



Addiction

Summer Edition : 2019

# Standard

F

FEATURE

## Gaming addiction

And the impact of technology  
on our lives // **pg 16**



OPINION

## Synthetics

Aotearoa grapples with drug policy  
reform, we debate // **pg 4**



NOTICE BOARD

## Registration & Forms

The latest news on registration  
and qualifications // **pg34**

**Gaming addiction**  
& the impact  
of Technology

**Pros & Cons**  
of disclosure for  
those with lived  
experience

**Synthetics**  
Policy reform &  
Street Opinion

**Learnt behavior**  
& repeat drink  
driving

**Compassion**  
**Fatigue**

**Noticeboard**





*Tuhia ki te rangi*

*Tuhia ki te whenua*

*Tuha ki te ngākau o ngā tangata*

*Ko te mea nui*

*He tāngata, he tāngata, he tāngata*

*Tihei mauri ora*

## **Nau mai haere mai to the summer edition of the Addiction Standard.**

What exciting times for the sector. For the first time in many years it feels like the winds of change are blowing and this should have a positive impact on our workforce and people affected by addiction.

Firstly, the much-anticipated release of He Ara Oranga. The Government's courage in giving the inquiry panel such a broad scope coupled with extensive community consultation throughout the inquiry process, has resulted in an excellent report with sound recommendations.

It was great to see such a strong representation from addiction practitioners and those with lived experience. Dapaanz was vocal throughout the consultation process in advocating that the needs of real people are reflected in all aspects of the design and implementation of any new system.

As a result of a meeting organised by dapaanz, members of the inquiry panel got to hear first-hand from 25 people in early recovery about the things that helped them achieve and maintain recovery. Also, our submission reflected the views of the workforce and people with lived experience including family members (465 practitioners; 200 from those with lived experience).

If the Government has the courage to commit to the recommendations of the inquiry, those affected by mental health and addiction (those needing treatment options and hope) will have access to a well-resourced system that understands the cultural, spiritual, and family/whānau needs of people seeking treatment and incorporates these psychosocial needs into treatment practice.

The potential of a reformed system to dramatically improve the health and wellbeing of addiction affected individuals, their families and whānau, and the communities we live in is huge, but only if the Government has the courage to act.

Also, great news the Government announced their response to the synthetic related deaths just prior to Christmas. We commend them for acting on this public health crisis and making it easier for those with addiction problems to get treatment. We do however, have questions about how the new policy will be implemented.

Historically, there has been strong evidence that police diversion has not been applied equally (Māori are less likely to get it). We also hope that police will consider the reality of life for many synthetic drug users. For example, people sleeping rough will find it harder to access services and are more vulnerable to falling through the cracks of any diversion system. Another important thing on our horizon is drug law reform. Great that the medicinal cannabis bill has been passed and people who are terminally ill will have a choice about their treatment without being criminalised. With the cannabis referendum looming and a greater appetite for change than we have previously known in Aotearoa – it is vital that people working on the front line of addictions, people affected by addiction and iwi are at the forefront of designing change. Dapaanz will continue to advocate in this regard. However, we wait with baited breath to see the Maori report and how this influences recommendations.

He aha te mea nui o te ao? He tangata, he tangata, he tangata! What's the most important thing? The people, the people, the people!

Let's keep the main thing the main thing! If we lose sight of the people, we lose.

This is the first edition since a very successful Cutting Edge 2018 – It's all about connection. In this edition of Addiction Standard, we have published the position statement that we developed in response to this year's conference. We had almost 600 attend and with help from Te Rau Matatini were able to award a record number of scholarships for those with lived experience.

A personal highlight for me was seeing our own indomitable Professor Doug Sellman receive the award for excellent contribution to addiction practice. It was also fantastic to increase the number of tangata whenua keynotes. We often look for overseas wisdom and models of practice, and there is certainly a place for that, but it was awesome to be able to draw on the depth of wisdom of some of our own indigenous leaders including Ta Mason Durie, Hinewirangi Kohu-Morgan and Tāmami Kruger. And of course, let's not forget our four amazing guests from overseas.

This edition has some great reading and covers some very current and topical issues. There is a thought-provoking article based on Lisa Phillip's research on addiction practitioner wellbeing. There are some challenges for us to face as a sector that are highlighted by this research. This particularly relates to practitioner burnout 5-6 years into their time as practitioners. Dapaanz is very keen to raise these issues and to advocate for more resource and care of practitioners.

Both Roger Brooking and William Blakemore provide an interesting alternative perspective on drink driving issues and we delve into online gaming with James Driver – arguably the new frontier in addictions. Sheridan Pooley's article reminds us of the importance of putting the person using our services at the centre. This is more than being person-centred – it is about continually improving our services based on consumer feedback.

Remember, if you would like to submit anything in the addiction Standard please email [sue@dapaanz.org.nz](mailto:sue@dapaanz.org.nz) with 'addiction standard' in the subject line or contact me on 04 282 109 to discuss. I hope you have had a great time with whānau over Christmas and a bit of a break from your mahi!

## **Tau hou hari**

**Sue**





# Synthetics

## Street Opinion

In the midst of these and other debates around drug policy reform, it's easy to lose sight of the massive impact legislation, (for good or for bad) can have on the lives of those affected by addiction.

As Aotearoa grapples with drug policy reform, the voices of those most affected are at risk of being side-lined in the inevitable societal debates change incites.

The homeless community have suffered the most from synthetic cannabis use and their voices are important to hear. Addiction Standard spoke to Ross and Kawana and here's what they had to say about synnies and the decriminalisation or regulated supply of cannabis.

”

By Nathan Frost

**In the wake of over 50 deaths related to synthetics (synnies), the two compounds mostly responsible for the fatalities – AMB Fubinaca and 5FABD – are being reclassified as Class A drugs under tough new measures announced by the Government last week.**

Those enjoying lucrative profits from the synthetics trade are being sent a clear message; get caught manufacturing or supplying these substances and you can expect Judges to impose a hefty sentence up to a maximum of life in prison.

Coupled with this tougher stance on drug profiteers comes a softening in attitude towards drug use and addiction affected people. For possession involving personal use, the government is directing police – where possible – to support people into recovery and treatment settings while allocating 16.6 million in extra funding to boost community addiction services.

The backdrop to these announcements are the recently released recommendations from the inquiry into Mental Health and Addiction to decriminalise all drugs and pump substantial funds into the chronically underfunded and highly stressed mental health and addiction treatment sector. 16.6 million is an excellent start, however, addiction treatment, early intervention and adequate community resourcing will require significant increases in funding.

Some see the measures taken by the Government as decriminalisation by stealth. However, the Government announcement signals their willingness to embark on a brave new direction for drug policy in Aotearoa.

What remains to be seen is how these bold new changes are implemented and how the police exercise their discretionary powers in deciding who to prosecute and who to refer for help.

**Ross** I started using synnies when it was legal and on the shelves. The reason I used it was because I was on the streets and cold. Synnies would put me to sleep, I'd pass out and then when I woke up I'd do it all over again. By the time it got taken off the shelves I was already hooked. Those who made synnies and the government who allowed them on the shelves are to blame. When they took the synnies off the shelves more people became interested in making it because of the profits they could make. Before then hardly anybody knew how. Now it's too late, I've seen my kids start using synnies, now there's teenagers everywhere hooked and it's too late and the government are to blame. They need to legalise marijuana because you can't stop marijuana, its natural, it grows in the ground, and it doesn't kill people.

**Kawana** I started using synnies after it was taken off the shelf. I was on the street up in Auckland and there was lots of it everywhere. It's got a really powerful buzz but it wears off quickly and then you want more. The buzz from synnies is so strong that marijuana has no effect so you can't use marijuana to come off synnies. It's very difficult to stop using because you get withdrawals like your stomach cramps up and your body aches. I've seen heaps of people fitting on synnies and I've tripped out and seen some weird demonic shit. I went a bit crazy on the stuff. I think the government needs to decriminalise drugs and start helping people. So many people need help. I support decriminalisation but not legalisation/regulation. I'm pro-weed and against all synnies.



# Compassion Fatigue



By Nathan Frost

## Does a Career in Addiction Treatment Affect Practitioner Wellbeing?

DAPAANZ Registered Practitioner Lisa Phillips' recently completed Master's thesis measuring addiction practitioner wellbeing was motivated by personal experience of working in the sector. While employed as a Clinical Team Leader at a residential service in Wellington, Ms Phillips witnessed firsthand how the wellbeing being of her team of 14, as well as the wellbeing of her colleagues, was being impacted in relation to the work they did. This personal experience, coupled with seeing practitioner related stress impacting the lives of her colleagues, caused Ms Phillips to become invested in improving the wellbeing of the addiction practitioner workforce in Aotearoa New Zealand. Addiction Standard spoke with Ms Phillips recently about the research she undertook for her thesis, and what it has revealed about the current state of hauora within the addiction practitioner workforce.

