sister Suzanne Aubert, came with the job.

Although Jock began learning te reo Māori from Māori schoolmates, he really began learning te reo Māori from kaumātua at the Aorangi marae, which was 200 meters down the road from his school.[35] He reported that these kaumātua would gently correct his mistakes, as opposed to pointing out where he'd gone wrong.[36]

Michael King said that as he was assigned by the Waikato Times to do the 'Māori' round within weeks of joining the newspaper in the late 1960s he suddenly found himself attending hui and tangi in the weekends and quickly discovered that these occasions were normally done in te reo Māori and he couldn't understand the kōrero, not a word.[37] He described it as being a "culture shock", which he soon remedied by enrolling in a te reo Māori class, reading books, such as Tainui by Leslie Kelly and seeking out people who could help him.[38]

Joan Metge also began learning te reo Māori as she began doing her initial research on Māori migration from rural (Ahipara) to urban centres (Auckland).[39] My wife's whanaunga, John Snowden, remembered her kōrero i te reo Māori (speaking Māori) with his uncle Simon Snowden, his father and other whānau members when she lived with their whānau in Ahipara.[40]

Kaumātua - Mentors, Elders

Sister Suzanne Aubert had many mentors and kaumātua throughout her time with Māori in the areas she served. This included being initially mentored by Bishop Pompallier, himself, in te reo Māori and tikanga Māori.[41] Another significant mentor in all things Māori, was "Hoke" (Hoki), known also as Peata.[42] Besides being very committed to the church she was also a whanaunga (relative) of a rangatira (chief) of Ngāpuhi, Rewa.[43] Wherever Sister Suzanne Aubert went she quickly developed close intimate relationships not only with kuia (elderly women), kaumātua (elderly men), rangatira, and whānau, hapū and iwi Māori but with all people she came in contact with, regardless of their faith, race or position.[44] In particular, she is still known for her mahi aroha (labour of love) with the iwi of the Whanganui River and continues to be revered on their awa (river) to this day.[45]

Jock McEwan also had a range of mentors in his life. Besides learning from the kuia and kaumātua at Aorangi marae he was also encouraged by his father and several uncles and great-uncles who also spoke te reo Māori.[46] He was

34 Ibid, p. 160.
35 McEwan, M. (2016), p.9.
36 Ibdid, p. 9.
37 King, M. (1999), p. 76.
38 Ibid, p. 77.
39 Metge, J. (1995). New growth from old: The whānau in the modern world. Wellington: Victoria Universty Press.
40 John Snowden, personal communication, 22 July 2017.
41 Munro, J. (1996), p.64.
41 Ibid, p.83.
42 Ibid.
43 Ibid.
44 Munro, J. (1996), pp. 3-4.
45 Boy Thomson, personal communication, 28 April 200746 McEwan, M. (2016), p.9.
47 Ibid, p.27.
48 Ibid, p.28.
49 McEwan, M. (2016).
50 Metge, J. (2015).
51 Metge, J. (2010). Tuamaka: The challenge of difference in Aotearoa. Auckland: Auckland University Press.
52 Metge, J. (2004). Rautahi: The Māori of New Zealand. United Kingdom: Routledge.
53 Metge, J. (2001). Kōrero tahi: Talking together. Auckland: Auckland Univeristy Press.
54 Metge, J. (1995).

further mentored by the likes of Kīngi Tahiwi, who was a senior staff member and chief interpreter for the Native Department, who Jock worked for. He went on to develop a friendship and was mentored by Apirana Ngata[47] as well as being mentored in whakairo Māori (Māori carving) by a tohunga whakairo (master carver) Pine Taiapa[48].

Michael King described being mentored and learning about tikanga Māori from a wide range of kaumātua and kuia, such as Te Uira Manihera (spokesman at the time to Te Ātairangikahu, Māori Queen), Heeni Wharemaru, Piri Poutapu, Wetere and Emily Paki, Hori Paki, Pei Te Hurunui Jones, Winara Samuels, Herepo Rongo, Eva Rikard, Ngakahikatea, Rangi Ruri, Tumokai Katipa, Wi Huata, Paraire Herewini, Pine Taiapa, John Rangihau, Mohi Wharepouri, Harry Dansey, Whina Cooper, and others.

Joan Metge, likewise described having many kuia and kaumātua Māori who she learnt te reo Māori and tikanga from, such as Atama Nikora, Hineari Babbington, Wiremu Hohaia, Elizabeth Hunkin, Keri Kaa, Jossie and Wiremu Kaa, Priscilla Manukau, Maori Marsden, Joe and Violet Matete, George Parekowhai, Rose Pere, Ani Pihema, Hone and Lena Pirihi, Hapi Potae, Haimona Snowden, Amster Reedy, June Tangaere, August Tangaere, Ephriam and Harriet Te Paa, Tawhao Te Tioke, Haare Williams, Sonny Wilson, and others.

Te ao Māori – The Māori World

When we explore Pākehā who dared to enter te ao Māori, we quickly discover that on their hikoi (journey) they all:

- developed a moderate to high degree of fluency in te reo Māori and understanding of tikanga Māori
- learnt how to greet, meet and communicate with Māori and their whānau, hapū and in some circumstances, iwi
- learnt about Māori history, religions, whakapapa, and the varied views, and beliefs they have
- developed close intimate relationship with both the tangata whenua and urban Māori, enabling them to kōrero and work with them on their marae and in other settings
- learnt about Māori psychological models, philosophies and frameworks

Consequently, all these Pākehā are respected for their manaakitanga of the whānau, hapū and iwi Māori they built relationships with and also what they gave to them as well.

As stated, Sister Suzanne Aubert continues to be revered for all the mahi aroha (labour of love) she contributed to Māori and Pākehā communities from the 1860s to the 1890s. She was not only bilingual, she was multi-lingual (French, Spanish, Māori English), and showed what could happen for those in our communities, especially the most vulnerable who are impoverished, homeless, and have problems in their life, whether it be, addictions, mental health and/or other problems. The most incredible thing about her is that the work she initiated over a hundred years ago continues today.

Jock McEwan, likewise, learnt to be in kaupapa Māori situations without feeling threatened or insecure because of his decision to learn te reo and tikanga Māori. He also became a tohunga whakairo in his own right. He was never patronising and was just as quick to help out in the back or to sit on the paepae (orators' bench) if needed. He also gave back to Māori on many levels. For example, he supported Apirana Ngata when he worked for the Native Affairs Department, was one of the founding members of Ngāti Pōneke, was the president of the Polynesian Society Council for 21 years, played a lead role in revising the Māori dictionary, supported Orongomai marae, was the lead tohunga whakairo for inmates at Rimutaka Prison, and master minded the carving of marae and buildings throughout the lower North Island.[49]

Michael King became well known as a New Zealand author, especially for books he wrote on rangatira and kaumātua Māori. Although he was aware that he was a Pākehā writing about Māori he knew how important it was to have the tools to establish close intimate relationships with those he wrote about and their whānau, hapū and iwi. His work continues to be cited on a regular basis today, especially if the kaupapa is about Māori.

Joan Metge, likewise, developed strong intimate relationships with Māori throughout the motu (country), particularly with Te Rarawa, my wife's iwi in the North, as she'd spent 14 years living, learning, and working among them. She's also given back to Māori and New Zealand through the publications she's written.[50, 51, 52, 53, 54,]

Whakamutunga (conclusion)

If we, as practitioners, want to improve our ability to 'kōrero' in a manner that is going to be purposeful and mana enhancing for Māori, then we need to look at a pathway that can help us develop the appropriate skills, knowledge and experience that can do this. I purposely used well known New Zealand Pākehā who chose to move into te ao Māori to provide a glimpse of what they did to enter, engage and embrace whānau, hapū and iwi Māori. Should you want to develop your ability to kōrero and be 'client' and 'whānau' focused with Māori, this can be achieved, but like the above rangatira stories, this requires engaging in a process, takes time and practice and requires having close relationships with Māori. What is also important to remember is that these luminaries also started off with small steps, just like us.

