National Committee
for Addiction Treatment

Addiction Leadership Day
Tamaki Makaurau, Auckland
2026

E te Atua

E Te Atua, tukua mai he ngākau māhaki (ki a mātou)

Kia tau tonu te rangimārie I roto I ngā uauatanga

Me te kaha ki te whakatika I ngā mārōtanga

Kia mātou, kia Mārama hok I ngā rerekētanga

National Committee
for Addiction Treatment

Welcome and Potential Addiction Leadership Day Changes

MCs:
Deb Fraser-Komene, NCAT Co-chair

Rawiri Ihimaera, Pou Rautaki, dapaanz

National Committee
for Addiction Treatment

Te Whatu Ora Update

Phil Grady, Health NZ

National Committee
for Addiction Treatment

Building a Connected Addiction System

National Addiction Leadership Day

Health New Zealand
Te Whatu Ora

Phil Grady

National Director, Mental Health and Addiction Services

Health New Zealand
Te Whatu Ora

Our role as the national team

1

Set strategic direction

Provide clarity about national priorities and long-term investment.

2

Enable regional delivery

Support regions with tools, guidance and consistent approaches.

3

Connect the system

Bring people and networks together to solve problems collectively.

4

Listen and learn

Use data, evidence and lived experience to improve together.

What success looks like

- Strong national leadership
- Connected regional networks
- A confident and capable workforce
- Evidence-informed commissioning
- Strong provider partnerships
- Clinical excellence
- Lived-experience embedded in Decisions
- Better outcomes for people and whānau

A year of delivery

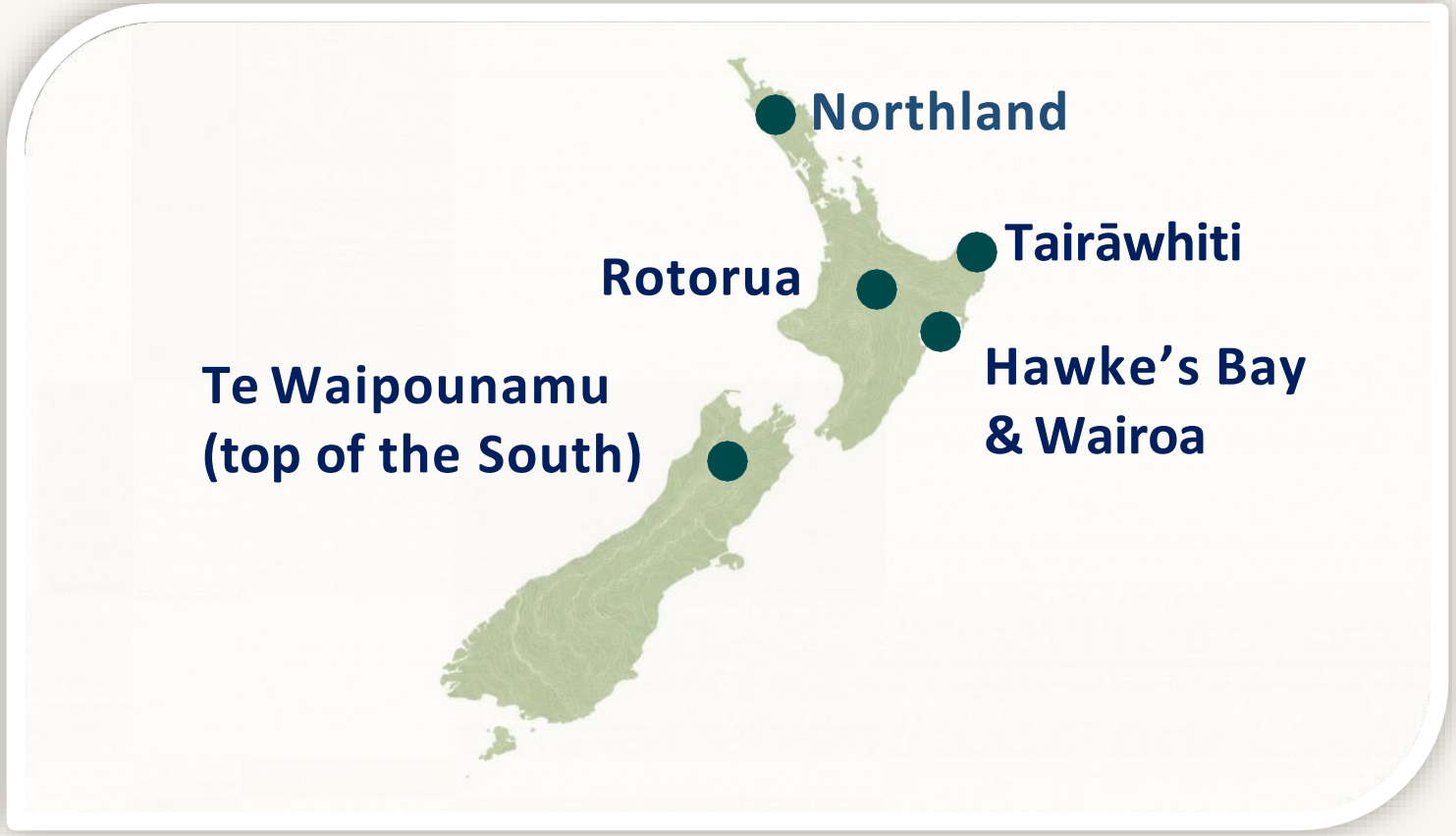
1. **Government investment**
   Budget 2025
2. **Meth Sprint**
   National response
3. **Substance Harm Action Plan**
   Beyond meth
4. **Workforce strengthening**
   People & capability
5. **Quality Improvement and Evaluation**
   Shared Learning
6. **Integrated commissioning**
   Outcomes Focused

