dapaanz
fostering excellence in addiction practice

# BULLETIN

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

At the May dapaanz Executive Board meeting we discussed how integral cultural competency and Te Tiriti o Waitangi are to dapaanz and the addiction sector. The Executive Board consider it really important that Te Tiriti o Waitangi and cultural competency are not a tag on or tick box, but are central, guiding principles in all that we do. Given this, it is great that this edition of the bulletin has a focus on cultural competency from both a practitioner and service-user perspective. Check out the great feature article by Maynard Gilgen on the 4K Model and the very helpful Le Va Engaging Pasifika model. We also want to acknowledge CareNZ and Yustein Sang for their great articles and service-user stories of how re-engagement with culture provided a robust basis for recovery.

You will see that this Bulletin has much more content than previous bulletins. I really want to thank the amazing people who contribute their time to making the bulletin a really good and at times provocative read. We are blown away by the willingness and enthusiasm of people to contribute and by the quality of articles. Both Ian MacEwan and Nathan Frost continue to challenge our thinking and bring us back to what is most important – what works for the client.

If you would like to submit anything in the bulletin please send to sue@dapaanz.org.nz with 'bulletin' in the subject line or contact me on 04 282 1809 to discuss. We are committed to providing a place where your voices are heard, where issues are raised, where controversy is explored and your excellent work celebrated.

On another note, we are really excited that our website has now gone live! If you haven't already – check it out at dapaanz.org.nz and set up your login. The login facility means you will be able to check online when you are due and update your contact details.

Don't forget if you are in Wellington – pop in and see us at Level 5, 342 Lambton Quay (in the AMI Plaza).

**Nga mihi**
**Sue**

## Psychotherapy 1, CBT 0: *return of the therapist?*

**Ian MacEwan**
**Registered practitioner and accredited supervisor**

Psychotherapy: the excavator of the catacombs of why we do what we do. Why am I alcoholic? Why can I stop after a few smokes, but you can't? Why do you eat like that? Through understanding will come healing. Very popular in our sector forty years ago, seen in its various approaches: group therapy, interpersonal therapy, transpersonal therapies, transactional analysis, and long-term humanistic therapy. But they lost out in our sector to one triumphal emerging approach that was born as a reaction to Freudian analysis and (separately) confrontational 'tough stuff' ideology. CBT. Loved by cost-cutting funders for its promise of change within 8 hours of training and practise. Use it myself all the time. Effective with mild to moderate level of severity. But, widely being used for severe level of severity. This is not just a funding and higher level malfeasance but a reflection on training biases for our sector. Brief interventions are taught. Therapy is not.

CBT is a down-to earth technique focussed not on the past: not on inner drives or personal moral inventory and reform; but on the present: adjusting unhelpful thinking and practising behaviour change. It does the job for which it is intended: mild to moderate level problems and is supported by a raft of empirical studies. It assumes a client who is largely integrated psychologically and enjoys a certain social and interpersonal stability and who can harness the energy for personal goals and use the means to achieve them.

Have you noticed that as we increasingly work with people presenting with complex psychological and social and interpersonal issues that CBT doesn't cut the mustard? And increasingly our client loads are reflecting complexity, not medium to moderate level problems? Trauma, both historical and current, important primary relationships that are broken, psychological pain, deep despair, historical and current abandonment, depression that is a stabbing pain in your stomach, loss of hope

that recovery is possible, inability for the moment of identifying need or goals or how to reach them. CBT isn't designed for this. I thought to see how the evidence appears to stack up for CBT working with the kinds of presentation that are now common in the addiction practitioner's experience. Please forgive this rough overview.

Weston et al's (2009) meta-analysis of longitudinal outcome studies from 2004-8 showed that psychotherapy was more effective than CBT with depression, anxiety & related disorders including addiction. They showed that CBT studies excluded those with multiple problems unlike the psychotherapy studies. Shedler et al, (University of Colorado large studies 2004-2010): by 2008, addiction treatment follow-up of 1400 over 2 years post-treatment showed outcome to be ineffective with less than 16 sessions, and by 2010, 13% relapsed after 5 years post-treatment with psychotherapy, and 87% relapsing after CBT. Tolin's 2010 meta-analysis of 21 outcome studies showed CBT had superior outcomes with mild-moderate dependence but was ineffective with moderate-severe problems and that CBT failed completely to meet treatment goals for those with moderate-severe problems. The Tavistock Clinic in 2015 measuring treatment outcomes for depression found that 18 months of psychotherapy showed 44% positive health gains at 2 years post-treatment against 8 sessions of CBT showing 10% positive health gains at 2years. At each 6 month follow-up, psychotherapy showed 40% better outcomes than CBT. Liechsenring's 2016 meta study of 13 RCTs on effectiveness of psychotherapy over CBT for moderate-severe AOD showed the former had consistently better outcomes.

Return of the therapist? Just saying.

# Culture in Practice

*Tihei uriuri, tihei nakonako*
*tihei mauri ora*
*ki a tatou matua I te rangi*
*te timata me te otinga o nga mea katoa*
*nga mate, haere, haere, haere*
*ki a tatou nga kanohi ora*

*Ko wai au!*

*Ko Takitimu te waka*
*Ko Kahuranaki te Maunga*
*Ko Manawatu te awa*
*Ko Ngati Kahungungu te Iwi*
*Ko Kevin Pearce toku ingoa*

## The role of Culture in Recovery


### By Kevin Pearce
### CareNZ


As far back as I can remember I can recall people saying that it's really important we know our "roots," who we are and where we come from. While I may have heard it, it really didn't hold any relevance for me until it became an important piece in my own jigsaw puzzle of life and is now something I personally believe and know to be true.

My name is Kevin Pearce and I'm the Clinical Manager of CareNZ's Drug Treatment Unit (DTU) at the Otago Corrections Facility. CareNZ Manaaki Aotearoa operates 10 Drug Treatment Units across eight sites in New Zealand prisons. Since January this year I have been travelling from Dunedin to Whanganui on a weekly basis as acting Manager of the Maori Focus DTU in Whanganui Prison.

"Te Tirohanga" is a kete of three programmes based in the Whanganui Prison "Whanui"Unit.

"**Te Waharoa**" focusses on Te Reo me ona Tikanga – Language and protocols.

"**Mauri Tu Pae**" is the Maori equivalent to the Medium Intensity Programme (MIRP) that looks at the tane's journey of change through a Maori perspective, and how their behaviour and actions have affected whanau, hapu and iwi. The tikanga programmes work around the concept of "Prison is not in our Whakapapa."

The **Drug Treatment Programme (DTP**) is about learning to manage emotions, looking at values and beliefs, and acquiring new tools that will help tane to function in the community without depending on substances.

This is an impressive unit and grouping of programmes. The overall focus is on Tikanga, a powerful intervention in itself that compliments and links well with the AOD work CareNZ Manaaki Aotearoa do within the unit.

Tikanga means the customs and traditions handed down through the generations from our tupuna. Tane here are learning the protocols, customs and concepts of their ancestors in order to gain an understanding of themselves and their culture, where they come from and who they are. Being immersed in this rich cultural environment provides tane with meaning and purpose, opens the door for self-reflection, and unearths aspirations for future possibilities. I will add here that while this programme is being delivered to our whaiora, there is so much for us as kaiako to learn also. Tuakana/ Teina, Whanaungatanga, Kotahitanga, Manaakitanga, Wairuatanga and Ko wai au, are the pivotal aspects of everything that happens in the unit. For tane who are making a connection to their whakapapa- many for the first time- this can bring about an increase in motivation and sense of identity. To see these men korero in Te Reo Maori in morning hui, doing their pepeha, singing waiata, performing haka/taiaha and participating in powhiri for the new entrants and visitors to the unit is- from my observations- enormously empowering and healing for the tane involved.

This is Tikanga, it starts from the top and cascades down through the unit staff to the tane on the programme. It's been exciting and encouraging for me to see these tane responding to the programmes within this unit and how they are enthusiastically supported by the Corrections Department.

Perhaps the benefits of "Te Tirohanga" are best summed up by two of the tane who have participated in the programme:

### Tahi

*"I am in total support of Te Tirohanga Maori Focus unit in Whanganui prison. I have done a lot of jail time dating back to the 1980's. Earlier on there were not many opportunities to do any rehabilitation, or anger management programmes that could help me to address my behaviour and offending issues. I ended up being an angry, rebellious man who hated the world and authority. I arrived in this focus unit in August 2015 as part of my sentence plan. I was only supposed to be here 3 months for the Mauri Tu Pae course. Being a Maori based programme I could relate to it in a lot of ways. It opened my eyes and heart and gave me an understanding of who I really am by addressing my core beliefs and unmindful thinking, which was just what I needed. I went on to attend the DTP (Drug Treatment Programme) which was another opportunity to refresh, enhance and learn new tools. Te Waharoa was about learning and understanding more of my Maori culture and values of being Maori. I am also about to complete a marae catering course which has been good for me. Finally, this whole focus unit and the Maori values of Tikanga, Tika and Pono has definitely made me a better person. I feel balanced in my spirit, in my mind and in my body, something that I have never really had for a very long time. I know now that I am ready to be a real father to my children, grandfather to my moko's and a role model for our Maori people and society"*

### Rua

*"I have been in the unit now for almost a year and a half and have been very fortunate to have had the opportunity be a part of Te Tirohanga 3 baskets of knowledge. I have been given the tools to develop positive coping strategies to minimise the risk of any further offending upon my release. To me it has been the combination of the 3 programmes, the kotahitanga between staff and mauhere (inmates) and having a PCO (Principle Corrections Officer) that is totally committed to the kaupapa. We are all on the one kaupapa, kotahitanga and tikanga maori."*

In summing up. There have been many groups who have graduated from Te Tirohanga who would have similar testimony as the above two. In a system where Māori are very much over-represented in the prison population statistics, the opportunity to participate in culturally based programmes is integral in their search for identity and change.