Kia ora

Maynard Gilgen

Election for 2017-19 Board – *See profiles and election feature, Pg 16*

It's time to vote for the 8 nominees you think will best represent your interests on the 2017-2019 Board. We encourage you to have a read over each of the 31 nominee profiles in this edition of the bulletin (you can find them at the back, after the Notice Board), they are also profiled on the dapaanz website under the member pages tab. Scan and email your voting paper to office@dapaanz.org.nz, or fax to 04 499 3216, or post to PO Box 25283, Featherston Street, Wellington 6146, by no later than Wednesday 6 September.

2017-2019 Board ratified at AGM 10.30 am 27 September 2017

You are warmly invited to attend the dapaanz AGM. The new board will be ratified at this AGM held 27 September at Heartland Hotel, 14 Airpark Drive, Mangere (close to airport), Auckland.

With Cutting Edge just around the corner, we are preparing for what we know will be an unbelievable few days at Te Papa. We have a strong line up of international and local speakers (you can get a taster for some these below). The programme this year is outstanding. We are excited to announce that we have just secured a keynote who will talk on a personal and professional level on the newly funded treatments for Hepatitis C.

We have also received a lot of outstanding and diverse abstracts - the best posters of the day will be offered a two-minute oral presentation plenary slot.

Cutting Edge is a fantastic opportunity to connect with others in the sector and to grow in understanding of current issues and models of practice to enrich your mahi while earning CPD points. It is your chance to be reinvigorated, challenged and affirmed in the great mahi you do.

Awards Nominations

We want to validate excellence in the addiction sector. Please nominate staff or colleagues for the awards listed below. Nominations close Monday, August 14

- dapaanz excellence in contribution to addiction practice award
- dapaanz excellence in peer support award
- dapaanz newcomer award

For more information go to the Oscarz page at cuttingedge.org.nz

Oscarz Awards Dinner

We really want to encourage you to register for the Oscarz Awards dinner. The Oscarz is an evening where we come together to celebrate and award excellence in addiction practice. This year we have extended the awards to include 'Excellence in Peer Support' and 'Excellent Contribution to Addiction Practice'. There is also the dapaanz 'Newcomer', 'Best Abstract' and 'Best Poster' awards. Matua Raki will be awarding 'Emerging Researcher' and Workforce Innovation' awards.

There will also be excellent entertainment with Unity Wara providing the music and Owen Pomana sharing his incredibly inspiring and funny story, make sure you don't miss out on this fabulous evening!

Osarz Awards Dinner Tickets

Member:	$55
Non-member:	$80

Make sure you register for the Oscarz Awards Dinner when registering for Cutting Edge!

For more info go to www.cuttingedge.org.nz

Workforce Development

The School of Addiction (SOA) has been a real icon for dapaanz, however, you asked us for more opportunities for professional development in the regions and we have listened to your request. We have therefore moved resources into providing more localised workshops. Over the past 11 months we've held 12 regional workshops and

Keynote Speakers


Harry Tam


Jeanette Grace


Dr Arthur C Evans


Justice Mata Keli Tuatagaloa


Dr Seema Clifasefi


David Hanna


Rachael Stace


Dr Jamie Berry

have had a total of 175 attendees, and we have a further two workshops scheduled for November. This is almost triple the 60 attendees at the last SOA. We are really chuffed to see more of you accessing dapaanz training opportunities.

Regional Workshops

We have two transactional analysis workshops facilitated by John Savage coming up in November (Auckland and Dunedin).

If you have a specific training need in your region and think around 15 people would be interested in attending in 2018 please email office@dapaanz.org.nz with Regional Workshop in the subject line.

Earn 30CPD points

- Auckland, Tuesday, November 7
- Dunedin, Tuesday, November 28

Register for workshops via the Events Calendar at www.dapaanz.org.nz

Member Profiles

You can now view your join date and renewal date when you log into your personal profile. We also want to remind you to update your contact details, if these are out of date you will be missing out on important information such as invoices, renewal reminders, or from receiving our other communications. To update your details, you:

1. Go to the 'login' button in the top right corner of the dapaanz website
2. Enter your email address and password and update your info
3. If you cannot remember your password, click on 'forgot your password'
4. Enter your email address in the box and click 'submit'
5. You will be emailed a new login link to follow to reset your password

If you are still having trouble logging in or if you never set up your login, please contact us at the office on 04 499 3083 or registrar@dapaanz.org.

Scoping AOD peer workforce career progression pathway

We are very excited that Matua Raki has supported dapaanz to undertake work to scope AOD peer support career progression pathways. Paula Parsonage has been commissioned to do this work.

Aim

The key aim of the scoping exercise is to identify how dapaanz could best support the peer workforce career progression pathway.

Background

Dapaanz will undertake a scoping exercise to explore options for supporting an AOD peer workforce careers progression pathway. Such a pathway has the potential to:

- Enable greater accountability
- Provide clear benchmarks of skills and experience
- Support training providers to develop relevant training options
- Support employers to feel more confident about creating and recruiting to positions for peers
- Create an acknowledged and valued career development pathway for the peer workforce.

Deliverable

The key deliverable is a report which outlines the options for developing a career progression pathway for the peer workforce, the implications of these options for the workforce and for dapaanz and a summary of the views of key sector stakeholders. The report will provide the basis for dapaanz to determine a way forward in supporting the AOD peer workforce.

Timeframe

The timeframe for completion is 30 November 2017.

How the board operates

The dapaanz Board provides strategic governance for dapaanz. There are also significant operational activities undertaken by sub-committees outside of Board meetings. One example in 2016, is the Education Subcommittee's review of 18 addiction-specific courses to assess whether they covered the dapaanz competencies and so could be listed on the website as meeting qualification requirements for registration.

Board members are expected to exemplify the values and principles expounded in the Code of Ethics, and Practitioners on the Board are expected to abide by best practice principles and be fully competent in their practice.

Te Tiriti o Waitangi

We are committed to Te Tiriti o Waitangi. Our objective is that rangatiratanga permeates the operation and delivery of the dapaanz business. To achieve this:

- we seek to actively protect the interests of Tangata Whenua/Māori and Te Tirit o Waitangi
- the duty of dapaanz is not passive but is active protection of Māori people in the use of their Taonga 'to the fullest extent practicable'
- we seek to make informed decisions
- in order to act reasonably and in good faith, dapaanz will make sure it is informed in decisions relating to Tangata Whenua
- dapaanz will ensure Māori participation and understanding of tikanga Māori on the Practice Standards Committee and in making all critical decisions
- the Pou Whakarae role will be a voting member of the dapaanz board (this person will be put forward by Māori caucus – not an elected member)
- we ensure that the role of Pou Whakarae and voice of Māori are protected in the Constitution
- we seek to review our responsiveness to Tiriti o Waitangi every two years
- we promote cultural fluency to our members through CPD and the recognition that cultural competency (including te reo) as of equal importance to clinical competency

Check out the TOW background paper after the nominee profiles.

Nominee Profiles

Tommy Benefield

Employer: Corrections

Job title: Principal Adviser – Alcohol and Drugs

Membership status: Registered Practitioner

Nominated by: John Savage

Biography:

I have worked in the AOD sector within Ngo's and DHB's for the last 16 years as a clinician, a Supervisor, an AOD Specialist within Severe Mental Health teams, a Clinical Director, a General Manager, and now as the Principal Advisor for the Department of Corrections.