**Thanks for agreeing to be interviewed for Addiction Standard Lisa. Can I ask you where this idea for your Master's Thesis originated from?**

Its origins came from my conviction that Aotearoa New Zealand needs a strong and well supported addiction workforce to ensure that the people we love - who may experience substance use issues - get the best possible support when they access services. I noticed how often my team, my colleagues and myself as an individual were sharing about the impact of our roles on our own wellbeing. Conversations about our mood, our energy levels, and our relationships were common break-room banter. As I got to know my team better, we ventured in to the deeper challenges of the role. Questions like 'should I still come to work if I've lapsed?' and 'what if I don't want to tell my supervisor I'm attracted to that client?' were being asked.

I understood the reservations that people had about talking to their supervisor about these honest, messy, complex human issues. So I started thinking, this has to be a much wider experience for practitioners than just this service. I started finding myself having conversations with friends who were working in day programmes, and who were hating addiction work. Hearing how the job was impacting on them lit a fire within me about this topic needing to be more public. Not the sanitised version of workplace wellbeing, the real version. The version you can only get when there will be no impact on your practice. The kind you can only get with complete anonymity.

I enrolled in a Master's thesis program to allow my research findings a platform for further consideration. Often, research

that isn't backed by a learning institution doesn't gather the momentum that it deserves. As a beginning researcher, I was aware that I needed the backing of my supervisors to gather the support to implement the research findings. I needed to see what was going on for the workforce across New Zealand to make this a legitimate piece of research, rather than just an opinion drawn from personal experience. My driving force was to give the workforce a chance to be heard, with the safety that can come from the korowai that anonymity can provide. So, I decided to commit. To commit meant enrolling in an academic program and decimating the voice of doubt that has been a constant friend of mine from childhood.

My thesis specifically explored how the wellbeing of addiction practitioners is affected by their professional practice. The research framework that I wanted to pin all the data to needed to be an Aotearoa model of health, because I looked at all these international scales for measuring health and none of them actually fit for Aotearoa. None of the international models recognise the karanga of our Māori whānau, which demands for health to be viewed with a much larger holistic lens. Applying a measurement tool to a person, without considering the beliefs and attitudes that sit behind that measurement tool, means New Zealanders are silenced in the many areas that contribute to our sense of hauora.

Reviewing literature from some revolutionary Māori thinkers in health revealed the Hua Oranga assessment. This tool was developed by Mason Durie and Te Kani Kingi in 1997, and what quickly became clear was the relevance of this way of considering health, when thinking of addiction practice in New Zealand. I had to opportunity to meet with Mason and asked his permission to apply the elements of Hua Oranga to my research. After some extensive questioning, permission was granted.

This research represents the first time that addiction practitioner wellbeing in New Zealand has been considered by application of a model of health specific to New Zealand, and where the application of a measurement tool for wellbeing has been supported by the designer of the tool. My research addresses a gap in addiction practitioner specific literature in New Zealand and internationally.

This research should be of interest to the entire sector because we actually all have a role to play in promoting wellness. We're advocating for wellness in the lives of tangata whai ora, but what about workforce wellbeing? Registering bodies, advocacy agencies, the colleagues of addiction practitioners, and the practitioners themselves all have an ethical responsibility to support each other in relation to improving practitioner wellbeing.



## So where did you go for your data pool?

The data pool I used was the DAPAANZ register, which is an online public register where you have the function to send a message to registered practitioners. So I got all the approval letters and info sheets, held my breath and sent them out.

There were 600 registered from various services across NZ at that stage. The response rate was only around ten percent so I think given that more people didn't respond, the biggest validation the research can get is to find a way to increase the sample size. In terms of the research methods employed, I gathered my data using a questionnaire with qualitative and quantitative components. The research took a pragmatic stance, working with a series of scales and multiple-choice questions, as well as opportunities to provide free form narrative. All questions related to how respondents were doing in terms of their own wellbeing, and specifically how they were doing since starting practice as an addictions practitioner. The questions covered things about respondents' physical, mental, social and spiritual wellbeing and as I looked through the data, it became evident that stages of practice had a lot to do with practitioner wellbeing.

So in your first year you're more likely to be impacted in certain ways than you will be in your second and third year and so on.

Hey that is really interesting, in what ways, can you give me some examples?

Yeah sure. In their first year of practice, (some practitioners dubbed it 'the honeymoon phase'), people believe that their clients are basically good, they believe that their work has meaning, they're making a difference and their mental health tends to improve; but they're consuming more caffeine, (laughs), so some funny little things like that. First year practitioners love telling people what they do for a living, they're proud of the job all of those sorts of things. This was certainly the case for me.

I felt like my role was some kind of opportunity to give back all I had taken during my messy years, and the contribution I was making helped rebuild my sense of identity. I was motivated by my work, and avoided the habits and routines that contributed to my own decline in hauora. I truly believed I was doing good work, and my lived experience was a key contributor to this.

The research reflected that in the second and third years of practice, there's a bit of a disturbing deterioration in what practitioners consider their mental wellbeing, so their beliefs about the inherent nature of people changes, their belief that their work makes a difference decreases, they spend less time with their loved ones, they're more likely to be using illicit substances or prescription medications to manage depression and anxiety, all sorts of quite heavy impacts are occurring in terms of the job impacting on their health and wellbeing.

And then after the third year of practice, the shit really hits the fan. So between the third and fifth year was the riskiest period for this sample of respondents in terms of deterioration in every single area of Hua Oranga.

## And so what sort of percentage of the sample were these negative impacts affecting?

Practitioners within the sample at this stage of their practice were the most likely to be impacted in terms of their mental health.

Their rates of mental health deterioration become higher at this point of practice than at any other stage, with 83.3% of them reflecting on a deterioration between their fourth and fifth years of practice and this is likely to be occurring alongside deteriorations in physical, social and spiritual wellbeing.

Practitioners from this sample in their fourth and fifth years of practice were 39% more likely to develop a substance use issue while working in addiction services than those in their second and third years of practice, and 50% of respondents noticed an increase in their caffeine use, with an increase of 22.23% in the use of alcohol to manage stress related to the role. Also, 22.23% of respondents at this stage in their practice noted an increase in confidence to express their thoughts and feelings, alongside a 16.6% decrease in feeling their life made sense and a 15.5% decrease in believing that people are basically good.

Other decreases respondents noted included a loss of sense of personal identity, ability to prioritise spiritual wellbeing, and overall positivity. This stage of professional practice was reflected by the sample to be the most turbulent for practitioners across all dimensions of Hua Oranga. 66% of practitioners within the sample at this stage of practice were male, with females comprising 33% of the sample and 0% identifying as non-binary.

## Survey respondent quotes published in the research included the following:

- I have less sleep, I feel worried about the job. I have less energy.
- Due to (an) unhealthy initial toxic work situation, my health deteriorated markedly. Since the work situation has changed my health has improved, but a lot of damage was done that has repercussions for the rest of my life.
- I have learned the value of every little interaction. Everything you say can affect another person, you have to be so careful with people because you never know what could hurt them. I still have a strong faith in God, I just understand him less since working in addiction.
- It can be quite isolating. Many people have strong views about addicts and it can get peoples heckles up.



- I am more careful about who I share with, as you quickly realize how small a town can be when working in addictions.
- Once I realised the sedentary nature of the work. I was able to adjust my diet to suit.
- The role is far more sedentary than my previous work. I think this is a key cause of the weight gain.
- I started using amphetamine in the weekends only. It gave me energy to get things done, because I was so tired from the working week. I don't think I have developed an addiction, I just feel it helps me get the most out of my week.

## So is the data revealing a form of compassion fatigue?

Yeah, I think that's right, it's like an erosion or scar tissue growing over your ability to care. You're hearing the same story again and again, and the story stops being unique because you've heard it so many times. If a client has lost their children, or developed lung or heart issues, or survived abuse, or lost their home because they couldn't make rent; practitioners hear that story again and again and again.

It can get to the point where practitioners are at risk of becoming so calloused by the depressing regularity of these types of details coming up, that it stops being personal somehow, and all you hear are bits of information that fit somewhere in addiction assessment profiles. We can become detached, running straight for the functional analysis form when we 'discover' that a client has 'used', rather than respecting the value of sitting with the person for a while, and hearing them out when they choose to talk.

## So does this process you're talking about have a really personal component for you? I guess what I'm asking is when you decided to become an addiction practitioner, what did you think you

## were going to achieve and did your expectations match up to the realities of the job several years in?

I felt as I reflected on who I was as a person, that my practice didn't match what I believed I went into the job for. So, I felt like when I did my training, I was going to nail it yeah. I was going to work wholeheartedly to impact motivation for change in someone's situation. But then when you get into the job, you realise how many restrictions you have, what's considered professional and unprofessional, how strange the criteria for 'over-disclosing' are.

All these terms that don't exist in a normal human relationship, exist at work, and you start wondering how much of the job is you, and how much of the job is in fact organisational policy. Surely who you are as a person contributes to your effectiveness as a practitioner, but often it's not allowed to.