No reira, tena koutou, tena koutou, tena tatou katoa

# Articles

## The 4K Model: Cultural Comptency and Working with Māori


### By Maynard Gilgen
### Matua Raki


*Ka oho to wairua*
*Ka mataara te tinana*
*He aroha ki te aroha*
*Ka kā te rama*
*Nā Te Raupahara*[1]

When Sue Paton (dapaanz) approached me to write a paper on "cultural competency" I decided to describe, from my perspective, what knowledge and skill I consider a competent practitioner should have to work therapeutically with tāngata whai ora Māori and their whānau.

Instantly, the 4K model came to mind. I've used this model when supervising Māori and recently referred to it in discussions at a Supporting Parents Healthy Children (SPHC) workshop.

The "K"s in this model represent, 'Karakia, Kaumātua, Kōrero and Kai'. For most people these words generally roll off the tongue easily, they are reasonably well known kupu (words) in Aotearoa, especially in the helping professions. Most people have at least, a superficial understanding of them.

A common theme in the research and writing of Māori clinicians and practitioners who work with tangata whai ora Māori and their whānau,[3] is that an understanding of te ao Māori (the Māori world) and kaupapa Māori frameworks is necessary for effective therapy to happen.

Hence, over the coming dapaanz bulletins I hope to explore each of the "K's" to help those practitioners who don't have, or have a limited understanding of, Māori frameworks or models to explain their purpose and relevancy to tāngata whai ora Māori (Māori clients) and their whānau.

1. *"When the spirit is awakened, the body is alerted, Love is shared together, so follows enlightenment"*. Composer, Te Rauparaha.
2. This SPHC Workshop took place at the Wellington SPCA on 16 February 2016.
3. Britt, E., Gregory, D., Tohiariki, T., & Huriwai, T. (2014). *A guide to motivational interviewing for Māori. Wellington:* Matua Ra i. Cave, T., Robertson, P., Pitama, S. & Huriwai, T. (2008). *He tētē kura: Māori addiction treatment 1980-2008*. Matua Ra i, Ōtautahi, Christchurch, New Zealand. Cargo, T. (2007). Hoea a mai tōū waka – Claiming Spaces for Māori Tamariki and Rangatahi in Cognitive Behaviour Therapy. In M. Levy, L.W. Nikora, B. Masters-Awatere, M.R. Rua & Waitoki (Eds.), *Claiming spaces: Proceedings of the 2007 National Māori and Pacific Psychologies Symposium.* Hamilton: Māori and Psychology Research Unit. Cherrington, L. (2002). The use of Māori mythology in clinical settings: Training and needs. *The proceedings of the national Māori graduates of psychology symposium.* Durie, M. (2001). *Mauri ora: the dynamics of Māori health*. Auckland: Oxford University Press. Fernandez, C. A. (2015). *Whaka whirinakitanga ahua: Exploring a Māori model of health service delivery*. Unpublished doctorate thesis: Masey Univeristy. Marsden, M. (1992). God, Man and the Universe: A Maori view. In M. King (Ed.), *Te Ao Hurihuri: The world moves on. Aspects of Maoritanga* (pp. 117-137). Auckland: Longman Paul. Pitama, S., Roberstson, P., Cram, F., Gillies, M., Huria, T., & Dallas-Katoa, W. (2007). Meihana model: A clinical assessment framework. *New Zealand Journal of Psychology* Vol. 36 (3) Nov 2007, 118-125. Milne, M. (2005). *Māori perspectives on kaupapa Māori and psychology: A discussion document*. Wellington: Unpublished report for the New Zealand Psychologists Board. Taitimu, M. (2007). *Ngā whakāwhitinga: standing at the crossroads, Māori ways of understanding extra-ordinary experiences and schizophrenia*. Unpublished doctorate: University of Auckland.

This kōrero is not an in-depth piece of work on karakia, but rather an introductory paper to the fundamentals of karakia. My aim is to address the following bullet points:

1. What is karakia?
2. Where do karakia come from?
3. How are karakia used?
4. Examples of the use of karakia.
5. How can I as a practitioner use karakia in my practice with tangata whai ora Māori and their whānau if I have never done karakia or if I am an athiest?

## Karakia

### 1. What is karakia?

The first "K" is appropriately, "karakia". One defintion states that to karakia (as a verb) means:[4]

1. *v. To recite chants, say grace, pray, recite a prayer, chant*

As a noun, a karakia is said to be a:

2. *n. Incantation, ritual chant, chant, intoned incantation, symbols and structure...*[5]

Barlow[6] , likewise reported that a karakia

> "*consists of pleas, prayers andf incantations addressed to the gods who reside in the spirit world.*"[7]

Britt et al. defined karakia as being a:[8]

> "*process of acknowledgment and invocation of divine energy*"

### 3. Where do karakia come from?

Britt et al.[9] Lyndon[10] and Rewi[11] state that karakia are used by people to mediate with the Atua (Gods) to assist them with dealing with life. Karakia originate from the realm of Māori views of the beginning of the universe. Karakia, therefore, connect us to a time when there was no time, known as 'te kore'.[12] My friend, Mokena Reedy once explained te kore as being similar to when we ask one of our tamariki what they are up to, and they reply, "Nothing!" They may say 'nothing', but a lot is going on. From this space of nothingness came chaos and matter unorganised, from which the realm of te pō (the great darkness) and our Sky-father and Earth mother Ranginui and Papatūānuku evolved, and had children, all of whom were male.[13]

These children became the gods of the world and while it is said there were 70, only 8 were widely known: Tāne-mahuta (god of the forest), Tūmatauenga (god of humankind and war), Tāwhirimātea (god of the winds and elements), Tangaroa (god of the sea), Rongomātāne (god of the kumara and cultivated crops), Haumiatiketike (god of the fern-root and wild fruits and herbs), Rūaumoko (god of earthquakes and volcanoes), and Whiro (god of evil, disease, and pestilence).[14]

As Ranginui and Papatūānuku's children grew they became distressed and agitated for having to live in cramped and dark conditions and discussed amongst themselves what they were going to do with their parents.[15] They canvassed three options: do nothing and remain in darkness; kill their parents, or separate them.[16] Although Tūmatauenga wanted to kill his parents, Tāne-mahuta suggested instead that they separate them, which he went on to accomplish after his brothers failed to do so.[17] Tāwhirimātea became enraged against his siblings, as he did not want his parents separated. Subsequently, he promised them that from here on in, they would have to deal with his anger, thus, he went on a rampage attacking each of his brothers.[18] Meanwhile, Tūmatauenga also became angry at his siblings for not supporting his suggestion to kill his parents, subsequently, he attacked each of his brothers and consumed their children.[19] Shirres[20] added that once Tūmatauenga had conquered all, but his youngest brother, Tāwhirimātea, in battle he was given a karakia so as to maintain control over his brothers. This is supposedly, according to the Te Arawa rangatira Te Rangikāheke[21], one of the earliest references to karakia.[22]

4. Moorfield, J. C. (2012). *Te whanake, Te Aka, Māori-English, English-Māori* Dictionary and Index. Auckland: Pearson.
5. Ibid, p.60.
6. Barlow, C. (1991). *Tikanga whakaaro: Key concepts in Māori culture*. Auckland, Oxford University Press.
7. Ibid, p.37.
8. Britt, E., Gregory, D., Tohiariki, T., & Huriwai, T. (2014) *A guide to motivation al interviewing for Māori*. Wellington: Matua Ra i, 4.
9. Britt, E., Gregory, D., Tohiariki, T., & Huriwai, T. (2014). *A guide to motivation al interviewing for Māori*. Wellington: Matua Ra i.
10. Lyndon, C.G. (1983). *Beliefs in tapu, mate Maori and makutu and the relevance of these beliefs to the diagnoses of mental illness amongst Maori*. University of Auckland: Unpublished thesis.
11. Rewi, P. (2010). Karakia Māori: Māori Invocations to Spiritual Authorities. In *He Pukenga Kōrero, Raumati* (Sumer), Vol 9, No.2, pp 16-20.
12. Barlow, p.37.
13. Grey, G. (1971). *Nga mahi a nga tipuna*. First published 1854 (Reed: Wellington).
14. Barlow, p.37.
15. Shirres, M. (1997). *Te Tangata: The human person*. Auckland: Accent.
16. Rewi, P. (2010). Karakia Māori: Māori Invocations to Spiritual Authorities. In *He Pukenga Kōrero*, Raumati (Sumer), Vol 9, No.2, p.16.
17. Barlow, p.12.
18. Grey, G. (1971).
19. Ibid, p.28.
20. Ibid, p.28.
21. "*Wiremu Maihi Te Rangikāheke, of Ngāti Raniwewehi, was a renowned chief of the Te Arawa district in the mid – 1840s. His manuscripts have provided a valuable sources of information about Māori tradition, narratives and practices.*" (Rewi, 2010, p.20).
22. Rewi, p.15.