From individual programmes to the beginning of a nationally connected addiction system

Delivering the Methamphetamine Action Plan

A national response, locally delivered.

1. Intensive treatment
2. Pou Whānau Connectors
3. Peer recovery support
4. SBIRT
5. Workforce capability



Common service model. Local implementation. Shared learning.

Access to Primary MH&A services within 1 week

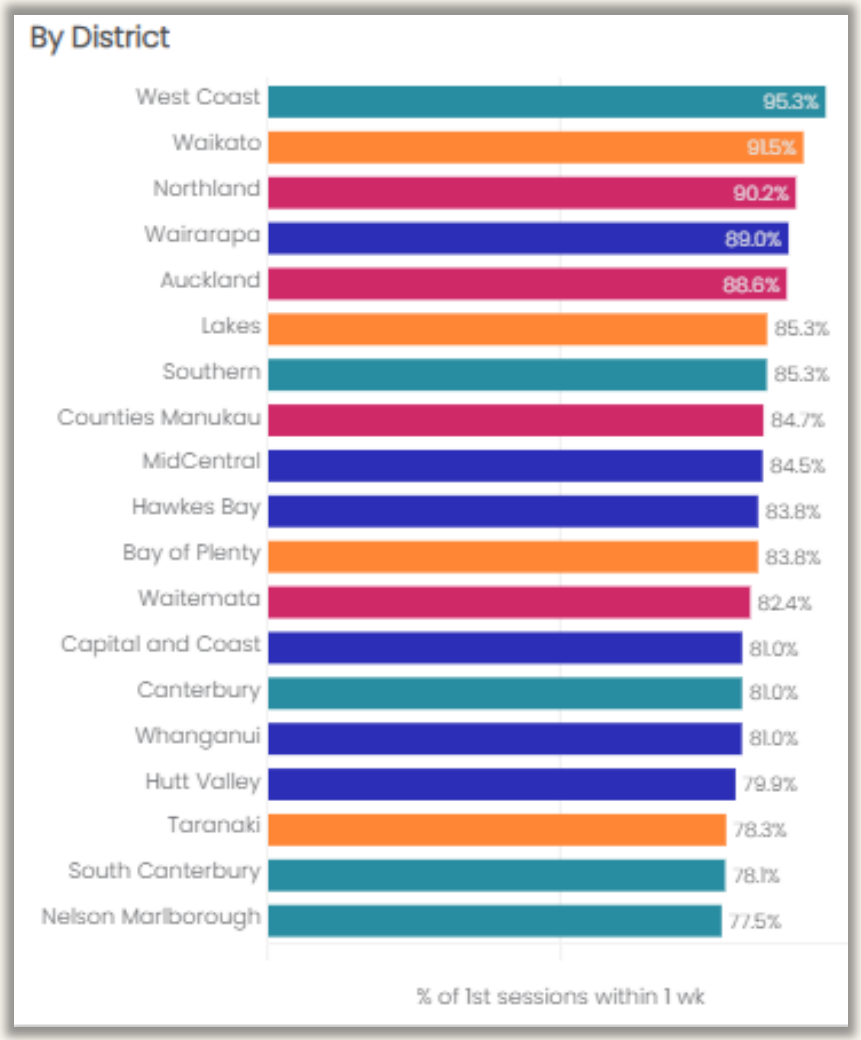
83.7%

*National average Quarter 3

