Winter Edition 2019

Addiction Standard

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THE WELLBEING BUDGET
30 May 2019
BUDGET 2019
New Zealand Government

Tuhia ki te rangi

Tuhia ki te whenua

Tuha ki te ngākau ō ngā tangata

Ko te mea nui

He tāngata, he tāngata, he tāngata

Tihei mauri ora

Nau mai haere mai to the Winter 2019 edition of Addiction Standard.

We have now have the Government's response to the Inquiry into Mental Health and Addiction coinciding with the first ever Wellbeing Budget. A lot of us are still trying to work out exactly what the injection of funding will look like for us and whether it will result in significant change, but it is great that there will an increase in support, early intervention and treatment for those affected by addiction.

It is rare that a Government has the courage to make significant and systemic change – so even if it is not all we had hoped for let's make hay while the sun shines.

The dapaanz mantra over this time of change is that it is vital that people working on the front line of addictions, people affected by addiction, and those bearing the greatest burden of harm – Māori, are at the forefront of designing the way forward. Dapaanz will continue to advocate in this regard.

The Government has taken a step back from decriminalisation, though diversion for small amounts of all substances is arguably decriminalisation to some extent especially if equally applied across the population. Given that they have committed to a binding cannabis referendum it is important that we all think about this and make an informed decision. To this end we will be sending out a survey to you shortly to get opinions from the coal-face on the proposed legislation. We also seek to find ways to foster debate so that all sides of the argument can be heard. In this edition, you will find opinion pieces from Darryl Wesley and Jack MacDonald on the proposed legislation.

In the Hawke's Bay focused section, there are two examples of great models of care from the organsiations Whatever it Takes and Te Ara Manapou. In the interview with peer worker Alana Geddes from Te Ara Manapou there is an incredible quote about her attending mental health services during her active meth addiction with symptoms relating to meth use, but never being asked about her drug use. I really hope this is the type of thing that will be addressed in this era of change.

There is also a well worth reading personal account from Professor Ron Paterson of his experience of engaging in communities through his role as Chair of the Inquiry.

I hope you enjoy this edition of addiction standard and are feeling well-supported in your important mahi.

Remember, if you would like to submit anything in the addiction Standard please email sue@dapaanz.org.nz with 'Addiction Standard' in the subject line or contact me on 04 282 109 to discuss.

Noho ora mai
Sue

The Great Canna

What side of the green line are you on?

Handcuffs Not Health

By Jack Mcdonald

In April the New Zealand Drug Foundation partnered with six other organisations to launch the Health Not Handcuffs coalition, a movement for people who want to overhaul our outdated drug law and transform the harm reduction and treatment landscape in Aotearoa.

We all see the harm that drug use can cause, and want to make sure that those who need it can access support. We also see the harm that treating drug use as a criminal issue causes, in particular to young people and Māori communities. We need to stop the convictions and move to treating drug use as a health and social issue.

Kaupapa Māori advocacy is one of the central pillars of the Health Not Handcuffs campaign, as the evidence is well established that the negative consequences of drug use fall heavily and disproportionately on tangata whenua. We were proud to launch this movement alongside kaupapa Māori health organisations Te Rau Ora (formerly Te Rau Matatini) and Hāpai Te Hauora.

The campaign is now really coming to life. Shortly before Budget 2019 was released in late May, the team were excited to deliver our petition to the Prime Minister calling on her to double funding for drug-related treatment and harm reduction initiatives in Budget 2019.

The petition was signed by 1126 New Zealanders and 16 health, social justice and Māori organisations, including DAPAANZ. Your voice has made a real difference.

A significant increase in funding can't come soon enough for New Zealanders struggling with drug use and the addictions treatment sector that support them.

As DAPAANZ members will know better than anyone, frontline organisations in the sector are stretched far beyond what they are resourced to do, and a staggering 50,000 people are need in of treatment that they aren't currently receiving. Many people want to access help, but find it's just not available.

We were really excited by the Budget announcements. It promises major investment of $1.9 billion in mental health and addictions over the next four years. No longer will people have to wait until their problems are out of control before they can access help. The proposed investment is comprehensive - there will be more money for mental health and addictions in hospitals, in prisons, in schools, in treatment centres, and in primary health care.

This is really great news for those struggling with addictions, and their whānau. It also represents a significant milestone and victory for the Health Not Handcuffs movement.
One of the next milestones will be the upcoming 2020 referendum on the legalisation of the personal use and possession of cannabis. A priority has to be to build public support for cannabis regulation in the effort to improve public health.

A recent Horizon poll released by TV3's The Hui shows that 75 percent of Māori plan to vote in favour of cannabis legalisation. But we can't take that support for granted.

A simple but incredibly effective way of winning the referendum campaign is by talking with friends, whānau and people in your community about this once-in-a-generation opportunity to change NZ's approach to cannabis, the illegal drug that is used most in Aotearoa.

Fundamental to Health Not Handcuffs is elevating the voices of those who are experiencing the effects of drug use at the coalface; service providers, whānau, iwi, community groups and of course, most importantly, people who are or have been personally affected by drug use.

Some people won't know which way to vote yet, and others won't have even thought about it. That's where you come in – whether it's through chatting to your cousins, debating with your dad, or kōrero with your kuia, you have the power to convince the people you know. And this has a ripple effect, because

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once you convince someone they are then likely to talk with others and the momentum for change will only grow. This is of paramount importance for us as Māori – our people have to engage with the debate now.

In 2018 Canada decided to legalise cannabis and put in place a regulated market. The Drug Foundation hosted one of their drug policy experts, Eric Costen, earlier this year to talk about Canada's approach.

He said that many of the First Nations in Canada don't feel the regulated model that was chosen fits their needs, or enables them to easily participate in the economic development opportunities that legalisation presents. And from his perspective, part of why this is the case is because many of those communities didn't engage in the debate about legal regulation until too late.

This is a clear warning to us as hapū and iwi Māori that we stay out of the debate at our peril.

There is a responsibility on the Crown to engage with Māori on the design of the regulations, but as we have always known, they will also need to be held accountable to ensure that happens. Whānau, hapū and iwi Māori should be central in designing the regulatory model for legal cannabis.

No one wants to see more harmful or prevalent use, and so it's important we advocate for a tightly regulated market and much greater resources for the Māori health sector, and look at the intersection of addiction treatment and Whānau Ora provision. Cannabis regulation and drug law reform has to be about true and enduring justice for the people who have been the victims of the war on drugs. In Aotearoa, that means ensuring that Māori voices, and solutions, at the forefront of the debate.

The Health Not Handcuffs movement will be successful if we are able to mobilise the thousands of people who know just how important a new approach to drug use and treatment is. Together, we can shift the drug policy landscape in Aotearoa for good. Join the movement and be part of the change - https://www.healthnothandcuffs.nz/whakahau_maori

Jack McDonald is Māori Advocacy Advisor at the New Zealand Drug Foundation and is a descendant of Te Whakatōhea, Taranaki Tūturu, Te Pakakohi and Te Ātiawa.

The Great Canna

What side of the green line are you on?

Legalisation of Cannabis for Recreational Use in Aotearoa NZ – How Dopey?

By Darryl Wesley

Something I value about Aotearoa New Zealand (NZ) is our fresh clean air, vibrant with smells of nature mingled with the freshness of the landscape intersecting mountains and ocean. A team member I work with, recently holidayed in California and travelled from San Francisco to Los Angeles with her family of six – the prevalent smell that her children learnt to recognise throughout their travels, was that of cannabis wherever they went. It will be a sad day if whilst walking to the beach for a surf I smell cannabis instead of sea air.