Rewi stated that, from the time of the separation of Ranginui and Papatūānuku, karakia:

*"...appear to have been used in the construction of ocean voyaging vessels' the production and harvesting of natural resources; house construction; the assignment of unwritten, inferred laws and protection, amongst other uses.*[23]

**4. How are karakia used?**

Barlow reported the following regarding how karakia are used:

*"He maha ngā momo karakia, ā, he karakia mō ngā tāngata katoa. Ko ētahi ingoa he tauparapara, he karakia whakawātea, he karakia pure, he karakia tohi, he karakia whakanoa, he karakia mākutu. Ka akongia e te tamariki, kaumātua, kuia, tohunga hoki he karakia hei tiaki mai i a ia, hei manaaki mai i a ia. Nō reira, ko te nuinga o ngā karakia e mahingia ana e te Māori e aru atu ana i ngā karakia o te karaitianatanga.*

*There are many types of karakia, and in ancient times all people used some form of prayer in daily life and on special occasions. Some prayers have special ritual functions, while others are used for protection, purification, ordination, and cleansing. In traditional Māori society, people of all classes, from children to adults and priestly experts, possessed a repertoire of karakia for use in all kinds of situations."*[24]

This account also supports the idea that karakia were used for all aspects of life within the Māori world, such as, in the design, construction and blessing of voyaging waka[25] (canoes), in the production and harvest of māra (gardens), building and opening a wharenui (meeting house), rāhui (prohibition), blessing whānau members, for war, changing the weather, dealing with sickness, addressing mākutu (curses), tangihanga (funerals), and doing daily tasks.[26]

Given that Māori had always been invested in wairua and were 'culturally assured' in their spiritual tikanga, when Pākehā missionaries arrived at the beginning of the 1800s, at first Māori had no interest in their new Christian religion.[28] However, this soon shifted for the following reasons:

- Missionaries also brought with them new technology and literacy,
- Missionaries began learning te reo Māori,
- Māori became highly motivated to become literate and the first texts to be translated into te reo Māori were biblical. Plus, becoming bilingual was seen as increasing one's mana,
- The high number of deaths caused by epidemics, for which karakia and ancient rituals had been ineffective, and,
- By the 1830s most tribes had now secured guns. Too many young men had died in tribal wars and the missionaries' gospel of peace offered a significant new direction.[29]

Anderson and colleagues[30] reported

*"...that some scholars have suggested that Māori 'conversion to Christianity' was essentially about literacy, that the connection between conversion and printed texts was rather incidental".*

Subsequently, by the mid 1800s large numbers of Māori had converted to Christianity and karakia Māori were being replaced by karakia Christian[31]. Shirres reinforced that Christian Māori continued to,

*"...draw their spiritual strength from both streams - the Io [Māori] tradition and the European Christian tradition".*[32]

King put it this way,

*"...Māori did not so much convert to Christianity as convert Christianity, like so much else that Pākehā had brought, to their own purpose."*[33]

Hence, many Māori have held both Christian and Māori religious views without issue since the mid-1830s to date. Consequently, Māori will also use karakia Christian, as Barlow reported, which follows a Christian process and structure, depending on which Christian denomination the kaikarakia (person saying the prayer) aligns with.[34]

Karakia, therefore, are used for not only the purposes outlined earlier, but also for:

23. Ibid, p.15.
24. Barlow, pp.36-37.
25. Cawthorn, M.W. (2000). Maori, whales and "whaling": an ongoing relationship. *Conservation Advisory Science Notes No, 308*, Department of Conservation, Wellington.
26. Moorfield, J. (2011). Karakia. *Te Aka Māori-English, English-Māori dictinary and index*. Retrived on 30 May 2016 from *https://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&histLoanWords=&keywords=karakia*
27. Anderson, A., Binney, J., & Harris, A. (2015). Tangata whenua: A history. Wellington: Bridget Williams Books Ltd. (p.169).
28. King, M. (2003). *The penguin history of New Zealand. Auckland*: Penguin.
29. Anderson et al. p.176.
30. Anderson et al. p. 172.
31. King, p.144.
32. *Ibid*, p.110.
33. King, p.144.
34. Barlow. P.37.

- Protection: for when whānau travel or are involved in a activity where there might be risk or feeling that someone is placing or has placed a mākutu (curse) against you;
- Purification: blessing water, kai or a whare;
- Ordination: to set apart a whānau member in preparation for them either leaving home, or beginning a challenging activity or journey;
- Cleansing: again, this can apply to a whare or area especially if someone has died in the house or area;
- Design, construction and blessing of voyaging waka (canoes);[35]
- Production and harvest of māra (gardens);
- Building and opening a wharenui (meeting house);
- Rāhui (prohibiting people from accessing or using a public resource such as a shellfish bed);
- Blessing whānau members for war. This was done in ancient and contemporary times;
- Changing the weather;
- Dealing with sickness, such as, blessing whānau members who are ill, have psychological issues or suffer from mate Māori;
- Defending against mākutu (curses), that is, blessing whānau members who feel that someone has cursed them and/or their whānau;
- Unveiling: using karakia to unveil and bless the headstone at the urupā of a departed loved one; and,
- Tangihanga (funeral) rituals.

Karakia are also used for daily tasks, such as:

- Opening and closing meetings and/or hui;
- Blessing kai;
- Opening and closing the day; and,
- Blessing whānau, loved ones and others who are having challenging and difficult times.

## 5. Examples of the use of karakia

There are a number of recorded uses of karakia within many areas of life.

### *Breach of Tapu*

Eruera Stirling shared numerous examples with Anne Salmond[36] of how he used karakia to deal with a wide range of issues, such as, breaches of tapu. He spoke about a farmer who, unknowingly, kept on walking over ancient Māori burial grounds and became unwell and had strange things happen and come to him at night. Eruera directed him to have a Bishop go and bless his land, which he did and he has had no problems since.[37]

### *Healing*

King reported the account of a Tainui kuia, Ngakahikatea, about how King Tāwhiao had healed her blind left eye as a girl.[38] Other tohunga, such as Hori Gage, also gained renown for healing the sick, such as when he reputedly healed Hēni Brown's gravely ill baby.[39]

### *Wartime protection*

Canon Wi Huata also shared how karakia became an everyday matter for soldiers in the 28th (Māori) Battalion, citing how Major Porter urged his men "to pray like hell!" after setting up a dummy wire to deter oncoming German tanks heading for their position to make them think they were heading for a minefield. Fortunately, the scheme worked.[40]

Both Sir James Henare and Peta Awatere, who both were company commanders of the 28th (Māori) Battalion, spoke about how their respective tribal tohunga, Hare Te Rangi[41] from Te Taitokerau (Northland) and Hōri Ngāwai[42] from Te Tairawhiti (East Coast) had said karakia and put them through rituals that ensured their safe return from World War Two.

In my own life I grew up in a whānau where karakia were also used to protect, heal, give thanks, uplift, and to use as a vehicle to seek help to deal with the many different challenges life dishes up to whānau. My wife and I continue to use karakia in these ways today in our whānau.

35. Cawthorn, M.W. (2000). Maori, whales and "whaling": an ongoing relationship. *Conservation Advisory Science Notes No, 308*, Department of Conservation, Wellington.
36. Salmond, A. (1985). Eruera: *The teachings of a Māori elder*. Auckland: Oxford University Press.
37. Ibid, pp209-210.
38. King, M. (1992). *Michael King: Hidden places*. Wellington: Hodder & Stoughton. (pp. 82-83).
39. Binney, J., & Chaplin, G. (1986). *Ngā mōrehu: The survivors*. Auckland: Oxford University Press. (p.42).
40. Spence, R. (1994). *Whakaaria mai: the biography of Canon Wiremu Wi te Tau Huata*. Palmerston North: Dunmore Press. (p.56).
41. Awatere, A. (2003). *Awatere: A soldier's story*. Wellington: Huia Publishers. (p.123).
42. King, M. (1988). *One of the boys?* Auckland: Heinemann Publishers. (p.13).

**6. How can I as a practitioner use karakia in my practice with tangata whai ora Māori and their whānau if I have never done karakia or if I am not religious?**

Many practitioners may not have grown up in a religion, church and/or marae. Several may be atheist or profess no spiritual life. Firstly, it is important to bear in mind what Lyndon concluded from the research she did with her whānau in Pipiwai,

"Despite nearly two hundred years of contact with Pākehā and one hundred and forty three years of sustained contact with them, the Māori still retain many of the beliefs of their ancestors..."[43]

It is simply more likely that Māori clients will be familiar with karakia to some degree. On the other hand, Māori are not all the same and it is important to check whether or not a tangata whai ora and their whānau may want to open a session with a karakia or not. If they do, you may face an expectation that you will be required to do this for and on behalf of them and their whānau. Here are two options you use to manage this situation:

1. If you have been raised in any religion you may ask if you can open the session by using a karakia process which is familiar to you and in your language (whatever this may be).
2. You may decide to inform the tangata whai ora and whānau you were not raised saying karakia but you'd prefer to open the session by doing a mihi (greeting), that is welcoming everyone to the session today for the purpose that the hui has been called or you can inform the tangata whai ora that you would like to open the session with a whakatauākī (proverb or saying) that is appropriate for the hui at hand.

Alternatively, should you want to begin to learn more about karakia there are several paths you can explore that will give you information. It may be necessary to decide a process by which you can distinguish good from indifferent or poor information about karakia. Such a process might include talking to others knowledgeable about karakia about the information that you find.

Such sources include:

- Your own whānau or extended family
- Institutional learning of te reo Māori. At all learning institutions where a beginner will learn te reo Māori, tauira will be taught basic opening and closing karakia;
- Books by authors such as Marsden[44], Shirres, King, Salmond, Moon, Rewi, Barlow, Smith, Mikaere, Awatere, Walker, Binney, Mutu, and others;
- Personal relationships: develop your understanding of te ao Māori by spending as much time as you can with Māori without being a hōhā (nuisance);
- Professional (and personal) relationships: spend time with a practitioner or kaumātua who uses karakia and other Māori clinical models of mauri and whānau ora;
- Māori Television, and local Māori radio stations;
- Google, and,
- YouTube.

Remember, when getting comfortable with saying karakia, you will need to become very familiar with them, by repetition, and by practice. It will be vitally important that you believe and have faith in your karakia. Sincerely used karakia will be of great value to you and the tangata whai ora and whānau you work with.

Although a small gesture, when a karakia is used appropriately it can help start, settle and lay the foundation to have a session which acknowledges the wairua dimension, which for many Māori is often overlooked or belittled.

## Whakamutunga (conclusion)

This discussion can only introduce the concept of karakia, their whakapapa and how they can be used. It provides a beginning point for a practitioner who may want to further develop their understanding of what karakia are and why karakia are relevant for Māori.

Māori are not all the same and it is important to check with your tangata whai ora and/or whānau whether or not they may want to open their session with a karakia.