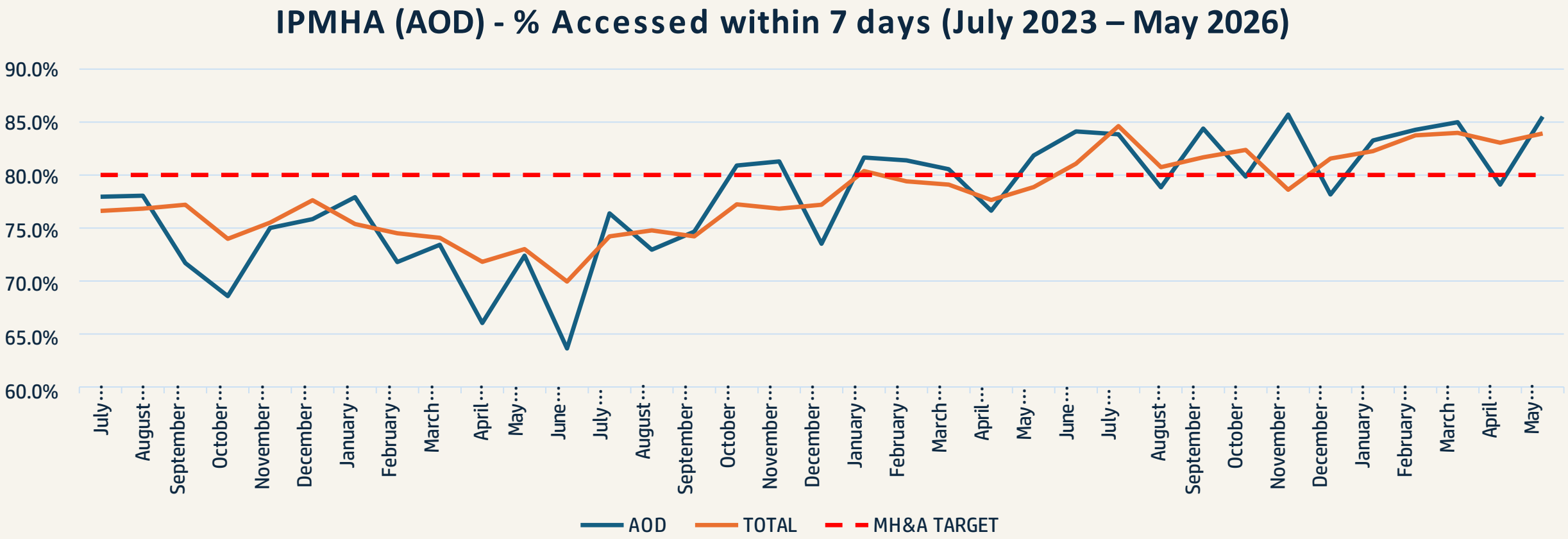
Number of MHAC Sessions - 68,782

- First sessions - 23,133
- Follow up sessions - 44,073
- Other sessions –1,576

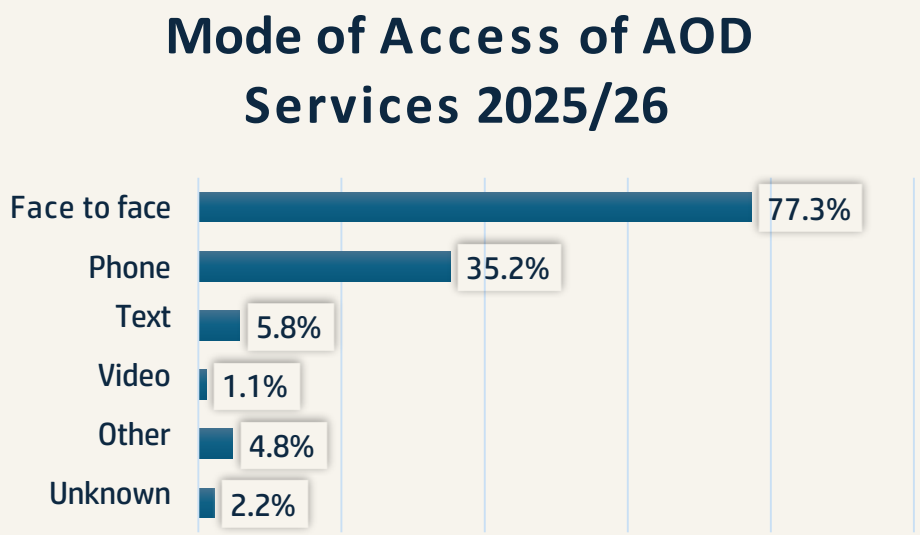
Number of distinct people seen –36,977

