In response to the growth of the Alcohol and other Drug (AOD) peer support workforce, Matua Raki hosted the first Addiction Peer Support Workers’ Day in Auckland on 20 December 2013.

Titled “Bridging the Gap”, the day aspired to provide an opportunity for peer support workers from across Auckland to gather together for connection and sharing of experience as a peer support worker in the addiction sector.

The programme comprised workshops and speakers with opportunities for attendees to participate and share their experiences, strengths and hope.

Alcohol and other Drug Treatment Court peer support worker Kim Barnett said there was an excellent turnout.

“There was some really great discussion around the commonalities of our work, as well as the differences in organisational policy and how this affects our practice. Networking was an important aspect of the day, one that I found particularly helpful. I realised that many of us face the same challenges and can celebrate some of the same successes together.”

(Continued page 4).
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Coming Events

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For more details please contact Patricia Rainey (patricia.rainey@matuaraki.org.nz). Would you like your event listed here? Go to our website, www.matuaraki.org.nz, click on the events calendar and complete the Add your event form.
Keeping an eye on changes here and around the world

With the recent news of some impending changes to service delivery happening within our sector, particularly in gambling and the helplines, we are very mindful of the potential impact on our small but highly skilled workforce.

The Ministry of Health has indeed indicated for the last couple of years the need to consolidate and create efficiencies of our resources in order to get the best service for cost. In my opinion this also needs to be balanced with ensuring that we are able to retain our specialist workforce and provide transition arrangements where necessary so clients of our services do not ‘fall through the cracks’.

Diverse world views on drugs

I was very honoured to attend the 57th session of the Commission on Narcotic Drugs at UNODC in Vienna last month as part of a small New Zealand non-government organisation delegation. It was an intense and stimulating experience and I was struck by the diverse views around the world on the issue of drugs and the treatment of those who use drugs.

Although aware of these diverse views, it was quite a different experience being confronted by the reality of those opinions, particularly those that argued strongly to retain death penalties and other sanctions that we would not contemplate in New Zealand. In reflecting on this however, I am also aware that these views are not the exclusive domain of certain countries but in fact are reflected in the range of opinions and views in our own country and it was a good reminder of the work yet to do here to reduce stigma and discrimination for those who experience problematic drug use.

Key sector events

Matua Raki has sponsored some key sector events over this past quarter and we feature several of these in this issue of the newsletter. So, even if you didn’t get to attend the Growing Pacific Solutions conference or the Māori and Indigenous Suicide Prevention Symposium you’ll get a good summary here. We were also delighted to host the inaugural addiction peer support workers’ day and plans are afoot for further events to support this emerging workforce.

Applications are also now open for Matua Raki’s National Workforce Innovation Award so think about how your organisation is making it easier for people to do their jobs well and contribute to a healthier workplace.

Let us know what you think about our newsletter and how Matua Raki can support you in your work, we are always keen to hear from you and welcome your feedback.

Nga mihi,
Vanessa Caldwell
National manager, Matua Raki
Defining workforce development

Many of you will be familiar with having the right people in the right place at the right time, doing the right thing. If we add in ‘with the right outcomes and the right cost’ we are working towards the World Health Organisation definition of workforce development and our work in evidencing workforce planning.

It’s no easy task doing workforce planning. Considering the supply of our workforce through education providers, or our peer workforce opportunities, then demand of need from communities, coupled with our current and future plans, it can all feel a bit overwhelming. Our role is to help with these issues at a local and national level.

We are focusing on workforce planning this year. The great challenge is making the complex simple. We have had advice from organisations like the World Health Organisation or the Office of the OECD that workforce planning can get really complicated, depending on the formula used. We are aiming to do two things:

1. Gather national data to understand our workforce constitution (which can really help us understand the resources we have, in order to plan for the resources we need).
2. Work with services to use evidenced-based workforce planning - to bridge a gap in service and workforce development.

We are taking the first steps in this process by doing a national stocktake of our workforce, then later in the year, doing a workforce census. We want to understand the aspirations, makeup and challenges of our workforce. We hear that there is an increasing pressure to do more with the same, so we need to think about productivity. We also hear we have a great talent pool, an aging workforce (with a depth of experience we don’t want to lose), too much paperwork and people who are passionate about their field of expertise.

The gathering of workforce data might feel bland to some, but in my view it provides us with a richness of information that we can use to encourage support for our workforce - training, supervision, good support systems in the workplace, the growing need for peer workforce and best use of clinical time. Unless we ‘evidence’ workforce planning, we will continue to guess what is needed. Whilst our data will never be perfect, it gives us some markers that we can use for resourcing.

I hope many of you contribute to this really important work and in return, we aim to support you with information on workforce planning.

Nga mihi nui
Robyn Shearer
Chief executive, Te Pou

Bridging the Gap - AOD Peer Support Workers’ Day (continued from page 1)

Haydee Richards opened the day sharing her story of lived experience and recovery plus the process of becoming an addiction peer support worker with the Phoenix Centre based in South Auckland. This was followed by a ‘self-care’ workshop facilitated by Fiona Greenman and Diane Mitchell from Puna Whakataa.

The MC, Jennifer Hill from CADS Auckland Pregnancy and Parental Services summarised:

“A wide range of AOD peer support workers attended and shared. It was an opportunity for highly relevant questions around boundaries and self-care to get asked and answered by other peer support professionals who, not only had an understanding, but had a different understanding.

“It was also a great forum to discuss some previously highlighted ‘grey areas’ in the AOD peer support profession.

People had an opportunity, some for the first time, to express their frustrations within the field of peer support and to feel heard and understood.”

Evaluations indicate the desire for more similar days, with more time for discussion and sharing.
Around the sector...

Addiction Training Providers’ Network

The Addiction Training Providers’ Network has been running for a number of years. It was established to facilitate the meeting of addiction training providers with the objectives of:

- liaison – meeting together to share information about various training programmes and activities
- central information – about the various training programmes and activities that exist, career pathways and ways of accessing training
- informing and monitoring progress of the Workforce Development Strategy in terms of training
- discussion of key issues related to training.

Previously, with the support of Matua Raki, the group has met three times a year, typically one day before Addiction Leadership Day. Attendance at these meetings has been erratic of late and largely determined by the location of the meeting. Consequently there is rarely a good cross section of training providers present and a lack of continuity from meeting to meeting. This clearly diminishes the value of the meetings and the impetus to attend.

In consultation with members, the purpose and function of the group has been reviewed to ascertain how the needs of the group can best be addressed.

As a result an e-bulletin will be produced once a semester which will reflect members’ interests but could include:

- advice on under-graduate and postgraduate courses currently running
- advice on short courses, symposiums and adjunctive training opportunities that allow clinicians and services to develop their capabilities and professional development portfolios
- general updates on what is offered in the addiction training providers’ field – new people, new programmes or courses
- NZQA and workforce development updates
- dapaanz updates.

Additionally a full-day symposium for training providers will be offered once a year. Again the programme will be developed to respond to members’ expressed areas of interest.

If you have any contributions for the e-bulletin; suggestions for the content of the symposium; are interested in joining the Addiction Training Providers’ Network or would like any further information, please contact Klare Braye, klare.braye@matuaraki.org.nz or Patricia Rainey, patricia.rainey@matuaraki.org.nz.

Recent developments

New Zealand Practice Guidelines for Opioid Substitution Treatment 2014

The New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 are available from the Ministry of Health, www.health.govt.nz. These guidelines update and replace the Practice Guidelines for Opioid Substitution Treatment in New Zealand (Ministry of Health 2008b) and the New Zealand Clinical Guidelines for the Use of Buprenorphine (with or without naloxone) in the Treatment of Opioid Dependence (Ministry of Health 2010). Matua Raki has developed the guidelines on behalf of the Ministry of Health with support from the National Association of Opioid Treatment Providers and consumer representatives.

The guidelines provide clinical and procedural guidance for specialist and primary care services that deliver opioid substitution treatment (OST). The guidelines reflect current best practice for providing OST that is person-centred and recovery-orientated.

Raine Berry, lead author, at the launch of the guidelines
**OST and you: a guide to Opioid Substitution Treatment**

Matua Raki has developed a companion document to the New Zealand Practice Guidelines for Opioid Substitution Treatment 2014 for people who are receiving or contemplating receiving OST. *OST and you: a guide to Opioid Substitution Treatment* has been written by Sheridan and the Matua Raki Consumer Leadership Group to help people understand what they should expect from services providing OST, their pathway through treatment and what services will expect of them. Copies of this guide are available from Matua Raki and can be downloaded from www.matuaraki.org.nz.