Keri Opai[45] gave this karakia to my service to open and close meetings and hui; to settle the hearts and minds of those present, and to pave the way for positive korero. Please feel free to learn and use this karakia for a similar purpose:

| | |
|---|---|
| *Tui, tui, tuituia!* | *Bind together, strive together* |
| *Tuia ki runga* | *Weave all that is above* |
| *Tuia ki raro* | *Join all that is below* |
| *Tuia ki roto* | *Connect all that is within* |
| *Tuia ki waho* | *And link all that is without* |
| *Tuia ki te kaupapa tangata* | *Interweave the myriad threads of humanity* |
| *Tihei Mauriora!* | *And celebrate life's vitality!* |

**Nō rerira, tēnā koutou katoa, nā,**
**Maynard Gilgen**

43. Lyndon, p.113.
44. Marsden, M. (1992). *Kaitiakitanga: A definitive introduction to the holistic worldview of the Maori.*
45. Keri Opai is Paeārahi Strategic Lead for Te Pou o te Whakaaro Nui. Nō Taranaki ia.

# Consumer stories Culture in Practice - CareNZ

My name is Jack (not real name). I'm 46 years years old, of Ngati Toa descent on my mother's side. Ever since my childhood I was always told not to follow my Māori heritage as being Māori would never lead to anything in my life, and there would be more opportunities for me living in the European world. I now know these statements were the result of my mother and grandmother's experiences of being judged and discriminated against by Pākehā and also Māori - which left a sour taste of bitterness in their lives.

I have five siblings and four of us lived our lives not experiencing our Māoritanga, accept our youngest sister, who gravitated towards it and nourished it into her life, and now speaks the reo and is a Māori liaison officer for WINZ.

Ever since I was five years of age there had been a spiritual pull to acknowledge my Māori heritage, but because we weren't supported in any way, it was difficult to respond to it. There were several occasions throughout my childhood where it felt good to perform a haka and feel the ihi and wehi running through my body. It made me feel proud. Unfortunately, as I got older things changed. Because of their insistence to protect my future, I found it fearful and shameful being Māori, and because I felt inadequate, signed all documents stating I was "NZ European"

Now reflecting back, my offending which started around 15 years of age, was part of a product of my confusion. I started cooking 'crank' for a white federated gang at 17yrs of age. This carried on for a few years until I was cooking "meth" on a daily basis for all gangs, and making a lot of money. Also I was using by 28 years old, I had my first child and left the scene and started growing and selling cannabis. Shortly after, returned back to cooking meth until I was charged and sentenced to 18 months. On release I continued cooking for the gangs. Around the same time I had another two daughters with Māori heritage who have been supported [as Māori]; and today are involved with kapa haka and learning to speak te reo through their mother.

It's only been the last year that I've stopped using and cooking meth. In 2013 I engaged with Care NZ Intensive Outpatient Programme. Back then the motivation for change was different and more about ticking the box. Since then I had been diagnosed with a life threatening disease which has seen me hospitalised for months on end. Late 2015, I re-engaged with Care NZ, this time I needed support to maintain abstinence from meth and cannabis and also over court charges. Through group processes and one-on-one sessions I've been able to explore my Māoritanga in depth, which has helped me to come to understand my mother's reasons and also the importance to acknowledge my Māori side in 'ko wai au'. Not just for me, also for my daughters.

My perspective has changed and part of my aftercare plan is to explore courses which will support me being Māori. Just recently I signed documents as me being NZ Māori. Thank you Care NZ for helping me reclaim my Turangawaiwai (standing place).

# Peer Support for Former Inmates – DTU graduate stories


## Nathan Frost
## Special Projects Advisor
### New Zealand Society on Alcohol and Drug Dependence


The names of those interviewed for this article have been changed to protect their anonymity.

Former inmates are meeting in Auckland to support one another to recover from alcohol and drug addictions. These men are graduates of CareNZ's prison based Drug Treatment Units (DTUs) and for them, recovery began behind the wire. Now released back into the community, they see their attendance at the DTU graduate's group as crucial in maintaining the changes they've made as they re-integrate back into society.

Dave Burnside, a DTU graduate from 2010, and now working in the addictions treatment sector at Auckland's Drug Court, acts as the group's facilitator. He believes the shared experience and support of his peers help him to retain the changes he made in the DTU.

'We all have that thing in common, and I hear that from a lot of people that come to this group, that something changed for us down there, we learnt something, found something. And it sort of stays with us – stays with me. I work in the addiction field, and the ideas of connection, mutuality and looking at ways to move forward, it's so powerful, I love it. Absolutely love it. I think the humility that I find in recovery, in peer support, and fellowship and also the stuff I learned in DTU, just keeps me grounded. I don't get too far ahead of myself, and life's good.

Spring Hill Corrections Facility DTU Manager Ed Kitchen, believes effective treatment involves an obligation to provide post release inmates with continued care through opportunities to re-engage with their prison programme while navigating the challenges of fitting back into society.

'Treatment is especially effective when it creates pathways into optional programmes and support groups. It is important to remember that a shared experience bonds people and this bond is the glue that gives a support group life. The DTU graduates group provides that unique shared experience for this demographic within an aftercare community setting.'

As Tony who graduated from the DTU in 2015 puts it,

> *'We all know where we've been and we've all had different experiences in jail, but we all come out, we're all facing the same things. I like reconnecting with Larry who I did the DTU with, and I saw warren there who was a mentor – just finishing when I arrived. Catching up with Mark who I met in the unit,*

*who has changed so much. So that sort of urged me on a bit, yeah. So it's good to be here.'*

Warren, who graduated in 2015 believes the connections he maintains through the graduate's group keep him from returning to jail.

*'Coming to these groups here, it just makes me reconnect with everyone, and I feel that I get help from everybody here. If I didn't, I probably wouldn't come, but it's worthwhile coming and I'd like to see a lot more of the other guys that did the DTU. Whether it was Spring Hill, Waikeria, Rimutaka, or Mangaroa, coming here. This is a good group. I feel, if it wasn't for this, I probably would be back in jail I'd say, doing the same old thing. Same cycle – hard to break the cycle. But I'm glad I've broken that cycle. I tell my nephews that same thing. There's nothing in jail. What you're going to get in jail is probably a hiding, and stood over, so there's nothing there. You're better off staying out here. Education's out here. Embracing the DTU and what I wanted to get out of it gave me back my lifestyle, my family, and especially my kids. And I owe that to the DTU.'*

Mark, a DTU 2014 graduate credits the graduate's group with helping him maintain perspective,

*'In the DTU, I had the power to say no, and that's something I've embraced. I've really enjoyed having that strength and just not wanting to even consider going back. Coming to these meetings here is a real good reminder of why I'm in this position in my life. What happened, why I went to jail, and how great it is not to... I'm lost for words. It's good to catch up with everyone. Everyone's been through the same shit, and that's something I don't come across every day, and it's a good reminder too. I don't do any other meetings – this is the only one I've been doing the whole time I've been out – it's coming up to two years'*

Ed Kitchen believes the success of the DTU graduate's group lies in the men's willingness to break the addiction and incarceration cycle and embrace change.

*'These guys here tonight they've reached a point in their lives where they're ready, they're really committed to making changes. That happens when a person gets to a place where the change is driven from within, and the changes made are made for personal reasons, rather than ticking the boxes and working the system. What is required alongside that desire for change is a little help and support from peers.'*

Dale - a lifer with years of prison behind him got to that place in 2010.

*'I've done a bit of time. I've done 24 years in prison and I like this group because we've been there on the other side of that fence. The DTU changed my life, but I was ready to have it changed. A lot of people go in there just to tick the box eh. I did- in the past. When I went there in 2010 I was serious I just wanted to do something. That's what it's got to be. We've got to want to do it, eh, for ourselves first. I've tried to do things in the past for Mum and Dad, but really, it all comes back to doing it for this fella. And when this fella's done it, they reap the rewards of it, eh. So yeah, that's my point of view. Thank you to the DTU.'*

For 2015 DTU graduate Larry, the changes he witnessed in his peers was enough to make him want to make his own changes.

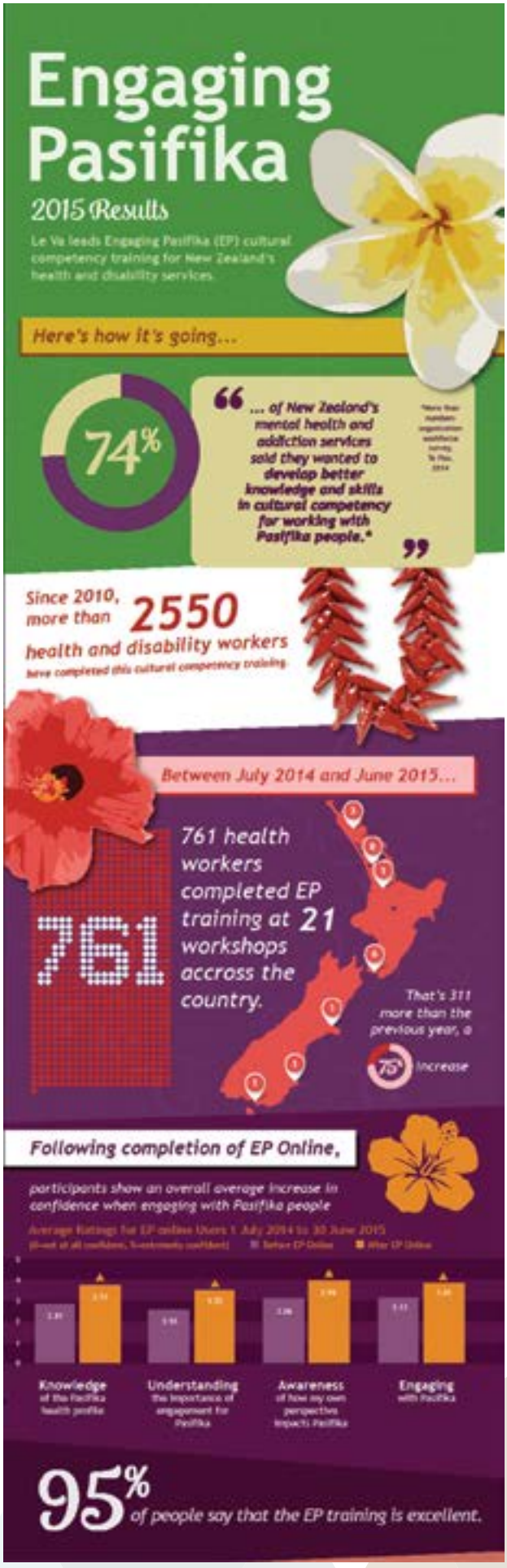
*'I went to the DTU to tick the boxes. And then once I got there and got into the group and saw the changes others had made, I learnt so much about myself, it gave me my mana back. Before that I'd lost it, and I didn't know who I was as a person. I feel like once I went through the stages I started to understand myself better, and just that alone helped me get through things on the outside once I did get released it helped me cope with things in a better situation. Normally I'd just over-react and just want to go and be on drugs and just do stupid things, but all the things that I've been through and learnt at the DTU, it just confirmed that I don't want to be in that lifestyle, cos I'm sick of it. I've been in jail, like all of us, years and it's sickening. And just having my son and my granddaughter, that's like even more wanting to stay out of jail and stay straight, cos you feel good. You're clear-minded and you can think straight and make good decisions. I've never had a job in my life, and all of a sudden I've got a job. First time ever.'*

