Addiction
Standard

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

Alcohol's continuing impact on New Zealanders

It's that time of year again - Cutting Edge 2018 – It's all about connection is just around the corner. We believe this year's gathering will be the mother of all Cutting Edge conferences. We have an amazing line up of international and local speakers, with a strong representation of tangata whenua. The timing of the conference is also fortuitous with the Inquiry into Mental Health and Addiction at report writing stage – this is a final opportunity for our sector to influence that report.

We are so pleased Tā Mason Drurie will open the conference, and he and Dean Rangihuna will be present for the day. We are also pleased there will once again be a strong presence of people with lived experience. Te Rau Matatini have generously supported 10 of the dapaanz consumer scholarships and so dapaanz has been able to award 21 consumer scholarships, with a further seven supported by the Health promotion Agency (HPA). If you haven't registered yet don't miss out!

It was great to submit a strong submission on the Inquiry into Mental Health and Addiction. It was really heartening that nearly a third of you responded to the survey to inform our submission and that a further 200 people responded to a survey that we sent out through various consumer/recovery networks. Check out the summary in this edition or go to http://www.dapaanz.org.nz/vdb/document/126 to check out the full submission. The dapaanz meeting with the panel was also great with around 25 people in various stages of recovery welcoming the Panel with a haka powhiri and sharing their stories of what works for them. Thank you He Waka eke Noa!

This edition of Addiction Standard features alcohol. Alcohol continues to be New Zealand's most commonly used drug and is the substance that carries the biggest burden of harm so its important to keep it on the agenda – both in data on harms, treatment perspectives and policy/law reforms.

Thank you to all who have contributed to the Addiction Standard. Particularly those who have courageously opened their lives up to influence better practice such as Akinihi Dawson. We love to publish real stories of real people who have been through treatment and are on a recovery journey. It is important, that our practice is informed by consumers. Thank you Akinihi and others for your vulnerability.

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

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Tuhia ki te whenua
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He tangata, he tangata, he tangata
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Kia ora

Meet our new office manager Kat Kerr

Born in Wellington, Kat has resided on the Kapiti Coast for the last 28 years. With a heart for the community, Kat spends her free time coaching and playing netball and likes to get out and about exploring nature. Whanau is a huge part of Kat's life and she enjoys spending time with those close to her. Kat is a real people person and loves working with the team at dapaanz to make your experience a positive one.

OPINION

A drug policy and treatment utopia? Let's imagine...

By Rob Zorn

Portugal decriminalised all drugs in 2001 and now has fewer overdoses and lower drug use and harm than most other countries. Switzerland has almost completely solved its heroin problem by giving people with addiction free heroin (and treatment support). In Philadelphia, connecting services to the community has dramatically reduced homelessness and addiction harm. Here in New Zealand we've led the world in reducing HIV and hepatitis C infections through our pioneering needle exchange programmes.

New Zealand is not the international public health leader it once was, but in the light of the harm reductionist non-punitive successes seen in other countries, we will soon be considering legalising cannabis use. If we were to do so, and introduce a regulated market, this writer (and probably most readers) believes we will see a lot less harm resulting from drug use here in Godzone.

But what might New Zealand look like if we actually went the whole hog and based all our drug policy on the evidence around what really works? What if we put in place here the best of what's working elsewhere in the world and the best of what's yet to happen?

Let's imagine a Kiwi Utopia where we're getting drug policy and addiction treatment exactly right.

Society

As a society we'll have grown up and understood that drug use and addiction are part of the human condition and will always be with us. We'll accept people with addiction in the same way we do those with cancer, dementia or physical disability. Instead of blaming them for the poor choices they've made and leaving them to 'suffer the consequences', we'll have systems that are well-funded, evidence-based and compassionate to provide the help and support they need. People with addiction will not be any more ashamed to ask for help than a person with any other illness, so they will come forward for treatment and they will get into recovery and achieve the better and more meaningful lives they want and we want them to have.

Because we recognise that addiction is really a health problem, we'll have decriminalised all personal drug use. We won't be stuffing people into overcrowded prisons in the foolhardy belief that we can punish their addictions away. Police won't be wasting resources on less harmful drug use and will be able to concentrate on the predators who manufacture and supply instead. Just as has happened in the Netherlands where treatment consistently happens in jails, we'll be shutting down prisons not building more because re-offending rates will have drastically fallen.

The people in our utopia who use less harmful drugs like cannabis occasionally, unproblematically and without developing addiction – in the same way a lot of people currently use alcohol – would also not have to fear prosecution. Our young people experimenting with low level drugs (as most probably will at some stage) would not end up with criminal convictions hampering their travel and employment prospects for years.

As is done is Switzerland, we'd supply already addicted people with the drugs they need through approved clinics, as we sort of half-pie do now with methadone. People could then use drugs that are contaminant free in medically supervised conditions where they would also receive assessment, other health and social care, and treatment support to overcome their addictions. The black market for drugs would pretty much have disappeared as a result and dealers would have given up and gotten day jobs because no one wants or needs what they sell. That would mean far fewer opportunities for young people to get mixed up with illicit drug use in back alleys, filthy squats or nightclub bathrooms.

And if there are cases where people have resorted to crime to fund their addictions for whatever reason, there would be regionally accessible drug courts in place where treatment would be part of the process and sentences would be community-based, positive and non-custodial for those who truly wanted help.

Legality

While all drug use would be decriminalised, some recreational drug use would be legalised and regulated. Tight restrictions would apply to the sale of some recreational drugs like cannabis and maybe some synthetics that were proven to be low risk, much in the way our psychoactive substances act originally intended. And because this is a utopia, we'd have found a way to test those substances without having to harm any animals.

People wanting to use cannabis medicinally would be free to do so and to grow a small number of their own plants just like anybody else and, of course, a range of cannabis-based pharmaceutical medicines would be available on prescription alongside other medical products.

We'll have gotten over the reefer madness stupidity of the prohibitionist past that made us believe users of low level drugs should be punished while we enthusiastically advertised alcohol and sold it as cheaply as possible from just about anywhere.

In fact, we'd have recognised that alcohol is among the most harmful of drugs and we'll be heavily restricting its sale and supply. Alcohol advertising and sponsorship would be a thing of the past. All booze would be heavily taxed and a whole lot harder to get.

Treatment

But whenever you have drugs and people in the same place, you are going to have issues. A regulated market will have reduced drug harm immensely, but we will still need to provide treatment for those who develop problems with substances just as we need to now for people who have problems with alcohol.

The treatment available in our future utopia will be well-funded and highly professional. We'll have become enlightened enough to realise that society as a whole is much better off when people with addiction receive the health and social care they need to begin recovery and take more responsibility for themselves. We have screening and other systems in place at all social services to spot addiction early. Services collaborate and pathways between them are clear so nobody falls through the cracks.

Clinicians will be extremely well paid (as will teachers and nurses), and there will be pay equity across government or non-government organisations. This will make it attractive for people to do the rigorous training needed to enter the profession. Clinicians will form the core of the treatment spectrum, but they'll be well-supported by social workers and primary care professionals such as nurses, but especially by peer support workers whose lived experience means all treatment practice will be well informed.

Treatment professionals will be registered because we realise that addiction is a serious business and we don't want unqualified people offering dubious treatment. We'll be staggered that back in 2018 we didn't take treatment seriously enough to require all providers to be qualified.

Treatment will be holistic and will recognise that substance use is driven by a raft of things including mental health, socioeconomic status, history of trauma and cultural disassociation. Treatment will therefore not given in isolation from other forms of therapy or the meeting of immediate needs such as housing, financial assistance and cultural connection.

One size never fits all. We'll have understood that people respond differently to different forms of treatment so people with addiction will have a wide range of options available.

For some, standard Cognitive Behavioural Therapy or Motivational Interviewing will be enough in a regular one-on-one setting – others may thrive on group therapy. Some will need detox before treatment and/or residential rehabilitation services. Some will need medication or substitution therapy and for some a 12-step programme will work best. And, of course all treatment will be culturally aware, and a decent portion will be provided by tikanga- or Pasifika-based services.

We'll look back at what is now the present and be amazed at how far we've come. We had all this stuff back in 2018, but it was sparsely available. If you were in a main centre you may have had an option or two, but by now we've fully understood that people with addiction in the far-spread regions suffer just as much and have the same rights as city-folk. So, services will be widespread and well-resourced. Most will be mobile so professionals can visit some people in their homes.

Education

In our utopia we'll also be getting education right. We'll have realised that the best thing we can do for young people caught using alcohol or drugs is to keep them in school, not further alienate them by doling out suspensions or expulsion.

We'll have evidence-based, harm reductionist programmes in schools that cover things like safest use and risk of addiction – at appropriate age-levels – alongside the many good reasons not to use drugs. The honest and hysteria-free way we do this will probably have removed a lot of the allure that illicit drugs now have for some young people. These education programmes will also help students understand all the stuff we've already mentioned about treatment, compassion and social inclusion.

And of course, we'll always tell our kids the truth about drugs, and admit that, no, trying cannabis will probably not lead you to heroin addiction. That means our kids may actually listen to us when we tell them the truth that drugs are potentially very harmful, and the safest use is no use at all.

We're going to need our kids to have this sort of learning and understanding if they're going to grow into the sort of adults who will usher in our drug policy and practice utopia, so we'd better start teaching them now.

POLICY

Submission to the Mental Health Inquiry

by Sue Paton, Kristen Maynard, Nathan Frost. photo credit: Office of the Speaker, New Zealand Parliament

In June of this year dapaanz provided the Government with a strong submission for their inquiry into mental health and addiction services in Aotearoa New Zealand. Our submission was informed by two surveys we conducted with our members (the addiction workforce) and within our networks of those with lived experience. Almost **a third of our membership** (mostly addiction practitioners) **responded** (ie, 465) and **we received 200 responses** from those with **lived experience**. Given the response rate we feel confident that our submission largely reflects the views of our members and those with lived experience.

To better meet the needs of New Zealanders experiencing addiction dapaanz suggests the following three pronged approach:

A PARADIGM AND SYSTEMATIC SHIFT FROM A PUNITIVE JUSTICE FOCUS TO A HEALTH AND RECOVERY APPROACH IS REQUIRED.