I am standing because:

I care deeply about the people of Aotearoa and through my AOD experience and expertise seek to make a meaningful difference to communities. In my new role, I have the responsibility for creating Corrections AOD policy, program development and design, and overseeing the extensive contracting of providers.

I would like to be part of this group partly for what I believe I can contribute with 16 years diverse professional experience in the AOD industry and partly for what I can learn and use to make increasingly current and informed decisions within my role.

Matthew Bird

Employer: The Salvation Army

Job title: Caseworker

Membership status: Registered Practitioner

Nominated by: Self

Seconded by: Malcolm McSporran

Biography:

Matt entered the addictions workforce in 2008 and currently works as a caseworker for the Salvation Army Bridge Programme, Auckland. He is passionate about the addictions sector, ongoing development for practitioners, and enhancing outcomes for individuals, whānau, and the community. Matt is also a Registered Practitioner.

I am standing because:

My passion for the addiction sector grew from my personal experiences of addiction and mental health challenges, and addiction within my whānau. I have dedicated my career primarily to residential services, and have worked in a varied range of treatment settings. I have been fortunate enough to be surrounded by a number of mentors within the addictions workforce that have expanded my outlook on enhancing service delivery within our sector. I have an unrelenting passion for professional development, appropriate service

delivery, national policy implementation, access to care and recognition of the systemic issues that contribute to both addiction and recovery. I believe in our workforce and recognise that we still have a long way to go as a sector. I believe my lived experience and professional journey could provide a unique perspective on the board. I would be honoured by the opportunity to serve dapaanz and give back to the sector that I attribute much of my own recovery to.

Having entered recovery at a young age, I have witnessed the incredible potentials for recovery, yet recognise the numerous privileges that allowed for this to be possible. The longer I work in the sector the more I recognise the enormous disparities that hinder individuals accessing the care they need, and the systemic issues that prevent them from finding their own recovery. My hope is to work toward addressing these disparities and advocating for sustained national movement toward effective, accessible treatment and interventions for all those affected by addiction. While these are long-term, complex goals, I firmly believe they can be achieved by an organisation that advocates for development and change, and a sector that works collaboratively, assisting individuals, whānau, and wider communities to address the impacts of addiction in Aotearoa.

Thank you for your consideration and the opportunity to give back to our sector.

Ben Birks Ang

Employer: New Zealand Drug Foundation and Odyssey

Job title: National Youth Services Advisor

Membership status: Registered Practitioner / Accredited Supervisor / Current Board Member

Nominated by: Claire Aitken

Biography:

Ben grew up in rural Manawatu, before moving to South Auckland. He has extensive experience working with young people using drugs and alcohol and has lead the development of treatment and early intervention services for young people. This includes establishing and overseeing school-based, community, and residential drug and alcohol treatment programmes. He now works as the National Youth Services Adviser for the New Zealand Drug Foundation and Odyssey Trust, and is also the current Deputy Chair of dapaanz, the Addiction Practitioners Association of Aotearoa New Zealand.

Ben is passionate about empowering communities to create space for taiohi to grow and develop. He is excited to be leading a number of projects focused on building the capacity of our services, schools, and communities to really engage young people who use substances and also to support them to remain engaged in education.

Being of mixed ethnicity, he is particularly interested in supporting the strengthening of cultural identity and traditions, and also supporting younger generations to understand how they can both be proud of who they are and move confidently between different cultural worlds.

I am standing because:

- I believe that the experience I have gained as current Deputy Chair of dapaanz, and active involvement in many of the board's subcommittees, will support the Board to continue functioning well and moving in a positive strategic direction. I am particularly excited to support new Board members who would like to develop skills at governance level.
- Being based between a treatment organisation and policy/advocacy organisation, I bring a unique perspective about how our workforce can best support New Zealanders to reduce substance-related harm. This role also means that I am well positioned to support dapaanz to progress its activities.
- I believe that my experience working with young people and communities in a variety of settings (e.g. earlier intervention, community treatment, residential treatment) and providing training both for our workforce and for other sectors, such as primary care, enables me to understand and represent a range of perspectives within our dynamic and varied workforce.

Denise Blake

Employer: Te Kunenga ki Pūrehuroa / Massey University

Job title: Lecturer School of Psychology / Joint Centre for Disaster Research

Membership status: Standard

Nominated by: Self

Seconded by: Suzy Morrison

Biography:

Dr Denise Blake has engaged in the social justice sector as a consumer, health professional and researcher for over 20 years. She currently works at the Joint Centre for Disaster Research at Massey University, where her work in the social justice space informs her commitment to the welfare of vulnerable populations both within a disaster context and more generally. She argues that we must address the knowledge-practice gap for providers and end users, while valuing the intersubjective experience of both.

I am standing because:

I support, endorse and appreciate the kaupapa of dapaanz. That the addiction workforce has a professional association is important to the development and integrity of both people working in the addiction space and ultimately the clients. Governing

bodies such as dapaanz enable practitioners and researchers to be culturally responsive, ethical and accountable in their professional and personal lives. I believe I possess the skills, experience and capability to be a productive board member. I have served on

boards before and appreciate the way in which service roles, like this, enable me to engage in practical ways as an academic.

Mary Caffin

Employer: Higher Ground Rehabilitation Trust

Job title: Supervisor

Membership status: Standard Member

Nominated by: Rebekah Robinson

Biography:

I am studying at Auckland University and near completion of my BA in Sociology. With 7 years since recovery and 5 years employment at Higher Ground and the Phoenix Centre, I am grounded in my recovery and experienced at supporting others in both sponsorship and peer support roles. I am a qualified yoga teacher, a mother, and still have a sense of humour.

I am standing because:

I believe being on the dapaanz board would be a wonderful opportunity to become more actively involved as a positive advocate for recovery, to ensure New Zealanders get the best services possible, clinicians and peer support workers have complimentary trainings, long term supervision, and support to ensure a sustainable addictions sector. I have studied Māori and Pacifica papers and am committed to celebrating cultural diversity. Recovery is about healthy connections to others, I see a seat on the board as a means to unite people both within the sector and those searching for it.

Jo Cook

Employer: Otago Polytechnic

Job title: Kowhai Practice Manager

Membership status: Registered Practitioner / Accredited Clinical Supervisor

Nominated by: Self

Seconded by: Rachael Cape

Biography:

I originally come from Auckland and moved to Dunedin about 25 years ago. Most of my professional experience in AOD has involved primarily working alongside women. Last year I completed my Masters (Counselling) project which involved finding out the value of a community-based therapeutic group for women who use substances and have survived rape or sexual abuse; (I co-facilitated this group in partnership with Rape Crisis). Working particularly alongside women is something I greatly value and appreciate and 'where my heart is'. I aim to start my PHD this year and want to work in policy development in the AOD sector, which is my long-term goal. My current position is at Otago Polytechnic, Kowhai Practice Manager (a student training counselling service), and lecturer. I teach on and coordinate the Working with Addictions paper and primarily work (teach and provide supervision) in the counselling specialty of the Bachelor of Social Services.

I am standing because:

I have both personal and professional experience of the addiction sector. Even though I now identify as an AOD professional, I respect my past personal experience and believe my perspective could be valuable to this role. I value inclusiveness, participation and respect diversity. I am grateful for the opportunity to apply for this role.