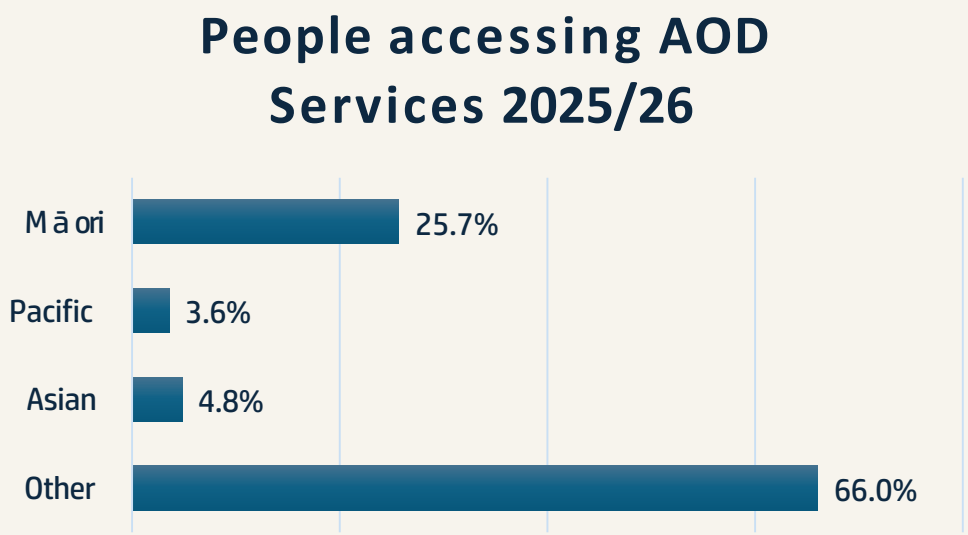


Timely access to Primary Care AOD services



Accessing AOD services in primary care

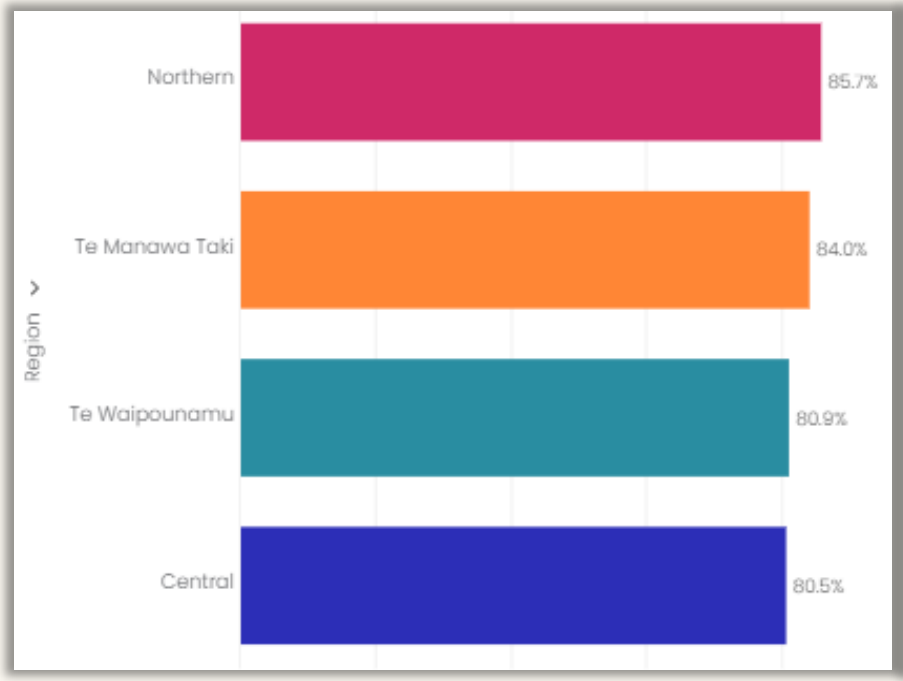


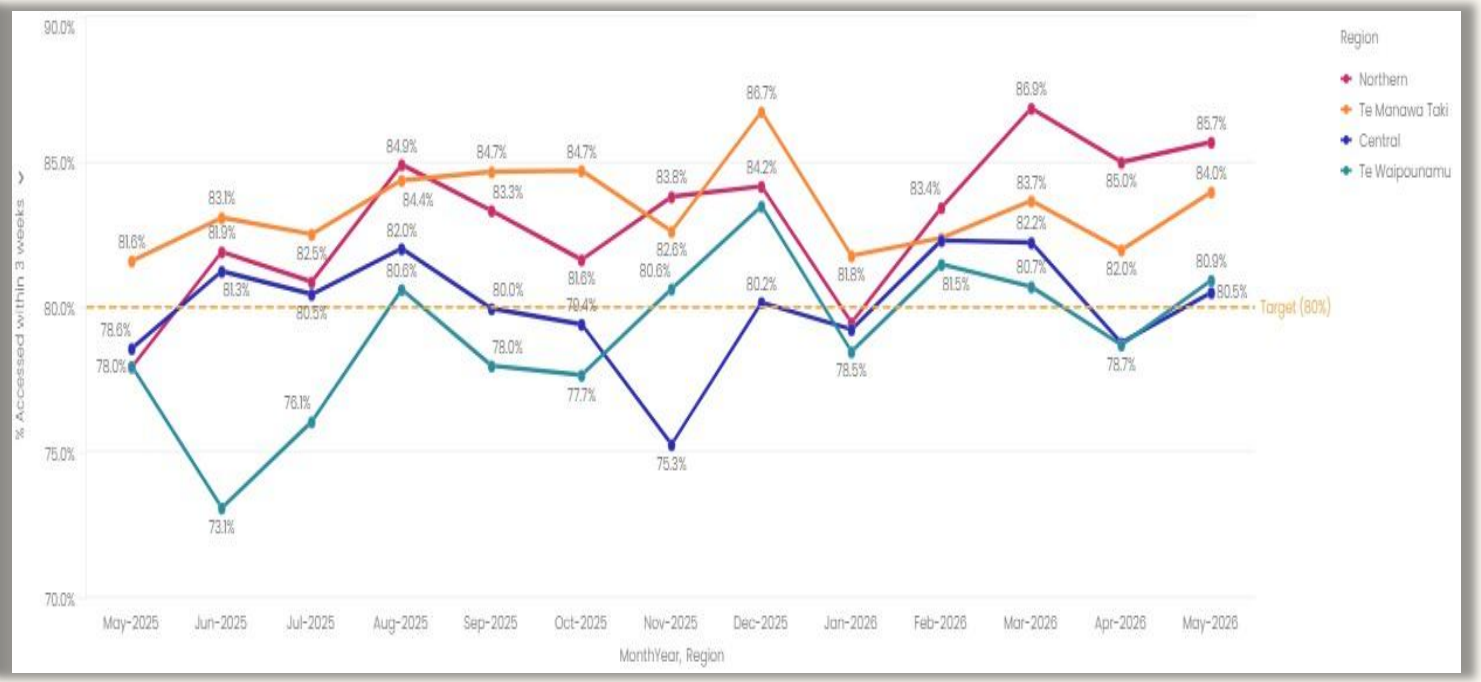