So I started to become that wanker who is speaking with a client, and the client is telling me the precious and tapu details of their life, and I'm sitting there guessing exactly what happened next because I've heard and lived this story before, which is a horrible place to be.

## So you felt you became cynical?

I think so. A lot of practitioners aren't completely vanilla, as in they have their own lived experience of mental health and addiction, so that sort of egotistical 'I'm on to you' attitude comes in too you know, and it's a yuk way to think of another person. When I began working as an addiction practitioner, I bought with me many elements of my own lived experience. I believed these would be tools for my practice, but I was naive about how little of my own experience would be welcome as shared knowledge within my practice. When you've lived through something, there's a certain way of being that only people who have lived through that thing truly understand.

When you have lived experience as a sex worker, you notice things that many other people don't. There are automatic thoughts that go through your mind because of that lived experience. You will always notice where other people choose to sit in a room. You will always feel more comfortable in a seat where you can see every other person in the room, as well as every exit. You will always ask yourself why a person is talking to you. You will always automatically asses every person in a room and decide what you might need to do to each person to get out of a room. You are always aware of a person's tone, their proximity to you, and what this might mean for your safety. When tangata whai ora come in to a service, and you can see them going through the same thought process before every group or 1-1 session, you naturally want to reach out to them and tell them 'it's OK, I've been there too, here's what you can do to interrupt the fight or flight and let your mind rest'. But you can't,

unless you're employed in a role which specifically allows that conversation to happen, such as a peer role.

You would imagine that bringing lived experience to work would allow you to contribute to bringing policy to life and ensuring that the service you work for reflects the needs of the people it serves. Staff members with lived experience serve as a valuable filter to ensure policies make practical sense. Despite this, many practitioners feel like the sharing of their own experiences is discouraged. So yes, it might be safe to say that I did become cynical!

**So to me you've just touched on stuff practitioners may face on a personal level but what about the impact of the organisational structure and policies of the services practitioners work for?**

If you can't be the complete version of yourself, heart, head and human at work, clients may as well be reading recovery websites or reading a recovery book. Recovery is messy and does not lend itself to sections in an assessment or wellbeing plan. Human to human, mess to mess and heart to heart – these are the components of effective practice that employees are nervous to navigate. We still have subconscious beliefs regarding who is fixed, and who is broken in the practitioner/client relationship. When we read our organizational policies and procedures, and our codes of practice do we see the subtle expectation that the practitioner is 'fixed', and tangata whai ora are 'broken'?

My biggest driver now is reframing professional practice, and the concept of professionalism in the mental health and addiction workforce. Looking at our codes of ethics, and our codes of practice, are we able to see any person being able to measure up to these? Are we able to see any humanity in these documents at all? I think, if we read our roles from these codes and frameworks, professionalism and clinical practice can become so cold and dehumanised that it removes the effectiveness of face to face recovery.

I really do believe that professionalism is about something much broader than the words you choose to use, or the way you choose to dress. It is more than knowing when to shut your mouth, and it is more than some letters after your name. Professionalism involves having the courage to challenge policies and practices that don't make sense, and organisational hypocrisy is one part of this. One aspect of addiction practice that many find confusing is the emphasis that services place on 'lived experience' being reflected in the workforce. This emphasis looks good on paper, but then when a staff member with lived experience begins to struggle, their struggle may be perceived as an inability to fulfil the tasks of their role.

This comes across as hypocrisy by the services who state that addiction is a 'chronic, relapsing condition', while at the same time expecting their staff to carry out their duties

without symptom presentation. I know that it's about reframing professional practice, but I'm wondering; who is responsible for doing this, and how do we do it? Is it client led, is it practitioner led, is it DAPAANZ led, I don't know. I just know it needs to happen.

**What about some of the structural issues around internal supervision, did your research delve into that at all?**

Yes, it did. Most of the practitioners in this research don't like internal supervision. Clinical supervision and EAP aren't working for many but talking to somebody employed at the same level at a different service is seen as useful. It needs to be somebody not directly involved with their service, somebody who doesn't have an influence on a practitioner's ability to progress in their career.

Most respondents stated they fear transparency with somebody who works within the same service as them, due to the possible impact honesty may have on their career paths. I can totally relate to this sentiment. I would wonder what might end up being passed on about me and how that might stunt my career. I absolutely believe there's a role in redesigning what supervision looks like and what purpose it serves.

And, how much of supervision is for the staff member and how much is it for the client? Because currently, it seems to be so client heavy that we forget the wellbeing of the person who's providing the support, which is a risky thing on its own.

**So are you saying the core role of what supervision should exist for – that you can turn up and basically be completely transparent and honest with someone – isn't being met?**

Well, I never was completely honest with my supervisor, never. I came to mandatory supervision with great little examples of my practice and things I could talk about. Supervisors weren't asking 'how are you really doing Lisa?', and if they had asked that, I'd say 'great' and it would not have been true. This was no reflection on the competency of my supervisor. This was a reflection on the impact of fear on the supervision relationship.

I mean how many of us would be OK with telling our supervisor that we are doubling our Citalopram because we're not coping? Would we share that the pot we smoke to help us sleep is getting in the way of the three nights a week we work as a call girl to cover the costs of the facial surgery we had to have to rebuild our noses after our ex booted us out of a 2nd storey window?

Do we share that it's hard to sit up straight because our ribs hurt so much, after they were broken, and went through a lung, which had to be removed, and now we're always short of

breath? Would we say that the tramadol and codeine really help with our pain, but we're nervous about driving the work van while we're under the influence of opiates? How much truth are we comfortable telling? How much truth are we allowed to tell before we are 'unsafe' for practice? How close can we skate to the line before someone decides we're not OK?

These are the questions that need an answer. Our practitioner workforce need more than EAP. They need the assurance that their lived experience, and all the fluctuations this may entail, will be treated as an asset, with the full support required to maintain excellent standards of service with tangata whai ora.

Until this happens, many practitioners will continue to show up to supervision with sweet little snippets of their practice that provide a pleasant distraction from the issues they are tackling in their own life. Meanwhile, the supervisor drives home believing they have built a genuine therapeutic alliance and pats themselves on the back for facilitating such a robust session.

**And it was because of those concerns around your career that you weren't completely transparent?**

Yeah, one hundred percent. I have heard the generalisations people make about tangata whai ora. I have been in the position of tangata whai ora. Having been in both camps, I was acutely aware of what topics to avoid with my superiors in terms of protecting my own career.

**So I imagine one area people would be loath to talk about in their private lives would be admitting any drug use. What percentage of the sample admitted as much?**

It was really high. 25 percent. And, the highest illicit drug use within the registered practitioner workforce happened within the turbulent time frame of 3-5 years. So if you've been practicing for over 15 years, the majority of that sample weren't using any substances whatsoever. It wasn't clear if that's a general aging trend, or if that's unique to practitioners. I do think the high rates of illicit substance use are unique because I haven't been able to find other literature that talks about that in related professions like nursing etc. So I'd love to compare it but there's nothing to compare it to, because we don't ask it.

**And was this just illicit and did you break it down further for example 'I'm smoking pot' or 'I'm smoking methamphetamine'?**

There was quite a bit of amphetamine use related to fatigue, and a lot of prescription substances that weren't being used as prescribed but just substance use in general be that alcohol, smoking, the whole range.

We don't seem to like ourselves, or the system we work in, very much in this workforce. There's something that needs to change so that our hauora workforce aren't feeling the pull to use illicit substances, and so that the journey alongside whai ora is sustainable and life giving.

If we take what we have, which is a committed, knowledgeable, resilient and genuine workforce, and we breathe life on the way we support them, we could have revolution in the way we practice working with recovery. We already have the skill, the means and the motivation within this workforce, so let's get it done.

We have a responsibility to support each other through this, and this is reflected in our own registering bodies values. My hope would be that the addiction workforce could access any supports they may need, without fear of reprimand or discrimination. Addiction is a health issue and needs to be treated as such.

The findings of Ms Phillips research should be of interest to every invested party within the sector that has a critical role to play in improving addiction practitioner wellbeing. Addiction practitioners in Aotearoa and those who train, monitor and support them, are capable of building on the findings of this research to improve the health and wellbeing of the workforce.

Ms Phillips believes that the addiction workforce needs to be encouraged to be bold when sharing their own backgrounds with addiction, which would serve to normalise these issues, as well as reflecting that addiction does not discriminate. We can be employed, hold down a full-time job with a family, and still have issues with addiction. According to Ms Phillips, the key is that we talk about these challenges, and the more we do, the less those of us who are in recovery, or working towards recovery, will feel isolated and unable to connect.

Ms Phillips' Doctoral research (commencing 2019) will also be dedicated to the addiction sector. This research will progress the findings of her master's research, by designing and developing a nationally recognised suite of addiction workforce support tools and recommendations. These resources will be designed with key stakeholders in the Aotearoa New Zealand addiction space and will be informed by the needs of the workforce.