The system requires more than just tweaks and increased funding.

WE NEED TO BUILD A SYSTEM THAT SUPPORTS WELLBEING AND RECOVERY; PROVIDES A WIDE RANGE OF HELP OPTIONS; AND ENABLES EARLY AND TIMELY ACCESS TO PROFESSIONAL HELP.

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

WE NEED A DIVERSE WORKFORCE THAT CAN MEET CURRENT DEMAND AND DELIVER A MORE HOLISTIC APPROACH.

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

The Consumer Voice - Survey responses from those with lived experience:

With over 200 responses from those with lived experience it is impossible for us to publish every comment. Please find below a representative cross section of responses. dapaanz is greatful to everyone for taking the time to respond to our survey, your comments were not only informative but together they truely formed the heart and soul of our submission.

- There is no in between, its the cells at the police stations and the mental health ward then people are sent on their way after a lapse. There are many mentally unwell people and people living with a substance misuse disorder that are being failed by the current legislation. Many families are unable to access support to effectively support their loved ones affected by MH&A issues because they are unaware of what is out there.There are too many people out on the streets with nowhere to be safely recieving treatment and support.

- My son has been an addict for the last 12 years and I'm horrified the court system would allow a meth addict home detention with no drug or alcohol conditions, it's like putting a kid in a candy store and telling them they can't have one! It's setting up young addicts for total failure as it goes round in circles for ever. They get bail they reoffend by using.... NZ needs a huge overhaul for treatment of addicted people they need rehabilitation not imprisonment.

- All of the above are vital for change. We have one of the highest rates of methamphetamine use in the BOP but limited support. No residential rehabilitation in Tauranga which results in months of waiting to get a place elsewhere, so the problem gets worse in the meantime. Our child has been suffering with addiction over 15 years. Has tried to take his life on numerous occasions. If you call for help, you're told to call the police. Lock them away so they're introduced to more drugs and a life of crime when they get out. Addiction is not a choice it's an illness like diabetes or MS and needs to be treated accordingly. Families are torn apart by this disease. They live in shame because of other people's opinions, and are powerless to help their loved ones.

- I am now a year clean, thanks to narcotics anonymous. The public health system denied me treatment at a residential facility so I have been going through ACC to get into some form of rehab. It has taken 2.5 years so far to even get on the waiting list. I've been on the waiting list for 6 months now and could be up to another two years before I actually get a place on the programme. A 4.5 year wait for treatment is completely unacceptable.

- What worked: Non judgmental workers. Culturally sensitive Strengths based approach Manaakitanga Whanaungatanga What didn't work: Appointments that were a waste of time- just getting your personal details and that's it until the next appointment which is ages away! Wait times to see someone, anyone, were outrageous. Feeling judged. Relationship not a trusting one, therefore not helpful at all. Made to feel like a number.

- We are desperately short of treatment centres and detox centres. These are urgently needed NOW in all main and provincial areas.

- A peer support worker saved my life. Her lived experience was similar to mine but she made it very clear this journey was my own Nd she would stand by me. She showed no judgement towards me and had my back. She was straight up and called me on my bull***t, kindly. She planned with me not for me. It was what i needed. Its what eveeyone needs

- I would like to see more funding at addiction services instead of Prisons. We has a community needs to support each other and not discriminate against people who stuggle with addiction. We need more education within the community around Drug awereness.

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

- Reconnection with my culture as a Maori was very important and to have Kaupapa maori treatment available with the skills to access the healing knowledge of my Tipuna is vital.

- I did three treatments one after the other. An intensive therapeutic community programme was where I made the most progress. Avoiding my issues was keeping me in active addiction , once these were removed so was my want to use . Then a solid 12 Step fellowship continues to keep me on track. I went to jail after my treatments and stayed clean , even in an anti-social environment thanks to the work at an 18 week intensive programme. Incarceration for drug or alcohol use offenses should be the last resort, rehabilitation needs to be more freely available without extended wait times.

Any Given Weekend - Injuries, violence & self-harm
Alcohol in Emergency Departments

Dr Paul Quigley Mr Nathan Smith Ms Sandra Almark

photo credit: Nathan Frost

A national system for the collection of data relating to aberrant presentations to ED that links with the new "National Alcohol Involved" question is needed. If the correct data is collected, especially at a national level, then we can get appropriate funding to establish intervention programs.

It is well accepted that alcohol intoxication increases the risk of injury leading to presentations to the Emergency Department. Most New Zealander's can recall an anecdote of being slightly too tipsy and spraining an ankle or getting road rash from an uncontrolled fall or a misjudged attempt at leaping a parking meter. These incidents while increasing the burden of work load to NZ EDs are often just isolated events causing harm only to one's pride, and ankle, with limited collateral injury.

However, EDs also see a significant amount of alcohol related aberrant behaviour. If you work in an Emergency Department on a Friday or Saturday night, every week you can expect to have patients presenting that are intoxicated, rude, threatening and often outright violent towards staff and others. The department smells of alcohol and vomit and can be an intimidating place to work. Nowhere are the resulting harms of alcohol use more apparent than in EDs. While efforts are often directed to reduce the supply and volume of alcohol to the community, little is done to provide treatment or support to those where it is clearly evident alcohol related harm has already taken place. A national system for the collection of data relating to aberrant presentations to ED that links with the new "National Alcohol Involved" question is needed. If the correct data is collected, especially at a national level, then we can get appropriate funding to establish intervention programs.

A review of ED presentations involving alcohol consumption was undertaken at Wellington Hospital. The behavior of intoxicated patients deemed to be outside the normal behaviour of patients presenting seeking help and care we decided to call "aberrant" presentations. Technically patients who present because of a desire to hurt or kill themselves are regarded as aberrant as well and because alcohol is recognised as often being involved they were also included in our injury study.

Our criteria for review was to look at injury presentations where the patients' presentation could be regarded as departing from the usual standard for behaviour, where there was violence (either victim or perpetrator) or self-directed violence (self-harm) and then examined whether drug and alcohol use was present.

This is important because violent presentations have a significant impact on staff and other patients present within the Emergency Department and are a leading cause of reportable events and stress within the workplace. Even patients presenting with self-directed violence are difficult to manage when intoxicated and often require a significant increase in security and nursing care to be safe.

We reviewed the violence presentation data for 2016 (Wellington ED has been collecting violence data since 2009) in order to establish an idea of the magnitude of the problem. From this we found 429 incidents via matched ACC records and another 525 cases where violence had been a contributing factor from notes review. While this only represents around 1.5% of all presentations it needs to be put into real terms. The majority of these aberrant presentations occur on weekend evenings and equate to around 8 aberrant presentations presenting every Friday, and Saturday night.

Because it was already clear we were missing a significant number of these aberrant presentations we decided to conduct a detailed review looking at every case for the month of March 2017. During this month alone, 370 patients presented to ED with injuries or illnesses directly related to violence, self-directed violence, or harm related to Alcohol and Drug use. This represents 13.6% (209) of the ACC cases for this period, and 6.6% (370) of the total ED presentations.

This clearly demonstrates that we are very poor at collecting data on the volume and burden of aberrant behaviour. We found double the violence presentations alone than we had originally thought (based upon data collected via ACC visits). This failure to accurately collect the amount of harm being caused by aberrant behaviour is critical because as health professionals we cannot ask for funding to improve; staff and department safety, patient interventions and, follow-up services if we cannot quantify the level of the problem.

We then reviewed these cases to establish those that were truly aberrant, not simply "accidents" and where alcohol had been a contributing factor. Alcohol use was a significant factor in a least 68% of cases. Alcohol positive was determined as; the patient presented in an intoxicated state, the patient states that they were drunk at the time of injury or collateral information confirms intoxication (ambulance reports, police). Even this rounded approach will still likely result in under-reporting especially for patients who delayed their presentations to ED.

47% (174 cases) presented primarily with alcohol related complications, while these were not necessarily regarded as aberrant - as they were the expected effects of alcohol - they cannot be regarded as totally benign. 40% had an injury related to alcohol with the majority of these from falls. Of significant concern, 27% of these cases were head injuries. 51 (30%) were also so intoxicated as to need admission for observation and care. 22 (13%) had an illness caused from alcohol consumption with the most common being vomiting with gastritis. 31 patients (18%) presented with another medical illness but had consumed alcohol immediately prior to presenting!

TABLE 1 : PRESENTATIONS OF ABERRANT BEHAVIOUR MARCH 2017

1st - 31st March 2017	Alcohol Positive	Alcohol Negative	Total
Violence	38	32	70
Self Violence	42	84	126
Alcohol & Drugs	173	1 (Drugs Only)	174
Total	**253**	**117**	**370**

Of the remaining 196 (57%) cases that could be regarded as aberrant, a presentation that was outside of "normal" behaviour. There were 70 presentations related to injury caused by inter-personal violence; 54 patients reported that they had been assaulted, 8 admitting they were the initiator of the violence, 5 from being injured while being arrested and 3 from other (play-fighting, martial-arts).

Overall 68% of 370 cases reviewed as being aberrant had alcohol involved and where alcohol was present as a contributing factor there was a significant increase in resources used. 48% of all alcohol positive cases were brought to hospital by Ambulance compared to only 30% of the overall ED population for the same time. This alone equates to a significant resource and financial burden that can be attributed to aberrant effects of alcohol.

Extrapolating the March data to a year is not an exact science as we are aware of month to month variations, however, at the most

basic level in a single year we would expect to see around 420 patients due to violence and 750 presentations of self-directed violence that are alcohol related.

We have also demonstrated that self-directed violence prevention strategies are best targeted at the adolescent female population who represented 60% of the attempted suicide presentations.

Whereas anger and violence strategies should be directed at males and in particular young Maori males who are significantly over represented at 15% of the violence and self-violence aberrant group which is twice the expected rate based on Wellingtons 2013 census data. (7.3% of population recognised as Maori)

We have also clearly demonstrated that the inventions should be age and gender targeted for greatest effect. Self-directed violence prevention strategies are best targeted at the adolescent female whereas anger and violence strategies should be directed at males and in particular young Maori males who are significantly over represented compared to population data.