Access to Specialist MH&A services within 3 weeks

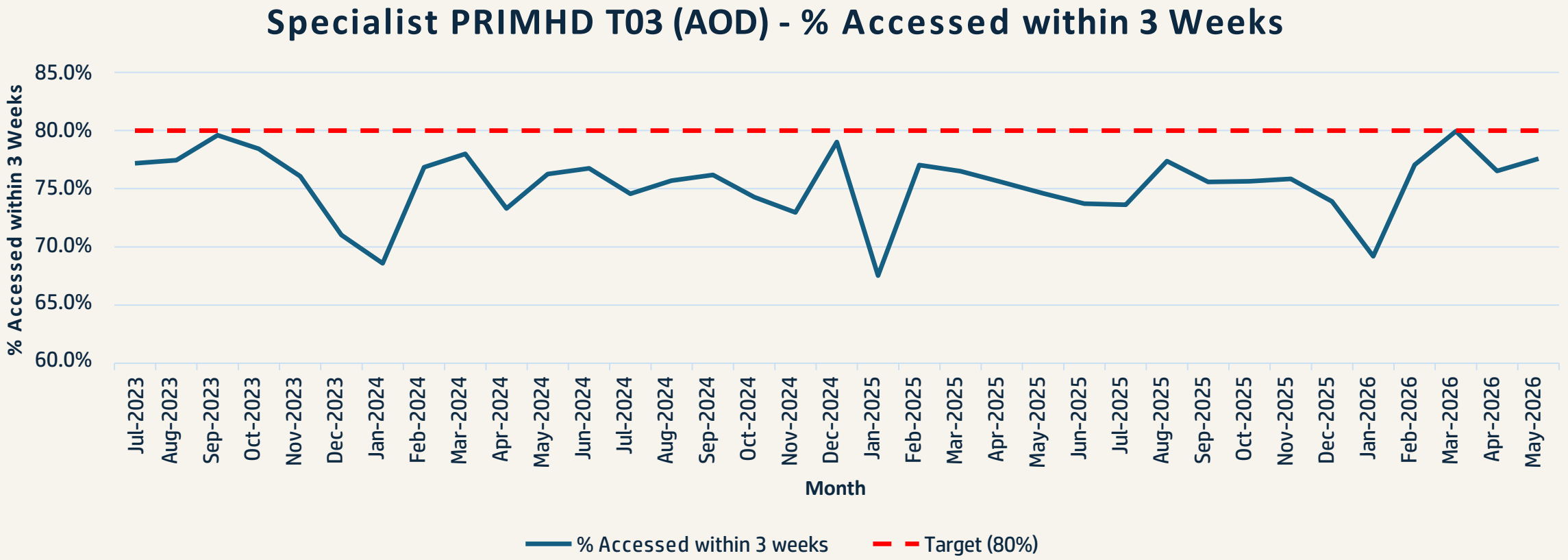
82.2%

*National average Quarter 3





Timely access to Specialist AOD services

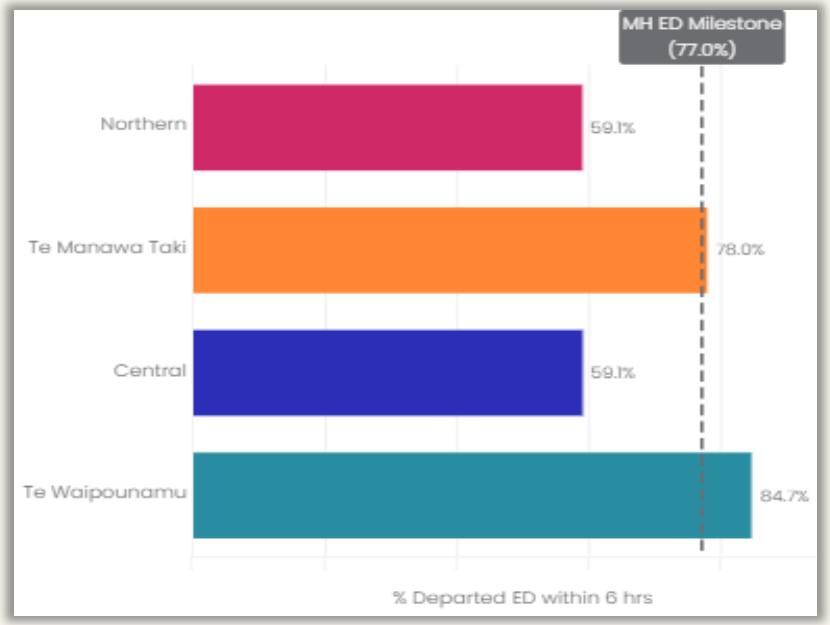


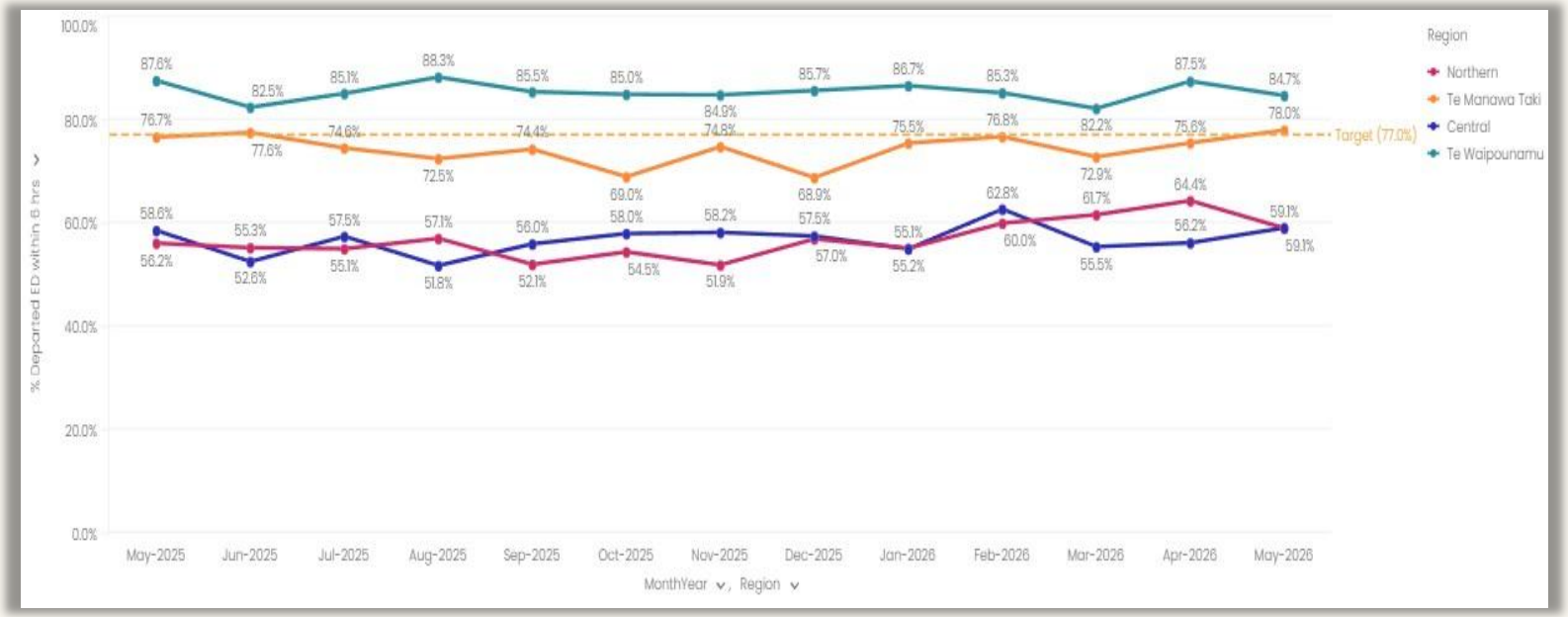
Shorter Stay in Emergency Departments

Admitted, transferred ort discharged within 6 hours

68.5%

*National average Quarter 3





What the future could look like

A nationally connected system, locally delivered.