Cannabis is no longer the same plant that it was in the 1960's, then it had a tetrahydrocannabinols (THC) (the compounds that make you high) content of 0.3%, by the early 1980's it had a THC content of 3% and by 2000 a THC content of 5%, last year plants in Colorado were grown with a THC content of 42% and legally sold (Cort, 2019). Throughout the above time period the Cannabidio's (CBD's) have stayed around 0.4%. CBD's moderate the psychological harm that THC contributes to, but only when those numbers are equal or closely similar. The average plant grown in NZ has a THC content of 10.9% – however hydroponically grown cannabis has been reported at up to 30% THC (NZ Drug Foundation, 2010). If we were to legalise recreational use, there is no reason why we will not see similar potencies of plant as Colorado, being sold legally in NZ. A according to proponents of legalisation it is more likely we would follow the Canadian model with a few changes eg allow edibles. Canada has no restriction on THC content in cannabis plant matter being sold legally – largely because the cost of enforcement is prohibitive as was Oregon's experience. But at what cost to Aotearoa NZ would a "Yes" vote bring:

- more cannabis driving related fatalities on our roads,
- more attempted suicides,
- more cannabis related mental health admissions and ongoing management thereof,
- more people using cannabis than during prohibition. (SAM 2018)

Do we really want this for Aotearoa NZ? Legalisation equals "normalisation" therefore people perceive it as safe due to regulatory approvals endorsed by government. Why do many health professionals in NZ and overseas see cannabis as a harmful and (now) powerful psychedelic drug which has increasing links to mental health distress and ongoing harm? (Hall 2014, Cohut 2019)

As a parent I want the best for my children as we all do, however I do not think commercial cannabis companies share these values, just as we have seen with the alcohol industry and the desire to keep the age of purchase at eighteen – when there is evidence showing harm went up after this legislative change. The cannabis industry will be allowed to introduce new products (as they have overseas) with THC contents of up to 90% as outlined in the cabinet paper released by the Minister of Justices' office on the 7th May 2019. These are the fastest growing product lines in US States where their sale is allowed and have progressively become problematic for some people using them. Increased potency equals higher dependence, which equals more sales – which is what commercial business is about.

It takes away people's hope in tomorrow

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At its most benign level of harm, cannabis is a drug that impacts motivation. if you were to buy a V8 motor car you would be most unhappy if it only ran on three cylinders, and yet this is what cannabis does to people who use it – do we want this for our loved ones? Unfortunately this is only the beginning point on the spectrum of harm that cannabis use has been linked with. At its worst cannabis is connected to psychosis (how is not yet fully understood – however increased potency does correlate with greater mental distress), which may or may not reverse with abstinence.

Proponents of "legalisation" in NZ say that it would increase regulation and control, not liberalisation – unfortunately overseas experience does not show this – usage, access, product options and potency increase. We have now found out that home growing would be allowed under proposed legislation – I am not confident that this will keep it from our young people but potentially make access easier than it currently is.
Revenue gained from taxation has been worked out at $1.00 per every $4.50 of increase in social harm as reported overseas – not a good return on those numbers (SayNopeToDope 2019).

A Colorado Plantation

Overseas evidence (including Canada) is increasingly showing that "legalisation" does not decrease harm nor gang activity but escalate it; maybe it would be better to resist the legalisation of Cannabis in Aotearoa NZ, and instead decriminalise it for personal use, allowing a health approach to be taken, and significantly increase funding to the Alcohol and Drug sector for wages and services.

A thought to leave you with - a Police Officer in NZ was asked what he thought of Cannabis: It takes away people's hope in tomorrow

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Inside the Mental Health & Addiction Inquiry Panel

By Nathan Frost

The long awaited response to He Ara Oranga arrived last month with the Government announcing it had accepted all but two of the inquiry panel's recommendations.

The following day, the Wellbeing Budget set aside 1.9 billion to invest in what Prime Minister Jacinda Ardern stated was a transformation in both the Government's thinking and their approach to mental health and addiction service provision.

This story is not about any of that.

Much has been written – both here and abroad – about the bold new direction Jacinda Ardern's Coalition Government has taken to include New Zealanders' level of wellbeing when determining the success or failure of an economy.

Rave reviews in the international press have trumpeted Ardern as a daring political innovator, while voices closer to home have cautioned of the headaches the Wellbeing Budget may bring.

But this story is not about that either.

This story is the most important story, because it is the story of Kiwis in pain.

Kiwis who after years of underfunded addiction and mental services were in desperate need of help with nowhere to turn.

It's a story of agencies dealing with those falling through the cracks that had widened to crevasses; a story of the police responding to up to 90 mental health related calls per day.

It's a story of grieving family and whānau members who have lost loved ones to suicide, beautiful bright lives full of promise gone forever.

It's a story of simmering anger, because in many cases families had sought help only to be told there was none, and this had led to disastrous outcomes for many.

It's a story of frustration at not being listened to, so much so psychotherapist Kyle Macdonald launched the 'People's Mental Health Review Campaign' after the previous government refused to sanction an official one.

This is the story of the Inquiry Panel, tasked with the job of listening to the stories of New Zealanders affected by a flawed system in desperate need of an overhaul.

The story of six diverse individuals who over a ten month period travelled the length and the breadth of the country, received 5200 plus written submissions, attended over four hundred meetings including 26 public forums.

The panel's job didn't end with listening to the people. They then had to face the challenging questions raised by their stories and work out what recommendations to make to the Government.

Addiction Standard recently spoke to the Inquiry Panel Chair, Auckland University Law Professor Ron Paterson about his experiences over the course of the inquiry.

His reflections on this time provide an interesting social insight into Kiwi families, whānau and communities affected by not only addiction and mental health issues but lack of related health and social services.

Hi Ron, thanks for agreeing to this interview, I wondered if we could start at the beginning of this journey with your appointment as the inquiry panel chair, do you think you knew at that point what you were getting yourself into?

The job was never something I sought. I suspect they asked me because of my background as a Health and Disability Commissioner – a job that I loved. It was a job where I met with a lot both consumers and providers right across the spectrum; doctors, managers, patients, consumer groups. I connected with a lot of people in the health and disability sector around New Zealand. So, I guess that's why they asked me, but I'm not sure, it wasn't something I was expecting.

When I found out I went and personally visited Ken Mason (from the Mason Inquiry). Ken used to be my neighbour at Mum and Dad's place. I knew him from popping over for a beer from time to time. After talking with him about the role Ken said very clearly to me, 'go and listen to the people Ron, they will tell you what to do.' And that really became the panel's ethos over the course of the following ten months.

Our core function was to listen to people, the panel needed those skills, I needed those skills.

We agreed that we wanted to honour the voices of the people and put them first. Once we agreed on that as our approach that really shaped the recommendations the whole way through.

Do you think you were prepared for the level of pain that was displayed at the public meetings?

I knew it was going to be hard but I don't think I appreciated the enormity of the heartache of people, families and community members around the country. The people who stood up at meetings and talked about the pain of losing loved ones to suicide.

A father holding a pair of sneakers and saying these were the sneakers my son was wearing when he took his own life.

The mum who says I can't talk to him, I'm just talking to the addiction.

Parents of children with anorexia, families affected by methamphetamine, families who've lost someone to suicide and not received any help, you know they haven't got the help that they needed.

There was a lot of emotion, a lot of hurt and pain, some anger, and that was really hard because you're human and it affects you.

One of the things that I had to learn was we had to sit there and just listen and that was really hard because it could look like you're not responding. So just listening attentively but not trying to respond to every individual as they tell their story and then at the end of the evening we would try and acknowledge what we'd heard and summarise the themes of what we'd heard.

At the public meetings we would often stay around after the meetings had ended and have a cup of tea and talk to people and individuals would come up to you and say thank you and that the meeting had been helpful but far more afterwards would send in messages, Facebook messages, emails, occasionally a letter.

The overwhelming sentiment was that people felt heard, for the first time people felt heard and that was very special feedback to receive because you felt as if the inquiry process itself was a healing process for some people. Not for everyone but for some people.

The other thing about the public meetings was it brought people together, tāngata whaiora, community groups, people affected by addiction, family and whānau groups affected by drugs and mental illness, provider groups. The inquiry ended up being a bit of a catalyst for bringing people together.

What were some of the examples of the positives you saw happening in the community?

What is working in the community, is the community. It's people coming together and supporting each other. There are so many people out there doing amazing things.