Ruth Cooley

Employer: Virtue Health Care Education

Job title: Training Director

Membership status: Standard Member

Nominated by: Self

Seconded by: Kerry Henderson

Biography:

Hi, my name is Ruth Cooley from Palmerston North. I have been working in the Mental Health and Addictions sector for the past 15 years. I spent 5 years at A&OD for Midcentral Health and 3 and ½ years with MASH Trust A&D rehabilitation programme. I also have my masters in Nursing. I have now transitioned into Education and am working part-time for Massey University as a Tutor and Clinical Teaching Associate and part-time for Virtue Health Care Education as Training Director and Lead Facilitator. I am passionate about creating better outcomes for tāngata whai ora through education. I have a strong personal belief in moral integrity based on my Christian faith.

I am standing because:

Along with my professional experience and passion in this sector, I feel that I could be helpful as a member on the board. I would like to be involved in supporting and developing the Addiction workforce community and also learning how best I can be best effective in my own role.

Selina Elkington

Employer: He Waka Tapu

Job title: Clinical Co-ordinator Addictions Team

Membership status: Registered Practitioner / Accredited Supervisor / Current Board Member

Nominated by: Michelle Fowler

Biography:

Kia Ora Koutou Katoa

Ko Wetekia te maunga
Ko Whararikiki te awa
Ko Tainui te waka
Ko Whakatu te marae
Ko Ngati Koata raua ko Ngati Toa nga iwi
Ko Sam Elkington toku koro raua Ko Ester Hippolite toku kuia
Ko Jim Elkington toku papa raua ko Patricia McDermott toku mama
Ko Selina Elkington toku ignoa
Ko Hinekawa Elkington taku tamahine

Her mother's family is from the Winton/Invercargill area, with strong links back to Scotland and Ireland.

I am standing because:

Having a seat at the table of the dapaanz board is a privilege that I take seriously. I have been fortunate to be involved in many areas of the board duties, some included, competencies, policy, and strategic planning. The addiction sector is an area of health that is so vital to well-being, the people that work in this sector (US) deserve a robust, competent professional body to protect the people we work with and the members.

Rebecca Greig

Employer: Nelson Bays Primary Health

Job title: Mental Health Manager

Membership status: Standard Member

Nominated by: Mathew McMillan

Biography:

I work at Nelson Bays Primary Health, where I was originally employed in 2016 as the Youth Addiction Clinician. I moved into the Mental Health Manager role in January 2017 in an acting role and have recently been appointed a permanent contract for this position. I trained as a Social Worker and have worked in Mental Health and Addiction for 19 years for both the Nelson and Christchurch DHB's. I completed my Masters in 2015 studying the Mental Health and Addiction issues of the diners who attend the local community meal.

I am standing because:

I am passionate about giving the best to the people that we serve. I am driven by best practice and policy and want to be a part of a sector that ensures these are constantly being moved forward. The Addiction field is an exciting and ever-changing environment and dapaanz need to continue to strive for excellence.

Tina Harrison

Employer: CADS Auckland

Job title: Clinical Team Leader

Membership status: Registered Practitioner and Accredited Clinical Supervisor

Nominated by: Melanie Boortman

Biography:

Tina has a strong background and many years of experience in both leadership and clinical roles within the following areas:

- Co-existing problems
- Trauma counselling - including domestic violence and sexual trauma with both women and children
- Addictions
- Forensic AOD
- Cultural Māori – including whānau, tangata whai ora and rangatahi

Tina has worked in both co-existing residential treatment and community treatment services including as service team leader of Te Atea Marino the WDHB Māori Specialist AOD Service. Her current role is as team leader at CADS Auckland which encompasses the pilot programme for the drug court assessment team. Tina is a dapaanz Registered Practitioner and Accredited Clinical Supervisor.

I am standing because:

I would like to make a contribution to the ongoing development of the AOD field in NZ, ensuring that it is responsive to the needs of our diverse population.

At the same time, I feel it is vital to support our workforce by providing the resources required to maintain current through evidence based practise which is underpinned by a sense of professional satisfaction and workplace wellbeing.

Kevin Hollingsworth

Employer: Te Utuhina Manaakitanga, Rotorua

Job title: AOD Youth Clinician

Membership status: Registered Practitioner

Nominated by: Self

Seconded by: Shirly-Anne Rikiti

Biography:

Tenā kotou katoa, he mihi nui ki a kotou
Ko Motatau te maunga
Ko Akerama te Marae
Ko Hikurangi te Awa
Ko Nga puhi te Iwi
Ko Ngati Hine te Hapu
Ko Mataatua te Waka
Ko Rotorua ahau

Ko Ngongotaha ahau
Ko Kevin Wiremu Hollingsworth taku ingoa
Tenā kotou, tenā kotou, tenā kotou katoua.

While my whakapapa is from the North, I was born and raised among the Te Arawa Iwi in Rotorua. On my own journey of self-discovery, I have developed a passion for working with whānau who have addiction issues. With my own 'lived experience', I feel you can never stop learning when working with people. I want to contribute this to whānau wellbeing.

Brought up in a home with very strong tikanga principles, supports the way in which I would like to work with whānau e.g. Manaaki, respecting other people's values and beliefs and showing support with generosity. Whanaungatanga, respecting relationships through shared experiences. Guided by these principles and others, I would like to promote positive change and be a role model for my whānau. Nga mihi nui ki a koutou.

I am standing because:

I am a highly motivated, hardworking, and passionate Alcohol and Drug Clinician with proven abilities in supporting people in recovery while maintaining a high level of professionalism and integrity. My skills and abilities not only generate high levels of client engagement but model excellent service delivery while establishing and maintaining quality standards to achieve positive results. I want to contribute to driving positive change for those working in the addiction field and whānau who are affected by addiction.

Sandy Jackson-Donlan

Employer: Ashburton Community Alcohol and Drug Service (ACADS)

Job title: Clinical Team Leader

Membership status: Associate Practitioner / Accredited Clinical Supervisor

Nominated by: Self

Seconded by: Chris Levitt

Biography:

Woman, mother, wife, grandmother, mother in law, artist, person of all trades.

When human beings experience either their own addiction or live with the consequences of someone they love it is not uncommon for their lives to unravel. My great passion is to support healing through these experiences. I work with clients and that includes young people, individuals, and families find healthy perceptions of themselves that strengthen their relationships and make changes that enhance their wellbeing physically, emotionally, and spiritually.

I know that no single approach is the right one for every individual so I have trained in a number of modalities, and draw strongly from a Social Work background. I am a trained Supervisor and provide external supervision to a number of people from diverse backgrounds, as well as the provision of in-house team supervision. I love the diversity of working with individuals and the creative practise of providing and developing groups.

I believe in working in the community and creating good alliances with all other services. I am a panel member on the new Vulnerable Children's Team, and have served on the Care and Protection Resource Panel for the past 20 years. I have been a volunteer for Victim Support for 25 years with specific training in sexual abuse and family violence, and have roles in many other local committees. I am the clinical team leader of a small team of very special dedicated staff who are all as equally passionate as I am and a pleasure to work alongside.

Over the years I have been involved in the Hakatere Marae initially with the Kōhanga Reo when my youngest (who is now 25) was attending, he is of Ngāti Porou origin and then as he grew with the attendance of taiaha wānanga and other cultural events.

He is an avid rugby player and has played for the Canterbury Māori squad and in the past two years in the New Zealand Heartland team. My second eldest son has played basketball for New Zealand at representative levels and is now coaching, having just returned from a tournament coaching the Canterbury under 19 team. My only daughter lives in the North Island and is a long-haul flight attendant for Air New Zealand in her full-time job but is a part time actor on Shortland Street. My eldest son has resided in heaven since 1999, when at the age of 23 he died of an adult cot death, so my greatest gift in life has been the experience of being a mother and believe me my life is abundant for having each and every one of them in it.