**CEP – online learning modules**

Matua Raki is developing a series of online learning modules based on the work of Dr Fraser Todd who has continued to develop the clinical framework described in *Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Addiction Problems 2010*. The first module will introduce the context and history of co-existing problems (CEP) along with some tools that can be used to enhance engagement and wellbeing. This module will be useful for any worker in the mental health and addiction sector who wants to learn about CEP and what strategies can contribute to the wellbeing of people with CEP. Future modules will be based on the seven key principles of the framework described in *Te Ariari o te Oranga* with the aim to enhance the knowledge and skills of practitioners and clinicians working with people who have CEP.

The content of these modules will be developed using a series of workshops that Dr Todd and Michelle Fowler delivered on behalf of Canterbury DHB and MHERC. The modules will be advertised as they become available online.

**‘More than numbers’ – organisation workforce survey**

*More than numbers* is a stocktake of adult mental health and addiction services. The national mental health plan, *Rising to the Challenge*, describes the need for better use of our resources and changing models of care to meet the needs of our communities. These challenges have many implications for the workforce, including planning to ensure services are equipped with the right numbers of people, with the right skills and attitudes, doing the right work at the right time and with the right work output (World Health Organisation, 2010, p.1).

*More than numbers* will contribute to and strengthen existing workforce development data to support future workforce planning at local, regional and national levels. The first step is to discover the nature and extent of adult mental health and addiction (AOD and problem gambling) services are currently funded through their district health boards or, in the case of problem gambling, the Ministry of Health.

By now your organisation should have received an information pack and survey forms pertaining to phase one of the project - a workforce survey of organisations profiling the workforce by team type and organisation needs and other service priorities. The results are due later this year and will be discussed at various regional and national forums.

Phase two will follow later in the year as an individual workforce census. This will help us gain a better understanding of the workforce demographics, skill mix, competencies, education and training needs.

If you or your chief executive have not received this survey, and you feel you should have, please contact Jo Richdale, joanne.richdale@tepou.co.nz.
Getting to know Saveatama Eroni Clarke

Eroni is the Pacific addictions workforce coordinator at Matua Raki

How did you come to be working in addiction?

I had been working previously with a personal development organisation and wore a number of hats including marketing, counselling, human resources and research and development. But I had a genuine desire to be working in the Pacific community. Friends suggested I take an opportunity to work for a year in the addiction sector.

What does your job involve?

I’ve been in the saddle now for eight months and still feel I’ve much to learn. I’m guided by the Pacific Addiction Workforce Strategy and typically work with other project leads on projects that serve as a deliverable to the strategy and impact the Pacific workforce. Then there are programmes I am privileged to be involved with like Engaging Pasifika, a cultural responsiveness programme for non-Pacific services to engage better with Pacific peoples.

I feel as if I’m having more “Aha!” moments all the time and am contributing a lot more to our Pacific workforce and building good relationships.

What motivates you? What makes you jump out of bed in the morning, keen to get to work and take on another day?

It might sound cheesy but I strive for excellence in everything I do. I relate so much back to my sporting life. I achieved not because I was the fittest or the strongest or the fastest, but because I just got stuck in, had huge passion for what I did, faith and belief in the ability I was blessed with.

In this role I work with and for Pasifika, it’s a privilege. We don’t have much but we contribute a lot - to the workforce, to relationships, to our communities, to this nation. My heart is in continuing the good work that’s already been done by those before me and contributing to the capacity, capability and resourcing of the Pacific workforce!

How do you think you’re making a difference?

I don’t really know. Ask me after a couple of years in this role! I’m a “connector”. One of my strengths is bringing groups, individuals, organisations together to work for a common goal. If I can open more doors for the Pacific workforce and help build capacity, I feel that I’m doing my job, because ultimately it impacts our wider Pacific community.

Tell us a bit about your family.

I’m married to Wonder Woman, Siala, the Penina o le Pasefika (Pearl of the Pacific). She is Samoan/Rotuman and we’ve just celebrated our twentieth anniversary... and she’s still madly in love with me! We have five beautiful children, daughter Shekynah and four boys: EJ (Eroni jnr), Caleb, Jireh and Zion.

I’m all about family - when I retired from sport I instantly became a full-time cheerleader at their sports games, school events etc.

What’s the most awesome book you’ve read or film you’ve seen, and why?

I’m a real sucker for movies where underdogs overcome huge challenges. My favourite movie has to be Rudy, with Daniel “Rudy” Ruettiger played by Sean Astin and based on a true story.

I loved it because, in a way, it told my story – coming to play for the greatest rugby team in the world against all odds. I’ve come to understand the privilege it is to be in that place of “influence” and about persistence and the integrity to cope with countless disappointments.

In a sense that’s how I see my life. I still get asked to speak and coach the next generation of athletes, leaders, mums and dads. It’s the kind of legacy I want to leave behind. At my funeral, 100 years from now, what sort of person do I want to be described as in the eulogies? The only way to answer that is by living it today.
Indigenous Suicide Prevention Symposium and the launch of Waka Hourua

Suicide is a serious and significant issue for New Zealand communities. Every year around 500 people take their own lives; ending their own potential and affecting the lives of many others.

The figures are worse for Māori and Pacific peoples. In 2011 the Māori suicide rate was 1.8 times higher than for non-Māori and the Māori youth suicide rate was 2.4 times higher. There were 24 suicide deaths among Pacific peoples, and at least 92 Pacific people presented with intentional self-harm.

On Monday 10 February 2014 a Māori and Indigenous Suicide Prevention Symposium took place at Wellington’s Shed 6 to examine Māori/Indigenous specific approaches to suicide prevention. The symposium was part of the Public Health Summer school run each year by the University of Otago, Wellington.

Dr Keri Lawson-Te Aho, from the University of Otago’s Department of Public Health, was convenor of the symposium and led in the invitations to speakers including the Governor General Sir Jerry Mateparae, Hon Luamanuvao Winnie Laban and Moana Jackson. She also invited Te Rau Matatini leaders to use the symposium to launch the Waka Hourua programme, which aims to ensure families, whānau, hapu, iwi and communities have the capacity and support to prevent suicide and reduce its impacts.

The programme is being implemented and coordinated in partnership by Te Rau Matatini and Le Va with funding from the Ministry of Health.

The Governor General of New Zealand Hon Sir Jerry Mateparae opened the symposium and delegates were welcomed by Dean of the University of Otago, Wellington, professor Sunny Collins.

Hon Tariana Turia, Minister for Whānau Ora, began by saying all those who had been lost to suicide were never far from our thoughts.

“We now understand the importance of a unified, collaborative and well-planned approach to Māori, Pacific and indigenous suicide. Its prevention is everyone’s responsibility, and our whānau are key to leading the change.”

She told the story about Whangaehu Marae, her home, which was destroyed in the same storm that sunk the Wahine. Her people came together and purchased an old hall where they could gather together again and that too was destroyed, by fire.

Though these losses were traumatic, she said her people’s proudest achievement was “finding ourselves” and supporting each other.

“We knew where to go for help and I see this same approach occurring in the programmes being developed to help whānau within the context of suicide.”

“We now understand the importance of a unified, collaborative and well-planned approach to Māori, Pacific and indigenous suicide. Its prevention is everyone’s responsibility, and our whānau are key to leading the change.”

Ms Turia then announced the launch of Waka Hourua and the establishment of a national leadership group to provide a nationwide and coordinated voice.
We now understand the importance of a unified, collaborative and well-planned approach to Māori, Pacific and indigenous suicide. Its prevention is everyone’s responsibility, and our whānau are key to leading the change,” Ms Turia said.

Alongside of this group will be a national coordination centre for Pacific community and Māori community suicide prevention. The project will advance a strategic research agenda and build an evidence base of effective practices for Māori and Pacific communities.”

Ms Turia said she was also pleased to announce a one-off $2 million community fund to help create tools and resources and develop prevention approaches. Though coming from the Ministry of Health, she said these funds would remain outside of government control and stressed they should not be spent on infrastructure, but used appropriately and as closely as possible to whānau and families.

“Because that’s the way forward; whānau making their own decisions for their own futures.”

Applications for money from the fund can be made at the Waka Hourua website, www.wakahourua.co.nz.

Tuwhakairiora Williams, chief executive of the National Māori Congress, Waka Hourua National Leadership Group

National Māori Congress chief executive Tuwhakairiora Williams talked about the population groups in New Zealand that are at a greater risk of suicide, and the disturbing 2011 figures.

“These statistics form the context for Waka Hourua. A waka hourua is a double-hulled canoe, which provides a visual representation of the partnership between Māori health organisation Te Rau Matatini and Pacific organisation Le Va. It’s the first time in a long time that Māori and Pacific peoples have worked collaboratively to address an issue that has a significant adverse effect on our communities.