We heard about the positive impact of arts based programmes in the community, drop in centres and self help groups. We met with He Waka Eke Noa and they just completely blew us away. The honesty and courage of the people. People who are clean supporting each other, sometimes lapsing but supporting one another.

What are some of the things people talked about wanting to change?

People told us they don't just want to be medicated. They told us they want support centred in their own communities, not institutions or services where they can't get the help they need when they need it.

They told us they want addiction treated as a health issue, not a criminal law issue. There was a lot of emphasis on the impact of trauma, of unemployment, of racism. A lot of the social determinants of poor health were highlighted in a very personal way by the stories we heard at those public meetings.

The fact is people who talked to us kept on talking about the need for kindness, compassion and connection guiding a new way of doing things. They were themes that we heard universally. I think the approach we took made it possible for people to speak their hearts and they did.

We had this consultation document that we kept really simple, what's working, what's not working, how can things be improved, what things are broken that need fixing. People started to come together with ideas and some very clear themes started to emerge as we travelled the country.

So, when you say 'we agreed', who were your colleagues on the panel?

Yes and please make this story about them not about me!

We had Sir Mason Durie. It was like having God on the panel, he is just a wonderful and wise man with so much to contribute, but he's quite a shy man and you've got to get to know him. We all looked up to him and called him Matua. He provided wonderful guidance to us all.

We had a human Dynamo in Josiah Tualamali'i. Twenty-two, charismatic and extremely connected.

We had a driving Chief Executive in Dr Barbara Disley, who has enormous experience as the first Commissioner and is the current head of Emerge Aotearoa. Barbara knows the health sector backwards.

We had Dean Rangihuna who was our consumer member. Dean is just the most remarkable loving man. Every meeting we went to I would try to have him standing right by me because I learnt so much from him. He really helped me. In many of the meetings Dean would be the person who'd respond. He'd respond in te reo, he'd lead us in karakia, and he'd really respectfully acknowledge the pain in the room.

We also had Dr Jemaima Tiatia-Seath who has a huge amount of experience in Pacific mental health, and suicide prevention and postvention.

So we had this really wide range of backgrounds. We virtually lived together; travelled together, ate together, and went into difficult meetings together. And then every three weeks we'd have to work out how on earth we'd use all the stuff we'd heard, and pull that together and agree on the sort of recommendations we were going to make.

The way we bonded as a group was incredible. It's quite an unusual thing to be taken out of your normal routine for ten months and suddenly you've got to chair a group of people, completely different backgrounds, aged 22 to 79, who don't know each other.

What proved critical in the process was, well there's no other word but aroha actually. We became very closely bonded and established a very high level of trust in one another and that made it quite a lot easier.

They're all good people, I'd have them home for the weekend. I have had them home for the weekend! We've remained in close contact, the two younger guys I call my brothers.

So as a group you developed a collective gauge of the mental health and addiction service provision and saw very common sentiments expressed nationwide. What do you then do with that information?

As I said earlier, listening was a really important part of the inquiry process which was absolutely necessary and if we hadn't done that well then I believe the inquiry would have failed. But it's not enough just to listen, you've got to be able to think about the really challenging questions we'd been asked – I mean there was no shortage of views – and we had to come together and work out as a panel what we were going to say to the Government.

A lot of this interview has focussed on the idea of allowing people to have a voice, of respectfully listening to the stories of everyday Kiwis and taking action based on their experiences. Now that the dust has settled and the Government has responded to the recommendations of the inquiry panel, do you feel a sense of satisfaction, do you feel like the Government listened and was the panel's voice heard?

Yes, we do feel satisfied – that the Government has listened to the voices of the people, reflected in He Ara Oranga, has accepted nearly all our recommendations and has made a huge investment in mental health and addiction in Budget 2019.

Lived Experience & Recovery in the Worforce:

Alana's Story

By Nathan Frost

The women I work with are the bravest I have ever met. Their stories are filled with sadness, courage and strength. Their honesty is overwhelming and I feel privileged that they tell me what they do.

As the first Addiction Peer Support Worker employed by Hawke's Bay District Health Board, Alana Geddes wasn't handed a job description when she started working for the then brand new pregnancy and parenting service Te Ara Manapou in September 2017.

Ms Geddes developed and refined her role on the job with the constant backing of an employer who recognised the importance of peer support. Today the peer support Ms Geddes provides expecting and current mums engaged with Te Ara Manapou is an integral part of the treatment the relationship orientated service provides its clients.

Addiction Standard caught up with Ms Geddes - a mother of three - in Napier recently and asked her about the impact addiction had on her ability to parent, what she did about it, and the ways she uses her experience of addiction and recovery to walk beside her clients and foster healthy parenting and recovery.

Hi Alana, thanks so much for meeting with me today. I understand you're actually the first Addictions Peer Support Worker to be employed by Hawke's Bay District Health Board. Does being the only peer support worker for HBDHB sometimes feel like a bit of pressure?

Honestly..., No.

The only tricky bit around the role is it does come with a bit of stigma. I get some sticky and to be fair, rude questions at times. It used to get to me but now when I pick that up, I just respond with, 'I used to be a drug addict.' I guess it's harder for the stigma of the role to fester from others if I actually just own my past, which I do. If other people have a problem with that, it's their problem.

Te Ara Manapou has employed me knowing I have a really long standing history with addiction. Everybody at work knows my story and they don't judge me, they just roll with it.I was really nervous at the beginning. I wanted to be authentic and not appear like a fraud. As I met with more of my clients and worked with mums I realised that I'm not there to fix people and what I felt was really important was that they knew that I had some understanding about addiction, that I hadn't read it in a book, that I'd been through a lot of the same stuff.

I've lived that life. I didn't start realizing the harm I had done to myself and others until quite some time after I had stopped using. I use my experiences to show people they can and they will. Their past does not have to define them.

A big part of my role is to remind people there is always hope for anyone at any time. I didn't think there would ever be any hope for me, and I was wrong. If I can do it anyone can.

I've been thinking about some of the barriers preventing parents affected by addiction from engaging with services and it strikes me that the level of shame and guilt in admitting putting alcohol and drugs before the welfare and needs of children must make it incredibly tempting to remain in denial.

What were the circumstances that allowed you a moment of clarity to see through the layers of denial that accompany addiction and be confronted by the impact of your addiction on your children?

With parenting everyone says children are a protective factor and I don't necessarily think that's true. I think if you have an addiction you can still love your children and you can talk yourself into feeling like you're doing everything you can for them.

I used to go out and play with my kids and go to everything with my kids. They always had the best stuff but I was away with the fairies. As much as I wanted to put them first and the intention was always to put them first, my addiction to methamphetamine was stronger.

When my son was about six or seven I had a without notice parenting order handed to me by court bailiffs for my son, by his dad. I lost my son, and man did I grieve for him.

I had no contact at all. No phone calls, letters or visits with him for the next 6 months and that tore me apart. At the beginning I used as much methamphetamine as I could get my hands on. I had supportive friends but we used together, so really we just fed each other's addiction. I used a lot in a short amount of time and I thought the world was against me, and everything was everyone else's fault.

I realised then, honestly for the first time, that as much as I loved my kids - they were fed, clothed and I believed back then, well looked after - that something about that drug had a grip on me. A grip that clouded my view on my parenting, or lack of. I was putting it first, in front of my children's needs. That realisation broke me.

I was in so much denial telling myself there nothing wrong with what I was doing, that everything was fine. And then, at the first formal family court I heard the lawyers describe in depositions how I wasn't emotionally there for my child and pin point exactly how I put my drug use in front of my children.

I wish I could say that losing my son was my rock bottom but it wasn't. Standing in court that day with the realisation of what I had done, to my children emotionally was when I hit the bottom. I got high one more time that day, and apart from a lapse on New Year's Eve 2012, it was my last time.

I hated myself for lapsing and hated that I had planned it. I decided then and there that I was never going to disrespect myself and my children by touching it again. It wrecked our lives. I wrecked our lives. I sucked it up and I worked the hardest I ever had to get my boy back.