Ms Phillips believes the addiction workforce requires the same levels of tenacious, relentless support available to tangata whai ora. She would love to hear from anyone, especially workforce groups and peak bodies, who would be interested in informing the design and scope of her Doctoral work. She can be contacted at [lisajordanphillips@gmail.com](mailto:lisajordanphillips@gmail.com)





# The **Pros** & **Cons** of Disclosure for Those with Lived Experience

By Nathan Frost

We all love a good redemption story, especially those involving the overcoming of adversity. For those in recovery, the redemptive nature of recovery stories provides a narrative framework by which the progress of the individual is often measured both internally and externally. 'I was lost, I fought my inner demons, I overcame said demons and now I'm a shining example of wellness and a beacon of hope for others.'

This narrative not only serves the personal journey of change for the individual extremely well, it also taps deeply into society's subconscious conventions of hero/heroine quest mythology. You only have to check out the 'now showing' section at the movies to see examples of how in love with this neatly packaged narrative arc we are.

But myths; and the feel good literary traditions they create, are something quite separate from the often messy realities of life. It's why journalist Jenny Valentish was at pains to present the complexities of addiction and recovery in her Walkley Award-nominated book, *Woman of Substances*. In it, she uses a series of candid vignettes from her own life to illustrate some of the findings of the research around addiction presented in her book.

And yet, as she found out herself when giving interviews, the media is only interested in rewarding people for reaching rock bottom and then redeeming themselves. There's rarely consideration about the reasons that people might use, or the struggles that they might face in sobriety.

For some people, telling their stories is even more complex. In a discussion at her Write Your Own Story work-shop at Cutting Edge, Valentish heard firsthand the difficulties that those working in the sector can face when opening up about their lived experience, and she'll be building on those conversations in her upcoming workshop in Auckland in February.

Addiction Standard recently caught up with Ms Valentish in London and had a very interesting conversation around the pros and cons of disclosure.

**Hi Jenny, thanks so much for taking the time to catch up today. So there was quite some talk at your cutting edge workshop earlier this year around the issues people with lived experience can face with disclosure. What were some of the take home messages that came out of that discussion for you?**

In the cutting edge work-shop I ran, the participants – some of whom were peer workers – were talking about the stigma within drug and alcohol services, with accredited clinicians perhaps viewing people with lived experience as something that might go off in your hand.

That puts an awful lot of pressure on people who are in recovery, and if there's a lapse or relapse, they're likely to feel a lot of shame, and probably try to conceal it rather than seek help. People in this workshop were also talking about the fact that peer workers can and often do go above and beyond

# Pros & Cons



their job description. You feel a responsibility towards your community, so you do things in your own time, like you might take someone to a meeting or go and visit a family member, so you end up being very stretched. I think too peer workers are often expected to be shape shifters. Depending on the occasion, they're either asked to rein in their personal stories if that's become embarrassing to the service, or to make themselves relatable by presenting themselves as a peer and possibly by disclosing. But that has a price tag when you use your story publically, undoubtedly it does.

**Do you think practitioners find themselves between a rock and a hard place because they are being this person, this kind of role model for people trying to get recovery and they're stuck in a role as the unblemished poster boy/girl for recovery.**

I was talking to Jack Nagle in Australia, a former meth user who has launched this online programme called Real Drug Talk, which he's done in collaboration with researchers. That's unusual, because often these courses are along the lines of 'this worked for me; you should try it.' This course is evidence-based, and he made it because he was disgusted at the prices that private rehabs – such as the one he used to work at – charge. Anyway, he was saying he's shared his story quite a lot in the media and he does it to be relatable for his brand, but he thinks about the mates he used to use with and how they'd be scoffing, 'What a banana.' He himself would have roundly taken the piss out of the kind of person that puts themselves forward as this paradigm of wellness. So yeah, you're walking a really difficult line.

Also, sometimes the only difference between somebody with 'lived experience' and a co-worker is disclosure, because I would hazard a guess that many people working in the drug and alcohol field, even if they don't declare themselves as such, have lived experience. Those who don't disclose don't have the same kind of stigma levelled at them.

Personally, when I get invited to speak at a conference as someone with lived experience, I always laugh to myself as I'm sure most of the audience also have lived experience but haven't shouted it from the rafters.

So that goes back to what we were talking about earlier doesn't it about making a choice around disclosure. Am I more comfortable being that person who is totally transparent and everyone knows the details about or do you kind of keep a certain amount of your life secret?

I wrote an article for The Saturday Paper in Australia about drug and alcohol researchers who are debating whether or not academics like them should disclose that they sometimes use drugs. And ultimately they've decided that they can't, but they really want to, because they feel hypocritical. How can we really address stigma if we're not even prepared to talk about our own experiences – as people relatively safe in our ivory towers – for fear of being judged and punished?

**Two very different groups of people: peer workers or practitioners with lived experience and researchers, yet very similar circumstances around issues to do with disclosure really. Perhaps this is all about what we believe around professionalism?**

Yeah, and it also comes down to what kind of supervisors you have. Whether you work for a service or whether you're a researcher, if you have a supervisor who doesn't approve then you can't really stick your neck out.

It seems to be safer to disclose psychedelic use because there's definitely a hierarchy in peoples' minds about what drugs are acceptable and what aren't, even within drug-using circles. It's a class thing as well, isn't it? Psychedelic users are seen as more middle-class, contributing to society, paying their taxes, etc, and not committing crime to get their next fix.

I hope to turn the next workshop I run with practitioners with lived experience into a discussion about people's fears and their previous experiences of having been shut down by the services they've worked for, or, conversely, pushed forward and expected to give more of themselves than they're comfortable with. So I'd like to talk about boundaries people feel have been crossed, or boundaries that that they need to put into place – and turn that into an organic discussion.

**Details and dates for Jenny's upcoming workshops will be posted on the dapaanz Facebook page as they become available.**





# Gaming Addiction & the Impact of Technology

By Nathan Frost

With the rise of internet-based technology and increasingly faster platforms to support the technology, more people than ever are accessing potentially addictive digital content in the form of games, apps and social media platforms like Instagram and Facebook. In fact, gaming addiction alone is not a new phenomena and in the latest edition of its International Classification of Diseases, the World Health Organisation concluded that people whose jobs, education, family or social lives have been upended by video games probably meet the criteria for a new form of addiction called “gaming disorder.” If a person escalates or persists in their gaming behaviour despite obvious negative consequences, that is further evidence of an addictive disorder the new guidelines say. That new technology has created a new form of addiction isn’t in dispute what remains to be seen however, is whether increased availability and ease of access, will see gaming and other available digital content online fuel an increase in technology based addictive behaviour.

Addiction Standard talks to Psychotherapist and former gaming addict James Driver who specialises in treating people with technology-based addictions and provides training and supervision to clinicians working with this issue.

**Hi James, thanks for taking the time to talk to Addiction Standard. Can I ask you how your interest in gaming and technology-based addictions developed?**

Gaming addiction has been around for well over a decade now. I originally was a heavy gamer myself and a combination of gaming, depression and anxiety led to my failing university. Once I left university these symptoms became worse and I went through a period of what I now consider to be gaming addiction

for a least a couple of years. During that time I was playing every single day from the time I got up until the time I went to bed, fourteen hours a day glued to the screen and that was pretty much it. This led to a whole host of problems. I ended up physically quite unwell, was quite severely depressed and this kind of exacerbated other problems I had around social anxiety. That was over 15 years ago now and about ten years after that I became interested in a career change and decided to study psychotherapy.

During my training I was on placement at a drug & alcohol treatment facility: Higher Ground up in Auckland, and as a consequence of working there and hearing from people who had substance addictions talking about their experience, it became incredibly apparent to me that everything they were saying completely resonated with my own experience around gaming. As a result of this I became very interested in the idea of trying to understand my experience with gaming as an addiction. This led to my Master’s thesis which was looking at the experiences of people who have received therapeutic treatment for gaming addiction. Since then I’ve done a lot more research and a lot of clinical work with people around technology related addictions, but it all started with gaming.

**Do you think we’ve been unprepared for the ways in which technology has created social distraction and isolation?**

Oh absolutely, I don’t think there was any way we could have been prepared because the technology is always evolving several steps ahead of our ability to understand what its really going to do for us; or more to the point, do to us. So yes, absolutely, I don’t think it could be any other way.

**So is the emerging technology in gaming and the platforms now available to people to access that technology like high internet speeds and unlimited data driving factors in the presentations you’re seeing in your practice?**

Yes, some of the time but of much more concern to me than the types of technology being used are the presentations I’m not seeing in my practice because people are in fact isolating themselves and completely withdrawing from the world. I think that the unseen nature of technology-based addictions is somewhat unique compared to other addictions because other addictions tend to create a bit of a head on collision with the real world at some point. With gambling it’s going to be the financial debts or committing fraud or whatever in order to keep funding it. With drugs and alcohol, it could be drink driving charges, domestic violence, or ending up in A&E getting your stomach pumped. In one way or another these addictions tend to lead to something in the real world that draws attention to them. With technology addiction, for many people it’s quite feasible to spend months or years just kind of locked up in a room gaming or watching pornography online or whatever and no one else except perhaps those very close to that person will be aware that it’s happening.