“...For both Māori and Pacific peoples, evidence recommends focussing on primary prevention using a community approach to strengthen protective factors and reduce exposure to risk factors for suicide.”

Francis Agnew, Pacific Medical Association, Waka Hourua National Leadership Group

Pacific Medical Association executive board member and Pacific Inc (Le Va) board member Dr Francis Agnew gave a Pacific perspective on Waka Hourua.

“This programme is an exciting challenge because, unless we change what we’ve already been doing in suicide prevention, it’s unlikely we’ll see any improvements. The key to improving the significantly high rate of suicide attempts among Pacific peoples lies within our families and communities.

“Waka Hourua is New Zealand’s first Pacific suicide prevention programme. Its aims are to build strong, resilient Pacific families and communities, address at-risk groups and assist those families who have felt the impact of suicide.”

Moana Jackson

Māori lawyer Moana Jackson began by discussing the power of imagination.

“At a time when people in Europe were too scared to sail far for fear of tipping over the edge of the world, our ancestors imagined something beyond the places where they were. And that imagination gave them hope, which gave them courage, and they set sail across the biggest ocean in the world. What has happened since is that our young people, who are struggling to cope with the pressures of life, have been deprived of their ability to imagine, without which they lose hope and their will to live.”

He said this loss of imagination is due to what he calls “little colonisations”. Things such as the deliberate mispronunciation or substituting of Māori...
children’s names, and rangatahi being followed in shops after being profiled as potential shoplifters.

“As we look at preventative measures to stop suicide, we would be unwise to disregard the presence of these everyday little colonisations.

“I am filled with admiration at the way we have survived with pride and a sense of worth, considering what has been done to our people. But it saddens me that for too many of our young people, that sense of worth is lacking.”

Associate professor Luamanuvao Winnie Laban

Associate Professor Hon Luamanuvao Winnie Laban began by declaring each suicide to be a unique act of tragedy for all involved.

“Trying to understand why it happens is a difficult exercise and there are no simple answers. However, cultural identity is essential to understanding and addressing the problem. When we have a strong sense of who we are, where we have come from and what we value, we have strong anchors to hold on to when things start to unravel and we find ourselves in a dark place.

“Education and a strong spiritual anchor are key. We all need to feel we are not alone.”

“In early Samoan society everyone had a place of belonging, and everyone had an understanding of gender arrangements. When the missionaries came, they labelled our gender arrangements pagan, and challenged our theology. Now many Pacific people have become dislocated from their culture and spirituality, and this contributes to their confusion and lack of a sense of belonging.

“Education and a strong spiritual anchor are key. We all need to feel we are not alone. Our culture provides a sense of belonging, which provides strength in difficult times.”

Normand D’Aragon, First Nations, Canada

Guest speaker Normand D’Aragon, from Canada, told the symposium about his work contributing to the wellbeing and balance of the lives of the aboriginal people of Quebec through activities of community awareness and psychosocial interventions accessible in the language and the cultural context of each nation and community.

“We see so many causes of suicide, which can be tracked back to our cultural identity constantly being under attack. People don’t have a sense of where they come from anymore.

“When working with troubled families, we try to provide a sense of identity by rebuilding their family tree, and often what we find is a cycle of trauma, repeated over and over throughout the generations. Young people are the carriers of the things we need to go back to; to them suicide is a sacrifice, but not one we always understand.”

Associate professor Jacque Gray, Choctaw and Cherokee Tribes

International guest speaker Jacque Gray, from the Choctaw and Cherokee tribes, said the level of mental and physical support for Native Americans in North America is extremely low compared to the general population.

“Mental health issues and psychological distress among tribal youth is 170 per cent higher than the general population, and the suicide rate is three-and-a-half times higher than the national average. Among the general population the highest rate of suicide is among the elderly, but with the Native American population the highest rate is among youth.

“An approach we’ve developed to address this issue is adapting public-health based interventions that promote opportunities for youth to build their identity, to help them gain self-esteem and avoid substance abuse and risky behaviour.

“The best approach is to address four sides of their wellbeing: mental, social, physical and emotional, with their spiritual wellbeing at the centre.”

“Another approach is the incorporation of traditional tribal responses, looking at the lessons these have for defining identity and the purpose of their lives. These include storytelling to teach problem solving, talking circles to help address burdening issues, naming ceremonies to encourage pride and leadership, and learning through community activities.

“The best approach is to address the four sides of their wellbeing: mental, social, physical and emotional, with their spiritual wellbeing at the centre. This integrated model is important. We’ve found it decreases hospitalisations, lessens psychiatric and substance-abuse severity and we get better engagement and retention in the programmes.”

You can find out more about the Waka Hourua programme at www.wakahourua.co.nz.
The mind is for seeing and the heart is for hearing was not just the theme of the Māori Co-existing Disorders Summit held in Whakatāne last December. It’s also good advice for those of us who went to listen, observe and celebrate the journey of the Pū Wānanga o Anamata 2013 graduands who presented at the summit.

Matua Raki was a principal sponsor of the event. The Pū Wānanga o Anamata Applied Diploma of Co-existing Disorders focuses on co-existing problems (CEP) through a Māori lens. The course tutor is Dr Candy Cookson-Cox. “It definitely pulls together the threads of learning from the year,” Matua Raki national manager Vanessa Caldwell said. “It was great to see such talent and potential leadership on display.”

The student presentations were innovative and thought-provoking. Topics included the use of rongoa, the impact of poor leadership of the paepae, the impact of qualifications on the presence of Māori in the sector, the therapeutic benefits of utilising dance with youth and an exploration of stigmatisation.

The audience was also treated to sessions by Kirsten Rei who leads the Glenn Inquiry into Child Abuse and Domestic Violence and Maynard Gilgen, clinical leader at Ora Toa Mauriora. Both spoke to the need to think and practice differently if we are to contribute to flourishing whānau.

Phil Siataga and Dr Hukarere Valentine wove stories and compassion which resonated with the theme. All spoke from the heart and their stories of transformation demonstrated the importance to wellbeing of identity and belonging. They reinforced the student message that working with complexity, with whānau and as a system is at the heart of CEP.

On day two, the audience was challenged about the relevance of tikanga and kawa to the therapeutic milieu and the quality of youth-focused services. They were also shown a novel perspective to whakapapa intervention that had people in fits of laughter. The final student presentations were about ethics and a reminder that a lack of cultural fluency by health professionals disadvantages whānau and practitioners as it impacts on engagement and contributes to poor therapeutic relationships.

Watching and listening to Sabrina Solomon (past student) and Carole Maruku (Te Menenga Pai Trust) challenge accountability for practice was a reminder of the whakatauki Ka pū te ruha, ka hao te rangatahi. The space shaped by CEP knowledge and the Māori lens showed glimpses of potential leadership in terms of the Māori sector and CEP.

Inspiration and aspiration were provided in the final presentation by the team from Tūhoe Hauora and Tame Iti. “Our tauira leave feeling relieved but also affirmed, our manuhiri leave feeling refreshed and with a sense of hope for our future workforce,” Candy Cookson-Cox said. “Māori are core business as is CEP. It makes no sense not to see them as part of the same solution.”

Matua Raki wishes the 2013 graduates all the best for the future. Mauri ora.
Testing the Bridge

An evaluation of the Salvation Army Bridge Programme model

The Salvation Army’s Bridge Programme was founded in Wellington in 1959, principally as a treatment approach for alcohol addiction. Over time, the programme has become multi-faceted, working with around 1500 clients each year who are experiencing various and often multiple addictions, including problem gambling.

The Bridge Programme model is centred mainly around the community reinforcement approach to therapy. In 2013 the Salvation Army engaged with the University of Otago to have researchers provide an independent and evidence-based assessment of the Salvation Army’s programmes, with the Bridge Programme prioritised as the starting point.

The Salvation Army wanted measures of outcomes that would reveal the strengths and weaknesses of the programme and identify what could be improved on.

The principal investigators are Tess Patterson, Julien Gross and Emily Macleod from the University of Otago. Four co-investigators will also become involved later in 2014.

“We’ve been quite amazed at the willingness participants have shown to share details about their own journeys.”

The project started in December 2013, with a nationwide review focusing on how effective the Bridge Programme is in reducing harms from substance use and how well it meets goals to improve service delivery for people accessing Salvation Army services. It would also act as a source of evidence for funding providers such as the Ministry of Health and district health boards.

Researchers will also take into account outcomes such as improved social functioning and vocation, reduced offending and reduction of relapse.

The study will take place over 12 months and gather client data on entry to the Bridge programme, when treatment is complete (usually 8-12 weeks), and after participants have been back in the community for three months. Outcome measures will be based largely on self-report or questionnaire data, but corroboration will also be sought (with consent) from people such as participants’ significant others.