I am standing because:

I believe in the work that AOD workers do, the complex nature of that work, the need to retain workers in this field, particularly in rural areas. I would like the voice of rural teams to be heard as I believe that we often work in more isolation due to the geographic nature of where we may be placed. I feel that training is essential to keep upskilled and would like to be involved in an exploration of how this takes place. Most of all I am passionate about the work we do and want to support in any way the continued professional development of the workforce.

Shilpa Kaushik

Employer: Salvation Army

Job title: Support Worker

Membership status: Standard Member

Nominated by: Self

Seconded by: Paul Schreuder

Biography:

I have completed a Masters in Psychology and worked as an Adolescent Health Counsellor in a public hospital in India. I recently completed a Graduate diploma in Drug, Alcohol and Addiction from WelTec and am currently working as a support worker in The Salvation Army Bridge Programme.

I am standing because:

I am passionate about working with people suffering from addiction.

Mike Kilioni

Employer: Independent Practitioner

Job title: AOD Practitioner

Membership status: Registered Practitioner / Accredited Clinical Supervisor

Nominated by: Rosemary Casey

Biography:

Hello, I live in Wellington with my partner and two teenage children. I've been working in the addiction and mental health field for the past 15 years. I'm registered with dapaanz as a Registered AOD Practitioner and Accredited Clinical Supervisor. I've had extensive experience working within hospital settings including the Regional Forensic and Rehabilitation Service in Porirua (Te Korowai Whāriki) and at the Acute Inpatient Ward at Wellington Hospital. I've run several groups within the community and for the Probation Service and currently deliver a contract with the Ministry of Justice in Wellington. I'm also a contract auditor with Central Technical Arm Services (TAS) and conduct provider audits including addiction services for most of the DHBs throughout the country. I'm a founding member of Drua, the Pacific Addictions Network and currently a member of the Pacific Advisory Group for the Health Promotion Agency (HPA).

I am standing because:

I believe that I can support dapaanz and its membership by sharing my experiences from what I've seen and learnt through my work. I would like to be a part of further promoting dapaanz as a signifier of confidence in practitioners. With the possibility of legislative reform, I would also like to represent fellow members in our push to ensure better funding and support for addiction treatment services.

Sonja Maher

Employer: Phoenix Centre

Job title: AOD Clinician

Membership status: Registered Practitioner

Nominated by: Supriya Maharaj

Biography:

I am a 53 year old Pākehā woman. I am married and have a 14yr old daughter and 8year old son. I started work as an AOD Counsellor in 1998. I have worked in the field of Addictions in Perth, Australia, London, UK, North and South Carolina, USA and in New Zealand. After travelling for 20 years we returned to live in NZ and raise our children.

I am standing because:

I am passionate about my sector. I wish to contribute in raising dapaanz profile and to assist in the continuing growth of dapaanz by providing its members with the best organisation it can be. I believe I can offer fresh insights and global expertise to help achieve this.

Maree Matthews

Employer: Higher Ground Rehabilitation Trust

Job title: Community Manager

Membership status: Registered Practitioner

Nominated by: Self

Seconded by: Johnny Dow

Biography:

I have worked in the addictions field for the last 7 years. I am employed at Higher Ground Rehabilitation Trust. I have worked in various roles in the organisation and progressed into management of the Community Team who work with tangata whaiora and their whānau both pre and post treatment. I have a Bachelor of Counselling, Certificate in Clinical Supervision, and am a Registered Practitioner with dapaanz. I have my own lived experience of the Justice System and recovery. I live in Riverhead, Auckland, am married and have one teenage daughter.

I am standing because:

I would relish the opportunity to work alongside others in upholding the professionalism of the industry to a high standard. I am passionate about the addiction sector and creating opportunities for education and upskilling others. I have a strong interest and experience in Justice work as it is becoming increasingly ingrained into some aspects of the industry.

Rachael Moore

Employer: Private Practice

Job title: AOD Counsellor/ Group Facilitator

Membership status: Provisional Practitioner

Nominated by: Self

Seconded by: Jo Cook

Biography:

I graduated with a bachelor degree in Alcohol and Drug Studies in 2006 from WelTec, Christchurch and since that time have worked in a DHB AOD service at a clinician level. I have also been employed as an Alcohol Harm Reduction project manager in a DHB Public Health

service. I have since gained a Post Grad diploma in Health Management at the University of Otago and a Diploma in Community Services Work in Australia. More recently, I have spent two years working in Central Australia with Aboriginal Communities and this has been an enriching experience both on a personal and professional level.

I am passionate about developing innovative practice to meet the changing needs of clients in terms of context, approach and method. I am a strong advocate for group work throughout my practice, whether it be a client, provider, cultural or family group — believing that the client is the expert and most valuable vehicle for change. I am currently undertaking study in Jungian Sandplay Therapy and am excited about offering this as an innovative tool in working with addictions both for staff and clients.

I live in Dunedin with my husband who also works in the AOD field. Between us we have three adult sons who continue to enhance our personal development as teachers for our own personal development.

I am standing because:

I believe I have the energy and motivation to enhance the competency of the AOD workforce in New Zealand and that dapaanz is pivotal to further this aim. My experience and expertise in many aspects of AOD practice and policy would be a valuable asset to promote excellence in this field and in this respect, put myself forward to become a member of the board.

Suzy Morrison

Employer: Matua Raki Addiction Workforce Development Centre

Job title: Project lead

Membership status: Standard member

Nominated by: Rhonda Robertson

Biography:

Suzy is the Project Lead with responsibility for consumer projects with Matua Raki, the Aotearoa, New Zealand National Addiction Workforce Development Centre within Te Pou o te Whakaaro Nui.

Suzy has lived experience of addiction and long-term recovery. In early recovery, Suzy trained as a social worker and worked for several years as part of the Community AIDS Resource Team (CART) supporting people living with and affected by HIV. During her time with CART, Suzy trained as a counsellor and went on to work as a practitioner in the addiction sector for fifteen years. She has worked in a range of services including Higher Ground Residential Drug Treatment centre, and Auckland Community Alcohol and Drug Service (CADS). During her time at CADS, Suzy specialised in working with older people affected by problematic AOD use, and with family and friends affected by someone else's use of AOD. Suzy joined the Matua Raki team in August 2013 in a project lead role, participating in and supporting the development of the addiction peer and consumer workforce in Aotearoa New Zealand.

I am standing because:

I've been working in the addiction sector for many years in various roles have been supported by dapaanz along the way. This is an opportunity to give back. In my current role, I am part of the Matua Raki Consumer Leadership Group (MRCLG). The MRCLG is made up of members in dedicated peer & consumer roles and diverse recovery paths. Making recovery visible decreases stigma and increases hope. Standing for the dapaanz board is part of that process of visibility.

Marino Murphy

Employer: Nga Manga Puriri Northland Problem Gambling Service

Job title: Manager

Membership status: Registered Practitioner

Nominated by: Self

Seconded by: Wini Frood

Biography:

Ngatihine te Hapu, Ngapuhi te Iwi

I am standing because:

Because the practitioners out there working in addiction intervention need a voice to represent them, to hear them, and to enhance their well-being in order to enable them to give their best to the whānau we work with, Tika, Pono, Aroha.