The graduates group will continue to meet and former inmates continue to encourage one another and cement the changes they embraced in CareNZ's DTUs. Those who successfully maintain this second opportunity at life will become mentors for those wanting to change. And so the therapeutic peer support of the group will continue to foster changes in others.

As Warren so succinctly puts it, *'If we didn't have this group we'd probably be back in jail.'*

The Graduates Group meets at 6pm on the first Friday of every month at Friendship House in Manukau.

# Engaging Pasifika




## By the Engaging Pasifika Team Le Va

If health services connected culture and care for Pacific people, we would see better access and service utilisation rates, earlier access of services, a reduction in 'did not attend' rates, more satisfaction with services and, ultimately, better health outcomes.

That's why we developed the Engaging Pasifika cultural training programme based on the principles of 'Va' and the Seitapu framework. The focus is on better engagement with Pacific people so that culture and care are connecting in our services.

## New Zealand's Pacific cultural competency training programme

The Engaging Pasifika (EP) programme focuses primarily on the basic and essential cultural skills and knowledge required to work effectively with Pacific service users and their families. The programme includes three key components.

- EP Online - an online learning module which all learners are required to successfully complete in order to participate in live training.
- EP Live - live training workshops facilitated by a team of expert Pacific knowledge holders.
- EP Forum - post-training support via an online forum.

## Who is Engaging Pasifika training for?

Engaging Pasifika is particularly designed for non-Pacific or mainstream health and disability workers in district health boards, non-government organisations, support services and primary healthcare. It is appropriate for people at all levels including:

- frontline workers
- administrators
- clinicians
- managers
- leaders

Engaging Pasifika is currently free of charge for Ministry of Health funded disability support service workers, and also Ministry of Health funded mental health and addictions workers (although we may ask for a contribution to catering or venue costs). If you are a registered addictions practitioner, you can gain dapaanz points to add to your professional development.

## What are the intended outcomes?

To date, over 2500 workers have participated in Engaging Pasifika training workshops across the country with a highly successful overall approval rating of 95 per cent.

Learners gain:

- an enhanced awareness of the history and conditions Pacific people are born into, and how they grow, live, work and age in New Zealand and the Pacific region
- an ability to identify cultural difference, similarity and diversity through self-reflection

- an understanding of the concept of 'Va', its operational utility and fundamental importance for Pasifika people as relational beings
- an understanding of family, language and tapu and the impact these may have on behaviour
- practical knowledge and skills to engage more effectively with Pasifika people, especially at the critical first point of contact
- skills to translate Engaging Pasifika knowledge into practice at the frontline and in the workplace
- ongoing support following workshops via an online web forum.

## The programme's approach

Practice-based evidence forms the foundation of the approach taken in the Engaging Pasifika programme. Engaging Pasifika focuses on three essential themes critical for successful engagement with Pacific families, especially at the first point of contact.

- Family - social structures, roles and obligations.
- Language - effective communication including non-verbal language and cultural nuance.
- Tapu - primarily understanding the Pacific person as a relational being.

Underpinning all of this is the Polynesian concept of 'Va', taken from a Samoan perspective and ensuring a self-reflective approach to cultural differences and similarities. Various ethnic-specific approaches are explored and vignettes and multi-media are also used to enhance experiential learning.

Engaging Pasifika workshops are facilitated by a team of up to four Pacific knowledge holders, who run the workshops with an action learning, family role-modelling, interactive and engaging approach.

The collective team and family-approach to facilitation is based on evidence and experience that Le Va has coined as the 'Five C' approach. That is, ensuring the full range of perspectives relevant to Pacific engagement are incorporated into learning.

- Consumer (service user perspectives, including disability, mental health and addictions perspectives).
- Cultural (matai and tulafale expert cultural knowledge).
- Clinical (and technical expertise and skills).
- Community (family/aiga/whanau and contextual knowledge and skills).
- Corporate (organisational, funding and policy).

## Want to know more?

Keep an eye on the Le Va events calendar for details about the next Engaging Pasifika workshop near you. For further information or enquiries about the Engaging Pasifika training programme, please contact Esther Faitala

# Implementing cultural competency to treat co-existing PTSD and addiction


## Yustein Sang


*"The spirit of a man is constructed out of his choices."*
**- Irvin D. Yalom, When Nietzsche Wept**

**The concept culture is complicated; it includes knowledge, experience, ethnic group, beliefs, values, the ways people express themselves, the approaches they make, their reflections, the essence of their interpersonal processes and the things they draw from for sustenance in their ways in recovery. Cultural competency in addiction practice is the ability of the practitioner to understand the client's culture, maintain cultural appropriation, and make the most of client's cultural awareness, cultural confidence and cultural strength.**

Firstly, we need to make sure we are cultural appropriate/sensitive in every possible way, which means we need to tune into the client's culture and act in their best interests. It's worth mentioning that cultural appropriation requires people of a majority/default norm group to engage in the culture of minority groups, even though they may have limited knowledge of their history, tradition, tikanga and principles. Why does cultural competency matter? To empathize with the client is to understand and experience them as fully as possible. Making efforts to comprehend culture is fundamental for forming a therapeutic alliance and setting therapeutic goals.

This article will discuss some treatment ideas developed after the onset of PTSD from a cultural competency perspective based on Bessel's theory.

"My mother left us when I was a baby. I cannot connect with anyone. I first used drugs at a party when I was 14. It was only club drugs. I was hanging out with a bunch of people and thought I could stop whenever I wanted. Now I need to figure out what went wrong. I need to know the things I can do to get back control of my life. I need to know everything!"

### 1. Go back to the origins of addiction

"Cannot connect with anyone", "club drugs", "hanging out with people", etc. all those clues in the statement could refer to client's life experience and coping preference, in other words, his culture. Client took his initiative as "social use" in terms of the abuse continuum. Addiction is the process of compulsive repeating behaviours in spite of its known negativity. The process can offer the individual a temporary sense of control and euphoria. However, it may also bring long-lasting sense of helplessness and loss of control. Therapeutic goals work towards the individual re-gaining a sense of control in their current life. Bessel said that "individuals are well aware of how they are affected by addiction, but still find it difficult to change. He argues that, denial and avoidance of pain in their subconscious leads to the repeating irresistible behaviours. The pain does not

disappear if the person is not able to acknowledge it through language. There is no pain more destructive than the avoidance of pain; there is no misery that lasted longer than the unnoticeable misery. They need to allow themselves to be deeply seen.

According to Bessel's theory, the key to get people free from addiction is to coach them how to overcome denial. Those who experienced trauma need to know that re-experiencing original trauma and describe the feeling doesn't mean trauma is back.

Through the description of the pain in our past, we chuck the pain in a certain time and location, which means we are experiencing the trauma back then, not now. Therefore, people can start distinguishing the pain suffered in the present and the original pain. For example, when the boy feels the fear of disconnection, he needs to be aware that the sense of fear is not formed from the present situation, but stemmed from the past. He need to focus on the present, instead of letting his original trauma play over and over in the mind.

Through the description and discussion regarding to the original trauma, individuals form the sense of control over their addiction at a conscious level.

Therefore, discussion of the traumatic event is important for positive treatment outcomes (though care needs to be taken so that this does not stimulate secondary damage). Prior to uncovering original trauma, addiction clients need to gain some control over their substance use symptoms. For example, we certainly wouldn't want to suggest a client who suffered from severe self-harm to talk about his experience without a proper safety plan.

**2. Interpersonal attachment and sense of security**

Bessel also proposed that the causes and treatments of addiction are highly associated with the sense of security and the level of attachment.

Due to the unsecure attachment experience, people may become oversensitive and up tight and utilize avoidance or attack, or overreact to interpersonal signals. Every time they adopt the coping preference learned from the first significant trauma to cope with present situation, they are likely to end up with similar outcomes.

If people want to work through the original trauma, they have to build a safe and strong bond with attachment figures, who can provide a necessary sense of security.

Therefore, the existence of (at least) one secure attachment figure is extremely significant for people in recovery. After re-shaping attachment type, people can examine their life, observe the world from different angles, learn and try new behavioural patterns, and harvest connections.

After building up an emotional security relationship, they will be able to explore what happened in the past and what's happening in the moment, and what are the triggers of risky behaviours.

Not only therapists, but caregivers, support workers and any other supporter can act as attachment figures.

In an attachment study, Mikulincer and Shaver (2007) asked those who significantly reduced risky behaviors (including substance use) following addiction treatment, what helped them get over the effects of original trauma. More than 50% participants stated that effective therapeutic alliance was the greatest factor (Mikulincer and Shaver, 2007).