The Salvation Army is employing research assistants at each Bridge site to collect data which will also contribute to the up-skilling of these workers.

Who’s involved in the evaluation?

Principal investigators:
- Dr Tess Patterson, Dept of Psychological Medicine, University of Otago
- Dr Julien Gross, Dept of Psychology, University of Otago
- Dr Emily Macleod, Dept of Psychological Medicine, University of Otago.

Co-investigators:
- Professor Andrew Bradstock, secretary for Church and Society, United Reformed Church (UK)
- Dr Richard Egan, Dept of Preventive and Social Medicine, University of Otago
- Dr Claire Cameron, biostatistician, Dept of Preventive and Social Medicine, University of Otago
- Dr Gavin Cape, consulting psychiatrist, Dunedin Community Alcohol and Drug Services (CADS).
Moral Reconation Therapy

A form of cognitive behavioural therapy that seeks to enhance moral decision making and improve behavioural outcomes looks set to make inroads within New Zealand’s Drug Courts and therapeutic community.

Moral Reconation Therapy (MRT) particularly focuses on the reasoning behind people’s offending and seeks to reset that thinking in a more positive way. Internationally it has been shown to work well with most offenders, including those whose offending is connected to substance use.

“MRT is not a replacement for traditional approaches to addiction treatment, but is now gaining ground as one of many practical tools clinicians can use to work with a population that is becoming more and more complex,” Odyssey House chief executive Philip Grady says.

‘Conation’ is an archaic word that refers to an individual’s conscious decision making, so ‘reconation’ is a term for revisiting that thinking. MRT combines elements from a range of psychological traditions to progressively address social, moral and behavioural growth.

Trained clinicians go through a programme with offenders involving 16 steps over 30 sessions. Clients work through a manual that guides them through issues such as honesty and trust, acceptance of rules and dealing with relationships that have been damaged by their use and behaviour. It looks at goal-setting and an action plan to help clients deal with what has occurred. They can take the manual away with them and do work outside the group setting.

MRT was developed by Memphis psychologists Dr Greg Little and Dr Ken Robinson and first used in 1985. It became a formal treatment method in 1987.

With the help of a grant from Matua Raki, Dr Ken Robinson came to New Zealand to provide MRT training to treatment providers Odyssey House, The Salvation Army, Higher Ground and the Wings Trust. This training was completed in February 2014 and roll out will begin in March with a suite of services planned. Evaluation will occur later in the year and Dr Robinson will return to New Zealand in August for more ‘train the trainers’ work.

Feedback from clinicians attending the training has been positive. They say MRT aligns well with current models of treatment.

The plan is to use MRT in two ways. Clients participating in treatment will be offered MRT in an adult residential service setting overseen by Odyssey House clinical lead Renee Denis. The focus here will be on clients who are early in their treatment. A community-based programme is also being developed for Drug Court clients and this will be led by Odyssey House clinical manager Polly Websdell.

“I’m confidently hopeful MRT is going to be a bit of a game-changer,” Philip says.

“It leads to better moral reasoning, better decision-making and therefore, better behaviour. It seems to encourage engagement and prepares clients for the in-depth treatment that happens within the therapeutic community.”

MRT is now being used in 47 American states and nine or more countries internationally. In some states where MRT has been used, prisons have even been closed due to lowered recidivism rates.

“If we can achieve just a little of what has been achieved in America and have a positive impact on those who come through the addiction treatment system in New Zealand, that’s got to be a good thing,” Philip says.
The APSAD (Australasian Professional Society on Alcohol and other Drugs) Awards are presented each at the APSAD Conference for those who have made an outstanding contribution to reducing the harms associated with alcohol and other drug use in Australasia. There are various categories. Auckland’s Kim Barnett received a consumer travel award to attend the 24-27 November 2013 APSAD Conference.

Kim works for the Salvation Army Addiction Services in Auckland as an AOD peer support worker within the Alcohol and Other Drug Treatment Court. Kim is in recovery, which is a requirement of the role, so she can walk alongside participants in their journeys.

“I took such a variety of information away not only to inform my practice but to feed back to the wider team I work within. There were some key discussions and research presented that highlighted the importance of informed, evidenced-based practice and some findings that suggested a change in approach may be more suited.

“This was thought-provoking and reminded me of the importance, perhaps, of altering my expectations and practice to take into account where a service user may be at.”

Peer support workers support participants to empower themselves, to take responsibility for their decisions and actions, and to advocate for themselves by setting goals and devising recovery plans. They help build relationships with treatment centres, court staff, community organisations and other agencies to assist participants into community networks and to start the rebuilding process.

Four travel awards are available each year for indigenous and consumer workers.

“It’s a fantastic opportunity for those who may not get funded through employment or have the personal finances to attend, especially as the conference happens in Australia,” Kim says.

She says the conference was a great opportunity to meet some fantastic people and build new connections with those who are dedicated leaders in the field.

Find out more about the awards at www.apsad.org.au/apsad-awards/apsad-awards.
Stepping up to leadership

The New Zealand Society on Alcohol and Drug Dependence (NSAD) – with support from Matua Raki – has created a suite of workshop initiatives that aim to encourage and foster the leadership qualities of individuals within addiction sector organisations.

“NSAD believes the addiction sector needs to find and foster its future leaders and these workshops are an initial step toward building leadership capacity in what is becoming a dynamic sector,” NSAD executive director Michael Bird says.

“These will be highly stimulating events that will help raise the bar around thinking about leadership.”

The one-day workshops will be led by Aly McNicoll from the New Zealand Coaching and Mentoring Centre. Aly has years of experience developing leadership programmes and specialises in training and consultation for not-for-profits.

Each workshop will have a maximum of 12 people at any time in order to create an intimate training environment and encourage full participation. Dapaanz continuing education points are awarded for successful completion of this workshop.

“We hope the workshops will provide the opportunity for participants to step away from the distractions of their day-to-day activities so they can examine their leadership points of view and reflect on strengths and challenges as leaders in the sector,” NSAD’s Steve King says.

“They’re for those already in a leadership positions and for people who have been identified as wanting to become strong leaders. This is more than a once-over-lightly session.”

Participants will be expected to engage in pre-course tasks and, after the workshop, will be paired up with a peer coach so they can debrief about their leadership challenge experience and practice their coaching skills.

The workshops are being held throughout May. The first will take place in Dunedin on 2 May. Workshops will also be held in Auckland, Wellington and Christchurch depending on registrations. To reduce costs for participants and strengthen commitment, the cost is $100+GST, including lunch and morning/afternoon teas.

Register your interest now by contacting Steve King at steveking@nsad.org.nz, or on 021 190 6542.

Workshop topics

- **The leadership journey** – an experiential activity to start the day
- **What is leadership** – a tour through the latest thinking from the leadership literature
- **Management versus leadership** – the roles and tasks of the leader versus the manager; raising the bar and strategic thinking
- **Working outside the walls of your organisation** – dealing with external stakeholders
- **Be who you are with skill!** – personal strengths and challenges as a leader in the sector
- **Why should anyone be led by you?** – research findings about followers’ needs; taking people along with you
- **Coaching leadership** – getting the best out of the people you lead; tools for coaching conversations.
The second GPS 2.0 – Growing Pacific Solutions for our families conference (GPS 2.0) was held in Auckland 4-5 March 2014 to bring people together people from across sectors – integrating approaches for collective solutions to issues facing Pacific peoples in New Zealand.

The conference was convened by Fa’amatuainu Tino Pereira and, after welcomes from members of the Northern Region Matua Council (led by Levaopolo Seupule Tiava’asuo’e), the opening lotu was delivered by Rev Uesifili Unasa.

He spoke about liberation theology and its emphasis on giving the poor and marginalised a voice. He welcomed all those who had come along as radicals, activists and “trouble makers” who wanted solutions that were “specific for Pacific” and to challenge the norm in the quest for social change.

Hon Tariana Turia

Associate Minister of Health Hon Tariana Turia dedicated GPS 2.0 to the families that make up New Zealand’s Pacific communities. It is these people who are faced with decisions at every point in their journey who will influence their own future growth and wellbeing, she said.

“I love the fierce determination to be proudly Pasifika – it is absolute proof that the solutions to the issues we face are embedded within us, within our communities and within our cultures. We must never lose faith in our cultures to shape our futures.”

She said solutions will come from every aspect of our lives, not just from the academic reaches and scientific research, but from challenges that are negotiated on the sports field, in bands and choirs at church services, and at the supermarket “in every sphere in which we all engage.”