Anna Nelson

Employer: Matua Raki

Job title: Programme Manager

Membership status: Standard Member / Current Board Member

Nominated by: Self

Seconded by: Suzy Morrison

Biography:

I began my career in the AOD sector in 1996 when I worked as a dual diagnosis social worker in the Waikato (under an HFA pilot with the Salvation Army Bridge Programme). In 2000 I graduated with a Master of Social Work from Massey University, having completed a thesis on effective interventions with substance using adolescents in Aotearoa New Zealand. Since this time, I have worked in a variety of places and settings within the addiction and social work sectors, both in New Zealand and in London. I am currently the Programme Manager at Matua Raki supporting workforce development initiatives for the specialist addiction sector, and other health

and social care organisations. I have been with Matua Raki for nearly 8 years and love my role. I am currently undertaking a PhD in social work at the University of Auckland where I am researching addiction knowledge, skills and attitudes for generic social work practice.

I am standing because:

I have been part of the current dapaanz board since 2015, when I was lucky enough to be voted on with a number of other strong leaders in the sector. We have worked really hard in the last two years, not only at a governance level but also hands-on with organisational activities focused on continuing to build dapaanz. Now I understand more about dapaanz and its internal processes, I acknowledge what is required to continue to build a robust professional registration body to support a strong and diverse addiction workforce. I believe I still have a lot to offer dapaanz and would like to have a continued opportunity to do so.

Annabel Prescott

Employer: Real Youth Services

Job title: Youth Clinician

Membership status: Provisional Practitioner

Nominated by: Tony Carton

Biography:

She has been involved in the addictions sector for the past 15 years. Holding a variety of roles including, clinical, supervision, academic, research and a previous dapaanz board member. She is currently completing her PhD looking at how school develop and implement their school drug policies, with a hope this will open up conversations to improve primary prevention and secondary interventions within school settings. Having recently moved to Taupo and returning to clinical work she is keen to support the strategic direction of dapaanz, with a regional focus.

I am standing because:

Kia ora, thank you for the nomination and for taking the time to read my application. I am wanting to stand for the board because I have worked in clinical and strategic workforce development roles previously and feel this would be a wonderful opportunity to bring my lenses of youth health and cultural responses for tangata whaiora, to support the shaping of our workforce. Also, now being in Taupo, in my view it's important the regions are represented.

Simon Rouch

Employer: Thorpe House Social Detox, Christchurch City Mission

Job title: Supervisor

Membership status: Registered Practitioner

Nominated by: Jan Spence

Biography:

I have worked for the last 8 years as supervisor of Thorpe House Social Detox at the Christchurch City Mission. During that time, I have undertaken post-graduate study through Otago University gaining a PGDip in Health Sciences endorsed in Addiction and Co-Existing Disorders. I am also a dapaanz Registered Alcohol and Other Drug Practitioner. For the last 4 years I have been a member of the organising committee for the Liaison of Alcohol & Drug (LOAD) in Christchurch.

I am standing because:

I believe in the guiding principles of dapaanz and in the association's aims. Ultimately, it's about delivering the best level of service we can to those that need us. I would be grateful for the opportunity to participate in this as a dapaanz board member.

Qiuyue Sang

Employer: Emerge Aotearoa

Job title: Navigator

Membership status: Provisional Practitioner

Nominated by: Self

Seconded by: Kun Zhang

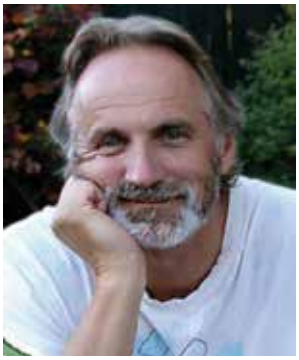
Biography:

3 years work experience within mental health/addiction industry in New Zealand. Sang is currently engaging with Matua Raki (Te Pou) to provide physical wellbeing programmes to mental health consumers within the Wellington region. Sang is also engaging with Matua Raki to provide mental health education seminars. She is part of the alcohol addiction AUDIT advisor group. Song has had articles published in the local Chinese Newspaper to raise awareness of mental health, alcohol, drugs, gambling issues, and community resources.

I am standing because:

I'm passionate about the addiction sector and that I contribute my knowledge to add diversity to the board. I and Kun Zhang are working together to boost the level of addiction awareness in the Asian community from this year by delivering mental health and AOD seminars and publishing mental health and AOD related articles in local Chinese newspapers on a weekly basis.

Paul Schreuder



Employer: Wellington Institute of Technology

Job title: Senior Lecturer

Membership status: Standard Member / Accredited Clinical Supervisor

Nominated by: Mirjana Vilke

Biography:

Over 25 years' experience in the field as a counsellor for NSAD, a facilitator for After care, facilitator for PGF relapse prevention, Lecturer in Addiction studies, dapaanz supervisor. I am passionate about integrate practice and integrating the arts with therapy. I have presented at several conferences including in the United States, Rome, Pisa, and Melbourne as well as at Cutting Edge.

I am standing because:

It would be advantageous to have the voice of someone who was on the original board and can represent the needs of students intending to be practitioners. I also can represent the gambling and other non-substance disorders as I am the course leader for that course and supervise PGF practitioners.

Toni Snapes

Employer: ICAMHS (Infant, child, adolescent mental health service)

Job title: AOD Clinician

Membership status: Registered Practitioner

Nominated by: Self

Seconded by: Mike Murphy Scanlon

Biography:

My work in the addiction field to date has outlined both drug treatment within a correctional facility and currently in the community, working with children and youth. Therefore, I have worked alongside people who were working towards both absence and harm reduction. In addition to this, exploring the effects of past and present trauma and coexisting mental health issues with the individuals. While this work has been challenging I have found it vastly rewarding in that it has enabled me to grow as a person both professional and personally. Both successes and failures have contributed to this growth, in that, I have had to explore different treatment options, gained a greater understanding of culture and ethnicity and the impact it has on treatment outcomes, and understanding how powerful and vital engagement and connection is, it is the underpinning element required in successful outcomes.

I am standing because:

I can only say that I am passionate about my work and have been inspired watching people as they undertake their journey of self-discovery and enlightenment. Therefore, this why I would like to become a board member as being part of addiction community and progressing towards achieving better outcomes in New Zealand is an exciting and rewarding opportunity.

Debby Sutton

Employer: Odyssey

Job title: Programme Manager, AOD Provider Collaborative

Membership status: Standard Member / Current Board Member

Nominated by: Suzy Morrison

Biography:

Debby has worked in the addiction treatment sector for over 20 years in a variety of roles, including Alcohol & Drug Counsellor at CADS, Senior Lecturer at Central Institute of Technology/ WelTec, and in Workforce Development roles for CADS and Matua Raki. For the last few years she has worked for Odyssey in programme management roles establishing new initiatives including Odyssey's COPMIA family resiliency programme and various projects implemented by the AOD Provider Collaborative, such as Recovery College, and collaborations with primary care.

These roles have provided Debby with opportunities to contribute to the advancement of the addiction workforce, such as assisting with the development of the Bachelor of Alcohol & Drug Studies degree, and the Addiction Practitioner Competencies (2001 and 2010), as well as writing publications such as, A guide to the addiction treatment sector in Aotearoa, New Zealand (Matua Raki, 2012), and the Supervisors' Guide: Integrating Family Inclusive Practice into clinical supervision for the addictions workforce (Kina Trust, 2010).

I am standing because:

Over the years, I have always appreciated being part of the addiction treatment community in New Zealand, and strongly believe that it offers a unique and valuable perspective to delivering health services. Dapaanz is an important representative of this community and in seeking re-election to the board I hope to contribute to the successful continuation of dapaanz into the future.

Over the 2015-2017 term of office the board and dapaanz staff have made many changes which have aimed to enhance how dapaanz operates, and its services to members. I have particularly enjoyed working with my board colleagues to enhance communication between dapaanz and its members, and strengthening the registration system to ensure that dapaanz registration continues to reflect quality addiction practice. I believe that dapaanz has made good progress in many areas over this period, and there are other initiatives planned for 2017-2019 which I would like to support with my commitment and capabilities.