**Is there typically an age attached to technology fuelled addictive behaviour or is it across all age demographics?**

You do see it more with younger people and they are definitely more susceptible but its certainly not limited to that demographic exclusively. The games and apps have been trying



to expand their market base with content that appeals across a greater demographic. Others at risk would include those already socially isolated or those with changes in circumstances that have led to more time on their hands. Examples of this could include people who have immigrated recently or stay-home parents whose kids have started school when they haven't returned to work, and so not only are they potentially isolated and a bit disconnected but suddenly they've got a whole lot more time on their hands.

**Do you think there's a case to be made that the gaming industry are aware of the addictive nature of the games and apps they design and actually set out to cash in on that by building in addictive aspects to the games they design to keep people engaged for longer periods of time?**

I think they absolutely do although I imagine they wouldn't be talking about it in quite that way though. They'd just see it as

design features that ensure people enjoy using their product for longer. Software companies often employ psychologists with the aim to design systems into games that increase user engagement. Of course it makes sense from a revenue point of view - social media is all about the time you can keep someone engaged with the platform because the more exposed to advertising they are the more likely it is that they'll make purchases. Many of these things are designed with the explicit intention of getting the user to engage more actively or for longer periods. I don't necessarily think it's their intention to get people addicted, but it is their intention to get people to play or engage for longer and the consequence of that for some people is addiction.

**Given that so many of these apps and games are driven from a purely revenue building basis, i.e. keep you there for longer so you're exposed to more advertising, does there need to be some form of regulation around all of this?**

I never know quite what to think around regulation because it seems like a double edged sword. It seems like whatever you try to do, you solve some problems and you create others. We've got examples like alcohol which is substantially less regulated than lots of other drugs yet we still have addiction issues with all of them. Its not like something being completely illicit actually prevents people from finding it and using it either. We've seen increasing regulation around cigarettes, and e-cigarettes now filling that gap and all the kind of knock on effects from that. You can regulate around cannabis but then you get legal synthetics, which are infinitely more harmful, so it seems too complex I guess. If anything, attempts to regulate more often cause more problems than not. So I don't know. There's absolutely an argument for doing it and if we can find the right way to do it I think that would be fantastic, but I don't know what that right way would be.

**So what do you encourage people to do in terms of practical steps to overcoming their technology addictions?**

The best thing anyone can do as a protective factor against developing addictive behaviours is to make sure that their basic psychological needs are being met in other ways and that's not always an easy thing to do. We all have things that we're not totally satisfied with in life but failure to address these things is often where addiction begins because we start meeting core psychological needs through using substances, or addictive behaviours. So it's about recognising those deficits, things that we're not happy with and trying to find a way to change them. That might mean changing a relationship or changing a job or career path, or it might be recognising something internal that needs to change. Perhaps that internal critic is too harsh or a person is stuck in some unhelpful thought processes and that might mean getting some therapy or something like that. I think people need to be consciously mindful of those psychological

needs not being met and making conscious choices about how they're going to address those needs in order to remain less susceptible to addiction.

**Do you think more needs to be done in terms of raising awareness in the community around the prevalence of emerging technology addictions?**

I think it would be really helpful for people to have some kind of information to know how to assess their own behaviour and have a system or tools they can use to be able to reflect on how they are using technology a little bit more consciously. One of the things that leads to problems is the fact that we end up making automatic or semi-conscious decisions around technology use. People mostly aren't deliberately thinking to themselves, 'oh I need to check my phone right now', they're often quite unconsciously picking up their phones and engaging with their preferred apps, social media platforms, or whatever. So people are making a lot of these decisions in an automatic way. If people had more awareness around this unconscious decision-making process and had some tools in place to enable them to make more conscious and deliberate choices about how they use technology to evaluate the impact it is having on their life I think that's what we probably need.

**Do you think ironically some of that stuff might come in the form of apps?**

Oh absolutely! I mean there's some good apps out there already that have been designed to help people limit their smart phone usage and some of these are established and widely used. I think actually using those tools that are available to us to manage our own behaviours can only be a good thing.

**Typically, what is a pathway to recovery for someone with a technology addiction?**

I think the key to it really - and this is true with all addictions - is that there is always a lot of ambivalence around the addiction. There are ways in which an addiction genuinely does kind of work for the person in a sense. Addictive behaviour or using a substance is an available option to effectively modify a person's mood - particularly if they're stressed out or depressed or angry or whatever. So in a way it does something kind of useful at the time. For someone to actually start to take steps towards changing, they've got to start to be able to really consciously see and feel that the costs of the addiction actually do outweigh the benefits that it is providing. So the first step really is helping them look realistically at that and obviously that can't come from somebody else saying this is bad for you, it's got to come from them doing an honest evaluation and looking at that for themselves. That is often the core of the work, and that can take a while. Often that's most of what needs to happen and the rest is looking at meeting the needs they've been meeting through the addiction in other healthier ways. So if you have a need for mood modification or if you're using gaming as a means of

online socialisation, then it's important to look at how you can meet that need in a different way.

**Apart from gaming, typically what type of technology and internet-based addictions are the people you see in your practice presenting with?**

The ones I see very commonly are pornography addictions and I've also had a few people where it was really focussed around online auctions like ebay, and trademe that kind of thing. To some extent social media comes up as well although it doesn't seem to have quite the same impact, or people don't recognise it as a problem in the same way.

**Would that be because it's a connective tool whereas I imagine gaming or pornography would be quite isolating?**

Yeah that's part of it. When people become addicted to something a big part of that is using the substance or the behaviour to modify the mood, and with social media that might be part of it but it's not necessarily the overriding reason or the only reason people use social media. I think also, the nature of social media makes it a bit easier to engage with it in bits and pieces whereas with a game the very nature of a game often means it's not easy to just drop it mid way through. As a result I'm seeing fewer people spending endless hours on social media.

**What are some helpful things those close to someone with a technology addiction can do for them while also looking after themselves?**

It can be tricky because when it's someone you love and care about and you see them doing something damaging you desperately want to get in there and do everything you can to try and change things but of course that doesn't help - it creates an environment that the person with the addiction usually resists. So now they're fighting someone who's outside rather than having to deal with the internal conflict. The fact that a part of them knows that the addiction is bad for them and a part of them wants to keep the addictive behaviour. I think the key thing for family members, as hard as it is, is to really be able to step back from trying to make change happen, while also being available and supportive when the person is ready to change. Always giving that message of: if you want to do something about this, if you want some help, or want to talk, I'm here for you. It's knowing what you can work with without taking on the responsibility of changing the behaviour of your loved one because that actually makes them less likely to change and it makes the family member feel worse because they're assuming responsibility for the addiction. Then the family member ends up burdened with the responsibility - the idea that if I could just find the right thing to say, if I could just break through to them, then they would change. That type of thinking only ever ends up with



the family member feeling bad which in turn leads to frustration and anger a lot of the time. So it's a really difficult kind of a stance to take as a family member but I also think it's the only one that can actually be helpful.

**What about if you're somebody in a relationship with someone with a pornography addiction, what are some of the dynamics around that?**

In many cases partners don't know about it. For people I work with there's often a lot of secrecy around it and also a lot of shame and guilt. In many ways the addiction isn't about the partner and it's not about the sex life, it's often not about any of that rather the addiction is it's own kind of separate thing but of course from the partner's perspective, it certainly doesn't look that way and it can very easily feel like a rejection of them. So when the partner does know and is affected by these very delicate issues I think it is really crucial to have a therapist to help the couple work through those issues through some form of couples' therapy.