“The concept behind Growing Pacific Solutions is about building momentum amongst our communities by being responsive and respectful of the nations from which we come. The days are over when people talk about Pacific Islanders – we must honour the various nations that make up the people of the Pacific.”

Rev Uesilili Unasa

“I love the fierce determination to be proudly Pasifika – it is absolute proof that the solutions to the issues we face are embedded within us.”

Dr Joe Harrop and Ros Giffney run Sistema Aotearoa Orchestra, an after-school and holiday programme for troubled Pasifika and Māori children, teaching them how to play orchestral instruments.

They have more than 180 children participating in the programme, and are very proud of their 93 per cent attendance rate.

“We use the orchestra as the model of delivery of social change and development. We’re based in Otara, and all our instruments and tuition are free. We tutor a range of students from the entire spectrum of behavioural, learning and physical difficulties. Our kaupapa is to enable kids to develop into well-adjusted and happy adults,” Dr Harrop said.

“We take a holistic approach – we teach them music skills, but we also teach them responsibility, confidence, respect, cooperation and about the benefits of working hard. We have a long-term relationship with all the kids, from the age of six right through to 18 or 19 years old.”

After the presentation by Dr Harrop and Ros Giffney, delegates were treated to a performance of several pieces by the orchestra.

An orchestra for social change

Global perspectives of mental health and wellbeing for Pasifika

Waitemata DHB clinical director Dr Francis Agnew spoke about the motto of the French Revolution: “Fraternity, liberty and equality”.

“That motto was sufficient at the time, but when I think about it in today’s context, and when I consider what I know about mental health, I believe it is time we included equality.”

I love the fierce determination to be proudly Pasifika – it is absolute proof that the solutions to the issues we face are embedded within us.”
It’s clear that equality should be complemented by equity and resource distribution. Fraternity needs to be understood as solidarity with people who need help, and liberty should be interpreted in light of the duties and responsibilities all of us accept as members of society.”

“Liberty should be interpreted in light of the duties and responsibilities all of us accept as members of society.”

He explored the effects of globalisation on workforce movement among the populations of various Pacific islands and spoke about a paper on migration and mobility of skilled health workers from selected Pacific Island countries. Analysing data from the year 2000, the paper showed more than half of the number of Fijian health workers, and 40 per cent from Samoa and the Cook Islands, were working in either Australia, New Zealand or the USA. What’s more, three-quarters of these migrating health workers were women.

“There are lots of factors that either push or pull these health workers from one country to another. These include inadequate health funding, low salary levels, a declining health service, poor work conditions, heavy workload, racial discrimination and political instability.”

Validating cultural solutions

Keynote speaker Dr Joseph Betancourt is the director of the Disparities Solutions Center and associate professor of medicine at Harvard Medical School. He spoke about the key principles of incorporating culture into health care.

“Culture matters in health care. We all have a culture, so the goal is to improve our ability to effectively communicate and care for individuals from diverse social and cultural backgrounds. Cultural competency is an emerging issue because the world is realising it is a small place – and the link between communication, culture and health outcomes is becoming increasingly clear. The disparities each culture experiences are shared all around the world.”

He broke down cultural competency into two parts, the first being cross cultural foundational skills.

“This is the ability to relate to an unknown culture – one which a health care provider might have no understanding or experience with before. It allows the carer to identify the social and cultural factors that matter to that person. The key is to enter the relationship with curiosity, empathy and respect. It’s important to use words that won’t offend, and to find some common ground. We call this cultural competency, but it’s really nothing more than good, effective, compassionate care.”

He said the second part of teaching cultural competency was to be constantly evaluating – has the carer learned anything, are they using what they’ve learned, and does it impact outcomes when used?

“From our experiences we’ve identified five strategies for success. The first is we need to get people to really care. We need ‘buy in’, and need carers to see the value of the programme. The second is to focus on cases and stories, which bring a human face into the equation. The third is to use evidence, which shows the connection between research and outcomes. The fourth is to think longitudinally. The development of attitudes, knowledge and skills will happen gradually over time. The fifth and final strategy is to integrate this learning wherever possible.

“The key messages we deliver are that, first and foremost, we strive to deliver quality care to all. Communication matters and it will be harder to communicate with some than others, especially across cultures. If we are not skilled in this area, the potential result is we become ineffective, we get frustrated, and our patients receive lower quality care.

“Now, more than ever, we need to be skilled at communicating across cultures in a much smaller world.”

Addiction stream breakout sessions

Metua Bates, senior advisor Pacific, Health Promotion Agency – Say Yeah Nah

Metua spoke about the Health Promotion Agency’s (HPA’s) plans for improving Pacific outcomes now and into the future. These include the “Say Yeah Nah” (SYN) alcohol campaign.

A Māori theme on SYN, Taihoa, already exists and the Pacific theme Y Tribe – Tribal Challenge was due for release around the end of March. This entails a group of young Pacific adults from across the country who have been engaged to help spread the alcohol moderation message in a uniquely Pacific way.

She said the areas the HPA was continuing to work on are areas
that impact Pacific populations heavily and that one of her responsibilities is to develop a framework for the organisation to think about how to improve Pacific outcomes, whatever the issue is.

“The HPA has a Pacific Advisory Group, but of 80 employees, only two are Pacific (and that’s not enough) so it’s important the HPA has a framework to guide their planning, implementation and evaluation of programmes and projects that work for and with Pacific families and communities.”

Metua said a successful HPA activity for Pacific peoples would:
- deliver successful initiatives and programmes
- have robust processes and systems
- Support Pacific leaders in health promotion (a specific programme for Pacific leadership is also in development)
- be visible within Pacific communities.

She said she is excited about all the work that’s in development and encouraged Pacific attendees to apply for jobs at the HPA.

Mata ni civa (Pearls of wisdom) - Dwayne Faletanoai, Tupu Services (Pacific alcohol and gambling service), Waitemata DHB

Mata ni civa was a six week pilot recently delivered in schools by Tupu Services and based on the Matalafi matrix assessment tool. The pilot involved a small group of five senior pupils with co-existing problems (CEP). The initial focus was heavily on rights, an issue Dwayne said was often missing in current programmes, and a potential good step towards engagement with boys who came with a lot of trust issues.

“Sometimes in order to get a good outcome we have to go through some failures and some real life lessons. It’s not rocket science,” Dwayne said.

He said pearls of wisdom were all around us and don’t necessarily come from those we consider “wise people.”

“It’s about taking learning from our pasts and applying that to our future - and a key way that is done is through stories. Stories, both learned and from lived experience, became the main driver for the programme.”

But he said young people also have pearls of wisdom and these boys were encouraged to share their own stories and thus the programme became a process of exchange or reciprocity.

“The idea was never to fix all problems or to get the kids ‘finishing the race’. It was more about helping our Pacific boys to get off the mark and get heading in the right direction.”

There was a strong emphasis on evaluation with the programme being tested every week in terms of how it was going to help young Pacific people move forward. Feedback from the boys and their families was also received once the programme was complete. They said they often failed at other programmes because they were poorly planned, but this programme was about helping the boys set up their own health care plans, which they then presented back in whatever way they wanted to, with their families present.

It was a pilot programme so not everything worked as well as was hoped. Not all the boys achieved all their goals each week, but that was also seen as part of the process.

“Sometimes in order to get a good outcome we have to go through some failures and some real life lessons. It’s not rocket science,” Dwayne said.

Phillip started by saying he didn’t see himself as a health promoter.

“We’re ‘natural buzz’ promoters – the idea is that you can live a full life free of those substances that cause you harm.

“Some of the most recent substance concerns that are of particular concern to our Pacific communities include synthetic drugs, solvent abuse (63 deaths over the last 10 years) and the glamorisation of alcohol. This last is something we really do need to fight with urgency. It’s still a binge drinking, party hard culture impacting our young people.”

He said CAYAD Otautahi was trying to:
- normalise the alternative
- delay the onset of use
- de-normalise the substance-using culture.

Community action: From practice to policy and back again - Phillip Siataga and Jenkins Alaifea, CAYAD Otautahi, Christchurch
Phillip encouraged delegates to think about why they bother and suggested it’s because we want people in our families and communities to live glorious lives. And it’s always a work of restoring dignity, not a work of judgement.

“This is CAYAD Otautahi’s vision. Young people, families and communities flourishing and embracing good opportunities. Young people don’t flourish with harmful drug use, opportunities are diminished in a number of areas education, employment, travel and relationships. It puts them behind the wall of exclusion (which is social isolation), while communities are all about inclusion,” he said.

Phillip spoke briefly about what he called Drug Policy 101. The three elements of New Zealand’s drug policy are demand reduction, problem limitation (treatment and services) and supply control (policy and enforcement). He said our drug policy is up for review and that CAYAD has written a submission to the Ministry of Health saying they’d like to simplify the policy, take out problem limitation and just call it intervention and treatment.