Michael Templeton

Employer: Auckland South Correctional Facility

Job title: Programme Facilitator

Membership status: Provisional Practitioner

Nominated by: Self

Seconded by: Steward James Eiao

Biography:

The area of counselling that I am focused on presently is with offenders in the criminal justice system. This is inclusive of group facilitation both in the prison and in the community with a wide variety of people in different life stages. I am experienced with working with high risk complex needs clients, including youth and those with significant mental health disorders both within group settings and individually. The scope of my practice includes working with a wide range of issues such as; grief, adjustment, depression, anxiety, anger, addictions and relationship issues. I favour working from a strength based and systemic perspective and have a good integration of therapeutic modalities to draw from.

My personal life experiences have given me substantial insight into the world of drug and alcohol addiction, crime, and prisons. While I am open about this when asked about it or it is known, I am skilled in maintaining firm boundaries and returning the focus to the individual and the therapeutic direction at hand. I have a proven ability to work inter culturally, especially with Māori and have a good understanding and appreciation of the principles and articles of the treaty of Waitangi. I hold Provisional Registration with dapaanz and NZAC, committed to ongoing professional development and have excellent regular supervision.

I am standing because:

I believe that I have a mature outlook with good life experience over a broad range of contexts. This, coupled with a passion to see constantly developing opportunities and high standards in the addictions field give me real desire to contribute and serve a community of professional's that drive innovation, care, and best practice outcomes. As stated in my bio, my professional focus is with the criminal justice system and it is in this field and the continuity of treatment from prison to community I am well able to contribute.

I have a deep appreciation for the values that dapaanz stand for and promote, which also connect with my personal philosophy in that: professional practice requires a high degree of integrity and care (Tika, pono and aroha) that profoundly regards the mana and difference of individuals in a way that promotes social collaboration and empowerment at all levels.

Brent (Tohi) Tohiariki

Employer: Salvation Army Christchurch Bridge Addiction Services

Job title: Operations Manager

Membership status: Standard Member / Accredited Clinical Supervisor / Current Board Member

Nominated by: Anthony Foster

Biography:

My Iwi affiliations are Te Arawa, Whānau ā Apanui and Tainui. I am a fully registered Psychotherapist and counsellor with Post Graduate training in Motivational Interviewing. I am also a member of the Motivational Interviewing Network of Trainers (MINT). I have previously been a lecturer in Alcohol and Drug Studies and worked in the addictions / mental health field for 15 years. My current role is Operations Manager of the Christchurch Bridge Addiction Services, Salvation Army and have been there for 6 years. I am an approved Accredited Clinical Supervisor and current dapaanz board member.

I am standing because:

I am standing because I have a passion for indigenous issues and supporting practitioners in the field to develop cultural intelligence. I am also interested in the application of evidence based treatment approaches with Māori in particular and the development of resources for the helping professions. Ethics is also an area of interest.

Anne Fiona Trevelyan

Employer: Odyssey

Job title: CEO

Membership status: Standard Member

Nominated by: Johnny Dow

Biography:

Fiona Trevelyan is Odyssey's new CEO, having taken up the role in December 2016.

Fiona Trevelyan has more than 30 years' experience in the health and social services sector, including as a training manager, team leader, social work consultant, programme manager and CEO. Some of that work took place at Odyssey House including, Service Manager for the Co-Existing Disorders Service and Project Manager for the AOD Treatment Court Pilot Implementation.

Fiona was born and raised in South Africa and knew from an early age that she wanted to build a career focused on social equity and strengthening communities.

In South Africa, she contributed to the development of a national primary prevention programme for the South African National Council on Alcoholism and Drug Dependence and helped establish an in-house substance use rehabilitation programme for a large multi-national company.

Fiona moved to New Zealand in 2002 and began work in the Co-Existing Disorders Service at Odyssey House and in 2008 became a Planner and Funder at Counties Manukau District Health Board(CMDHB) where she set to work implementing CMDHB's five-year AOD plan and this included establishing a number of new services, one of which was the AOD Provider Collaborative.

Fiona more recently held the role of Chief Officer for Directions Health Services in Canberra from 2013-2016. There her achievements included the expansion of services into New South Wales, leading the Strategic Planning process, rebuilding the organisation's quality system and rebranding the organisation with including new Vision, Mission and Values.

Fiona has post-graduate Social Work qualifications from the University of Cape Town, South Africa as well as furthering her studies in New Zealand at the University of Auckland and Massey University.

I am standing because:

I have extensive experience in the addiction field. I am committed to ensuring the delivery of high quality services to clients/tangata whaiora. This occurs when there is a well-qualified, experienced, ethical and passionate workforce. Dapaanz as the professional body for Drug and Alcohol Practitioners, is the platform to ensure the development of exactly such a workforce.

Cynthia Young

Employer: WelTec

Job title: Addiction Studies Tuto

Membership status: Registered Clinical Supervisor

Nominated by: Self

Seconded by: Tony Carton

Biography:

I have worked in the Addiction field for the last 20 years with 5 years at Odyssey House as the Parent Programme Administrator, 1 ½ years at WelTec Newmarket campus teaching Counselling, 9 years as the Programme Coordinator at the Salvation Army Auckland Bridge Programme, 1 year at Goodman (Odyssey Youth Residential Services), 3 years doing Clinical Supervision on a part-time basis and since Feb 2017 my current role as Tutor in Addiction Studies at the Auckland campus of WelTec. I am proud to be a New Zealander and although I have enjoyed living and working overseas (UK and Canada) I love here best!

I am standing because:

I would like to part of initiatives to bridge the gap between best and current practice, foster excellence in addiction practice, build resources to acknowledge and manage possible dynamics and keep workplaces safe and supportive for all diverse cultures.

Kun Zhang

Employer: Matua Raki / Asian Family Services

Job title: Project leader / Health Promoter

Membership status: Registered Practitioner / Accredited Clinical Supervisor

Nominated by: Qiuyue Sang

Biography:

Kun (Billy) came to New Zealand in 2002, he then become a Registered Alcohol and Other Drugs Clinician and has worked closely with family in Corrections, DHB mental health, addictions and Chinese community response towards AOD misuse, gambling and domestic violence over the past 7 years.

Recently, Kun was employed by Asian Family Services which focuses on providing services to Asian people in Wellington. He also works for Matua Raki Wellington as a Project lead, which provides mental health and addiction information for Asian people by creating and/or translating this into their languages. He is fluent in English and Mandarin; and also speaks Chinese dialects such as Cantonese. He is a father of two girls who are 4 and 7 and lives in South Wellington.

I am standing because:

Kun is knowledgeable and passionate about the AOD sector. He's committed to lead projects that support individuals or families to identify issues relating to mental health, alcohol, drugs and gambling, and then guide them to find the most suitable help. He is also driven to promote awareness of addiction issues at a community level at large and has developed several tools to address the issues.

Tiriti o Waitangi

Whai Kai ano tetahi taha, whai tao ana tetahi taha;
whakatika tonu mai te whai tao, ka mate ko te whai kai

Pursue food with one part (of you) and pursue the spear with the other;
always pursue the spear and pursuit of food will suffer

Dapaanz Treaty of Waitangi Policy Background Paper

By Takurua Tawera

In June 2016, the dapaanz board agreed to strengthen dapaanz's response and approach to Tiriti O Waitangi. This was done not just in acknowledgment of the mana status of Māori, and commitment to increase Māori participation in leadership; but additionally, in acknowledgment of Māori as a key Partner in the vision for the advancement of dapaanz and the Addiction sector.