**What would you say to the person possibly reading this who has a technology-based addiction?**

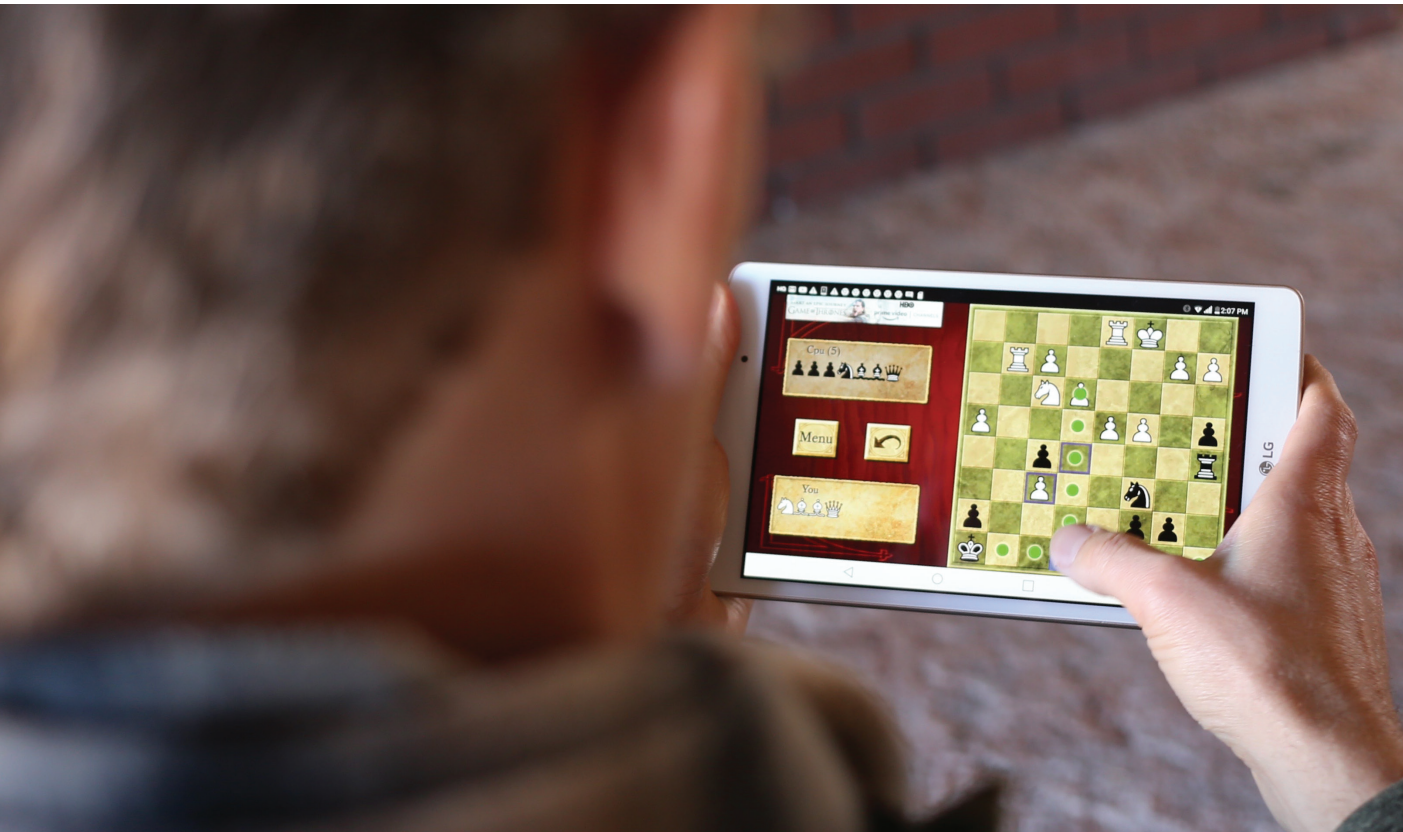
Successfully overcoming these addictions is more common than not. When people reach that point then there's a window of opportunity to really get alongside them and say what can we do about this and I've seen that process unfold many many

times. I believe recovery is the natural pathway for most people. It may seem as though people are stuck in something for life but most people come out the other side of that and usually that means finding some kind of rock bottom where remaining in that pattern of behaviour just becomes too painful compared to what you're getting out of it.

**Thanks for your time today James, it was a very informative discussion. For those reading this who want to know more, please visit: <http://www.netaddiction.co.nz> where you can find all the information both clinicians and gamers need to know.**

**Also, if you feel like your use of social media is affecting your focus and productivity check out this article for a list of apps to help you manage your use of social media:**

<https://www.reviewed.com/smartphones/features/10-apps-that-block-social-media-so-you-can-stay-focused-and-be-more-productive>







# Learnt Behaviour and Repeat Drink Driving

By William Blakemore

Why would anyone who's been caught driving over the limit do this again, let alone, again and again and again?

Let me be very clear - the number of times a drink driver gets caught is generally just the tip of the iceberg in terms of how often they've driven over the limit.

For the last five years I've had the pleasure of working with hundreds of people across New Zealand with a history of repeat drink driving behaviour through my role as a facilitator of education programmes for this demographic.

The programmes I run aim to provide drink drivers with an insight into why they've repeated these behaviours so often and work out what needs to be done differently to avoid future episodes of drink driving.

Developing empathy for other road users, and a heightened sensitivity to the potential consequences and harms caused by drink driving and alcohol use in general is also a key goal of these programmes.

Programmes are run in groups of up to 12 people held over 12 hours. What is offered to the group is a number of possible reasons why repeat drink driving occurs, and the challenge to the individuals in the group is to look out for, and recognise what it is they can relate to.

Where do they see themselves in both the material we cover, and from the personal stories that are inevitably shared within the group setting?

Each group is asked the question, "After you were last caught, or any time that you were caught, how many of you promised yourself that you wouldn't drink drive again?" Nearly always I'm answered with nodding heads and a yes.

This an important question as it speaks to the humanity in the room, the part of all these individuals who want to do better, and make better choices in their lives. It's a room full of people who don't want to expose themselves to the risks and hassles of drink driving again. No one in the group has to defend themselves or their past actions, I am offering to side with them to better understand what's been going on.

Another question participants are asked is what it was they learnt from the first few times they drove drunk. This may seem like a strange question in some respects, but when explored further people begin to realise that what is learnt is that - I can drive after drinking - nothing happened. I got home or to the party or wherever safety, no incident.

Then it happens again, and again and however many more times without incident. Each time the driver reinforcing the message and idea that they can drive drunk, and it's okay.

As stated earlier, the number of times a drink driver gets caught is generally just the tip of the iceberg in terms of how often they've driven over the limit.



The group is then asked to recall the first time, or first few times they drove drunk and got home. What did they experience when arriving safely home? The answer nearly all of the time is Relief!!

Now what does this Relief tell us? Well, one cannot experience relief without experiencing some sort of tension or stress beforehand. And why would a person be feeling tense while driving home drunk? Because part of them knows that they shouldn't be doing this, part of them is still worried about being caught.

This tells us that despite the fact alcohol is impairing the functioning of the brain's Pre Frontal Cortex - (the parts concerned with impulse control, decision making, forward planning and considering consequences) - some forward thinking and planning is still possible.

However, the forward planning may go only as far as something like this... Should I drive home? Yeah it's only down the road; I'm not as drunk as last time, or the classic kiwi motto, "She'll be right". Then some more planning occurs to avoid being caught. Taking the back roads, check lists of headlights on, seat belt on, don't drive too fast or too slow, appear normal. Whatever the tactics to avoid being caught, every time these are employed and they appear to work the driver is rewarded by arriving safely home and the learnt behaviour is reinforced.

And what does home represent for most people?

Safety. And at this safe destination, further rewards are offered in the form of food, alcohol, drugs, physical intimacy and the comfort of your own bed, to name a few

So while this external behaviour is occurring, it is likely that there is something else at play in terms of brain function, learnt and reinforced behaviours.

Most of us in the addictions field are aware of the role that dopamine plays in our brain's reward system. Simply put, anything we do in life that enhances our survival we are rewarded for.

Dopamine plays a major role in addictions to Methamphetamine, smartphones, sugar, pornography and gambling. We also know that just the anticipation of say using, methamphetamine, checking Instagram or getting a win on the pokies releases dopamine.

Another aspect of dopamine is that when we survive an emotionally charged event, such as being chased by a lion in the savannah, the amygdala in our brain's limbic system releases dopamine and stress hormones. Now when dopamine is released during an event we remember it more. It's like the save button in the brain. In this case, remember to look out for lions and if you see one get away as quickly as possible, ideally back to the safety of your home.

Once the threatening event is over our brain system then releases endorphins which give us a calming, fulfilling pleasure



experience. A reward for surviving a threat, and a way of calming down the nervous system so normal everyday life can resume. Which comes with a sense of relief.

The brain of drunk driver who experiences relief at the end of the journey, perceives the act of driving drunk as a threat and knows there is danger until safely home. Add to this the near miss of seeing a police car drive past, or somehow making it through a police checkpoint, and the sense of threat increases which in turn increases the emotional charge of relief. A greater hit if you like.

Or to put it another way, the drink driver has won the competition, or won the jackpot, the gamble paid off, and is rewarded for doing so.

Drink driving is an emotionally charged event. The brain's survival and reward system is at play when a person drives home drunk and this system plays an active role in repeat incidences of drink driving because there is an addictive potential to any external stimulus that releases dopamine and endorphins.

Research shows that it is the Pre Frontal regions of the brain that have governance over the emotional impulses stemming from our limbic system where dopamine is released. Research also suggests and points to deficient Pre Frontal Cortex functioning in those with alcohol use disorders and as well as anti-social personality traits.

The majority of repeat drink drivers would have at some point in their lives met DSM criteria for an alcohol use disorder, indicating that their brain system would display different functioning than those who have never experienced any type of addiction. Particularly where the Pre Frontal Cortex in its relationship to the reward/limbic system is concerned.

So is repeat drink driving an addictive behaviour with parallels to other addictive behaviours, such as gambling? Many of the people who have taken part in the programmes I run don't want to drink drive again and many, present as genuinely perplexed as to how this keeps happening.

Viewing this behaviour as an addiction helps give explanation to the out of control, impulsive nature of the behaviour.