“Problem limitation is a vague and unhelpful term, whereas treatment and intervention more accurately describe the strategies and activities our National Drug Policy contains.”

Jenkins Alaifea spoke about several projects involving community sports, arts and recreational activities that CAYAD sponsors or helps co-ordinate. These include introducing whānau-friendly alcohol and drug free policy into sports clubs and supporting alcohol and drug free community arts, dance, music and drama events.

More GPS 2.0 photos

Sistema Aotearoa

Engaging youth through education theatre: Delegates were treated to an entertaining and moving performance by Pacific young people’s theatre group Kinetic Wayfinding.

Monique Faleafa, chief executive, Le Va, at GPS 2.0

Patricia Rainey, Training and Events Lead, Matua Raki and Suzy Morrison, Consumer Project Lead, Matua Raki
Visiting Adelaide: The COPMIA Capital of Australia—Anna Nelson

One of the key pieces of collaborative work that the four mental health and addiction workforce centres (Matua Raki, Te Pou, Te Rau Matatini and the Werry Centre) are involved in is the Children of Parents with Mental Illness and/or Addiction (COPMIA) project led by the Werry Centre.

While not a very eloquent acronym, the term is an adaptation from the national COPMI initiative in Australia, with the ‘A’ added in New Zealand to include addiction.

Adelaide hosts three of the most significant and influential parties to the work that is being done in this area throughout Australia. Matua Raki programme lead Anna Nelson accompanied The Werry Centre senior advisor Bronwyn Dunnachie to visit the National Centre for Education and Training on Addiction (NCETA) at Flinders University, the COPMI Initiative headquarters and the Child Protection Centre at the University of South Australia. All of these centres have been involved in influencing their sectors to create better outcomes for COPMIA, in a variety of ways.

NCETA have worked extensively on their Family Sensitive Policy and Practice Toolkit (2010) available on their website (http://nceta.flinders.edu.au). These resources aim to build a bridge between the alcohol and other drugs (AOD) treatment and child protection sectors to improve cooperation and collaboration. The toolkit includes:

- Taking First Steps: A survey report of AOD workers
- For Kid’s Sake: A workforce development resource
- Family Sensitive Practice in the Alcohol and Other Drugs Field (brochure)
- a checklist for Family Sensitive Practice (poster).

They were able to give clear advice and direction for our project including the need for a national policy framework (like the children’s action plan), local and regional solutions and champions, a common language and goals approach, information sharing guidelines, community development and the knowledge and ability to work in partnership and collaboration effectively.

The COPMI initiative (www.copmi.net.au) in Australia does not specifically focus on children of parents with addiction related problems for a number of reasons relating to funding and political influences, however their advanced work striving for better outcomes for children of parents with mental illness means we have a huge amount to learn from their initiatives, resources and e-learning modules.

Brad Morgan, the director of the COPMI initiative, outlined the importance for us to take a stepped approach to implementation of COPMIA workforce developments in our adult mental health and addiction sectors. This was together with the need for benchmarks that allow services to see that even their relatively small changes to include family or children in their service delivery can make a huge difference to the recovery outcomes for adult service users. He overviewed a new initiative that will be launched in Australia in July called ‘Let’s Talk about Children’, a brief intervention model (originally developed in Finland) for exploring child development with parents in universal settings that could include adult mental health and addiction services.
The Child Protection Centre at the University of South Australia has been working on the Protecting and Nurturing Children: Building Capacity, Building Bridges (http://w3.unisa.edu.au/childprotection/projects/bcbb/) initiative which aims to:

- build the capacity of practitioners in adult-focused services to better support their adult clients to meet the immediate needs of children in their care
- support the development of strategies that strengthen collaboration between adult-focused and child-focused services to enhance the way in which clients who require multiple supports experience the service system.

Helen Francis from the Australian Centre for Child Protection project managed this initiative that was supported in 12 communities throughout Australia. She explained that the biggest surprise for them was that the practitioners they worked with appeared to have a lot of fear about asking parents about their children and generally did not know how to go about it. The training they had developed needed to be changed very early on in the initiative to reflect this reality.

Helen also reflected on the importance of working effectively in partnership and collaboration across adult and children’s services and identified this was also a huge need in the training that they ran. A focus on common language and goals was again identified as a requirement for effective collaborative work.

The visit to Adelaide provided Anna and Bronwyn with a huge amount of insight and information as they begin the next steps on the COPMIA project with their Te Rau Matatini and Te Pou colleagues.

For more information about COPMIA and the potential implications for your service please e-mail anna.nelson@matuaraki.org.nz.

Addiction Leadership Day, 27 March 2014, Wellington

To support existing and emerging leaders and managers, Matua Raki, in collaboration with the National Committee on Addiction Treatment, holds three Leadership Days each year. The most recent was held on 27 March in Wellington.

After an official opening by Matua Raki national manager Vanessa Caldwell, The Salvation Army’s Mike Douglas led a karakia and asked delegates to pause momentarily to remember all those struggling with addiction and working towards recovery.

New Zealand’s visit to the United Nations Office of Drugs and Crime, Vienna

Drug Foundation director Ross Bell introduced Associate Health Minister Hon Peter Dunne and discussed the Annual Meeting of the Commission on Narcotic Drugs in Vienna, from which both he (and several other NGO leaders) and Mr Dunne had just returned.

“The interesting thing about these meetings is that in recent years there’s been a bit of tension as to whether the global drug problem can actually be fixed by the ‘war on drugs’ approach, or whether a new approach is needed. And that debate is starting to get stronger. The debate will culminate in a major United Nations meeting in 2016, which was called by the Latin American countries who are struggling with the murder and mayhem in the name of the ‘war on drugs’, and they’ve said enough is enough.

“It’s very important New Zealand gets engaged in the debates leading into 2016, to make sure we have a voice. This year there was a group of five NGOs who went along to the meeting to observe and try to inject some of our views into the discussion,” he said.

Hon Peter Dunne opened by saying the various steps New Zealand has taken over the years mean we have quite a profile in the United Nations environment.

“And while the debate has significantly changed, the level of interest from other countries in what we are doing in New Zealand has remained constant.

“When I first went to Vienna in 2009 there was a very stark divide between those nations who believed in the highly punitive ‘war on drugs’ approach, and those who took a more holistic health perspective. But in recent times there has been a shift in international attitude. If you’d used the term ‘war on drugs’ five years ago, you would have found many ready listeners. If you said it at this meeting, you would have been sneered at, gently been laughed at and totally ignored.”
listeners. If you said it at this meeting, you would have been sneered at, gently been laughed at and totally ignored.”

Mr Dunne said there was a session this year in which every participating country talked about the need to see drug issues from a health perspective. There was also a strong undertone throughout of the need to impress this upon countries still wielding the death penalty for drug-related offences.

“From New Zealand’s perspective this is quite important – we’ve been of interest in recent years because of our approach to methamphetamine and psychoactive substances. Our meth usage was comparatively higher than other countries, and we seem to be among the first to take a more co-ordinated approach to dealing with it.

“Something we take for granted in New Zealand is cross-agency cooperation. To most in the audience the idea of a working relationship between Health, Justice, Police and Corrections is just not considered possible. And that’s the first barrier for most countries to get over.

“In terms of psychoactive substances, most other countries are two years behind us. Everyone acknowledges the seriousness of the problem, and the incapacity of current systems to control their spread. So everyone is curious about the New Zealand experiment, though they’re still taking the position of banning those substances, despite acknowledging it’s a battle they can’t win. They’re looking to us to provide a way out.”

Before the latest legislation was passed, there were around 4,000 unregulated stores selling psychoactive substances. Today there are just 156 stores with interim licenses. There were an estimated 300 types on the market, but now there are only 40. Further, the volume of presentations in emergency rooms is declining.

“If current trends continue the number of stores will continue to decrease, the types of products available will also decrease, and by the time of the 2016 meeting we’ll be in a position to report very strongly on this front.

“The whole combination of events is extraordinarily timely from our perspective. The change in international perceptions, the credibility we’ve built up in our meth and psychoactive substances approaches, and the fact that we are in the process of reviewing the Misuse of Drugs Act all bring us to a point where, in the next year or so, some fundamental decisions about the direction of drug policy in New Zealand will be made.”

Mr Dunne concluded by saying the times ahead are challenging, but huge opportunities will arise from the frameworks and policy changes being put in place. He also acknowledged the New Zealanders who attended the meeting in Vienna, as well as those attending the Leadership Day for the work they do and the impact they have.