TABLE 2 : WHO COMMITTED THE ALLEGED INTER-PERSONAL VIOLENCE?

	Alcohol Positive	Alcohol Negative/ Unknown	Total
Family Violence (victim)	2	8	10
Friend/Aquaintance/ Neighbour	7	5	12
Gang		1	1
Police	2	3	5
Stranger	12	7	19
Unknown	15	8	23
Total	**38**	**32**	**70**

Nowhere work needs to be done to focus on the effects of alcohol on violence and in particular, anger management and impulsivity in association with alcohol consumption.

OPINION

Reflections on the heavy drinking culture of New Zealand

By Doug Sellman
Professor of Psychiatry & Addiction Medicine, University of Otago, Christchurch

A mistake was made 30 years ago with the Sale and Supply of Alcohol Act (1989); a new liberalizing alcohol act right in line with the economic revolution sweeping across the Western World at the time, championed by the UK Prime Minister Margaret Thatcher and US President Ronald Regan - neo-liberalism.

Here in New Zealand Roger Douglas, the Finance Minister of David Lange's 4th Labour government spearheaded radical changes to the economy doing away with a lot of "unnecessary regulation", including alcohol regulation. NZ neoliberalism was termed "Rogernomics" and later by the more pejorative term "Ruthanasia" when Ruth Richardson was Finance Minister of the next National government and brought in major cuts to social benefits with her "Mother of All Budgets", working closely with Jenny Shipley at the time. Shipley in time became PM and in 1999 oversaw the extension of supermarket alcohol (superconvenient) with the introduction of beer as well as wine, and to cap off the liberalization of alcohol she facilitated the dropping of the purchase age of alcohol from 20 to 18 years, bringing fresh life to teenage drinking and a deepening of a heavy youth drinking culture.

Alcohol liberalization was aided by a report by George Laking several years previously which ignored the evidence existing at the time that increasing availability of alcohol increases its use and therefore its harm. Ideology trumped the science. We were coaxed into thinking that it was a good thing for alcohol to be normalized; and that in so doing New Zealand was on its way to become a sophisticated country like France. The fact that France had one of the highest rates of cirrhosis of the liver at the time was quietly ignored. There was money to be made out of our favourite recreational drug and big business was ready to rumble (as it is now with cannabis). Besides, per capita consumption of alcohol in New Zealand had begun to decline from 1978, due at least in part to the beginning of drink driving campaigns. The neo-liberal reforms arrested this worrying trend for alcohol company bosses and alcohol industry shareholders of falling per capita consumption of alcohol.

The liberalizing alcohol reforms (brought in by both Labour and National) were in fact so successful that over the next decade through to the global financial crisis of 2008/9 per capita consumption in New Zealand increased by 10% as marketing of alcohol, to women and young people in particular, took hold, and progressively cheaper alcohol became available as supermarkets used it as loss-leading bait to get customers into their stores. More alcohol, more harm; and it was in the context of this increasing alcohol harm, especially following the violent murder of South Auckland liquor store owner Navtej Singh in June 2008, that the Labour government of the time instituted a major review of the liquor laws.

The review was undertaken by the Law Commission, the most extensive review of alcohol in New Zealand's history. Major reforms were recommended (along with a plethora of minor recommendations as well). But the National-led government decided to play a deceptive political game of pretending they were taking the review and its bold recommendations seriously, but in fact engineered a cynical response by passing an Alcohol Reform Bill, which contained no substantial alcohol reforms. Highlights of this political game are as follows.

First, they set a scene of low expectations by suggesting New Zealanders weren't wanting major reform and declared it would be unfair on "responsible citizens" if the government brought in major changes. Increasing the price of alcohol was casually dismissed by Prime Minister John Key before the Law Commission had even reported.

Second, the government made a lot of the fact they were adopting a majority (126 in full or in part) of the Law Commission's recommendations (153) but never acknowledged they ignored the major recommendations related to dismantling alcohol marketing, increasing the price, or leading change in reducing accessibility of alcohol; the recommendations that would've made a significant difference.

Third, there were a lot of political time games played. The government initially delayed introducing new legislation by over 18 months after hurrying up the Law Commission to produce its final report. They then timed submissions on the new bill to coincide with Christmas/New Year, delayed the 2nd Reading of the new bill until one month before the general election, and introduced further delays in passing legislation.

Fourth was arguably the biggest scandal. Peter Dunne, Associate Minister of Health with responsibility for alcohol policy, withheld the results of a high quality Health Sponsorship Council survey that showed majority support for substantial alcohol reform in contradiction to the government's rhetoric about the public not wanting major changes.

Fifth, the government quickly dismissed 22 Supplementary Order papers, and then using the conscience vote in Parliament and an unusual two-stage voting process to see off any change to the purchase age even though a majority of MPs indicated they wanted it changed.

Finally, the government had the gall to announce that the new "Alcohol NON-Reform Bill" was a great success. Perhaps it was a great success for the government's sponsors in the alcohol industry – good job done!, heavy drinking culture intact, money will continue to pour into the coffers – but the health and well-being of ordinary NZ citizens continues to be put at risk through the national drug-using pastime of heavy drinking.

The National-led government had dealt with the latest threat to the profitable heavy drinking culture not continuing, but decided to take further action to keep alcohol reform at bay. They duly knocked the Alcohol Advisory Council (ALAC) on the head, and buried it into a newly formed Health Promotion Agency (HPA), with a Board that steered the organization towards individually-based health promotion (individual responsibility) and away from population-based health promotion (government responsibility). In contrast to ALAC which frequently made public comments about the need for scientifically supported population-based interventions , including "the big three" – marketing, pricing and accessibility – not a squeak has been heard from the HPA on the need for substantial new regulations on alcohol since its inception in 2012.

There have been many efforts to right the harms unleashed by excessive neoliberal reform of alcohol regulations, and some small success has been achieved. Instituting a zero limit for drink driving for teenagers has probably been a factor in youth hazardous drinking rates dropping a little, and a lowering of the adult drink driving limits from 0.08mg/dL to 0.05mg/dL has probably helped a little as well; but as has been said previously, it probably requires two or three major reforms acting in synergy to have a substantial impact on heavy drinking in New Zealand.

Most recently, it has been very disappointing to hear senior members of the new Labour-led coalition government (Jacinda Adern and Andrew Little) put the chill on considering what to do about the continuing normalized alcohol crisis. In the short-term we can only hope the Tax Working Group and Mental Health & Addiction Inquiry Team make strong recommendations for alcohol reform that convince the government to be brave and act in the public's interest.

Cutting back on alcohol

The Health Promotion Agency recently published a report that examined how drinkers think about and attempt to reduce their alcohol consumption. This report used data from two national surveys of people aged 15 and over:

- the 2015/16 Attitudes and Behaviour towards Alcohol Survey, which asked questions of 'last occasion drinker' (those who had consumed at least two alcoholic drinks in the past three months)
- the 2016 Health and Lifestyles Survey, which asked questions of 'past-year drinkers' (those who had consumed alcohol in the past 12 months).

These surveys revealed the following trends

A quarter to a third of drinkers had thought about cutting back

A key finding was that 26% of past-year drinkers and 36% of last occasion drinkers said they had thought about cutting back on how much they drank in the last 12 months. Older drinkers (45 years and over) and risky drinkers were more likely to report thinking about cutting back.

One in five drinkers had made a serious attempt to cut back

Eighteen percent of past-year drinkers reported making a serious attempt to cut back how much they drank. Those more likely to report a serious attempt were older drinkers (45 years and over), risky drinkers, Māori respondents (when compared to European/Other) and European/Other respondents (when compared to Asian).

One in ten drinkers had received advice on cutting back, but fewer had looked or asked for it

Nine percent of last occasion drinkers said that someone had given them advice, information or help on how to cut back on their drinking in the past 12 months. Those more likely to say they had received such advice were younger respondents (15-24 year olds), risky drinkers and Pacific respondents (when compared to European/Other). However, only 4% of last occasion drinkers said they had looked or asked for advice, information or help on how to cut back on their drinking in the last 12 months.

Friends, family and health professionals were common sources of advice on cutting back

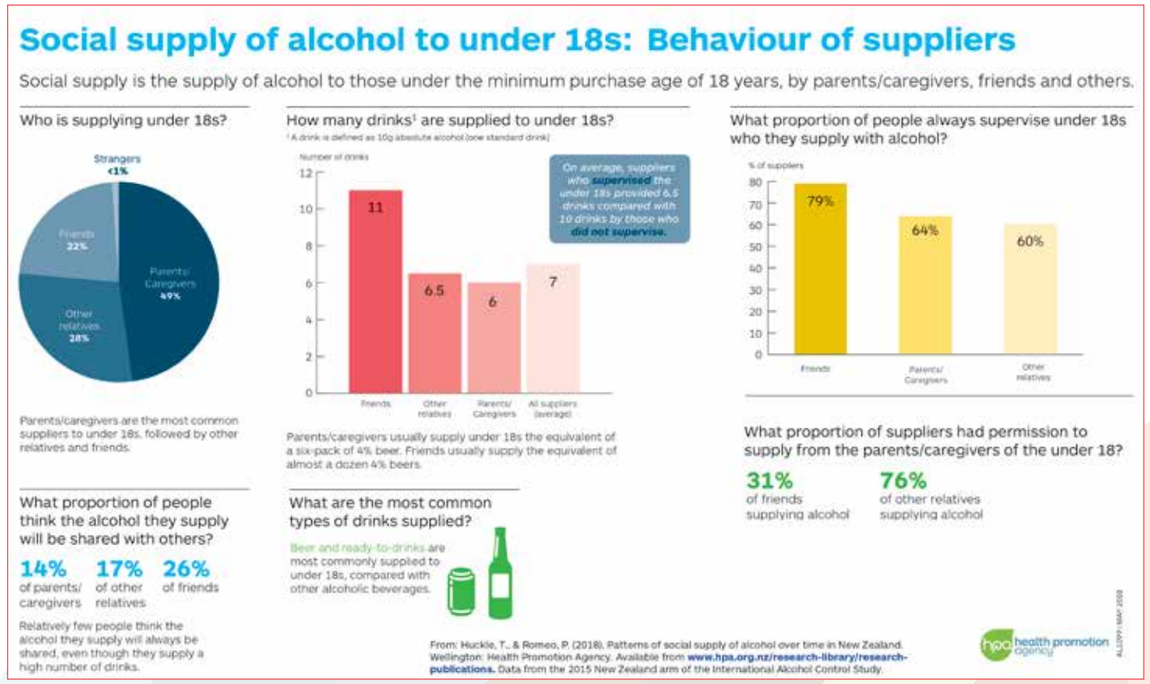
Past-year drinkers would mostly commonly look for advice or support on cutting back on drinking from friends or family (31%), a doctor/GP (22%) or a telephone helpline (20%). However, 39% of past-year drinkers would not use any of the suggested sources.