In Mikulincer and Shaver's study, the other factor that was reported as most helpful was peer support groups (AA and NA). This may be because of the attachment to like-minded people these groups provide.

**3. Create a new understanding of the present situation**

Self-help groups also coach substance use people with a meaningful cognitive framework to help them establish an awareness that can lead to a healthier lifestyle.

Whether choosing to join self-help groups or not, substance use individuals need to have the embodied cognition that "I am living in the moment". They need to build self-awareness that as adults, they have the potential to learn healthier life skills to protect themselves, which means their lives are not necessarily devoted to a harmful relationship and risky lifestyle via conscious choices.

Most of the time, we still look through the lens of childhood no matter what age we are. It won't heal until those "conclusion/diagnose" we have drawn during childhood can be spoken out. We re-examine then.

People with drug dependence can establish a new way of thinking - as children they were not responsible; however, as grownups, they have choices. They have the ability to re-write their story.

Self-help groups can encourage people to find alternative, healthier, more rewarding, and more powerful activities and experiences to replace substance use.

Cultural competency is particularly crucial in working with co-occurring substance use and PTSD. Looking for a secure attachment type, developing a trauma narrative, acknowledging the pain and establishing a new cognition, those 4 steps needed to be practiced in a culture-based and compassionate manner to let addiction clients' risky repeating patterns and pain to be seen, deeply seen.

References

1. Mikulincera & Phillip R. Shaverb, (2007). Boosting Attachment Security to Promote Mental Health, Prosocial Values, and Inter-Group Tolerance. Psychological Inquiry: An International Journal for the Advancement of Psychological Theory. 18, 3, 139-156. DOI:10 1080/10478400701512646Mario

# My Methadone Story

**Nathan Frost**
**Special Projects Advisor**

**New Zealand Society on Alcohol & Drug Dependence**

If you've been reading recent issues of the Bulletin you'll be aware of a series of articles I have written based on interviews with people talking about their experience as recipients of opiate substitution treatment (OST) in New Zealand. The purpose of these articles has been to present a consumer perspective that is important to hear and provide an opportunity to have a robust debate on current OST practice in NZ. My interest in this area was prompted by my own experience coming off methadone. This experience engendered a passion in me to give voice to those on OST who want more options. Today I've decided to share my story.

A couple of points before I get into my story.

Conflicting worldviews of what is appropriate opiate addiction treatment often leaves consumers caught in a no man's land between opposing ideologies of scientific pharmacotherapy and abstinence based recovery approaches. The level of personal opinion and value bias brought to bear on addiction treatment is quite unique from any other form of medical intervention.

Opiate addiction is difficult to treat and successful outcomes hard to quantify due to high rates of relapse. A medical model seeks to mitigate this risk of relapse by stabilising the person via maintenance doses of a legally prescribed opiate. However, this medical model may enforce a purely pharmacotherapy based treatment that may not suit the life aspirations of the individual receiving the treatment and inadvertently discount the possibility of that person achieving a life free from addiction.


Abstinence based recovery on the other hand believes that addiction cannot be treated with another drug and views OST as nothing more than a state sponsored trap of daily addiction. The abstinence world view maintains that recovery from addiction is only possible when a person is abstinent from all drugs.

Helpful treatment approaches should view treatment and recovery as a continuum that encompasses either harm reduction or abstinence based measures that take into account the individual consumer's treatment ambitions and goals. Polarised ideologies are not helpful to the person seeking treatment.

It was after a short stay in ward 27 that I ended up on the methadone (again). I didn't really want to go back on OST and asked to go to detox and rehab instead, but was told that due to my long history of opiate abuse and relapse, this was the only option CADs were prepared to offer me. The thought of being back on the DONE filled me with equal measures of relief and despair. Relief because I knew the chaos and unmanageability of my recent opiate abuse was over, despair because I believed that like so many people I knew, this time I'd never get off the stuff, the cursed liquid handcuffs. It was a bitter admission, accepting that despite my best efforts at trying to manage my opiate use, life had spiralled out of control and here I was, unemployed and about to join the ranks of black clad, foot shuffling, early morning pharmacy loiterers. That other treatment options were denied to me seemed unfair and for a while my life became a blur of methadone and alcohol fuelled depression.

Every day I walked the dreaded triangle. Home, to the pharmacy, to the bottle store, and back home - where I would drink myself into a stupor. The scary thing about reminiscing over this time in my life is that it could so very easily be my reality today. The path I trod to navigate my way back to life involved digging deep into previously unknown reserves and I still vividly remember the fear and uncertainty I felt about my chances of ever getting clean. I was haunted by what I referred to as my back catalogue of failure - all the times I'd tried to stop only to pick up again. The numerous trips to detox wards and rehabs (both here and overseas) and now back on the methadone, 'face it this is gonna be your lot in life,' was the awful internal dialogue going round and round inside my head.

I was really lucky that I had a case worker who understood my desire to get off methadone. He was able to temper my impatience with some really helpful suggestions about allowing myself a realistic period on methadone and using it to obtain some life stability before looking at eventually coming off. So I made a list of what I called anchor points of normalcy. This included getting a job, making my home surrounds more comfortable, stopping drinking, and forming healthy relationships with positive recovery peer groups.

So I stopped drinking and I got myself a pretty crap job that involved wearing a uniform, (I would hide whenever someone I knew entered the premises). I really disliked that job but I knew it was valuable on so many fronts. Getting up and going about a structured day was huge. I also made a concerted effort to make my surroundings at home nice, and started spending time with people in recovery peer groups. I'm not going to sugar coat this, many people in recovery circles judged me for being on methadone - but I wasn't in a position to turn up clean, so just turned up anyway. Once I had done all of this I started a long and gradual countdown, stopping when I needed to and resuming reductions when I felt mentally and physically able. This was me on the continuum, transitioning from maintenance to abstinence. I choose this path (which deep down I feared had a high likelihood of failure) because I didn't just want to be medicated for the rest of my life, I actually wanted to be opiate free.

Several years on, my life today is very different. I got off and I stayed off - it still blows me away that I got clean and it stuck. I bumped into someone the other day still on the DONE who expressed his desire to me to be methadone free - with eyes clouded by uncertainty and doubt. I so related! I remember those feelings and thinking I'd never escape the liquid handcuffs. It's a myth that people on the OST have reached the end of the line. Today, I personally know of many people who after being long term consumers of OST, now live lives free from opiate addiction.

I wonder what encouragement towards recovery treatment options consumers are currently offered as part of OST treatment plans in NZ? Or is OST purely a risk adverse holding pattern of maintenance medication? If this is the case, what are the repercussions for consumers of a service unwilling to believe in people's ability to evolve and change - often against all odds?

# Notice Board

# Cutting Edge – Celebrating Transformation

## Rotorua 7-10 September 2016

**Cutting Edge provides an excellent opportunity for addiction practitioners, academics, policy makers and the broader addiction sector to network, gain fresh inspiration, and learn more about innovative thinking and practice in addiction practice. It is hosted by dapaanz in partnership with the New Zealand Ministry of Health and Health Promotion Agency.**

Celebrating Transformation will focus on transformative practice for individuals and families, organisations and communities. We have an excellent line-up of speakers including Professor David Best from the UK, Kim Ledger (Patron of Scriptwise and the late Health Ledger's father), Dr Denise Blake, Dr Vili Nosa, Ian MacEwan and Mike King.

Make sure you register and get the dates in your diary, it's going to be another incredible few days together. We look forward to seeing you there!

For more information or to register go to cuttingedge.org.nz

## New website

We have listened to what you said about our website and processes and in response have developed a new, improved, user friendly website. You can expect to see many more changes from us as we work towards delivering excellence in promotion and support for our members. We have also upgraded our internal member database to help automate processes.

We apologise for any hold ups and delays caused during this transition time and look forward to much speedier processes.

**Key website features**

- Member profile, all members will be able to login to their profile to update personal information
- Secure online funds transfer payment option
- Pay/view invoices online
- Automated receipts for payments
- Online applications, renewal, and upgrade for all members
- Member directory with greater search function
- Automated renewal reminders

We are loving the positive feedback so far and hope you are enjoying these changes too!

## Increasing regional training opportunities and School of Addiction

You have told us that you would like us to provide more regional training opportunities. In response to this, we have made a decision to revert to bi-annual School of Addiction (next to be held March 2018), and increase regional workshop opportunities. If you have 15 people or more in your area who would like training on ethics, trauma, co-existing problems or another topic please contact sue@dapaanz.org.nz. If you are in a remote area and cannot get 15 people – please contact me anyway. We want to support your professional development. The cost for a one-day workshop is $220 for members and

$280 for non-members. Please contact us if you would like to book a workshop or talk about options.

## Important update on supervision

Some issues relating to quality control have been raised with us about the three year renewal period for supervisor accreditation. Also, some non-dapaanz registered practitioners have not renewed their membership annually, and therefore have not been subject to the Code of Ethics for up to two years of their three-year accredited period. To address these issues we have moved to annual renewal for accredited supervisors. This is effective immediately. As of 1 December there will be a $100 renewal fee for dapaanz registered practitioners and a $200 renewal fee for those that are not dapaanz registered practitioners.

## Flying Blind

Roger Brooking's book – Flying Blind: How the justice system perpetrates crime and the Corrections department fails to correct is now available online at meBooks for $9.95.

# Indemnity Insurance

Dapaanz encourages members to get indemnity insurance. Indemnity insurance will protect you against legal costs and claims relating to your practice. It is important to know that your organisation's insurance may not cover you. We see indemnifying as an important aspect to the professionalisation of the addiction treatment workforce.

## Dapaanz recommends Rothbury Wilkinson as a preferred supplier for your insurance needs

### INSURANCE COVER FOR MEMBERS OF THE ADDICTION PRACTITIONERS' ASSOCIATION AOTEAROA-NEW ZEALAND

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fostering excellence in addiction practice

Your membership of dapaanz entitles you to considerable savings on professional indemnity insurance with Rothbury Wilkinson.