How do your experiences guide you in supporting the mums you work with?

I know what that's like and the thoughts don't shock me. I just feel privileged that they are shared with me, that we get to pull them apart together and explore what is going on in a safe way.

The way that I work with people is I think that when you're in active addiction or early recovery, your head is a really dark place to be in. The things that are inside your head are not usually things that you want to say out loud to anybody because there's the shame and the guilt and the fact your children might be removed if they haven't been removed already.

I read an article a couple of weeks ago that really annoyed me. A parent had said to a service that they loved methamphetamine more than their children and I get that. Some of my mums say that, and I think that's really brave of them and I think it's such a great point to start from because they know that it's not right but that's how it is.

What annoyed me were the hundreds of comments shaming this mum, and all I could think was how amazing her honesty was and how she must be in such a dark place, because that would have been so hard to say out loud to a service. So who is supporting this mum, who is sitting alongside her with this guilt -anyone? Or is she just left to sit with it and be bullied by people who wouldn't have a clue about addiction?

What I like to talk about, to the mums I work with, is that I understand those thoughts but that sometimes the things that are inside our head aren't necessarily the truth. Addictive thinking can be really powerful unaired. I'll tell them how sometimes I feel like a really weird person because these things that used to be in my head - things that I thought defined me - were merely addictive thoughts. I learnt that these thoughts didn't need to become behaviours; I was able to separate myself from them.

I'll usually provide a couple of examples of my thinking, things that I thought were really strange at the time and when I share these thoughts with my clients they crack up laughing.

It's happened so many times that after sharing my own thoughts and having a laugh it all comes pouring out of whoever I'm with. I think it's really unsafe for dark thoughts to be trapped inside somebody's head and I think they need to come out but they're not going to come out unless they're in a safe space.

With peer support, if you're showing the people you're working alongside that it's happened to you, that you've had dark crazy thoughts too then you're providing them with a platform to say things out loud. When they say things out loud they hear it and its not stuck inside their heads circling around.

What I'm trying to do is support people to be uncomfortable in a safe space because I think that if you stay in your comfort zone the minute something gets uncomfortable or feels unnatural, you're just going to fight against it and it's not going to work. I want people to feel uncomfortable so they can feel. I want people to feel within a safe and supported space and it doesn't matter what that looks like.

Recognising that the need for this drug is stronger than the need for their children is the breakthrough and once that happens we see how we can work with that. So a lot of what I'm starting to do is supporting people to learn how to enjoy their children, which sounds really strange but heaps of them haven't been to parks or play areas or anything with their kids and it's uncomfortable for them.

One side to being a peer is you do have that added insight that's really helpful to be empathetic but I guess the other side to the lived experience coin allows you to cut through evasive answers, dishonesty and avoidance of responsibility too?

Yeah and I say that to people. One of the things I usually say during my first one-on-one visit with people is that I will call them on stuff and if they're not going to be honest with me, this isn't going to work.

I'll then say to them, you know I'll build up your trust, we'll work on that together but I'm going to need you to be honest with me because otherwise I'm just coming here every week and we're talking shit. I'm not actually helping you because I don't know what's really going on. That's usually the appointment where they tell me everything.

I like to have courageous conversations with people. People laugh and tell me 'Alana I can't get anything past you.' I might make a comment like 'oh, your skin is patchy, you told me that when you're coming down you get patchy skin.' They don't remember telling me those things.

I ask what being high and coming down looks like for them, I ask what to look for, I ask what the signs are, I don't assume them. I learnt everything I know about IV use from one of my clients last year. I openly just asked her all this stuff because I thought it was really important to be informed. I learnt more from her than I did from my diploma.

They've given me the information and I use that information to help them. I'll say 'hey, remember you told me that, I really appreciate that you told me that but it also means you're high right now, so what are we going to do about that? What happened for you to use again?'

Do you think it's often the weight of shame around messing up as a parent that makes people reluctant to admit a lapse or relapse? I mean it's taking a big risk because the consequences of an admission might mean having their kids removed.

Do you think that because you're a peer, because you've had similar experiences to the mums you work with there's a sense of relief for them, like finally here's someone I can talk to who gets it?

I think there is a sense of relief. I mean put it this way, I haven't worked with anyone yet that hasn't admitted drug use, even though it means their children could be removed from their care. Even when people have said they've been clean for a couple of weeks or something like that and then they've relapsed knowing they've breeched part of a plan meaning their children might not be returned to them, they still say it.

I think that's huge. I mean they don't say it because they have to. I can't assume anything like that. They say it because they want to and I guess they're saying it out of desperation. They just find the right person to say it to. Taking the time to build trust and actually listening to people sets up so many important conversations.

Do you have situations where you walk into a place and it's apparent the kids need to be removed immediately for their own safety?

I haven't been in that situation but I have been in situations where I have to register concerns about the welfare of children. There's a process around this.

A report of concern needs to be completed and that gets handed to Oranga Tamariki.

I'll advocate for those children but also for the parent. A lot of my mums will do it themselves. I try to empower mums to go in and tell Oranga Tamariki themselves and they do. Not all of them but a lot do. I think that's amazing, it's very bold, I've had quite a few do that now.

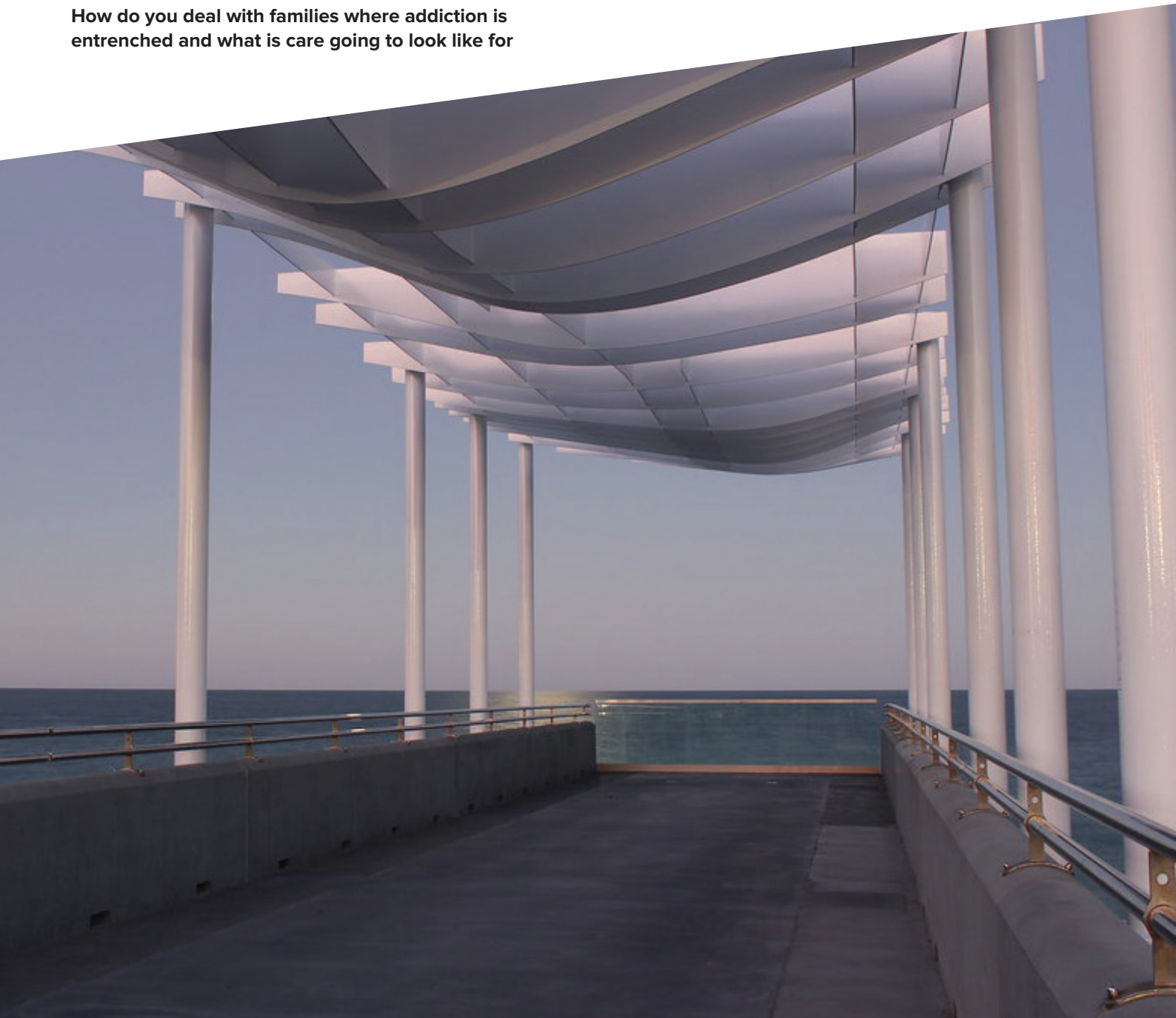
I'll support them through that and it means they are part of the plan, it's no longer a plan that's being made for them, they're part of it and they have input into it. It means they can be real about what's going on. It allows them to suggest which family members might be able to take care of their children and they might look at going to rehab.