Risky drinkers were more likely to take actions to cut back on drinking

After their last drinking occasion, risky drinkers were more likely than non-risky drinkers to decide to drink more water or eat more food when drinking alcohol, or to drink less.

Source: Health Promotion Agency. (2018). Cutting back on alcohol consumption: Key results from the 2015/16 Attitudes and Behaviour towards Alcohol Survey & 2016 Health and Lifestyles Survey. Wellington: Health Promotion Agency

For more information, see the full report on the Health Promotion Agency website at https://www.hpa.org.nz/research-library/research-publications/cutting-back-on-alcohol-consumption-key-results.



CONSUMER VOICE

Akinihi's Story:

Opiate Substitution Treatment and the Transformative Power of Connection

By Nathan Frost

photo credit: Nathan Frost

For Ngā Puhi woman Akinihi Dawson, connection is about people supporting one another with empathy and respect. It's these deeply human connections to others she believes allow positive change to take root and flourish. This kōrero has relevance for the addiction treatment workforce who interact with people daily wanting to change their life circumstances, and it's a message Ms Dawson is uniquely qualified to deliver.

An Opiate Substitution Treatment (OST) consumer, Ms Dawson had the resilience to get clean and use her life experiences to help other women while working as a clinician for an OST service. However, while working in OST, Ms Dawson felt there was stigma directed at her due to her former drug use, and a culture of indifference towards clients of the service. She recounts, how negative attitudes displayed by colleagues in the form of blatant assumptions of her character and subtle daily puts downs slowly ground her down and led her to leave the service and eventually return to OST.

Things didn't change, and the way Ms Dawson felt about herself and her life didn't undergo a significant shift either until she was allocated a wāhine case worker with strong values who she says really saw the real her and connected with her being. While a recipient of this supportive relationship, the first of its kind Ms Dawson said she'd ever received while in the care of an OST service, she changed from methadone to suboxone with immediate positive effects. However, there is much more to Ms Dawson's Story than merely the swapping of one drug for another.

> *"I WAS DEVASTATED BY THE COMMENTS I READ. IT LEFT ME FEELING AS IF I'D BEEN KICKED IN THE GUTS"*

This is her story:

You've experienced a lot of stigma in your life, haven't you?

Oh yes, I being the eldest of ten brothers and sisters and having a Pakeha father to the rest of my sibling's, their dad was Māori. I loved my step dad very much but growing up, I was keenly aware of that difference. As a child people would ask me, 'how come you're so fair?' I would say, I'm the eldest in my family and when we have a bath I go first, and then the rest follow. Being the eldest, I always felt responsible for looking after everyone and so when their big sister is out there doing drugs, obviously something has gone

wrong! Some of my brothers and sisters were shocked to learn that I was using intravenously and despised the whole injecting drug scene.

One thing I find interesting about reading your story and probably quite unique is that you worked in the field as a methadone case worker and yet you were painfully aware of the stigma and judgement directed towards you as a former user.

The first position in OST I ever got was at the Auckland Methadone Clinic. I applied and was absolutely delighted when I was employed as a case worker. One day after the doctor's clinic I was putting away the files when I across the name Anne Dawson, (my name at the time) When I pulled out the file and began reading my notes, I was devastated by the comments I read. It left me feeling as if I'd been kicked in the guts. Here were these sentences describing me in some painful states and there was nothing, just cold and clinical observations. There was no connection whatsoever. As I continued to read with tears in my eyes, the hurt I felt was impossible to articulate.

And it wasn't just notes either, I can still remember the putdowns! In the start I believed people were just a bit curious you know. I evoked interest due to the mere fact that I was a Māori woman who had cleaned up after using drugs intravenously, went to school and studied at the same institutions as they did and eventually became employed at the same services as they did! But whatever else they thought about me they internalised in their heads and it'd come out in these nasty comments directed at me. One guy would say to me, 'Oh the only reason you're working in methadone is because you want to give them what they want.' I would look at him and say what are you talking about?! And he'd say, 'oh you're only doing it because that's what you used to do.' I'd say, listen

> *"I'VE ALWAYS THOUGHT OF YOU LOT AS JUST PEOPLE PICKING UP YOUR METHADONE AND BACK OUT THE DOOR BUT I SEE YOU AS REAL PEOPLE NOW"*

here, get a life. I'm not into that anymore! I'm here working next to you and, why are you working in methadone anyway and being so negative? Why not, go somewhere else and work if you don't like working with clients who are receiving methadone.

But it was just the constant undermining of my work you know, grinding me down all the time. It wasn't just him either. I remember sitting at my desk in Hawkes Bay and its nice and sunny and I've got a tattoo on my shoulder and a colleague said to me, 'I suppose you got one of your junkie friends to put that on you.' It was just awful stuff.

You talked of encountering an attitude of indifference towards clients of the service too.

I started a group for women on methadone and it was awesome! And this group went on for about 12-16 months and we met weekly. We heard of a conference being held down in ChCh and decided to fundraise to send down four women. The woman got together, had garage sales, did sausage sizzle, raffles and varies other things. It was quite the success! And, four of the women travelled down to Christchurch, the women enjoyed the conference! You want to see those women today, I was told that one did an accounting degree and the others changed their lives too and that's what it's all about.

I started putting out a magazine. And I'd get the clients to contribute, bring in their poetry, their stories, or whatever. We called the magazine The Score. I was doing these things for the clients, I was trying to build their self esteem and they used to feel great having their articles printed and getting read. The clients chose the name. None of my colleagues ever expressed much interest in the magazine.

Some of the women from group felt confident enough within themselves to stand and share their stories with the community. We put an advertisement in the local paper about the women presenting their stories. We set up a meeting for the public to attend and listen to their stories. Even some of the pharmacists came to the meeting that night and they were just blown away. I remember one guy saying, 'I've always thought of you lot as just people picking up your methadone and back out the door but I see you as real people now.' He was talking to the women who picked up from his pharmacy. When I think back on it, at the time it wasn't really heard of people sharing stories like these with the community and so I think we were ahead of time.

And you said that you felt stuff so keenly you actually got to a point where you wanted to go back on methadone because you were sick of feeling that way.

Well no, I didn't really know that I wanted to go back on methadone then, it just came right out of the blue. I went to my manager and I said I want to go on methadone, and she said, 'what?!' And I said again, I want to go on Methadone, and she said, 'have you been using? I told her no, I'm constantly miserable, and I don't feel ok. I just wanted to go back on methadone without having to use and to feel better. And she said to me, 'Akinihi, you can't do that!' She got the doctor at the clinic in the room and he was just blown away because he was also my GP down at his practice. Anyway, we made an agreement that I'd go and see a psychiatrist out of the Hawkes Bay area. When I saw the psychiatrist she said to me, 'Akinihi, why? Why do you want to go on methadone?' And I said it doesn't seem to matter what I do I just can't seem to feel happy. She said to me, 'Akinihi, when was the last time you've laughed, really laughed?' And I said, oh I don't know, probably when I was on methadone, and that's probably why I want to go on methadone again. I did all these positive things for others but nothing was helping me overcome the way I was feeling at the time about my life.

She prescribed me some anti-depressants to take. I took them for about six months but they had no impact on my mood. Then after a wee while John Marks came over from Scotland and he was the guy that set up the heroin programmes in London and he came over to NZ to give talks. He was sitting in the office with us one time talking and he said, 'oh well I suppose none of you would ever get into heroin if we had it legalised in NZ.' I said, you wanna bet? I would! And he looked at me and he was quite surprised. I knew it was still in me, I wanted to feel ok.

I quit working in OST and ended up working in a trust in Central Hawkes Bay and then at Arohata Women's Prison. I knew my heart was not in my work. One day I just decided to use, I asked my friend for some and that was it. I ended up back on OST after a person who worked in the field of Addiction spotted track marks on my hands during a meeting. She said, 'you've been using!' This wasn't the way I'd planned to expose my using but I just thought, oh well, its better now than later, at least I'm going to get some help now.

And you ended up with a case worker at the service who you really connected with, and there were some quite special outcomes in your life because of the respect this person showed you right?

Yes, Louise became my case worker. She did the best she could for me, which I really respected her for. She was open and explained each of goals that I worked through. She really listened with her puku, not with her head you know? I mean she was brilliant. I'd never had that before someone being there for me. The respect she gave me, respect as a woman, and respect as an older Māori woman made a lot of difference. I couldn't believe it.

So this difference you're talking about, it's the difference of actually being seen by someone as a human being as opposed to just being seen as a druggie right?

Yes, having someone there supporting me without judgement, that was the main thing, having her there in my corner. Everybody else I saw at OST never acknowledged that I had a life away from drugs. She saw the qualities that I carried as well. Not just the mere fact I used drug again but how difficult it was for me to choose drugs again. It was because of her support that I successfully swapped over from methadone to suboxone. I was able to count down from 115 milligrams of Methadone to about 40mgs. And I think because I'm an older person and who has arthritis she ensured I was in a safe place for the changeover to happened. Her encouragement and support made the process of my swapping to suboxone so smooth. It was because of her that I had good medical care and support throughout that process.

So you're on the ward and obviously Louise was a staunch supporter, so did she visit you regularly while you were up there?