Ross Bell closed by saying the sector will continue discussions with Minister Dunne to ensure our NGOs continue to have a voice leading up to and including 2016.

Other NGO representatives at the Vienna meeting included NSAD and Kina Trust director Michael Bird and Matua Raki national manager Vanessa Caldwell.

“The big shift I’ve seen since my attendance at these meetings in Vienna isn’t just that health is now on the agenda, but what health actually means. There was a resolution tabled by the United States this year, and it was the first ever to include the word ‘recovery’. And once that happens it’s so much harder to talk about incarceration and death penalty. By the year 2020 there will be a huge shift in international drug policy, and a change in the way we view people with addictions.”

“I considered it a real honour and privilege to be a part of the NGO contingent at the meeting this year. I believe drug policy heavily influences our sector, what treatments are supported and how we perceive those who receive our services.

“When you hear people discussing these issues, and hear their genuine disdain for ‘addicts’ and the way they discuss these people in such a derogatory manner, it makes you realise how fortunate we are, and how flexible our environment in New Zealand is. And that says to me that we’re on the right track, and encourages me to keep going. And the benefit of the New Zealand NGO presence there was other people could come and ask us more about what we’re doing in New Zealand.”
Navigating organisational growth

Phillipa Gaines spoke about the launch of NZ Navigator, a free online self-assessment tool that helps community organisations review the way they operate and provides guidelines for improvement. Phillipa is the project manager for the tool.

“NZ Navigator is a simple tool which helps community organisations identify their strengths as well as any areas for further development. It then suggests ways they can improve their performance to become more effective in the services they offer their communities,” Phillipa said.

“It breaks down an organisation’s everyday operations within nine domains - direction, governance, leadership, people, administration, finances, communication, evaluation and relationships.”

It asks questions about the organisation’s current performance for each of the nine domains. Users are able to easily select a description that best fits their organisation’s current performance from a five-point scale that starts with the description ‘at risk’ and ends with a description ‘thriving’. Ratings convert to numbers to produce a score for each of the domains.

At the end of the assessment, the tool creates a tailored report card that includes a spider graph which communicates the organisation’s strengths and highlights areas for development across the domains. It provides an overview of the results and a recommended goal for each domain. The tool also gives organisations a selection of resources (sourced from CommunityNet Aotearoa) to help improve in areas of organisational performance that need it the most.

Phillipa said while the tool is deceptively simple and elegant, it is evidence-based and the product of three years’ development.

“NZ Navigator is designed for any community organisation, from youth clubs to service providers. At the latest count there were around 97,000 not-for-profit organisations in New Zealand. For these organisations to be effective in their communities they need to function well, and this tool gives them the opportunity to jump online and assess where they are at and get an idea of where they need to be.

“It supports people and organisations, regardless of previous experience in ‘improvement methodology’, to develop a plan outlining who will do what and by when. This plan is based on what is known as the ‘Plan-Do-Check-Act’ cycle. Essentially, this is about understanding a problem and figuring out how to address it in a systematic way.”

To measure improvement, organisations can visit NZ Navigator at a later stage and answer the questions again. The tool then generates another spider graph that displays how things have changed or improved over time.

“When implemented, this continuous cycle of reflection and improvement means organisations will benefit from more effective and efficient operational systems, better quality services for people, greater credibility and legitimacy with funders, greater accountability back to local communities and enhanced organisational learning and improvement.”

NZ Navigator was developed as a partnership between Platform Trust, ANGOA, Social Development Partners, the Bishop’s Action Foundation, and the Department of Internal Affairs.

Organisations can visit NZ Navigator at www.nznavigator.org.nz.

“ For these organisations to be effective in their communities they need to function well, and this tool gives them the opportunity to jump online and assess where they are at.”
Wise Group strategic policy advisor Helen Lockett spoke about *Equally well – take action to improve physical health outcomes for New Zealanders with a mental illness and/or addiction*. This is a new programme of work by Platform members, in partnership with Te Pou, to bring a range of stakeholders together to understand and reduce disparities in health for people living with mental illness and/or addiction in New Zealand. Helen is leading the project.

“People who have a mental illness and/or an addiction have higher rates of a range of physical health conditions and have a reduced life expectancy. We’ve known this for some time but now there’s accumulating international evidence and increasing concern about this growing health gap – particularly in countries where the quality of health care is generally considered to be good,” Helen said.

**Many of the contributing factors to this health disparity are things we can do something about.**

The first phase of this work has been a review of evidence, comparing available New Zealand data with international evidence reviews. This review included a call for evidence to identify unpublished information from across the country.

“Many people contacted us following the call for evidence, including academics and practitioners, and that’s helped us identify a number of new and unpublished evaluation reports. Others contacted us to let us know how pleased they were that this work is being undertaken, and to tell us about projects they’d initiated in their local areas, even though they had not been able to evaluate them.

“Most who made contact expressed the need for concerted work to be done, both at a national and local level, to acknowledge peoples’ significant physical health needs alongside their mental health or addiction.”

Helen said many of the contributing factors to this health disparity are things we can do something about, especially if we work with a multitude of stakeholders, both within and external to the mental health and addictions sectors.

“The evidence is clear there are a number of systemic and workforce factors which compound the issues for people, including the separation of mental health and addiction services from primary care and general health services, the stigma and discrimination people experience when seeking help and a lack of formal acknowledgement of this group as ‘at risk.’”

Within the presentation there was the opportunity for a short discussion and some group work so audience members could feed back some of the ways these issues were being addressed in their localities. Examples included that at Capital and Coast DHB Child and Adolescent services, everyone has a physical health check. In Whangarei, practice nurses are being trained in working with people with a mental illness and/or addiction.

“The feeling was that although we can do monitoring and screening, we need to build strong collaborations with other health agencies to be able to provide the holistic and on-going support and care people need. This would include shared care arrangements and better use of integrated IT systems.”

Helen said it was timely to have such a discussion about these matters at the Leadership Day and that it was a conversation expected to continue as this work progresses.

The next phase of *Equally well* is to develop a position statement, based on the evidence review and to gain endorsement for this by organisations and representative bodies across the country. From this, a call to action will be launched alongside a co-ordinated programme of further work.

For more information on *Equally well* see [www.tepou.co.nz/improving-services/physical-health](http://www.tepou.co.nz/improving-services/physical-health) or email Helen, helen.lockett@wisegroup.co.nz.

**Information sharing and better public service**

Office of the Privacy Commissioner senior health policy advisor Sebastian Morgan-Lynch began by discussing the history of privacy. He talked about how our idea of privacy began at a nineteenth century garden party where someone from a newspaper had poked their head over the fence and written in detail what had happened at a party hosted by two lawyers, who were incensed and invented the idea of privacy as an intrusion on seclusion.

“And now, with the development of new technologies like email and smart phones, it is even harder for an individual to maintain control over their personal information. More information means more knowledge, and more knowledge means more power, so we need a way to balance those scales.”

Sebastian briefly discussed the 12 points of the Health Information Privacy Code which dictate how information can be collected and used in New Zealand. These are:

1. Only collect the information you need
2. Get it from the person concerned
3. Tell them what you’re doing
4. Be ethical when you’re doing it
5. Take care of the information once you have it
6. They can see it if they want to
7. They can correct it if it’s wrong
8. Make sure it’s accurate before you use it
9. Get rid of it when you’re done
10. Only use it for the purposes you got it for
11. Only disclose it if that’s why you got it
12. Be careful with unique identifiers

He elaborated on each. For example, the first point means...
your purpose for collecting the information must be clear, and you shouldn’t deviate from that purpose. The second means the person concerned retains some control over the information. The third point governs the mechanism under which most privacy codes operate – making sure people know what’s going on with their information.

“In fact, it’s all about trust. If people don’t trust you, they won’t give you their information.”

He went on to discuss the complications of ownership in regards to information.

“Ownership of tangible things is easy to define. However, ideas of ownerships don’t equate so easily to information. An agency can own your records for example, but not your information.

“This is why trust is so important. In fact, it’s all about trust. If people don’t trust you, they won’t give you their information. In the health context there is a huge element of trust, but that could easily change if there was a major news story about an information breach such as has happened in other sectors.”

Sebastian also explained that, within the health sector, information can generally be shared for purposes of care, and also for the purpose for which it was collected. However, there are a number of rules that allow for that information to be disclosed in different circumstances. These include with authorisation (where the person has since given permission), and also where necessary to address a serious threat or to protect the law. Doctors can actually ask anyone who holds health information about a patient to provide it, and they’d have to, unless the person had expressly asked them not to.

He continued by discussing the escalation model, which is useful when you “find yourself in a conundrum about sharing information.”