How do you deal with families where addiction is entrenched and what is care going to look like for children if another family member steps in? Is it going to be better, is it going to be worse, are there going to be other threats to their welfare? How do you navigate that stuff?

I am getting quite good with that. I've been in a situation before where I knew the whole family was using because I'd been told by my client but my client hadn't felt in a place to say anything to their family. I discussed it with a social worker and offered some ideas around non-confrontational strategies.

Saying things like 'if anyone can put their hands up for these children that would be great, we'll get the forms signed and do the hair follicle testing.' All of a sudden the people withdraw, they say 'oh nah, not going to do that.' Even just mentioning in passing that part of the policy is you fill in these forms and do a drug test is a simple little strategy to prevent kids going from one bad situation into another.

It strikes me that the impact of addiction on family and whānau is often multigenerational and while it's not



always the case, many parents with addiction issues have had childhood's marred by familial addiction and trauma.

What bearing do the families your mums come from have on all of this? I mean what types of trauma has today's parent suffered when they were children? How many generations of addiction are at work in the family dynamic?

It's very common to see situations where blame is put on the parents of the person with the addiction, I see this a lot, I'm just a victim of my family circumstances and while I'm not discounting any of that outright I do see it the other way too.

I have a really good friend who did all of the things I did and she grew up in a really stable family with lots of love and wanted for nothing. When her addiction got really bad everyone pointed fingers at her parents. Actually she just wanted to do this. It's not always about the parents.

But childhood trauma a part of your story isn't it?

Yes, definitely. I grew up in a home where we kind of really just existed. Both my parents are deaf and in many ways they didn't parent. They couldn't speak and so growing up I was their voice and their ears.

I had quite a few traumatic experiences when I was young. I was sexually abused by two different family members and a so-called family friend. I was always told that the perpetrators 'were good people' and it 'wasn't their fault', so I was never able to really feel or talk about how that affected me.

I was exposed to a lot of family violence, gambling and alcoholism by the people around me at a young age. My mother attempted suicide numerous times in front of myself and siblings, and that continued throughout our younger lives. When I look back on my childhood, I have very clear, specific memories about a multitude of events, which were made out to be ok and 'normalised' but they really really were not.

What happened to me became these deep dark family secrets that everyone pushed to the side and pretended didn't happen. It felt like I was part of that secret and pushed to the side with them. As a result of the abuse I was no longer able to live in the family house, so I grew up feeling really disconnected from my immediate family.

I didn't feel connected to my siblings because they lived in other houses. They were my family members but we weren't close, I didn't get to spend much time with them and when I did, I was an outsider. I was lucky enough to have a few different groups of people that would take me home sometimes in the weekends and make me feel like I belonged.

I would call them my aunties etcetera but due to the trauma, I always had this part of my brain that would tell me I was un-loveable, and that people didn't really care. It was difficult to shake.

When I turned 16, I was over life and I wanted to die. I felt like I'd go out with a bang and so I moved to Auckland and I tried every drug under the sun. And I just continued to do that and magnetized towards people who could provide me with a high. This started with Ketamine, cocaine, speed, Rinse (GHB) and methamphetamine.

I moved to Wellington and I did the same thing and started using methamphetamine more often. Back then I wasn't really 'addicted' to anything, I was more choosing to use anything I wanted to on any given day because it was exciting.

After burning all my bridges and leaving behind a multitude of debt and a string of unhappy people I moved back to Napier. Not long after moving back I became pregnant and stopped. I felt like having this baby was going to fill the void inside me and I always used to say he saved me.

However, when I started to be able to go out again (which was about when he was two I think) and do things and have a social life I got drawn back into that scene. And that scene was just methamphetamine and that was when it was hidden in Hawke's Bay but it was everywhere and I always knew where to find it. So I started again and I didn't stop.

I used to see a mental health counsellor when I was smoking about a gram a day and seeing a psychiatrist and a counsellor for basically 'my come downs'. I was able to go in and say all of the symptoms of my addiction without saying I was an addict. I was treated for all the symptoms of my addiction, without being asked the most obvious question, are you using drugs?

I would say I can't sleep, I've lost a lot of weight, I can't eat because my teeth hurt and I've got really bad teeth and I've got really dark days where I don't want to be around people because I have issues.

They'd give me diazepam, clonazepam, quetiapine, zopiclone and also ensure-plus for weight gain. I was prescribed everything to treat the symptoms of meth addiction. It concerns me that this still happens today. The symptoms of addiction are treated with medication, ultimately numbing trauma further and supporting an addict's desire not to 'feel'.

Did you do rehab?

No, only one of my children was removed from my care. I had a younger child as well who wasn't removed so at that time rehab wasn't something that was really offered or on the cards.

I tried N.A and got some unwanted attention from another male member that became very scary, very quickly, so I cut that off.

I started going to a relapse prevention group every week. The relapse prevention group was great and I loved how non-judgemental it was. I got a small community of people together who wanted to meet on Friday nights, socialise and have pot luck dinners. I guess my recovery took a lot longer because all I had were those Friday nights.

When I first tried to stop I remember putting a cutting agent into a pipe and thinking well it's not meth so if I just smoke this then it's not meth, it's not a drug so its ok I'll just use this to get through the early bit but obviously that didn't work.

At that time all my old friends were still using, I did try to get most of them on board, but they weren't ready yet.

I kept this up for a couple of years and then I just stopped. I stopped going to dinners, I stopped going to groups and I just began to live my life I guess.

How did you end up working in the Addictions Treatment Sector?

I actually wanted to be a journalist and write children's books! That was my dream, maybe it's still on the cards. No one in my immediate family had ever had a career. My mum had never had a job; it wasn't really expected in my family. Last year I completed my level 6 diploma in applied addiction studies which for someone who was never going to make anything of herself feels pretty good.

When I originally started studying I thought it might be cool to work with kids who have been affected by addiction. That's what I wanted to do when I started it and I didn't really know if I would follow through, so I didn't tell anybody that I'd started studying, just in case I dropped out.

I'd started lots of courses when I was in active addiction. A chef's course, a journalism course, I started heaps of stuff. When I was in early recovery I did the same. I started a Batchelor of Applied Social Studies, I started lots of stuff and just didn't finish it.

I did a placement at the Te Waireka Residential Youth facility when they were winding down their services as they were doing a merger with Te Taiwhenua O Heretaunga. The staff were incredibly passionate about the work, which I loved but there just wasn't enough for me to do.

My next placement was at Te Potama Tautoko (TPT). While working there I heard from a team leader during a meeting that a new service, Te Ara Manapou, was looking for a peer support worker and straight away I was all over it.

I kind of took over the meeting asking questions like, 'what does that person need to have?' 'What are the requirements of the role?' 'What kind of person are they looking for?' I then pretty much told everyone present a brief life history of myself!