Engaging and working with Māori can be daunting, particularly for those who have never worked in te ao Māori. Questions that are often asked: Why are traditional Māori Purakau/stories relevant to present Māori concepts of practice; What is the significance of Powhiri when two groups of people are welcomed? Why do they take turns in speaking? Why does one tribal people need to sit here? Who do I talk to? What do I say?

When protocols are not followed, this can lead to breakdowns, barriers or at times conflicts. However, engaging with Māori can also be exciting, and for the private and public sectors, opportunities abound if done effectively.

The shark asked the kahawai "let's work together" the kahawai replies "ae", then the shark eats him. We don't have a perfect case of what a fantastic organization resembles, however throughout the years we have realized what doesn't work.

The intent of this paper is to design and develop a dapaanz partnership model.

Statistics

Statistics New Zealand (2012) reported Māori make up 15 percent of the population and the prison population show Māori made up 51 percent (4,391) of the total prison population. European prisoners made up 33 percent (2,835), and Pacific peoples accounted for 12 percent (1,006) of the total. Notably, 58 percent of female prisoners were Māori.

Mental Health and Addiction: Service use 2011/12

In 2011/12, 147,972 clients were seen by mental health and addiction services. Of these, 80,259 (54.2%) were male, and 67,713 (45.8%) were female.

Of the ethnic groups reported here, Māori were the most likely to be seen by mental health and addiction services, with 5533.6 clients seen for every 100,000 Māori population.

Matua Raki and Te Pou 2014 survey of the Māori adult mental health and addiction workforce, Māori comprised a greater proportion of the addiction workforce (22 per cent) compared to the mental health workforce (19 per cent)

We are fortunate the addiction sector has recognized cultural appropriateness when working with Māori.

Tiriti O Waitangi

The Tiriti O Waitangi, marked in 1840 amongst Māori and the English Crown is not law, but rather, since 1975, numerous New Zealand laws have alluded to principles (matapono) of the Tiriti.

The dapaanz Code of Ethics implies members respect the worth, dignity and capability of every human being. In practice, this implies working within a diverse and multicultural society that is the result of a unique and special social arrangement forged originally between two parties, Māori and non-Māori. Hence, the spirit and intent of the Tiriti of Waitangi is a crucial and overarching value to be treasured and maintained. Members should therefore acknowledge and have respect for cultural diversity in the practice of treatment for addiction disorders.

The current Tiriti O Waitangi, debates and highlights, the Māori Tiriti text. When compared with the English version it shows several crucial differences of meaning, especially in the first and second articles. Many people now focus on the differences between the English and Māori texts, especially regarding the crucial question of sovereignty (Rangatiratanga) and governorship (kāwanatanga).

The English version states the British goals were to safeguard Māori interests from the invading British settlement, provide for British settlement and build a government to preserve peace and order.

The Māori content proposes that the Queen's main promises to Māori were to provide a government while safeguarding tribal rangatiratanga (chiefly autonomy or authority) over their own area and Māori land possession for whatever length of time that they wished to hold it. The importance for dapaanz is to ensure Rangatiratanga is permeated within operations and delivery of our business.

Cultural fluency enhances communication

Diffidence in cultural fluency can further perplex addressing addiction cognate issues with Māori. Cultural fluency is defined as opportune application

of veneration, compassion, flexibility, perseverance, concern, inquisitiveness, openness, an open-mind, tolerance for obscurity and sense of humour.

The significant features of cultural fluency are recognizing opposing definitions of health and wellbeing, supporting choice of treatment approaches and presenting health care (and options) in a culturally responsive manner.

Cultural fluency goes beyond sensitivity and awareness and transcends vigilance and cultural safety. It can include, for example, understanding how or by whom decision making is made in a whānau, and considerations of how Māori values, beliefs and experiences might impact on the establishment and maintenance of a therapeutic relationship.

Cultural Competency

Te Rau Matatini recommends, cultural competency programmes for all kaimahi, that specifically includes information that may focus specifically on priority groups (in particular, Maori). Culturally capable kaimahi will be able to engage with and have an appreciation of the specific needs of Individuals and their whanau. Mātauranga Māori practice, needs to be integral to their everyday practice.

Durie (2001) said "the variances between cultural competence and cultural safety are possibly offset by their comparisons, they have quite separate starting points and in the New Zealand health context, slightly different histories. Both are about the relationship between the helper and the person being helped, but cultural safety centers on the experiences of the whaiora, while cultural competence is the ability of the health worker to enhance health service delivery by integrating culture into the clinical context. Recognition of culture is not by itself sufficient rationale for requiring cultural competence; instead the point of the exercise is to maximize gains from a health intervention where the parties are from different cultures."[1]

Culture describes the ways members of a group appreciate each other and convey that understanding. More often than not, the degrees of meaning are created by behavior rather than words, and much of the communication between members is determined by joint values working at an unconscious or 'taken for granted' level. Various groups have their own unique culture – the elderly, the impoverished, specialist groups, gangs, the army. The fact that a sixteen-year-old girl is a Māori for example, may be less applicable in health terms than the fact that she is sixteen.

Durie further said cultural competence is about the acquisition of skills to achieve a better understanding of members of other cultures. Consistent with the view that it is less about behaving correctly and more about practicing sound treatment, cultural competence is essentially another dimension to the clinician / client relationship that can provide additional information that will contribute toward better clinical results. A clinician who is culturally competent can use cultural impacts to improve performance.

Dapaanz Tiriti O Waitangi Policy 2017

Name: Te Kowhao

Whakapapa

Māori pedagogy concerning creation and the beginning of time starts with Io matua kore, the Parentless who was the Always Existent without beginning or end, who then begat Io-Taketake, the foundation of all – from, which all things originate, Taketake begat te korekore (the void), the infinite realm of the formless and undifferentiated, but 'potential being'. Korekore begat Te Kowhao(Abyss), together they lay down the foundation of all things.

The purpose of this policy is to provide direction and guidance to enable dapaanz to fulfill its obligations and responsibilities under Te Tiriti O Waitangi.

Guiding Principles

- Mātauranga Māori (Education)
- Tikanga Matatika (Ethics)
- Mana Motuhake (Autonomy)
- Dapaanz will demonstrate the guiding principles with mana, tika and pono
- Dapaanz ensures the Tiriti 'signified a partnership and interests of Māori.
  - Dapaanz will ensure that its Māori membership, its bodies and working groups demonstrate Māori interests with the most confidence
- Dapaanz will actively protect the interest of Māori
  - Dapaanz demonstrates active protection of Māori customs, beliefs and the use of Taonga in accord with the guiding principles
- Dapaanz should make informed decisions
  - in order to act reasonably and in good faith, dapaanz must make sure it was informed in making decisions relating to the Tiriti O Waitangi
  - Dapaanz will ensure that the guiding principles related to Tiriti o Waitangi are conveyed through the appointed Pou Whakarae specialist consultant,to provide advice to the complaints and other critical committees, to support their outcomes and recommendations.
- Dapaanz ensures that the Tiriti o Waitangi will mitigate reasonable and equitable solutions on the governance and operations in accordance with its chosen policy.
- Dapaanz in accordance with its Māori membership and Māori Addictions Leadership Caucus ensures the appointment of the Pou Whakarae as a voting member of the dapaanz board
- Dapaanz will ensure that the voice of Māori is protected and a legal and ethical obligation will be protected in the Constitution
- Dapaanz seeks to review its responsiveness to the Tiriti O Waitangi – every 2 years.
- Dapaanz will promote cultural fluency/competency to its members through CPD.