It's a slightly different perspective than seeing it just as an anti-social act performed by "bloody idiots" as a well-intentioned road safety campaign once told us, and gives us as counsellors and clinicians more room to work alongside clients and build therapeutic relationships to better understand and change this behaviour.

To see it as an addictive behaviour allows extra emphasis on the triggers and risks of relapse. Alcohol of course is a fundamental trigger, not only in it being the illicit element when driving occurs, but that it also impairs impulse control. Particularly when a recidivist drink driver's brain system is so conditioned through learned behaviour and rewards from past drink driving experiences.

To view it as an addictive behaviour means that longer term treatment is needed as it may well be that the brain of a repeat drink driver has wired differently. The field of Neuroplasticity tells us that long term sustained treatment for behaviour change is needed to form new neural maps. As Doug Selman recently said, 'it takes practice to become addicted, and practice to become sober.'

To see it as an addictive behaviour means considering an individual's broader life values and goals. Participants in the programmes I run come to the conclusion and admission that drink driving is a self-interested behaviour, with only the driver gaining any benefit from the decision to drive.

Yet contrary to this, all the groups identify family, children, employment and freedom as the most important values to them. Values that consider not just self but others in their lives. Values that enhance our sense of belonging. Values that are threatened every time drink driving occurs.

What would it take for someone, when considering driving home after drinking, to take their thoughts beyond the possible police car down the road to the broader consequences of their actions and the impact of their actions on the things they value? An idea promoted to participants of programmes is that the planning against future incidents of drink driving isn't done just to avoid the legal consequences but rather, an individual plans ahead as a way of protecting that which they've identified they value the most. Good planning is done in partnership with whanau/family members who have also been affected by past drink driving.

In the work I've done with individuals in their recovery from addictions, be it substances or gambling, those who have partners or family directly engaged with their treatment do far better and make speedier progress than those who do it alone. The same holds true for those with entrenched drink driving behaviours, they need their whanau involved.

Having some understanding of the neuroscience behind addiction and behaviour can help people come to terms with past behaviours and come to an understanding of the importance remaining vigilant in order to avoid incidents of drink driving in the future. Particularly when it's shown that despite overall numbers of drink driving charges decreasing, the number of repeat offenders isn't changing.

It becomes a question of lifestyle. In the way a person with say diabetes learns to manage their health through lifestyle choices, a person with a drink driving past can learn that they need to make extra effort in developing new lifestyle choices to avoid repeating the behaviour.

If the opposite of addiction is connection, then guiding our repeat drink driver population to strengthen connections with what they value and their significant relationships will help them form stronger connections in their neural pathways, and their hearts. A place where healthier decisions and behaviours can stem from, thus keeping everyone safer on the roads.





# Gavin Hawthorn: sending him to prison did not make us any safer



By Rodger Brooking

News that Gavin Hawthorn has recently been convicted of drink driving yet again has caused oodles of outrage in the media. Hawthorn has already killed four people in two separate accidents. In 2004 he was convicted of manslaughter over the death of his friend Lance Fryer and sentenced to 10 years in prison. He was released in 2013 and has now been caught drink-driving again – for the 13th time. On this occasion Judge Johnston sentenced him to six months home detention and disqualified him from driving for two years.

The headlines were horrified. Stuff stated it like this: Recidivist drink-driver Gavin Hawthorn convicted again, leading to call for permanent driving ban. Newshub harrumphed that it was ‘Appalling’: Porirua man Gavin Hawthorn escapes jail after 12th drink-driving conviction. The Herald highlighted: NZ’s worst drink driver caught drunk behind the wheel again. Duncan Garner was especially incensed arguing that:

“This judge has failed to keep us safe as New Zealanders. We’ve been let down by his profession once again. He has let us down, now we are in harm’s way.” He went on to say the case was an example of why the public “have little confidence in the justice system”.

Blaming judges is misguided and myopic. This is what Garth McVicar and the senseless sentencing trust have been doing for years. All that has achieved is a burgeoning prison population and a crisis in capacity. At \$100,000 per prisoner, per year and a reoffending rate of 60% within two years of release, clearly this is a failed strategy – and a massive waste of taxpayer money.

## Keeping us safe

The justification for all this moral outrage is the dubious assumption that sending ‘dangerous’ people to prison ‘keeps us safe’. Does it? Let’s look at the facts.

Gavin Hawthorn killed his last victim in 2003. Between 2003 and 2017, another 5,402 people have died on New Zealand roads – an average of 360 people a year – or nearly one every day. Half of these deaths are caused by drivers under the influence of alcohol or drugs, or both.

The point is that most of these people died during the ten years that Hawthorn was in prison. Clearly his incarceration did not make us any safer. Giving the judge a hard time for not sending him to prison on his current conviction does not change this reality.

So, what’s the solution? The only intelligent comments in the media came from Andrew Dickens on NewstalkZB who asked rather quaintly: What to do with our drinkiest drink driver? He argued with considerable insight that:

“Indefinite incarceration and licence deprivation is not what this man needs. What he needs is to STOP FREAKING DRINKING.”

## Drug courts

Dickens’ answer to the problems posed by the likes of Gavin Hawthorn is to put him into a drug court (in New Zealand known as AODTC – Alcohol and Other Drug Treatment Courts). To be eligible, defendants must be alcohol or drug dependent and facing a prison sentence. A treatment plan for each participant is set by the judge, taking into account the views of treatment providers, support workers and lawyers; it involves rehabilitation, counselling, drug-testing, community service and making amends to victims. Dickens describes the process like this:

“They’re a three-phase, 18-month-long programme designed for high-needs and high-risk addicts who are facing prison, or who have tried but failed treatment programmes in the past.”

Drug courts have the potential to help thousands of offenders, not just drink drivers. And there is no shortage of available candidates in New Zealand. In 2011, judges told the Law Commission that 80% of all offending was alcohol and drug related. In 2017, Northland district court judge, Greg Davis, who sees a lot of methamphetamine related crime, said up to 90% of all offending was related to issues with addiction.

Currently, the only two drug courts in the country are both in Auckland. Hawthorn is serving his sentence of Home Detention in Paraparaumu – so a drug court in Wellington would be helpful. We need such courts in all our major cities.







## Compulsory AOD assessment

Another strategy is available to target drink drivers in particular. It also involves assessment and treatment. Currently out of 20,000 people convicted of this offence each year, only 5% – those disqualified indefinitely – are required to have an alcohol and drug assessment to see if they have their drinking under control before getting their driver's licence back. Many of the remainder are sent to prison – just like Gavin Hawthorn. If any drink driver who incurred a second conviction was required by law to have an AOD assessment before their disqualification could be lifted, fully half of the 20,000 drink drivers would be assessed. As a result, there would be a lot less people in prison.

An evaluation of the NZ drug courts shows they also reduce imprisonment – 282 participants have been kept out of prison during the six years the two Auckland courts have been operating.

So if the government implemented these two strategies, this would shift the focus of our justice system away from punishing alcohol and drug addicted offenders towards treating them instead. This would surely help Justice Minister, Andrew Little, get closer to the Government goal of reducing the prison population by 30%. Maybe it would even moderate the media to tone down their moral outrage.



# CUTTING EDGE 2018

CONFERENCE

The importance of connections in addiction treatment  
and recovery





Good relationships and connections to friends, whānau, culture, spirituality and community are critical, as the roots of addiction are frequently found in an early breakdown of these important relationships and connections.

There is a growing momentum worldwide toward a health, wellbeing and recovery approach to reducing drug-related harm that strengthens meaningful connections. It is time for New Zealand to join this movement.



“The worst kind of poverty and the cruellest thing for the human soul is being in a state of kahupo or spiritual blindness – a person with no identity, place and/or community to which they belong or feel connected to”

**Tamati Kruger**



“Aroha ki te Tangata, love the people into being.”

**Hinewirangi Kohu Morgan**



“Best conference ever!”

**Jenny Valentish**



New Zealand needs to rid itself of the false narrative that prohibition and punishment works. Punitive systems do nothing but shame and stigmatise those needing help. What works is love, care, support and compassion.



Cutting Edge 2019  
Te toka tū moana

**Information for this year's conference coming soon.  
Can't wait to see you there!**



# PUTTING RECOVERY AT THE HEART OF WHAT WE DO AT CADS AUCKLAND

By Sheriden Pooley



## At Cutting Edge in Wellington 2012 Stephen Bamber challenged the sector to Dare Mighty Things.

The Auckland CADS Consumer Team took this challenge seriously and returned to work with enthusiasm. Fortunately several members of the CADS leadership team had also heard Stephen speak and they too saw potential to dare mighty things! So the Consumer Team took on the task of looking at CADS current service delivery and practice to see how well it reflected the 10 Characteristics of Recovery Oriented Services. Sitting in the conference audience I had felt proud that CADS Auckland had to a large extent achieved the first characteristic of recovery oriented services - that 'Recovery is visible at every level of the service'.