Oh yes, she would come and visit me daily, even if she was busy you know she'd rush in for a few minutes, she was connected with me throughout my entire time on the ward.

And did the respect and empathy she showed you contrast to doctors or nurses working on the ward? Did you find they were on board a bit more because of this person who obviously really believed in you, or did you find that they were a little bit less enthusiastic?

No, no, they were pretty good but it was different for them you know. I mean they don't know much about drugs, they're only doing their job but they were ok at the same time so I didn't feel like they were wary of me or didn't want to take my blood in case I gave them Hep C or something, you know, all that stuff.

> *"IF THE SHOE WAS ON THE OTHER FOOT AND IT WAS ME STUFFING UP MY MEDS THINGS WOULD BE DIFFERENT"*

But you didn't feel judged?

No, no, I didn't. I suppose I didn't feel it because I was just really open and I made an effort to be really pleasant to them and even the doctors used to say to me, 'what a brilliant patient you are!'

Suboxone has been a bit of a revelation for you hasn't it?

For me swapping to suboxone, it was like everything became a lot clearer, it was like a cloud had lifted and I was looking around me thinking the world seems like a happier place.

How is your experience of OST services today?

So just a couple of months ago I had to go to another pharmacy to pick up my suboxone but the one I usually go to was closed on Queen's Birthday Monday, so I had to go across the road and when I went in they didn't have it. The pharmacist in there tried to give me 115 milligrams of methadone and I said I'm not on Methadone and he said, 'I know that, but this is the script they've sent in to us.' The pharmacist said, 'I'm really sorry but that's all there is here, and I can't prescribe you suboxone,' so I had to go without.

I wrote a letter of complaint and before I posted it to the OST service responsible, I went and saw a lawyer as I did not want any consequences from the service for making a complaint. A doctor rang me up to apologise and after I made some comments he then said, 'oh well we all make mistakes.' I got annoyed with that comment! We all make mistakes, really? I contacted the health and Disability Services. The OST service then sent me a letter and they apologised. It didn't really satisfy me but that was all I was going to get.

So, you don't really feel like things have changed?

Definitely not! Its still the same. And that's what I said to the team leader. If the shoe was on the other foot and it was me stuffing up my meds things would be different. I mean people get punished on the programme if they stray from their prescribed meds, don't they? The GPs and doctors that write out the scripts ought to be vigilant, it's not on! 'Oh yes we agree, it's not on and this time round Akinihi, the doctors will be vigilant in writing out scripts.' It just felt like they were repeating what I'd written without any real commitment to change and it won't make a bit of difference and that's what I want to emphasise too. However, since having this conversation with them they have told me changes are on the way.

Having been a consumer and having also worked within OST services, what is your message about what must change?

One of the things that I did ask was whether they had a consumer in their meetings to advise them and provide a consumer perspective? And they replied that they didn't. Well that's got to be something that changes.

The way staff uses language with some of the people seeking treatment needs to be addressed too. People have skills.

Whether they've actively used in the past, are currently receiving treatment, or have stopped using drugs altogether all people deserve to be treated with respect and dignity.

I want them to seriously address the problem of making mistakes with clients' scripts too. I mean not only did they stuff mine up this Queen's Birthday weekend but I've had so many problems when travelling up to Auckland with family.

I've been really seized up with arthritis in Auckland and had to wait until the next day for scripts because of mistakes. I understand that methadone is not a cure for arthritis, picking up your daily dose sure helps with pain. To them it doesn't matter, you can go without for a day and still manage, this is what they say.

Akinihi story reminds us that at the end of the day, it's all about connection. If case workers connect and respect the people, they are working with then transformation can and does occur. So, let's leave the last words to Akinihi.

I wouldn't be where I am today if it was not for Louise believing in me, seeing me, and seeing beyond the addiction to the person – Akinihi a strong, caring Māori wahine.

Check out Akinihi's presentation The Stigma of Dependence at Cutting Edge.

The 4K Model:

Cultural Comptency and Working with Māori

By Maynard Gilgen

photo credits: Nathan Frost

Kai

"He toa kura, he toa pāhekeheke; he toa mahi kai, rangi tēnā e roa te kawenga"[1]

Kia ora (greetings)

In the mid-1960s, I recall how often kaumātua Māori (elderly Māori) would come to visit my father at his work. He was a horticulturalist and had a contract gardening business, as he looked after the landscaping and gardens of the Mormon temple on the outskirts of Hamilton. Alongside this mahi he also grew ngā putiputi (flowers) that he auctioned at Turners and Growers, as my grandfather in Switzerland often sent him seeds through the mail. I've recently come to realise now, with reflection, that kaumātua Māori and Pacific Islanders came to speak to my father about māra kai (gardening. I suspect they shared gardening secrets, techniques and knowledge that enabled them to grow māra kai effectively. They would often bring him paukena (pumpkin), kūmara, kamokamo, riwai Māori (Māori potato), kanga (corn), pūha, tomato (tomatoes), kūkama (cucumber), etc. In turn, my father would also give them a koha of ngā putiputi (flowers) and pot plants.

This story introduces my next kaupapa of the K4 model: Kai.

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

1. **What is kai?**

Definition

Examples

- Atua Māori
- Hekenga
- Māra Kai
- Pātaka Kai
- Marae
- Koha
- Tapu and Noa
- Aotearoa
- Kūmara
- Hākari
- Tangihanga
- Kaitangata
- Colonisation and Urban Migration

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

What is kai?

Definition

The following are definitions of kai:

(verb) (-nga,-ngia) to eat, consume, feed (oneself), partake, devour. *E te iwi, he haukai tēnei kei tō aroaro, kainga!* (TTT 1/7/1930:2099) / People, this is a feast placed before you, devour it!

(verb) (-nga,-ngia) to drink - used for any liquid other than water. *Ka rīria a Hōne e Apirana he kaha nōna ki te kai waipiro* (TTR 1998:184). / John was reprimanded by Apirana because he drank alcohol to excess.

(noun) food, meal. *He nui te kai: te parāoa, te huka, te tī, te pīkara, te tōhi, te pīwhi, te poaka, me te tini o ngā kai* (KO 15/12/1886:8). / There was plenty of food: bread, sugar, tea, pickles, toast, beef, pork, and much more."[2]

Atua Māori (Māori Gods)

Kai, similar to other indigenous people, is intrinsically connected to Māori cosmological beliefs[3]. I briefly spoke about a Māori view on cosmogny in my article on Karakia[4]. In the article I spoke about the separation of our cosmological parents, Papatūānuku (earth mother) and Ranginui (Sky father) and how from them, their tamariki (children) shaped the world as we know it today[5,6].

Walker speaks about this,

"The personification of natural phenomena in the Māori pantheon is fundamental to the holistic world-view of the Māori. Papatūānuku was loved as a mother is loved, because the bounty that sprang from her breast nurtured and sustained her children. Humans were conceived of as belonging to the land; as tangata whenua, people of the land. This meant they were not above nature but an integral part of it. They were expected to relate to nature in a meaningful way. For instance, trees were not cut down wantonly. If a tree was needed for timber, then rituals seeking permission from Tāne [god of the forest] had to be preformed first. Similarly, a fisherman had to return to the sea the first fish he caught as an offering to Tangaroa [god of the sea]. The first fruits of harvest season had to be offered to Rongo, the god of cultivation. It was believed these practices ensured the bounty of nature would always be abundant"[7]

Tapu and Noa (Restricted and Ordinary)

For those of you who have had the privilege of being formerly invited onto a marae (buildings around a meeting house courtyard) as a manuhiri (guest), the process used to welcome manuhiri is pōwhiri (a Māori ritual of encounter). Once, the wero (challenge), karanga (ceremonial call, summon), kōrero (speeches of welcome), waiata (songs), the hongi (pressing noses) and harirū (shaking of hands) and some whakawhanaunga (sharing who everyone is) has occurred, to break the tapu (sacredness) of this event everyone is invited to have kai (food). Mead reported,

"In a strict sense cooked food is an agent for bringing people back into a safe state of noa"[8] [to be free from the extention of tapu].

Barlow also speaks more about this principle, kai being used to return us to a state of noa (to be free from tapu, ordinary and mundane),

"I ngā wā o mua, a mahia he hāngi tapu, he tikanga mō ngā mahi whakanoa i te tapu o te whare, mea anō rānei. Ka tunua he kūmara ki roto i te hangi, nā ko te kai māoa te mea whakanoa i te tapu. Mā te hāngi e taea ai te eke o te hā o te kai ki ngā atua, tēnā pea koia nei te pūtake o te kupu hāngi, ka hāngia te kai kia puta te hā, ka noho kau noa iho te kikokiko (nā te mea kua patua te manawa ora o te kai e te wera)".

"In former times (and sometimes today), special sacred hāngi were made as part of the ritual for opening a new house, or at harvest time when the fruits of the earth were gathered in. For these rituals, kūmara were cooked in the hāngi because it is believed that cooked food has the power to disperse tapu. Through the process of cooking in the hāngi the essence of the food ascends to the gods, thus rendering the food useless and void of the power to reproduce. This may be the derivation of the word, hāngi: the food is roasted so that in the hā (or life essence) is released and the remainder is rendered devoid of its goodness as a living entity. Cooked food is also used in many ritual ceremonies to render the power of tapu ineffective"[9].

Hekenga (Voyaging)

One of the reasons suggested for how our tīpuna (ancestors) arrived here in Aotearoa had to do with problems of kai, that is, a lack of it[10] due to overcrowding, and having a shortage of gardening space and a depletion of lagoon resources[11], such as, ika (fish) and mātaitai (shellfish). However, there were a range of other reasons too, such as, personal feuds and warfare, boundary disputes[12] and as both King[13] and Walker[14] reported there was also a wairua (spiritual) dimension to them traversing Te Moananui-a-Kiwa (Pacific Ocean) as well.