### BASE PACKAGE OPTIONS

| POLICY | COVER | EXCESS | MONTHLY INSTALLMENT PAYMENT | ANNUAL PREMIUM (INCLUDING GST) |
|---|---|---|---|---|
| **PROFESSIONAL INDEMNITY** Designed to protect you against legal costs and claims for damage to third parties which may arise out of an act, omission or breach of professional duty. | $250,000 up to $500,000 in aggregate | Nil | $33.95 | $370.30 |
| **GENERAL LIABILITY** Designed to protect you in the event of being held legally liable for the damage to third party property. | $1,000,000 | $250 | | |
| OR | | | | |
| **PROFESSIONAL INDEMNITY** | $500,000 up to $1,000,000 in aggregate | Nil | $37.10 | $404.80 |
| **GENERAL LIABILITY** | $1,000,000 | $250 | | |

Rothbury Wilkinson

# Addiction Research Bulletin

June 2016

## Welcome to the Addiction Research Bulletin, June 2016

Welcome to the June edition of Addiction Research Bulletin (ARB). Matua Raki brings you this resource, in conjunction with dapaanz, to offer insights into recent addiction research activities that have relevance to New Zealand.

In contrast to our usual structure, this edition will focus on some of the amazing and insightful research summaries from the recent Addiction Research Symposium – an annual national forum showcasing addiction-related research. I encourage you to consider the implications of this work for practice. Please feel free to share this Bulletin with others.

## Summary of the 7th National Addiction Research Symposium

Prof Piri Sciasci opening the day

The National Addiction Research Symposium has been held since 2010 as a collaborative venture between the Universities of Auckland, Otago, Massey and Victoria, supported by Matua Raki. This year Victoria University of Wellington hosted presenters and participants, and an impressive line-up of oral and poster presentations exemplified the diversity of addiction research. A supportive networking environment was created, facilitating opportunities to share ideas and initiatives amongst senior researchers, clinicians, students and policy makers involved in the addiction field.

Professor Piri Sciascia, (Ngāti Kahungunu, Kāi Tahu) and Deputy Vice Chancellor (Māori) opened the day for us. Acknowledging the challenges and 'te 'po' (the darkness) that may be synonymous with addiction, he also affirmed the work done by those working in the sector with tangata whai ora and whānau that lifts some out of that darkness. His korero paved the way for a day of sharing, learning and understanding.

The breaks offered opportunities for networking and discussion. They also provided the opportunity to view poster presentations that crossed a spectrum of topics including: opioid trends and access, electronic nicotine delivery systems, family access to methamphetamine treatment information, cocaine inhibitors, non-addictive pain medication, therapeutic community training evaluation and the drug interactions between alcohol and pharmaceutical medications.

Many of the presentations are summarised below and I would encourage you to read some of the incredible work that is being carried out in the research arena.

More information can be sourced by contacting authors directly or by viewing abstracts and presentations at the Matua Raki website: www.matuaraki.org.nz/workforce-groups/addiction-research-symposia/163

## IN THIS ISSUE





Matua Raki

## Presentations from the Research Symposium

### The science and potential public health impact of reducing nicotine in cigarettes

Prof Eric Donny (University of Pittsburgh) edonny@pitt.edu

Decades of research demonstrate that nicotine establishes and sustains chronic dependence on cigarettes. New Zealand has in place tools that could break this link by mandating a reduction in the nicotine content of tobacco. My research focuses on establishing the empirical basis of the potential benefits and harms of this regulatory action. Data suggests cigarettes with only 3 percent of the nicotine in a typical cigarette reduce the number of cigarettes people smoke, how deeply they inhale, how much nicotine they are exposed to and nicotine dependence.

These effects are in contrast to so-called "light" cigarettes which are just ventilated cigarettes that do not contain reduced levels of nicotine and lead to more smoking, not less. Furthermore, research suggests the reduced reinforcing efficacy of low nicotine cigarettes is likely also to reduce smoking acquisition in adolescents. Finally, surveys show most New Zealanders, including smokers, support regulations that reduce nicotine to reduce addictiveness.

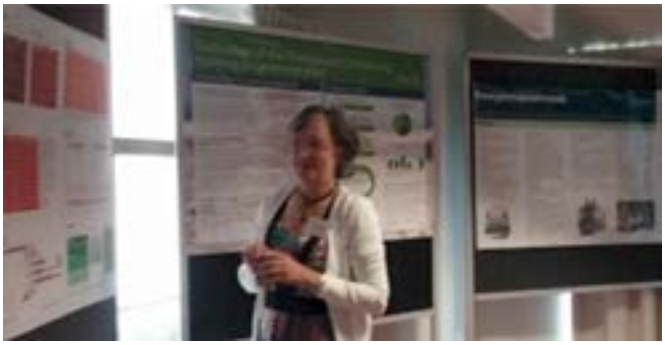
This evidence suggests a possible path for moving closer to the 2025 smokefree goal which includes a mandated reduction of nicotine in all combusted tobacco. This path may be consistent with the growing availability of and interest in e-cigarettes which provide an alternative and likely less harmful source of nicotine. Conversely, reducing nicotine in cigarettes could mitigate some of the key concerns about e-cigarettes, including that they will lead to smoking in some adolescents and that most smokers may not quit smoking even if they use them. Mandated reduction nicotine in all combusted tobacco products sold in New Zealand is worthy of public debate.

### Tobacco dependence: more than just the devil we think we know

Dr Penelope Truman (Massey University, Wellington) p.truman@massey.ac.nz

Nicotine is tobacco's main addictive agent; however conflicts in the literature between the addictiveness of nicotine and of tobacco encouraged us to test our hypothesis that tobacco dependence and nicotine dependence differed chemically.

We tested the addictiveness of a preparation from tobacco particulate matter in the rat self-administration model resulting in responses that were very similar to those from nicotine alone, demonstrating the importance of nicotine in maintaining tobacco dependence. However, the responses were significantly less attenuated by mecamylamine or by ketanserin pretreatment, and gave a higher "breakpoint" than the responses from equivalent nicotine preparations. The combined evidence showed nicotine had a chemical helper or helpers.



Dr Penelope Truman amidst a selection of poster presentations

Seeking the biochemical foundation of these behavioural differences, we have recently focussed on monoamine oxidase inhibitors in tobacco smoke, the most widely accepted as being responsible being harman and norharman. However, our work has clarified that immediate inhibition of less than 10 percent is expected from smoking, but only 5 -10 percent of that total inhibitory activity comes from harman and norharman. The other 90 percent is not well characterised and deserves a fresh look. Is there an irreversible monoamine oxidase inhibitor, or one with a long life that can build up in the body among the chemicals in tobacco smoke? Finding the chemical(s) that help nicotine be more addictive may help us find better ways of helping smokers quit.

### Readiness and recovery: citizens perspectives of switching from methadone to Suboxone for the treatment of an opioid use disorder: improving treatment quality

Blair Bishop (Capital and Coast DHB) blair.bishop@ccdhb.org.nz

This project explores citizens' perspectives of receiving Suboxone for the treatment of opioid use disorder. It employs qualitative interviews with service users who started on Suboxone, or who switched to it from methadone to better understand what they saw as its beneficial or detrimental impacts on their opioid use disorder.

Since July 2013 Suboxone has been a fully funded option for the treatment of opioid dependence, and services and service users have learned more about it. Current evidence suggests Suboxone is better than no treatment; that methadone is marginally better than Suboxone for retention in treatment; that those on Suboxone are less

likely to use illicit opiates while in treatment; and that it is easier to come off. As yet there is little research asking service users about their experiences.

Four themes were extracted: drivers for opioid substitution treatment change; readiness for Suboxone substitution treatment; absence of effect from Suboxone; and increased sense of citizenship on Suboxone. Participants had very different pathways into treatment but shared some very similar perceptions and experiences with regards to switching between methadone and Suboxone. The experience of internalised stigma about being on methadone contributes to a helpful switch to Suboxone. The absence of noticeable sedative effects from Suboxone is beneficial for those seeking cognitive clarity and sustained energy. Methadone was seen as unhelpful and 'another drug' that reinforced opioid use disorder.

Readiness to change can be explained as readiness to deal with lived trauma and a desire to shift away from a lifestyle focused on seeking sedation and substance induced euphoria. Switching from methadone and/or Suboxone was most beneficial when participants made recovery goals that included accessing psycho-social therapies, contributing to their community, and reconnecting with family. Participants also said switching from methadone and/or Suboxone made these recovery goals easier to achieve as they had more drive and could think more clearly.

Discussing these conclusions during initial consultations, either prior to the commencement of treatment or if a medication switch is being considered, will improve treatment quality.

## Causal models of the associations between unemployment, cannabis use, and alcohol misuse

Ass Prof Joseph Boden (Christchurch Health and Development Study, University of Otago) joseph.boden@otago.ac.nz

There has been considerable interest in the extent to which substance use and unemployment may be related, although the direction of causality is unclear. Longitudinal data were examined over 18 to 35 years to explore the extent to which cannabis and alcohol use predicted unemployment, and to the extent to which unemployment predicted use of each substance. We controlled for non-observed fixed sources of confounding; time-dynamic covariate factors and time-lagged measures of unemployment; and alcohol and cannabis use.

Results suggested reverse causal processes in which higher levels of unemployment increased the risk of cannabis dependence, and vice versa, although there was less evidence for this association between alcohol use and unemployment. While unemployment was a significant ($p < .05$) predictor of alcohol use disorder, alcohol misuse was only a marginal ($p < .10$) predictor of unemployment. There was evidence of a causal process in which cannabis use significantly increased the risk of alcohol use disorder ($p < .0001$), but no evidence that alcohol misuse increased the risk of cannabis dependence ($p > .10$).