I ended up applying for the job which was the most nerve racking thing ever for me because I'd never had a real job interview. So I jumped in and ended up having an hour-forty-minute-long interview which I was convinced went horribly wrong but I was told it was really good and I got the job.

Do you think the empathy peer support workers bring to the job places them at risk of burn out, because they're going the extra mile really wanting their clients to 'get it' they way they 'got it'?

There's plenty of people out there needing support and if people are passionate about helping then they go out and do it. Recovery people are great examples of this. I guess the flip side of that some people go out and do this in their own time. And while that's fine, does that mean people are getting addicted to work or that they're trying to save everybody?

Personally I don't go the extra mile. I'm ok if I know I've done all I can do to help a person over the course of my working day. My frustrations lie in the fact that while I have a level six diploma in addiction studies and feel like I could do more, I'm not a practitioner, so my role has its limits.

I think it's a mutual understanding that I do everything that is in my power to help. I will have open discussions with clinicians and my team and tell them what I think should happen.

I also give feedback. I'll say what I think might work. It might mean saying I think this person needs a little bit of peer support even if it's just like three weeks because we're trying out this thing where we are using peer support as a brief intervention.

I appreciate feedback too. I actually encourage people to talk to my boss, send an email, or let me know directly if there is something they don't like or that isn't working for them. I want to hear from my clients about anything they think either I or the service should do differently. I have learnt so much from my clients which is awesome.

That's why I registered with dapaanz as an endorsed support worker. So I have a code of ethics, so I have those boundaries around me. In my interview when they asked me what my biggest worry was, one of my responses was that I thought I would have too much empathy and that I would grow attachments to people but actually I don't.

So what are some of the tangible outcomes from peer support you've seen occur for your clients, their children and their wider families and whānau?

I have a client who had a really strained relationship with her parents and one day I went to pick her up but she wasn't there and her father answered the door. I don't share any information with family members because confidentiality is really important.

But this parent answered the door and asked me who I was and where I worked and I told him, 'I'm Alana and I'm a peer support worker.' He then asked me what a peer support worker did. I told him that I had lived experience and he asked me if he could ask some questions about my life.

I thought, oh yeah ok, I can do this because I'm not disclosing anything about my client's stuff. He asked me heaps of questions and I ended up talking to him for ages. He asked me if I had children and he asked me if I chose methamphetamine over my children. He asked me why I thought I'd done that and he asked me how I'd become addicted to meth and what addiction felt like.

I guess what I say to people all the time, and this is something I'm really strong on, is that the recovery journey comes in lots of different forms and it's really important to not get invested in just one plan, you should always have back-up plans.

He asked me questions that weren't anything that he could use against his daughter but he was desperate to understand what it meant. He then asked me how I came out the other side of it and I told him, 'look, I tried lots of different things until I found what fitted for me at the time and I went with it but I also fell over a lot in the process and I really needed people who believed in me during that process.'

I told my client about our conversation the next day and she said yeah I already know, dad's been a lot different since that conversation and he's saying different things. So from that point onwards the dynamic of what was a really strained relationship between the parents and my client changed to one where everyone now talks really openly to one another.

Their relationship has strengthened so much that at a family group meeting a couple of weeks ago they were able to sit and communicate with each other about the positives and negatives of the journey for all of them without flipping out.

The parents thanked me and my client thanked me. I still work with her and I think that's just such an awesome outcome.

Thanks so much for sharing your story with me today Alana.

Te Ara Manapou

Relationship Building & Connection Core Values for Hawkes Bay Pregnancy and Parenting Service

By Nathan Frost

Operating out of a converted respite care unit in Oamahu Road Hastings, Te Ara Manapou Pregnancy & Parenting Service came into being with its first referral in July 2017.

The Ministry of Health funded service - the first of its kind for Hawkes Bay - is modelled on CADS Auckland - Pregnancy and Parenting Service (PPS), and is one of three PPS services funded in response to an identified need to overcome barriers preventing pregnant women and parents using substances in ways that put children at risk from engaging with services.

Disproportionate statistics highlighting the harmful impacts of parental addictions on child wellbeing in Hawkes Bay, Northland and Tairawhiti, coupled with high numbers of pregnant women and parents with addictions having little to no engagement with existing addiction services saw each of these regions receive funding for PPS.

Te Ara Manapou - 'the pathway of sustenance' - is a name that truly reflects the relationship building ethos guiding the Hawkes Bay service's approach to working with clients. Te Ara is a pathway and Manapou is a way of sustaining and supporting life. The emphasis here is twofold - the pathway of sustenance and journey of wellbeing. It relates both to parenting and support.

For Te Ara Manapou's Clinical Team Leader Julie Oliver Bell, improving the wellbeing of children is of paramount concern and the reason for the service's being.

Addiction Standard spoke to Ms Oliver Bell recently about Te Ara Manapou's long term relationship building approach and the impact these meaningful engagements have on their clients and the lives of their children, families and whānau.

It strikes me that the background to PPS services like Te Ara Manapou getting funded, was an awareness of addiction and parenting issues and some frustration around that because existing service structures in the addiction sector weren't able to do enough for effective interventions and engagements to take place. How does Te Ara Manapou differ?

I'm a relationship person, I have a background in social work and believe that strong networks and relationships are at the core of this service, without that I don't think we could do the job we do.

What we know about addiction is that people need connections. Often our clients are very disconnected from any pro-social activities or people so our role is to connect them with whanau, services and people that support their change.

But connections don't happen overnight do they?

No that's right, they don't. Te Ara Manapou has a luxury many services do not, in that we have a level of funding that allows us to build long term relationships over a period of years.

Our referral window can be anything up to four weeks pregnant with a cut off at the age of three. So even if we get a referral the day before a child turns three, they can stay with our service. They don't have to leave at the age of three that's just the referral window, from pregnancy through to the age of three. We can then work with our clients for as long as needed.

By maintaining long term relationships, it means we're able to support our clients through any obstacles on their recovery journey. We understand that there's no easy fix when you've had a ten or fifteen-year addiction, to think otherwise would be short sighted.'

Another aspect in the background to PPS services being developed was the recognition that barriers to service provision for pregnant woman and parents needed to be removed. What are some of the ways Te Ara Manapou works with clients to achieve this goal?