“The first step is anonymous disclosure, which is always okay. You can describe the situation, such as needing to share information about someone with a GP, without having to mention any names. The second step is to ask if you have their consent to share their information. If so, that’s always okay, too.

“The third step is to ask whether the person has been told their information might be shared in this way. The fourth is to decide whether anyone is at risk or if there is a serious threat, for example, if something bad was going to happen if we don’t discuss this person right now. And the final step is to decide if there is another legal provision allowing you to disclose this information.”

He also said health providers are always immune from prosecution if they agree to provide a patient with their own information and they somehow use that information to cause harm to themselves or others.

In February 2013 the Privacy Amendment Act came into force which Sebastian said allowed for the disclosure of confidential information when there was a ‘serious’ threat, not just an ‘serious and imminent’ one. Before this change agencies could too easily hide behind the Privacy Act and avoid making hard decisions.

“Another recent change is the development of Approved Information Sharing Agreements (AISAs), which streamlines the process for sharing information between government agencies. Rather than having agreements which state information cannot be shared for whatever reasons, an AISA, which is always signed by the information holder, directly states the situations in which information can be shared across different government agencies.”

My thoughts on Leadership Day

Tangi Noomotu is the team leader, Youth Exemplar Service, at Mirror Services in Dunedin. He’s been there about a year and worked at the Moana House therapeutic community, also in Dunedin, before that. This is his second time at a Leadership Day.

“I’ve found the day really good,” he said.

“I especially enjoyed the presentation on Children of Parents with Mental Illness or Addiction (COPMIA). It was relevant to me because in working with young people, you have to work with their families.

“It was good to get an indication that our service is actually tracking pretty well in terms of early intervention and family inclusive practice!”
We had a turnout of over 50 nurses coming from as far south as Christchurch. Representation of roles and sectors was great, crossing the spectrum of addiction practitioners, mental health nurses, primary care nurses, education providers, practice nurses, pain management, smokefree coordinators, opioid treatment service providers, managed withdrawal and youth services.

While much of the day was planned with formal presentations for practitioners in the field, the informal opportunities were well utilised. The networking was fantastic, the sharing of ideas and innovations was inspiring and the assurance of support from colleagues was encouraging.

The programme included the following presentations:

- Future directions for nursing: providing interventions for people affected by substance use problems and behavioural addictions, Ref. Competency Framework, Daryle Deering, NAC
- An update on the NP AOD role and certification for addiction nurses, Louise Leonard and Moira Gilmour, DANA
- Nursing supervision, Henriette de Vries and Bart Van Gaelen, NDHB
- Practice nurse competencies, Mary Carthew and John Hartigan, Manaia PHO
- Wellbeing – theirs and ours, (the interaction and implications of the two), Sarah Barkley, Lakes DHB
- ABC model for General Practice, Agnes Hermans, Manaia PHO
- Project outline for improved responsiveness in maternal & child health services, Agnes Hermans, Manaia PHO
- Video-conferencing as a training and treatment access tool, Jewel Reti and Claire Glover, Northland DHB
- Themes from presentations and what’s needed now? Small group brainstorm and feedback, Steph Anderson, Nelson Marlborough DHB.

A selection of these presentations is available for download from the Matua Raki website, see ‘presentations from the fifth Matua Raki addiction nurses symposium’ under Matua Raki publications.

Future events of this kind will continue to be held around New Zealand, with the next one planned for Dunedin, in November.

If you would like to be included on the mailing list of addiction nursing activities or events please contact Klare Braye with your name, role, service and email, klare.braye@matuaraki.org.nz.

Help keep our social page up to date!

Are there any arrivals or departures in your service? Help us keep our social page up to date. Send a short bio and a photograph to patricia.rainey@matuaraki.org.nz.

Stay up-to-date with the latest Matua Raki and addiction treatment sector news.

Check us out on Facebook www.facebook.com/matua-raki and follow us on Twitter @MatuaRaki.

Social Page

Catherine Turner – Director for addiction services, Wellington and Central Region, The Salvation Army.

Catherine manages the development of Salvation Army services and compliance within the addiction sector for the greater Wellington and Central Region and looks at ways to increase opportunities and forge stronger partnerships.

Before joining the Salvation Army, Catherine was a project manager for Upper Hutt City Council and prior to that she was the area manager for Idea Services (intellectual disabilities). This involved working with people with extremely high and complex needs and it had a strong community focus.

One of her achievements was launching Q-nique, which now has a proud tradition of providing community-based services for people with mental illness, alcohol or drug issues and health and intellectual disability needs. Forming Q-nique has also given her a strong background in developing a broad range of life skill in health services, especially in mental health, alcohol and addiction.

In terms of goals she is eager to see the development of strong collaborative communities, especially among Māori and Pacific peoples. She wants to continue to develop and improve the way alcohol and addiction services are delivered and engage in strong partnerships with other services, such as police, corrections and education.

Florence Leota – Senior advisor, Addictions Team Services, Ministry of Health

Florence is the new senior advisor with the Ministry of Health’s Addiction Treatment Services Team. Her role includes being the Ministry of Health’s interface for inter-agency programmes and projects that contain AOD issues that involve community engagement and outcomes. She comes with a wide range of experience having previously worked in NGO, corporate and parliamentary sectors.

Florence’s work experience in the mental health and addictions sector includes being the former chief executive of Supporting Families New Zealand (formerly Schizophrenia NZ) and she is currently part of two advisory committees to the Royal Australian and New Zealand College of Psychiatrists.

Having worked in parliament for a decade and then in the corporate sector as an international public relations and media specialist, Florence had taken her knowledge and skills into the NGO sector with a desire to help provide better services and outcomes for families and consumers in the mental health and addiction sectors. That desire remains the same today but using a different vehicle.

Florence is enjoying her role in the ministry and is keen to engage with the addiction sector so she can better contribute to achieving improved outcomes and services for people with mental health and addiction issues.

Jo Claridge – Youth AOD clinical manager, WellTrust

WellTrust Youth AOD service has now merged with Q-nique to deliver an increasingly progressive model of youth-friendly quality alcohol and other drugs services in the region.

The nature of the arrangement is that the governance, respected identity and brand of the WellTrust Youth AOD service in the region remains independent, preserved and enhanced. WellTrust will continue to be known as WellTrust.

After seven years at the helm, Murray Trenberth has stepped down from his role as CEO of WellTrust to take on a new job at the Ministry of Education. The organisation structure has been reviewed and Jo Claridge has taken on an enhanced combined clinical and management role. She will work under the guidance of the CEP manager at Q-nique.

Jo has been working at WellTrust since 2006. She has a degree in Alcohol and Drug Studies and recently completed her post grad certificate in management. She came into WellTrust as a counsellor and has worked her way up the ranks as senior counsellor, clinical team leader and now into her new role.

She is really passionate about the work she does particularly working with youth and seeing the positive changes that they make. Jo is looking forward to her new role and is excited about the opportunities in front of her for new ventures.

Shane Collett – Principal advisor, Addiction Treatment Services, Ministry of Health

Shane originally trained as a registered nurse in the UK. He came to New Zealand in the late 1990s to work at Greenlane Intensive Care Unit. A change in career resulted in him taking a position at the Henry Bennett in-patient mental health unit and then later at the Waikato Community Alcohol and Drugs Service (CADS).

Opportunities later arose in Queensland Health for Shane to design, develop and implement two Alcohol, Tobacco and other Drugs Services (ATODS). He was instrumental in developing a consultation liaison service for a large teaching hospital in Brisbane, later presenting this at the Australasian Professional Society Alcohol and Drug (APSAD) conference in Darwin.

Shane has a keen interest in co-existing problems, having worked as a dual diagnosis clinical nurse consultant and statewide principal policy officer in Queensland Health with implementation of a Statewide Dual Diagnosis Policy.
IT’S THAT TIME OF YEAR AGAIN!

Applications are now open for the Matua Raki Workforce Innovation Award 2014.

Better Jobs – Better Service

This award seeks to showcase innovations in work practices that contribute to improving workplace wellbeing and staff engagement. This initiative is designed to focus national attention on addiction treatment organisations and services engaged in best workforce practices. Our desire is to highlight better jobs for our workforce resulting in better services and outcomes for tangata whaiora.

We want to hear about improvements in your workplace – these could include:

- work-life initiatives
- job or team re-design which improves effective practice
- staff contributions to improved service delivery
- workforce professional development initiatives
- environmental innovations.

The award will be presented at the Cutting Edge Conference, Dunedin on 18 September 2014.

Applications are available on the website www.matuaraki.org.nz or by contacting the office (04) 381 6471.

Please submit entries by 31 July either email: administrator@matuaraki.org.nz or by post: PO Box 6169, Marion Square, Wellington 6141.