"The maritime skill and navigation lore of Polynesians were supplemented by their religious beliefs pertaining to the deity of Tangaroa."[15]

1 "A warrior chief is uncertain in his position, but one who is expert at food production has influence for a long time". In Mead, M., & Grove, N. (2001) *Ngā pēpepha a ngā tīpuna*. Wellington: Victoria University Press, p. 126.
2 Māori Dictionary. Retrived from http://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywords=kai+. Retrieved January 14, 2018.
3 Walker, R. (2004). *Ka whawhai tonu matou: Struggle without end*. Auckland: Penguin Books, p.14.
4 Gilgen, ME. (2016), The 4K model: Cultural competency and working with Māori. In the Bulletin, Vol 14, No.5, June 2016, pp. 3-7.
5 Walker, R. (2004). *Ka whawhai tonu matou: Struggle without end*. Auckland: Penguin Books, pp. 11-13.
6 Anderson, A., Binney, J., & Harris, A. (2015). *Tangata whenua: A history. Wellington:* Bridget Williams Books Ltd, p.9.
7 Walker, R. (2004). *Ka whawhai tonu matou: Struggle without end*. Auckland: Penguin Books, pp. 13-14.
8 Mead. H.M. (2003). *Tikanga Māori: living by Māori values*. Wellington: Huia Publishers, p. 104.
9 Barlow, C. (1991). *Tikanga whakaaro: Key concepts in Māori culture*. Auckland, Oxford University Press, pp. 16-17.
10 Anderson, A., Binney, J., & Harris, A. (2015). *Tangata whenua: A history. Wellington:* Bridget Williams Books Ltd, p. 21.
11 King, M. (2003). *The penguin history of New Zealand*. Auckland: Penguin, p. 38.
12 Anderson, A., Binney, J., & Harris, A. (2015). *Tangata whenua: A history. Wellington:* Bridget Williams Books Ltd, p. 21.
13 King, M. (2003). *The penguin history of New Zealand*. Auckland: Penguin, pp. 27-28.
14 Walker, R. (2004). *Ka whawhai tonu matou: Struggle without end*. Auckland: Penguin Books, p. 35.
15 Ibid, pp. 27-28.

Aotearoa (New Zealand)

Once tīpuna Māori had arrived, the first settlers were fortunate to manage through the first winter due to the abundance of fish, seal, and bird life[16]. Although this period was called the 'Archaic Māori' phase, Roger Duff referred to it as 'the Moa Hunter phase of the Māori'[17]. However, considering the significance of moa as a main staple during this period (AD 900 - AD 1100) Walker reported that Māori folklores concerning moa were scant, only about "*..five to six references*"[18]. Consequently, as the numbers of moa declined horticulture increased and along with this the population[19].

"By [AD]1300, when the population grew to approximately 25,000, cleared fertile garden land became more valuable"[20]

Māra Kai (Gardens) and Pā (Fortifications)

This then preempted from AD 1400 onwards tribal warfare over gardens and resources and with this fortifications also began being built called pā. [21]

This phase essentially ushered in the rise of hapū (subtribes) and iwi (tribes) and mana whenua (territorial rights, power from the land), as Barlow reported,

"Ko te mana o te whenua koia tērā te mana e taea ai te whakatupu ki ngā mea ora katoa i runga i te mata o te whenua.

This is the power associated with the possession of lands; it is also power associated with the ability of the land to produce the bounties of nature" [22].

Kūmara

The science of growing kūmara developed as it was a staple kai, but growing it here required being more sedentary and focused, as growing kūmara was challenging.

"...preserving kūmara tubers in storage pits (a process that had been unnescessary in a tropical climate) meant the communities had to remain with those pits, particularly in an era of larger population when competition for resources meant that less well-provisioned neighbours might be tempted to raid your larder...They [pā] probably originated from a need to protect kūmara tubers; but they persisted and became more important with population growth, competition for all resources, the pursuit of mana or authority for one's own group, and a generally more martial culture meant the communities had to protect themselves from immediate neighbours or marauding enemies from further afield."[24]

Hohepa Kereopa reported how

"...the old people used to say was that the abundance of your kūmare crop showed the health of your community."[25]

Kereopa goes on to explain at greater length the discipline and art of growing kūmara; how kūmara had to be handled delicately, just like handling a taitamaiti (child).[26]

By 1840 Anderson, Binney and Harris stated that approximately 98 per cent of pā in the North Island were cultivating kūmara.[27] They also go on to report that at AD 1769 they estimated that the total population of Māori was in the 80,000 to 100,000 range and that major growth would have happened in the prior centuries, as Māori adapted to the climate and developed ways to grow, preserve and store kai.[28]

Pātaka Kai (Food Storage)

As māra kai, hunting and fishing were seasonal, kai was gathered and collected in season and then stored or preserved for during the winter months when kai was scarce. Hence, kaimoana (food from the sea) such as, mātaitai (shellfish), ika (fish), tuna (eels) and ininga (white bait) and manu (birds) would be cooked, smoked or sun dried and be preserved.[29,30]

Hākari (Sumptuous Meal, Feast, Banquet)

Barlow talked about how kai harvested and caught were used to provide hākari for whānau, hapū, iwi and community feasts,

"Ko te hākari he kai nui, he whakangahau hoki. I ngā wā o mua, ki te huihui ngā Māori ka tū he hākari hei whakamutu i taua hui. Ka takaia ngā momo kai katoa e te tangata whenua mō te hākari. Ka hangā e rātou he atamira, ā, ka whakatarea ngā kai ki reira. Nā, ka haere mai ngā tangata ki te tiki kai mā rātou. Kia pau rā anō ngā kai ka hokihoki ngā tāngata ki ō rātou kāinga.

...Kāti rā, ahakoa he nui mārena, hura kōhatu, huritau rānei, ko te hākari te kai nui o aua hui. Mā roto i ēnei āhuatanga ka mōhiotia pēhea te nui o te aroha o te tangata, pēhea anō hoki tō rātou kaha ki te manaaki tangata.

The hākari is a special feast or banquet and is often accompanied by entertainment. In the past when people gathered toegther for a particular function, they would draw to it to a conclusion with a great feast, and these were sometimes displayed on a specially erected pyramid structure. People would come forward and take whatever food suited their fancy, and when it was all consumed would return to their homes and villages.

...Regardless of whether it is a wedding, the unveiling of a tombstone, or birthday, the hākari is a special meal, and it is often a good measure of the generosity and hospitality of the people responsible for putting it on" (p.17)[31]

Mead[32] also speaks about how kai is used on the marae[33], at tangi[34] (funeral), and used as koha (gifts), in the process of binding marriages, and the kaupapa of the hākari taonga: feast for exchaing gifts.[35]

One of the aims of a rangatira (chief/s) of a whānau was always to create a surplus so they could provide hākari for different occasions, such as, a tangi (funeral), hahunga (uplifting bones ceremony), wedding, birthday, or whānau/hapū/iwi hui (meeting). Being able to do this was symbolic of chiefly and whānau, hapū and iwi mana (esteem, prestige, power).[36]

"The feast reflected deeply held values related to food, power and prestige"[37]

The first Māori king, Pōtatau Te Wherowhero's demonstrated his mana and rangatiratanga (chieftainship) in May 1844 when he and other Waikato rangatira hosted a massive hākari for over 3,400 manuhiri Māori from local iwi, with a 1,000 Pākehā observers at Remuera.[38] The kaupapa (purpose) of the hui was "*...part of a series of peace-making ceremonies between tribes*".[39] Te Wherowhero's show of strength confirmed clearly that Auckland came under his mana by this act, which was a huge relief for the those living in Auckland at the time as tensions were rising in the North and the colonials living in Auckland feared that they might be attacked from the North.[40] According to Firth (1959: 321-31), the ethnologist, he reported that at this famous hākari

"...the food consisted of dried shark, potatoes, pork, flour, sugar, rice and other delicacies. There were 11,000 baskets of potatoes, 9,000 sharks, and 100 pigs consumed at the hākari."[41]

Marae (Complex of Buildings Around a Marae)

Mead points out how a wharenui (meeting house) is always separate from the wharekai (kitchen and dining hall) and abolutions (toilet and shower block). He also described how the wharekai used to be called the kāuta (cooking shed) and were simply places for cooking kai over embers. I have seen some marae retain a place for cooking over embers, given the memories a kāuta brings back of tīpuna cooking and speaking over the embers in time gone by.

Tangihanga (Funeral)

Barlow explained why a huge amount of effort is put into a hākari at a tangi,

"Ko te kai nui mō aua hui ka whakatikatia mo te rā whakamutunga o te hui. I roto i ngā hui tangihanga, ka whakatūria te hākari i te rā nehutanga o te tūpāpaku. Ko tētahi on ngā tikanga, he mea whakahoki mai i te whānau pani i te wheiao (ao wairua) ki te ao mārama, arā, ki te hunga ora. Mō ētahi Māori, ka noho puku rātou i ngā rā e takoto ana te tūpāpaku, kia tae rā anō ki te rironga ki tōna takotoranga whakamutunga, kātahi anō ka kai te hunga e noho puku ana.

At funeral services the hākari is prepared for the day burial. One of the reasons for this custom is to uplift and support the bereaved family by leading them gently from the rituals by which they expressed their sadness back the world of reality, so that they can pick up their lives once more. It is a custom also among a number of Māori to fast while the body of a dead person is lying in state, and not to end their fast until after the burial."[42]

The writer is reminded of the generoisty and mahi aroha (labour of love) given by the ringawera (kitchen workers) at his mother's tangi, who worked tirelessly in the back. A very humbling experiences. In turn this manaakitanga (support, care, love) is reciprocated.

Koha (Donation, Gift, Contribution)

Mead[43] and Barlow both specifically speak about the custom of giving kai as koha,

"I ngā wā o mua, inā ka haere te tangata ki ngā hui me tari atu e ia āna koha hei āwhina i te tangata whenua. I ērā wā, he kūmara, he ika, he manu huahua, he tuna – ngā momo kai a Tangaroa, a Tāne – koia nei ngā koha. Mai i taenga mai o te Pākehā, he kau, he poaka me ngā kai hokohoko, kau mauri ake ki ngā hui. Ko ngā tāngata e noho ana ki uta mā rātou ngā kai o te ngahere; ko ngā tāngata kei te taha moana mā rātou ngā kai mātaitai.