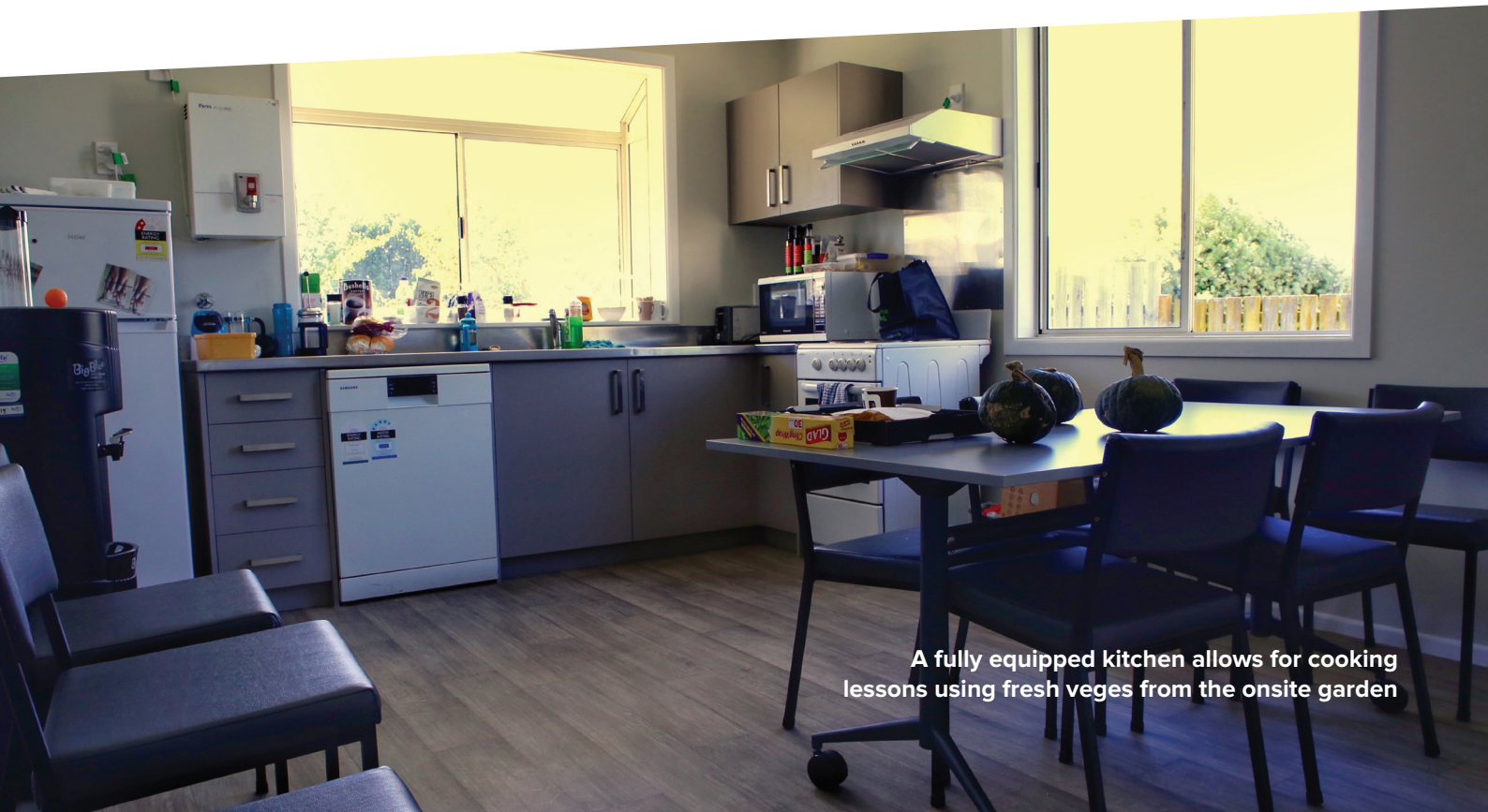
There's a lot of shame and guilt that can be a barrier to people seeking help. It's a very difficult place to get to where they're able to admit to themselves actually I don't parent well when I'm using and my kids are missing out. That admission is huge! Especially when you factor in societal judgement.

The gnawing anxiety of there being an extra mark against them, not just using but pregnant and using.' If you're sitting with feelings of guilt shame it makes it that much harder to engage with a service.

Barriers preventing people from engaging with services are not just about stigma though. We look for practical solutions to get people to where they need to be things like transport or child care.

We mostly visit our clients in their homes, often when you've got a baby, or you're heavily pregnant getting to a service is not always easy. We're working in a way that some people might consider too easy. They might say, "oh your clients just aren't ready, they're contemplative or pre-contemplative and you're doing too much" but we feel we are just being realistic.

Its much more than just, it looks good for a little while because what we find is that people do quite well to start with but then quite often there's a lapse or a relapse. By



A fully equipped kitchen allows for cooking lessons using fresh veges from the onsite garden

being there long term you're not just setting them up and then saying see you later.'

The long term addictions many of our clients have before arriving at our service, with all the negatives that go with that, might mean we represent the ambulance at the bottom of the cliff for them but we're aiming to be at the top of the cliff for their children.'

I like that about our service, I like the fact that our KPI's aren't like everyone else's, it's not you did not attend and you're out. We're always looking at creative ways we can maintain supportive relationships with our clients and we're resourced to do that, other services often don't have that luxury.'

Reducing harm within family and whānau households has an immediate positive impact for children, but through providing ongoing support for parents, Te Ara Manapou provides them with the best opportunity to live good lives and break cycles that are often multi generational.

We do have occasions where because of concerns relating to children's safety and wellbeing we are obliged to fill out a report of concern, however, most of our clients already have Oranga Tamariki involved. Children's safety and wellbeing has to come first in anything we do.'

In terms of addiction, what are the issues clients of Te Ara Manapou typically present with?

The majority of our clients are referred due to Methamphetamine use primarily because of the concern in the community around meth. That's where people start to worry and that's when other services feel like its getting out of control because it's not just the drug it's what it brings with it and the lifestyle around it.

People still minimise the impact of alcohol or cannabis but there are some really negative impacts on parenting for some of our heavy cannabis users and the impact of Alcohol has always been huge for both parenting and pregnancy.

You've also employed an addiction peer support worker, Alana Geddes whom I'm interviewing later on today. My understanding is that she's the first addiction peer support worker to ever be employed by the HBDHB. How do you see her role in PPS client relationship building?

PPS in Auckland employ peer support workers from women who have been through their service but when we opened our doors we couldn't afford to wait two years so we interviewed and were very lucky to get Alana.

I think what Alana offers our clients is hope, and that's really important. A lot of our clients feel hopeless with their situation. Alana can talk to them about a part of her story that they can relate to and this offers them hope for themselves and their recovery journey. This is really important for them to see that addiction can be overcome.

The Taonga at the entrance to Te Ara Mana Pou was carved at the Hawkes Bay Regional Prison

Whatever it takes

By Nathan Frost

Supporting Mental Health & Addiction Affected People in Hawkes Bay

An international art deco destination, Napier is possibly the most photographed provincial city in New Zealand. Yet beneath the veneer of geometric influenced architecture, faux bakerlite fixtures and the chrome detailing that draws over one hundred thousand picture snapping cruise ship tourists to the city annually, there exists a much less glamourous reality for many of the city's locals.

The nationwide housing crisis currently gripping the country has not spared Hawkes Bay and at the time of writing this article a report revealing the plight of over four hundred Hawkes Bay children (a number equivalent to the average student population of a regional primary school), living in emergency accommodation settings like motels hit the media.

However, nowhere is the impact of the housing crisis more visible than for some of the Bay's most vulnerable communities, those affected by mental health and addiction.

The groundswell of mentally unwell and addicted homeless people around the city has led the local Council in recent years to erect gates across central city bus shelters to prevent rough sleeping.

As Peer Support Worker Olaf Peka sees it, the housing crisis has dire repercussions for mental health and addiction affected people.

'If you're a drug addicted single male with mental health issues, you're not exactly going to find yourself high on the ladder of housing desirability,' he said.

Mr Peka works for Whatever It Takes (WIT), a not for profit trust that began a central city outreach in 2016 in response to the growing number of homeless in Napier and related issues of begging, drug addiction and increased levels of street crime.

WIT is a peer-based service that formed back in 2000 as a result of one person who was obviously falling between the cracks of the mental health system and needed help. Soon another person followed, then another, then more.

Left to right WIT peer support team members Taina Nukunuku Olaf Peka Charlene Whyte and Linda Lockie

These were the people seen as occupying the “too-hard basket” and were either living on the street, or not far from it and needed a service that would go the extra mile for them.

WIT takes its name from a HBDHB clinical manager who when asked at a meeting why their team was being so successful said, ‘because they do whatever it takes.’

The outreach is the spear tip of WIT’s system of care for people who are homeless, or at risk of becoming homeless in the Napier area and involves community collaboration with the Napier City Council, MSD, HBDHB, Police, faith communities, other NGO’s, and volunteers.

Located in a central city villa at 26 Clive Street East the Outreach is open Mondays, Wednesdays, and Fridays.

Mr Peka is one of three support workers based at the outreach, however, he describes working for WIT as being part of a large and dedicated team made up entirely of people with some form of lived experience relating to mental health and/or addiction.

The team make-up includes three full time client advocates, a Hawkes Bay District Health Board Liaison, a tenancy procurement manager, and eleven to twelve peer support workers.
They work closely with one another to ensure there are no gaps in the cover of their whaiora. Depending on the needs of the whaiora, they share caseloads, however, sometimes the whaiora will only work with the support worker they trust.

The team currently works with 16 people who could be classed as long term homeless but have over 90 people on their books at risk of becoming homeless and regularly have over 40 people coming in for breakfast, coffee, and lunch. Their combined efforts in keeping with the trust’s ethos to do ‘whatever it takes,’ gets results.