For 17 years CADS Auckland has had a Consumer Team - people with experience of AOD problems (some being current clients) to ensure CADS are responsive to the needs of people accessing the various services provided. And one of the characteristics of recovery oriented services is that consumers are involved at all levels of service delivery. (This is also Standard 2.5 of the Health and Disability Services Standards so is an expectation of ALL addiction services.)

The Consumer Team had further made recovery visible by collecting consumer stories of recovery and making them available in all reception areas. However, as we embarked on assessing whether recovery was visible in CADS we quickly realised there was more we could do because only the people who came into CADS had access to those stories. What about

the people who are looking for help or are unsure about what treatment can do? So we decided to seek people's consent to share their stories on the CADS website – and each of those people agreed. (Their stories are online at <http://www.cads.org.nz/our-stories/>) (As an aside: this idea grew into the Real people share their stories booklets developed by the Matua Raki Consumer Leadership Group so that people accessing services around Aotearoa would have access to stories of change.)

The team went through all 10 recovery characteristics provided by Stephen Bamber and looked at what CADS already did well and where there were opportunities for improvement. Out of this came a number of quality improvement and assurance projects which we then presented to the CADS clinical governance group. With their support the Consumer Team began a process which has been going for 5 years – and we're not finished yet!

1. Firstly we had to clarify with everyone what we meant by 'recovery'. It is CADS mission to reduce the harms caused by alcohol and other drugs so it made no sense to adhere to the notion of recovery as abstinence. As Stephen stated "Abstinence is a state. Recovery is a process". Also, abstinence is not necessarily an adequate measure of recovery –not using doesn't mean life is any better! So the Consumer Team met with all the CADS teams to have a discussion about what we mean by 'recovery', basically, that there is no one universally agreed upon definition - and that's okay.
2. We introduced all the staff to the recovery capital concept and tool as a way to kick off our strengths project. Ultimately this is about supporting strengths based practice throughout CADS. Historically AOD treatment

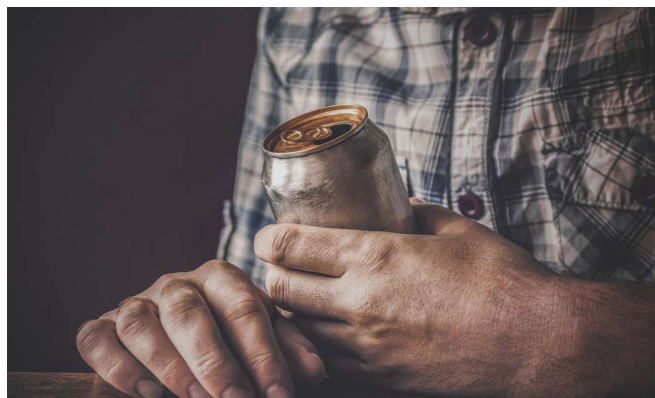


services have tended to focus on the problem and for those of us old enough to remember, there was a time when treatment aimed to break you down then build you back up again. That unfortunately was a traumatising experience for many people – some got broken down and stayed there. Thankfully that approach is largely a thing of the past and it is now recognised that everyone has strengths – sometimes we need someone else to help us find them. The recovery capital tool is great at helping people identify their strengths – their social, personal, and community capital - and at helping people identify the capital we would like to develop or regain.

**3.** We gave staff a tool to assess how recovery oriented is their own practice. This is a tool which can be used by individuals, teams, or whole services and can help people identify their strengths and the areas they need to develop to ensure their practice is recovery oriented.

**4.** Coming from a strengths base involves ensuring we speak and write about addiction and the people who use alcohol and other drugs in ways that are not stigmatizing, pathologising or objectifying. It is more common now to hear people speak of clients as “people who use drugs” than of “drug users.” A person-first and person-centred approach does not mean that a person’s AOD use is hidden or seen as irrelevant; however, it also is not the sole focus of any description about that person. Person first, problem/issue second: people who inject drugs NOT IV drug users. A resource that can help people develop non-stigmatising person-first language is *Addictionary - Glossary of Substance Use Disorder Terminology*

**5.** A strengths approach means people get to take control (as much as possible) of their treatment and recovery. Recognising people are the architects of their own future so providing all clients with the opportunity to develop a self determined recovery plan. While CADS is some way from that as yet, small steps have already been taken towards this in some of CADS’ groups and through activities like the ADOM.



We are currently working with the governance group for the Auckland Opioid Treatment Service to develop a recovery planning tool for AOTS clients and will use Bamber’s recovery capital model as our template. We recognise that not all clients will want to engage in this process but it is important that such tools are available for those people who want them and that staff have access to the tools which can help clients think about making changes in their lives.

**6.** Underpinning a recovery oriented system are the principles and practices of behavioural health recovery management one of which is that the community is an oasis of natural supports - self-help and mutual aid organisations, consumer driven services, and social networks – and that this should be incorporated into treatment protocols. When in active addiction many of us burn our bridges: family whanau are tired of us, our friends tend to be people like us, and we don’t engage in the life of the community - we retreat from activities other people take for granted like playing sport or going to the zoo. When we enter treatment both our social capital and community capital can appear to be running on empty.

Johann Hari says the opposite of addiction isn’t abstinence; it’s connection. However, rebuilding relationships and/or building new connections can be harder for some people than stopping AOD use. It requires confidence and resilience, both of which can take time to acquire.

Last year the Consumer Team shared with CADS teams a tool we’d been introduced to by David Best at a Cutting Edge workshop. The visual mapping tool can help clients identify the groups they belong to and the individuals within those groups who may be able to provide support – and the ones they might want to avoid!

**7.** One of the many positive consequences of CADS’ move to offering more group interventions is that people build a recovery network more quickly than if they just

engage in one-to-one counselling. Finding people who understand you and your journey is essential to recovery. However, recovery lives in the community so helping people identify social supports outside of CADS is essential. This is an area for development in Auckland as access to AOD peer support is limited (not picked up by all DHBs) and there are few AOD mutual support and self-help networks apart from AA and NA.

**8.** There is also a need to better develop continuing care into our pathways. The Consumer Team has built a ‘recovery check-up’ into the telephone survey the Detox Service Consumer Liaison does with all the people who have undertaken a withdrawal with the Community & Home Detox Service (CHDS). She asks people what they are doing to maintain their recovery and through this we are developing a clearer picture of the various activities and supports people are accessing in their communities. It is important to remember that not all supports will be AOD-related; people can get support from people who have no idea of the journey the person is undertaking. They speak of connecting with their neighbours by walking their dog every day; they take part in local sports activities, go to the gym, join art classes ... the list goes on and on.

It is clear from the comments that people get great benefit from the follow-up phone call with the Consumer Liaison who is able to remind them of recovery supports available in CADS and the wider community. As one person said last year Thank you for the ideas that recovery doesn’t just have to be about alcohol non-consumption. I like that it is about making changes to live my life in a healthier way.

The few people who say they have lapsed are encouraged to re-engage with CADS. Research shows that continuing care calls lead to people re-engaging with treatment services more quickly than if they had not received a call and of course they are less unwell when they do so. Researchers Godly and White (2011) assert:

**If there is a new frontier of addiction treatment, it is in extending the effects of treatment through assertive and other innovative approaches to sustained recovery management for months and years following recovery initiation.**

The logistics, the ‘how’ to do this - to build continuing care calls and follow-up into CADS’ pathways – is something of a challenge but we will find a way (solutions focussed!)

Whatever we do has to work for everyone while ultimately this is about providing services that meet the needs of the people we serve – so what do clients think?

The gradual nature of the move means clients are unlikely to notice anything different however it has been interesting to see how the language used by clients has changed since we began this process in 2013.

Each year the Consumer Team undertakes a number of different activities to elicit feedback from clients on their experience of the services CADS provide. This includes an annual Treatment and Service Perceptions Questionnaire for clients of AOTS (the opioid service); an annual CADS Counselling Service Client Survey; all clients admitted to the in-patient detox unit are invited to engage in a survey before they leave; clients of CHDS are invited to take part in a telephone survey; all CADS groups are evaluated for one month of the year; and clients engage with us via suggestion boxes, the website and Real Time Feedback.

We have noticed a significant proportion of client responses in all of the surveys now refer to being on a recovery journey, of their personal growth or wellbeing and recovery, that a whole new world of recovery has opened up. Such a change suggests an embedding of recovery language and concepts within CADS. In the AOTS survey there are four recovery focussed statements that we pay particular attention to as it is the responses to these particular statements which most strongly indicate how clients perceive the recovery orientation of the service. Providing a range of opportunities for clients to engage with the service, to have a voice that CADS genuinely want to hear, has helped create a culture where a shift to a greater recovery focus is supported and sustained. Having people with their own experience of addiction and of service delivery working in partnership with CADS leadership and clinical staff is a key ingredient in moving to a recovery oriented system of care. None of us could do this successfully on our own. Having clinical, consumer and management input into the process aims to develop a ROSC that works for everyone. Which brings me back to Stephen’s original challenge and the question: have you Dared Mighty Things for the service you provide?