Fomerly when people attended hui, they would, as a matter of custom, take with them some koha or contribution in the form of food and other gifts such as mats and baskets. It was common for them to take kūmara, fish, perserved birds, eels, or any foods gathered from the land or sea in their local areas. These were their offerings or contributions to their hosts. Those who lived inland would take the bounty of the forests and rivers; and those who lived close to the sea would take fish, seaweed, and shellfish."[44]

These days money is now commonly given as koha to help the challenge a marae has to feed their manuhiri and whānau.

Kaitangata *(Cannibalism)*

Kaitangata (cannibalism) is sometimes a topic also raised when speaking about Māori and kai. Whenever I hear this topic it reminds me of how my nana would often use the expressions, "*Pokokōhua!*" (boiled head) and "*Kai a te kuri*" (food for the dog) when she'd become hōhā (frustrated, annoyed) or pukuriri (angry) with people. The practice of canniblism was not only

16 Ibid, p. 28.
17 King, M. (2003). *The penguin history of New Zealand*. Auckland: Penguin, p. 62.
18 Walker, R. (2004). *Ka whawhai tonu matou: Struggle without end*. Auckland: Penguin Books, p. 29.
19 Ibid, p.33.
20 Ibid.
21 Ibid, p. 37.
22 Barlow, C. (1991). *Tikanga whakaaro: Key concepts in Māori culture*. Auckland, Oxford University Press, p. 61.
23 King, M. (2003). *The penguin history of New Zealand. Auckland*: Penguin, p. 72.
24 Ibid.
25 Hohepa Kereopa cited in Moon, P. (2005). *A tohunga's natural world: Plants, gardening and food*. Auckland: David Ling Publising, p.62.
26 Ibid, p. 65.
27 Anderson, A., Binney, J., & Harris, A. (2015). *Tangata whenua: A history. Wellington*: Bridget Williams Books Ltd, p. 82.
28 King, M. (2003). *The penguin history of New Zealand*. Auckland: Penguin, p. 74.
29 Walker, R. (2004). *Ka whawhai tonu matou: Struggle without end*. Auckland: Penguin Books, p. 76.
30 Mead. H.M. (2003). *Tikanga Māori: living by Māori values*. Wellington: Huia Publishers, p. 187.
31 Ibid, p.17.
32 Mead. H.M. (2003). *Tikanga Māori: living by Māori values*. Wellington: Huia Publishers.
33 Ibid, p.104
34 Ibid, p.138.
35 Ibid, p.185.
36 Walker, R. (2004). *Ka whawhai tonu matou: Struggle without end*. Auckland: Penguin Books, p. 76.
37 Ibid.
38 O'Malley, V. (2016). *The great war for New Zealand: Waikato 1800-2000*. Wellington: Bridget Williams Books, pp. 46-47.
39 Ibid, p. 47.
40 Ibid, p. 48.
41 Mead. H.M. (2003). *Tikanga Māori: living by Māori values*. Wellington: Huia Publishers, p. 186.
42 Ibid, 18-19.
43 Mead. H.M. (2003). *Tikanga Māori: living by Māori values*. Wellington: Huia Publishers, p. 185.
43 Barlow, C. (1991). *Tikanga whakaaro: Key concepts in Māori culture*. Auckland, Oxford University Press, pp. 16-17.
44 Ibid, pp. 48-49.

restricted to Māori as it was practiced throughout Polynesia.[45]

I still recall first reading about Thor Heyerdahl's meeting of a Marqueses kaumātua, Tei Tetua, who told him he had eaten humans and how a women's forearm was the most delectable as far as human flesh was concerned[46] and that human flesh tasted like sweet potato.[47]

Although often related to war, as eating your enemy was considered more than just consuming your enemies mana, Walker reported,

"It was the ultimate debasement to be passed through the ailmentary canal and emerge as excrement"[48]

However, as Moon highlighted the practice appeared to be a normal part of Māori community life even though alternative meat options were available.[49] When I read Stirling's example of how he once arose to tell off one of my whanaunga (relations) from Tainui, who had belittled Whaia McClutchie who had spoken for Ngāti Porou at a tangi he made it clear,

"...if these were the old days, I would call out and have you killed, cooked in the earth oven and fed to all the people! Who are you to insult your seniors? You threw your challenge on the marae, and now you have been answered – you're Nobody!!"[50]

Stirling's kōrero (narrative) reminds me of my nana and how they had grown up in a time with our tīpuna who were closer to the stories of kaitangata, the musket wars, raupatu (land confiscation), disease, poverty, trauma, mate (death), and loss.

Colonisation and Urban Migration

Their generation were born at the beginning of the 20th century (Eruera Stirling was born 1899[51], my nana 1914), they were native speakers who were raised on their whenua, my koro (grandfather) and her had had an arranged marriage because of whakapapa (genealogy) and whenua (land). Sadly, due to colonisation and the pressure that was brought to bear on them to assimilate meant that they left their whānau, hapū and whenua, moved into the city, only spoke te reo Māori at home, had to adjust to living with Pākehā and being discriminated against by them and worked as labourers, as they, like many other whānau Māori, were not privileged to have been educated.

Although iwi marae were engulfed by urban sprawl with the high numbers of Māori moving into the cities, urban marae were soon developed and built as a consequence of urban Māori wanting to have a place to host tangi, rather than turning their home and backyards into a '*mini-marae*'.[52] Kitchens in small homes were put under huge pressure to cater for manuhiri who would come to pay respects to whānau members who had passed.

Salmond articulated this point when she reported,

"The great importance of food throughout the hui makes the cooks key figures in its staging. When guests leave the marae and return home, one of the first questions they will be asked is "how was the food?", and according to their answer the prestige of the marae rises and falls."[53]

Wharekai, especially on large iwi marae, such as, Turangawaewae (Tainui), Te Papaiouru (Te Arawa), and Te Tii (Waitangi) run their kitchens better than military operations. The many hands and expertise used to plan, gather, hunt, kill, butcher and operate a wharekai is more often than not grossly understated, as wharekai let their "kai" do the talking.

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

Firstly, it is important that you understand what marae etiquette is all about if you are going to have a whānau hui at a marae or attend a tangihanga, such as:

- Arrive early. It is considered impolite to walk onto a marae once a pōwhiri has begun,
- Dress formally (particularly, for a tangihanga),
- Introduce yourself at the waharoa (marae entrance) to other people and whānau you don't know,
- Give your koha (monetary gift) to the kaumātua (elder) or person with the envelope (if you have brought kai, you may either want to leave it in your vehicle or have given it to the wharekai prior),
- Ensure that your group has a person to pick up the rākau whakawaha (baton that is placed by a kaiwero/challenger), a speaker, and kaikaranga (caller) organised,
- Ensure that manuhiri have gone to the wharepaku (toilet) beforehand, as it is rude to walk away from the pōwhiri, and,
- Ensure cell phones are switched off before the pōwhiri begins.

Secondly, during the pōwhiri:

- Do not walk onto a marae; you need to be welcomed on,
- Women walk on as a group commonly in front of the men who are also in a group together,
- Do not eat, drink or smoke during the welcome,
- Never walk in front of a speaker on the marae ātea (clear area in front of the wharenui),
- Speak in te reo Māori, not English, if giving a speech,
- Males sit at the front on most marae, and,
- At the conclusion of the welcome you should harirū (shake hands) and hongi (press noses). While on some marae kissing on the cheek is considered appropriate, others prefer that men and women just hongi and harirū.

In the wharekai (dining room):

- Manuhiri are called to the wharekai for kai. It is polite to first let kaumātua and tamariki (children) go first. Often the person calling people in for food will say who should come first (sometimes this will be done in te reo Māori, hence, it is important to observe what is happening and follow suit),
- Wait until a karakia has been said over the kai before eating,
- Do not pass food over a person's head in the wharekai, and,
- Do not sit on tables, this is considered highly insulting as tables are looked at to place food not bottoms.

In the wharenui (meeting house):

- Remove your shoes before going into the wharenui,
- Check where you can sit as parts of the wharenui are reserved for particular manuhiri and tangata whenua,
- Do not eat or drink in the wharenui,
- Do not step over people in the wharenui,
- Do not sit or stand on pillows, and,
- If you are going to stay there mattresses and pillows are commonly provided but you will need to bring your own blankets or sleeping bag.

Sometimes a whānau hui session might be held at a tangata whai ora (clients) whare (home). If this is the case, again most of the etiquette above will still apply, especially, if the whānau have their kaumātua involved.

In a whare, where protocols are less formalized, and a whānau hui takes place karakia and a mihi whakatau (welcome) will continue to be used to open the whānau hui. Once introductions have occurred, sometimes kai will be left until the whānau hui has ended to be eaten to whakanoa (remove the tapu) the hui process. Again the purpose of this process is to bring everyone back to noa (to be free from tapu), especially if hard and challenging things have been discussed in the whānau hui.

Also, the discussions that are held in the wharekai are also highly relevant regarding a tangata whai ora and whānau, especially, when you have whānau members sharing with you other relevant information regarding their whānau member. It is also another way of whakawhanaungatanga (making connections) with the tangata whai ora and their whānau that helps rapport and trust building.

Furthermore, never eat in front of manuhiri or people, make sure that manuhiri and other whānau are invited to eat alongside of you. There are many stories about kai and whakataukī (Māori proverbs) that speak about how wars were started over kai, such as, being greedy and/or not thinking about others.

I have also never worked with a tangata whai ora that were hungry. I'd always feed them. I was fortunate when I worked with one Māori organisation, we always had kai in our cupboards and would either cook a kai for our tangata whai ora or if I could afford it, I'd take them for kai.

Every once in a while, if one of our whānau had no kai, we'd get them kai. The second time round, we'd refer them to our budgeting team. These acts of manaaki (care, support) always helped the therapeutic process without fail. Plus, during the 12 years I was with this service I never had any tangata whai ora or whānau attempt to take advantage of our manaakitanga.

One of the things to remember when getting your tangata whai ora and their whānau kai is to think about what type of kai you would like your whānau to have should they be impoverished and had no kai.