In the last six months they’ve secured emergency housing for 57 whaiora, transitional housing for a further 34 of their whaiora, and placed 19 whaiora into permanent housing with further permanent placements being finalised.

Addiction standard asked Mr Peka to provide a personal account of his work at WIT and the ways his lived experience helps him connect in meaningful ways with his whaiora.

Peer Support at Work: Olaf Peka in his own words

My background with addiction

I am a support worker at the Outreach Centre at Clive Square, Napier. I am into my ninth year of my recovery from addiction. I spent the first two and a half years in NA, and receiving treatment from Addiction Services in Napier. At this time I was working in a casings department for a meat processor. I did service with NA and sponsored people into long term recovery. I then stepped back from NA, and got on with my life. I still supported friends and whanau through their recovery, and with their interactions with NGO's and government agencies. I happened to be supporting a whanau member at a NASC meeting, when one of my old counsellors asked me to support a drug rehab group. I was then asked to work in a WIT level four residential unit, then two years ago to work at the Outreach.

A description of the day to day realities of my job

My main job is to support and keep the whaiora alive till they are ready to accept help. Most of the whaiora are in the pre-contemplation stage of their recovery. With the cohort that we work with, we recognise that abstinence is not a realistic goal. We employ a number of harm reduction strategies to reduce the risk involved with our client's substance abuse. For example, the outreach is a drug and alcohol free area, and we will ask clients to leave the premises if they are under the influence. Furthermore, Clive Square, where the Outreach is situated, is a meeting place for many of our clients, and the Napier City Council will trespass from the Square any member of the public intoxicated there. So as a result our clients usually maintain their sobriety till the afternoon, and use or drink away from the Square and the Outreach, as they do not want to lose the use of the Square.

As our whaiora have been let down by most every other person or organisation they have ever had dealings with, at first I offer them nothing but the coffee and food available at the Outreach. However, I will sit alongside them, and listen to their story without judgement, or offering solutions. I gain their trust and build a relationship based on kindness, and being completely honest with any of their queries. When they finally ask for help I will move heaven and earth to deliver the required assistance to the highest standard. That often means supporting the whaiora to navigate MSD, police, DHB, legal processes and the like, at all hours of the day.

If you're a drug addicted single male with mental health issues, you're not exactly going to find yourself high on the ladder of housing desirability.

I've been in the mental health system for 36 years. I've seen so many abuses, people beaten, people locked up. Here its different, here you get treated with dignity and respect, you get treated like a human being.

Carl Mana Reiri

My first priority after signing new people into the outreach, is to get them in front of a GP for a check up, as they all initially present as unwell due to living on the street. We recently had a client who nursed a broken arm for nine days, and only sought ED attention when his fingers started changing colour to black.

During the course of listening to their stories, I take note of their situation to check their acuity, and chronicity to determine where they sit in the homeless framework, so that their needs can be accurately and efficiently met as resources at our disposal are meagre. Chronicity refers to the periods of homelessness, and acuity refers to the factors such as mental health, drug/alcohol use, violence factors, unemployment and the like. I also take note of their strengths, weaknesses, and core beliefs to use when supporting the whaiora in their recovery.

Through the Outreach, the WIT system of care, provides emergency housing, transitional housing, income related rent subsidies, supportive housing arrangements, financial assistance, and financial and case management for our whaiora, to assist them in their recovery.

We are a non-clinical service, but we rely heavily clinical models to support the well-being of our clients, and to manage their recovery. The overarching model I use is whare tapa whā. Then I check where they are currently sitting in the recovery cycle, and in conjunction with a strength based approach, we plan marginal gains across any number of facets. An example of a marginal gain is when supporting whaiora through MSD processes I will address the whaiora as Mister or Miss Smith when talking MSD staff, rather than use their given name, to enhance their mana.

This process is repeated for every area of the whare tapa whā model. I find this gives flexibility to contain most every variable that the whaiora present with. I have also noticed the greatest long term gains are made when we start working on the wairua aspect of the model. However, before support on the wairua aspect can begin, the three other areas need to be worked on first. I quickly take advantage of any opportunity to work on their wairua, for example we will support our whaiora in tangihanga, open meals with karakia and the like.

We have had many of our whaiora successfully reintegrate into their families, gain employment, and are deep into their recovery from alcohol/drug addiction. Some of our whaiora, when initially housed, sleep on their porch for days, before beginning to sleep indoors. We also sometimes need to support them in the most basic of tasks, for example on how to use a washing machine.

The successes are good, but also there is the brutal reality that many of our whaiora die as a consequence of living on the street. Four whaiora have died in the past six months as a consequence of being homeless. Two due to alcohol/drug use, another as he lost his asthma inhaler, and another is still before the coroner.

We utilise group and private supervision to work through the sting that death causes. I am heartened when speaking with the whānau pani, that they thank us for the time we put into their loved ones. They say that the time from when their tupāpaku engaged with the Outreach, has been the best they have been in years, as they have started to reintergrate with wh nau, and work on their health issues.

Another challenge is that some of our whaiora do not even acknowledge that they are homeless, or are reluctant to seek treatment for their mental unwellness or addiction. To overcome this challenge, we patiently continue to sit alongside of the whaiora, waiting for an opportunity to present itself.

The supply of drugs to these vulnerable people is also an ongoing challenge, and we employ every asset we have to interrupt that supply chain.

The impact of Synthetic Cannabis on the Whairoa

Synthetic cannabis is the drug of convenience for a number of our whaiora. Its use adds further layers of hardship to the whaiora. It alienates them from their whānau, and exposes a large potion of the cohort to violence. The homeless are already living in a fishbowl, and synthetic drugs helps attract an even higher level of interest from the public, police, and Napier City Council staff.

I have called emergency services a number of times for unconscious people affected by synthetic cannabis.

I have performed mouth to mouth resuscitation once, until emergency services arrived, as the person had stopped breathing. We patch people as best we can after they arrive in the morning, having had a 'fall' during the night. The whaiora sleeping rough normally buddy up to deter groups that go around and attack them while they try and sleep, or while they have passed out after synthetic drug use. There are weekly admissions to ED due to violence, with one of our whaiora in ICU after a violent assault as I write.

The Harsh Realities of the housing crisis

The greatest challenge we face is the lack of housing. Even when we locate suitable housing, we often cannot take tenancy, as the NIMBY syndrome rapidly develops in the neighbourhood. The whole team at the Outreach, and WIT are constantly trying to source housing. WIT is negotiating to be the lead contractor for the Housing First initiative, which should hopefully make the task of sourcing housing a little easier.

Notice Board:

Cutting Edge 2019 Registrations now open!

Just over 3 months until this year's Cutting Edge! Go to www.cuttingedge.org.nz to register or to apply for a scholarship. Early bird registrations close Friday 2nd August – please note that payment must be made also by this date.

Dapaanz Board Elections

It's time for the election of the dapaanz Board. All members should have now received a link to vote. We encourage you to look carefully at the bios and reason nominees have given on why they want to stand, so you can make an informed decision on who you want to represent you for the next two-year term.

This is your opportunity to vote for your new Board. Please take the time to vote.

More Exciting Things

1. If your invoice is being paid by your employer, it is your responsibility to forward the invoice on to your accounts team. This is not automated from our end unless otherwise prearranged by workplaces.
2. If you are an endorsed support worker or registered practitioner and need to take time out of addiction practice because of parental leave, illness, unemployment, overseas travel, or some other reason, you can apply for leave of absence (LOA) for up to 12 months. LOA will protect your registration over this period. For more information or to apply, click here.
3. We are required to expire memberships that are overdue (60 days or more), so that we are not endorsing people who are not currently registered. This includes being overdue with payment or paperwork.
4. Keep your registration current. If you are expired or overdue, you don't have a valid practising certificate (some people have been stood down by their employer for this)
5. If you lose your registration through expiry and you are a fully registered member, you will need to go back through the provisional pathway.

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