The findings suggest the linkages between unemployment and the use and misuse of cannabis and alcohol adhere to a complex pattern of causality. Unemployment appears to be a consistent predictor of substance misuse, but only cannabis use appeared to increase the risk of unemployment. While it is clear unemployment is an acute stressor, the present findings suggest the experience of unemployment specifically increases the risk of cannabis dependence and alcohol use disorder. Furthermore, cannabis dependent individuals are more at risk of becoming unemployed.

## Women who inject drugs: barriers to their access of needle exchange services, and gendered experiences

Kirsten Gibson (Victoria University) soldtocambodia@yahoo.co.uk

Stigma is a pervasive factor in the lives of women who inject drugs (WWID). They experience marginalisation more than men; are stigmatised due to violating society's norms around substance use; and for violating society's norms of femininity.

The Needle Exchange Programme (NEP) in New Zealand takes a harm reduction approach to people who inject drugs by providing sterile syringes, needles and kits. Despite the literature within an injecting drug context that suggests facilitators and barriers in accessing NEP differ for women, there are few gender sensitive NEPs.

This paper examines the experiences of women who have injected drugs and their access of NEP. Key questions focused on whether participants experienced gendered barriers and how they responded to these. Three key themes were identified: stigma and its effects; barriers other than stigma; and gendered experiences. Analysis of these highlights the pervasiveness of stigma in the lives of WWID but, additionally, challenges stereotypical notions of WWID as passive victims coerced into injecting drug use. Stigma was found to be a significant harm to WWID in both their access to NEPs and in their day-to-day lives. The research also identified other barriers that hindered NEP access and how gender norms affected women's navigation of their world.

## Is intimacy-focused therapy an effective treatment for out-of-control sexual behaviour? A treatment outcome study

Dr Karen Faisandier (Massey University/The Integrative Practice) drk@theintegrativepractice.com

'Out of control' sexual behaviour (OCSB) involves loss of control, associated distress and impairment regarding sexual behaviour, and is frequently referred to as sexual addiction, although no formal diagnostic criteria exist. Behaviours may include pornography use, multiple affairs, masturbation, paid sex, internet sex, and paraphilias. Amount, duration, and type of sexual behaviour are poor markers of the problem (excluding sexual offending) compounded by the subjective, value-laden, and culturally bound perception of what comprises normal or abnormal sexual behaviour. Estimates suggest 3-6 percent of the population may be affected.

The etiology of OCSB involves multiple interacting factors including: compulsive thoughts and feelings; impulse control and affect regulation difficulties; and intimacy and attachment deficits. Existing treatments are varied with no gold-standard or best practice.

This study reports on the effectiveness of intimacy-focused therapy (IFT) for OCSB used by Sex Therapy New Zealand (STNZ). Therapy guidelines were used with 10 volunteer men with sexual behaviour concerns. Compared to baseline, there were improvements in control over sexual behaviour, reductions in negative consequences and reduced distress regarding sexual behaviour. There was minimal change in adult attachment, fear of intimacy and self-reported sexual behaviour. Changes were largely maintained at three months post-therapy. These outcomes support the effectiveness of IFT in reducing OCSB for men and offer potential in the treatment of OCSB, although they do not support the notion that improvements to attachment and intimacy occurred. Future research is required.

## The experience of alcohol use amongst individuals with an intellectual disability in Aotearoa/New Zealand

Grahame Gee (University of Otago/ Capital and Coast DHB) geeforce@paradise.net.nz

There is little literature on alcohol use among those with intellectual and developmental disability, although international research indicates that alcohol use is associated with co-existing problems and negative social and health outcomes for this group. Within New Zealand, alcohol use is normative and the recent movement to community living by people with an intellectual disability potentially places them at increased risk of the adverse effects of alcohol misuse.

Semi-structured interviews were undertaken to investigate the experience of alcohol use among 10 individuals with an intellectual disability in New Zealand. Alcohol use was found to take place in highly complex social structures across a number of sub-systems. Critical sub-systems influencing participants' drinking behaviour were the formal support provided by NGOs, whānau, peer groups and spiritual community.

Alcohol consumption levels among participants were generally low, with limited binge drinking or long-term adverse effects. Protective factors mitigated the risk of pathological alcohol consumption and included: the power of family, social, spiritual, and support networks; learning from negative personal experience; internalisation of rules; and risk aversion.

## Findings from a three-year follow-up of participants in a randomised controlled trial of brief telephone interventions for problem gambling

Dr Maria Bellringer, Prof Max Abbott, Katie Palmer du Preez, Janet Pearson, Ass Prof Alain Vandal, Prof David Hodgins (Auckland University of Technology, Gambling and Addictions Research Centre)

International studies suggest very brief treatment can reduce gambling problems, although it is unknown

Participants at the Research Symposium

how long the improvements might last. This study compared the effectiveness of three brief telephone-based treatments for problem gambling to the standard gambling helpline treatment. A pragmatic randomised controlled trial was conducted in the real-life setting of the gambling helpline. Four-hundred and sixty-two first-time helpline callers were randomly assigned to one of four treatment groups. Follow-up data were collected at three, six, 12 and 36 months. The four treatments were: Helpline standard care; Single motivational interview (MI); Single MI plus cognitive behavioural self-help workbook; and Single MI, plus workbook, plus four follow-up motivational telephone interviews.

At 12 months, participants in all groups evidenced statistically and clinically significant, sustained improvement on primary outcome measures, as well as on a number of secondary measures including depression and quality of life. Contrary to prediction, there was no difference in primary outcomes between the treatment groups. The improvements in gambling behaviour achieved at 12 months continued over time (36 months later). While the outcomes were similar between the four treatment groups, the most intensive treatment (MI+W+B) achieved greater reductions in problem gambling severity and quitting or reduced gambling. The results indicate that stepped care service provision and the matching of clients and therapies could be beneficial.

## SPGeTTI: developing a smartphone-based problem gambling relapse prevention app

Prof Chris Bullen, Gayl Humphrey, Nikhil Magan, Dr David Newcombe, Dr Fiona Rossen, Varsha Parag, Dr Robyn Whittaker. (National Institute for Health Innovation and Centre for Addiction Research, The University of Auckland) c.bullen@nihi.auckland.ac.nz

Use of electronic gambling machines ('pokies') is the gambling activity most frequently associated with problem gambling and harm. People moving out of dependence on pokies are exposed to pervasive cues in their daily lives, making abstinence difficult. We investigated how smartphone technology designed to deliver theoretically-based, personalised 'anywhere, just in time' support could help people enrolled in existing support services.

Our research was undertaken in two parts: technical 'proof of concept' assessment, for which we developed and tested a prototype app; and acceptability testing involving focus groups of problem gambling practitioners

and service users. We found the prototype app to be robust and sufficiently accurate at locating individuals in relation to gambling venues. We also found high levels of acceptability of the idea, with some concerns identified (such as using the technology to locate, not avoid, gambling venues) although it was considered these could be mitigated.

Further content development and refining the technology underpinning the intervention among a larger group is ongoing. A randomised controlled trial will commence recruitment in June 2016.

### The epidemiology of gambling and gambling harm in New Zealand: implications for policy and practice

Professor Max Abbot (Auckland University of Technology, Gambling and Addictions Research Centre)
max.abbott@aut.ac.nz

New Zealand has a strong history (since 1985) of conducting national gambling and problem gambling surveys with much now known about changes in prevalence and risk factors. Recently a large-scale, high quality prospective study was undertaken (Abbott et al., 2015) with linked studies underway in Sweden and Victoria. The National Gambling Study commenced in 2012 with a baseline prevalence survey (n=6251) and re-interviews in 2013, 2014 and 2015. These studies provide jurisdiction-wide estimates of: problem gambling incidence (problem onset), duration and remission; information on transitions between other gambling states; the identification of risk and protective factors for problem onset, development, remission and relapse; and advance understanding of temporal relationships between problem gambling, other addictions and mental health disorders.

It has long been maintained that increased gambling availability leads to increased participation and harm (availability hypothesis). Others have proposed that when populations are first exposed, over time these relationships break down and both participation and harm decrease, even when availability continues to increase or levels out (adaptation). The New Zealand survey findings are consistent with both availability and adaptation. The highest problem gambling prevalence rates in New Zealand were obtained in 1990, a few years following the introduction of electronic gaming machines (EGMs), Lotto and Instant Kiwi. During the 1990s both regular participation in continuous forms of gambling and problem gambling prevalence reduced significantly. Since 2000 however, at variance with both the availability and adaptation hypotheses, there have been no further reductions in problem gambling prevalence. Participation has continued to fall but problems have plateaued. Findings highlight the importance of factors other than gambling exposure per se in determining problem gambling and other gambling-related harm.

Māori and Pacific people have substantially higher problem gambling rates than other New Zealanders. Other groups with high rates include males, young adults and people who lack formal qualifications, are employed, live in deprived neighbourhoods, have a non-Christian religion or belong to non-traditional Christian churches. However, Pacific people, and a number of the other high-risk groups, have low participation rates. Economic and other factors appear to be the major determinants of persistent and growing disparities between social and cultural groups.

Effective prevention programmes will need to address both exposure to EGMs and other forms of continuous gambling, and other risk and vulnerability factors, some of which are common to substance misuse/dependence and a number of other mental health disorders. Furthermore, of those who developed a problem during the past year, over half are people who had a problem in the past and are relapsing. Given these high rates of relapse, programmes will need to target first time onset and problem recurrence, and give increased attention to relapse prevention.

## Cutting Edge 2016 – Celebrating Transformation

Cutting Edge is the national addiction treatment conference. This, the 21st Cutting Edge conference, will be held 7-10 September at the Energy Event Centre, Rotorua.

Please note the two available awards for presentations:

- The New and Emerging Researchers Award awarded by Matua Raki for an oral or poster presentation of a research initiative
- The 2016 dapaanz award for best presentation on a matter of treatment awarded to a poster.

## Have your say!

We hope you find the Addiction Research Bulletin useful. We look forward to receiving your articles, feedback or suggestions for future editions. Is there something we've missed? Your views are important to us.

Email: klare.braye@matuaraki.org.nz or call 04 381 6473.