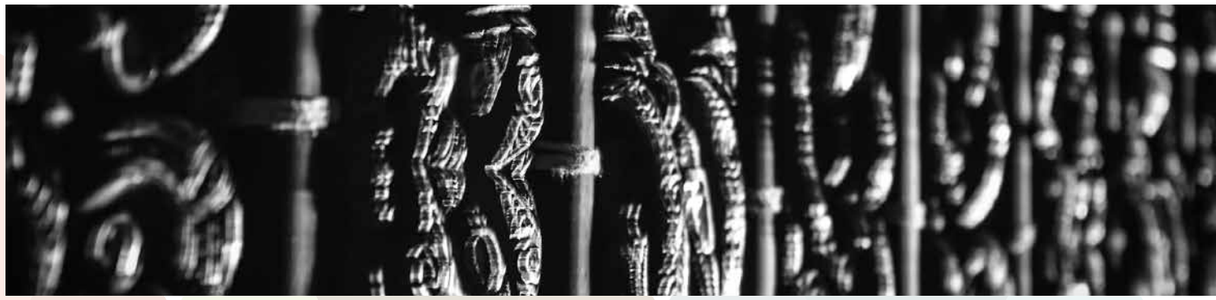
This level of manaakitanga was demonstrated by the whānau at Te Puea marae in Mangere, Tāmaki Makaurau (Auckland) when they opened up their marae to provide kai, a place to sleep and manaaki for the homeless and destitute.

Whakamutunga (conclusion)

Having an understanding and knowledge of how kai works in te ao Māori (Māori world) is imperative and can help in making and strengthening connections with tangata whai ora Māori and their whānau and the tribal boundaries you work in.

Kai, as has been briefly explained has a whakapapa connected to the beginning of time and is used as a process and tool in itself to manaaki (comfort) all who attend hui. Furthermore, having an understanding about marae etiquette and boundaries, such as, taking one's shoes off, not sitting on tables can also help keep us safe as practitioners and make our whānau feel respected. Likewise, as reported, kai is also used to return us to noa so we can move forward as a whānau towards whānau ora. To be invited into a whānau, is like being invited into a māra to help a whānau with their garden so their garden can thrive.

Kia ora, nā



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51 Ibid, p. 83.
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Word on the Street

I'm not domesticated, I'm urbanised

By Papa Smurf (Nellie)

photo credit: Nathan Frost

I personally have had a very hard time transitioning from the streets into a house since the streets are all I know.

The city and the coast are my go-to safe areas. I find staring up into the sky to see the stars graceful and somewhat poetic. The ocean reminds me of beauty so near but so far away, and I dream of another ocean sparkling emerald on the shores of Cyprus.

I dream of a childhood spent surviving on the streets and a missing mum confined to mental wards and the jail cells. I dream of bare and dusty sun baked roads, of breathing through wet cloths, of struggling to find a decent meal that wasn't mouldy bread and dirty water, the usual source of food or drink for those growing up on the streets of Cyprus. I dream of the constant danger facing little kids on the streets and the crumbling structures housing the naughty and orphaned. I picture these buildings in my mind's eye looking like they're about to collapse at any second.

I dream of the beauty of the sparkling emerald sea on the shores of Cyprus.

Two sides of a coin.

What is the hardest struggle? Leaving the streets to move into a house or moving from a house onto the streets. To the average person reading this the answer would seem easy, for who would want to live on the streets?

However, those of us who've spent our lives on the streets face many struggles moving into a house. I am comfortable on the streets. It's home. I don't quite know how to explain it. It's like trying to swim against the tide it doesn't really work unless you start flowing with the currents back, fourth, back, fourth and so on.

The decision to move into a house and off the streets was one of the hardest, depressing things I have survived and continue to survive.

Isolation:

It's like being in a padded cell, there is nothing to do, nowhere to go and no one to connect with. The streets have an energy I've never felt within the confines of four walls. Put me in a house and I start doubting myself and all I can think about is the best way to kill myself. My mind never shuts up. It's just so lonely, it's like breaking up with someone and feeling that constant heartbreak and not knowing what to do. That's what it really feels like.

Financial:

To have a house and continue to keep it, you must pay rent, power and other bills each week. You need drawers, a fridge, a washing machine, a dryer, stove and other appliances. You've got to learn how to use them without burning the place down too! Budgeting skills aren't exactly big on the street and every now and again I'd forget to pay and this gave me strife as well but these financial headaches have taught me valuable lessons too.

Maintenance:

Cleaning inside and out, the constant dishes and rubbish everywhere and loads and loads of washing. Then there's outdoor chores too, mowing lawns and trimming edges. I don't know why this is so depressing, but it is. All these responsibilities I had to maintain caused me so much stress I fell head over heels into depression. I would say that depression and suicidal thoughts are the thing I struggle with the most when living in a house closely followed by the financial struggle.

Over the last nine months I have been transitioning from the streets to a house. I have learnt a few valuable lessons but in the end I felt it was a waste of time and for a bit, lost all hope to this headache.

Confined within this suburban hell of four walls and fences that the rest of society seems to take great comfort in, my mind became an empty shell without the constant noises and sounds of life on the street.

This small isolated place wore me down, I felt like a hamster confined to a wheel day in and day out with no escape.

To deal with stress and pain I have used drugs and alcohol and for me personally, my drug now has become writing. It helps. It is a way to express all the tortured fear and pain. This is depression's tradition, so there is no surprise when we play with knives. There is no surprise when our hearts break. A cold chill always running down our spines. A predicament that leaves us broken and forgotten. It is written on the brick walls that make up a house.

So why the hell do I want to live like that. Houses killed my hope and made my soul visit the demonic land and I'm still trying to figure out why the demons are still following me and why they won't leave me in peace?

Now I live on my younger brother's floor on a mattress, at least it's better than the cold concrete of the streets.

One brick wall, two brick walls, a third and a canopy with a whisper of air through a cracked hole in my lookout window.

A chill in the air with temperamental vibrations that rattle without becoming a pain in the ass.

A house that feels like a cage with many voices and whispers of smoke I don't recognize.

The crushing thoughts of death peering in from every corner and the sense of being alone in a forgotten land.

A beginning that doesn't make sense but the reason to live free in the next life because isn't that how death is proclaimed anyways.

An escape of a lifetime but a familiar sense of struggling and that is all the struggling I can do.

I close my eyes and all I see is fun at my death bed.

I open my eyes and I've come back from death.

I sit up and see the dust slowly starting to swallow the empty space in my mind.

I lay my head down and the only thought I've got is how long will it take me to get back to my death bed.

I feel like this self-doubt is going to cause a safe return to nowhere.

I smell danger when it rests in my lap just to let it slip into the endless pit in my mind.

I'm a survivor not a zombie.

Johnny's Story

Personally, after being on the streets for a few too many years I have become more and more depressed because of the way people treat those who are unable to get back into a normal lifestyle.

The biggest struggle I've found is trying to stay warm as well as getting a good enough sleep. Although I am unable to sustain myself financially, it's even bad enough trying to get food that will last me long enough. Whenever someone asks me why I am where I am, I try to explain the facts to them, but they don't get it unless they have experienced it for themselves. And they think we are all on drugs and alcohol. Not all of us are the same, some do use drugs and alcohol for whatever, but others like myself prefer warmth and food.

Normally I sleep during the day and stay up at night because at night it get's way too cold to sleep, especially in winter. Half my money goes towards the internet café because that is the way I can stay warm as well as occupy myself, so I don't relapse back into my depressive state. When the public ask about my mental health, I say, dealing with depression while struggling to live on the streets is much more dangerous because of the possibilities of being a high risk to public people and myself. Not many people know if someone is suffering from depression, because they don't want to know, or they don't care. When people say they don't understand, it frustrates me because I must explain it on their level.

In memory of Tim, a friend and colleague

Obituary by: Naomi Wickens Mary Freeman Dr Richard McGrath

Sadly, Dr Tim McKenzie passed away on 10th July 2018. Tim was a general practitioner with a practise in Newlands, Wellington. He had a keen interest in addiction and worked with injecting drug users in the Wellington region.
He was instrumental in establishing the Wairarapa Methadone Service in 1993. Between the years of 1993 and 2007 Tim travelled from Wellington to Masterton every month to see clients. He often bought delicious morning teas with him. He was an absolute pleasure to work with, nothing was ever too much trouble.
He was compassionate and developed excellent relationships with his clients and their families. In 2007 Tim decided to focus on his general practise in Wellington but continued to see methadone clients in his practise and was a strong proponent of GP management of Opioid dependence. Tim had a great sense of humour and he was a dedicated family man. He is sadly missed by all who knew him.

Cutting Edge 2018

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Registration Fees

Staff and members have identified an issue with the current fee structure creates a lot of administration. For instance, when someone upgrades from associate or provisional to full registration the database automatically generates an invoice for the lesser amount owing for those two categories (their current status not the status they are applying for). This means there is a lot of confusion and to-ing and fro-ing. Given this we are making a small increase in the full registration fee and will align these other two fees with the full registration fee. This will take place 1st December 2018 and from then, we will be expiring people who are 60 days or more overdue. There will be no other fee increases at this stage.

Current fee		Proposed fee 2019	
Standard	$110	Standard	$110
Associate	$300	Associate	$325
Provisional	$300	Provisional	$325
Registered	$320	Registered	$325
Support worker	$200	Support worker	$200
Supervisor	$100	Supervisor	$100
Supervisor not dapaanz	$210	Supervisor not dapaanz	$210
Student	$50	Student	$50
Accredited supervisor	$100 (dapaanz reg practitioners)	Dapaanz reg practitioners	$100
Accredited supervisor	$210 (practitioners with registration outside dapaanz)	For practitioners with registration outside dapaanz	$210

Can you please quote your full name when you are making a payment and submit all required documents otherwise there can be significant delays in processing applications.

Importance for gaining and maintaining registration

There is increasing requirement in the DHB contracts for NGO employees/practitioners to be fully registered or on the pathway to full registration. It is really important to maintain your registration. Some practitioners have let their registration lapse and their qualifications no longer meet the requirements set in 2014. If working as a practitioner you registration (whether associate, provisional or full) should be up-to-date and valid at all times. We want to support you to maintain your registration so please get in touch if you have any issues.