1. National direction
2. Regional leadership
3. Providers
4. Workforce
5. Clinical expertise
6. Lived experience
7. People and whānau

A conversation for the future

How do we make the best use of what we already have?

1

National Leadership Days and Regional Symposiums

What should these be used for and how do they add value?

2

Te Pou

How do we maximise their leadership role?

3

Clinical Advice

How do we better connect clinical expertise?

4

Lived Experience

How do we keep lived-experience central?

The aim is to connect expertise, reduce duplication and make leadership forums useful to the whole sector.

Thank you for everything you do

Health New Zealand
Te Whatu Ora

GLE – Ideas into Action

Jenny Wolf, GLE; Fiona Trevelyan, Odyssey House; Sam White, dapaanz; Romy Lee, AFS; Brendan Short, Auckland City Mission

National Committee
for Addiction Treatment

Global Leadership Exchange

Global Leadership Exchange –

Working globally to develop and support leaders by sharing knowledge and experience

- Leadership Focused

- 13 member countries

- Meet face to face every 2 years

- Range of networks and collaboratives between-times

- Monthly newsletter

- Connecting people to share innovation, information, support, insight

Every 2 years in a host country:

- “Match” for 2 days on theme/ topic hosted by host country
- Travel day
- 2 day “Network meeting” (conference style)
- June 2026 Canada theme – “Ideas to Action: Inspiring Leaders to Mobilise Collective Solutions”

Aotearoa Delegation at the GLE Leadership Exchange, Ottawa

“Sex, Drugs, Rock and Roll – Including and Beyond Substances, Towards Intersectionality”

Behavioural addictions are closer to AOD addiction than many of us think?

Shared neurobiology

- Reward pathways
- Craving
- Loss of control

Shared impacts

- Relationships
- Finances
- Mental health
- Physical health
- Recovery

"The addiction isn't the substance. The addiction is the relationship with the behaviour"

What we heard from international research...

•Growing demand

- Gaming
- Digital technology
- Compulsive sexual behaviour
- Shopping
- Gambling

•Existing treatments work

- MI
- CBT
- Relapse prevention
- Peer support

Co-occurs with substance use

Rarely occurs in isolation

Often shifts between addictions

Early intervention matters

- Identify earlier
- Prevent escalation
- Integrate into routine care

"The evidence isn't telling us to invent a whole new treatment system. It's telling us to broaden the way we think about addiction."

So what should we do?

For services

✓Routinely ask about behavioural addictions

✓Treat addiction, not just substances

✓Build workforce confidence

✓Include lived experience

✓Strengthen research and evaluation

Our challenge is not to build a new system. It is to broaden the one we already have

What we observed in Canada

Canadian observation	Reflection for Aotearoa
Dr Peter Centre and Casey House treated the whole person rather than just the substance	Person-centred care remains essential
Kilala Lelum embedded Indigenous culture throughout care	Te Tiriti and mātauranga Māori remain strengths we should continue building on
Stonehenge and Portage focused strongly on recovery capital	Recovery is about rebuilding lives, not simply stopping use
Guelph Community Health Centre integrated physical, mental health and addiction care	Behavioural addictions fit naturally within integrated services

Behavioural Addictions Position Statement

The GLE match calls for:

- Recognition of behavioural addictions as a significant public health issue
- Integrated assessment and treatment
- Earlier identification
- Culturally responsive approaches
- Lived experience leadership
- Research and system development

- Full Position Statement and FAQ available

The “Match” participants

Through

Education, Research & Co-Design

Improving Substance Use Health

Why do we speak about people who use substances like they are in a different category?

Substance Use Is Already Part of Population Health

Unlike physical health and mental health, substance use is discussed primarily through illness and disorder.

This has created systems and culture where:

- People do not see substance use as part of their health
- Support is associated only with crisis
- People often wait until sickness and harm before seeking care.

Substance Use Health expands the conversation beyond disorder alone.

Substance Use Health Includes All of Us

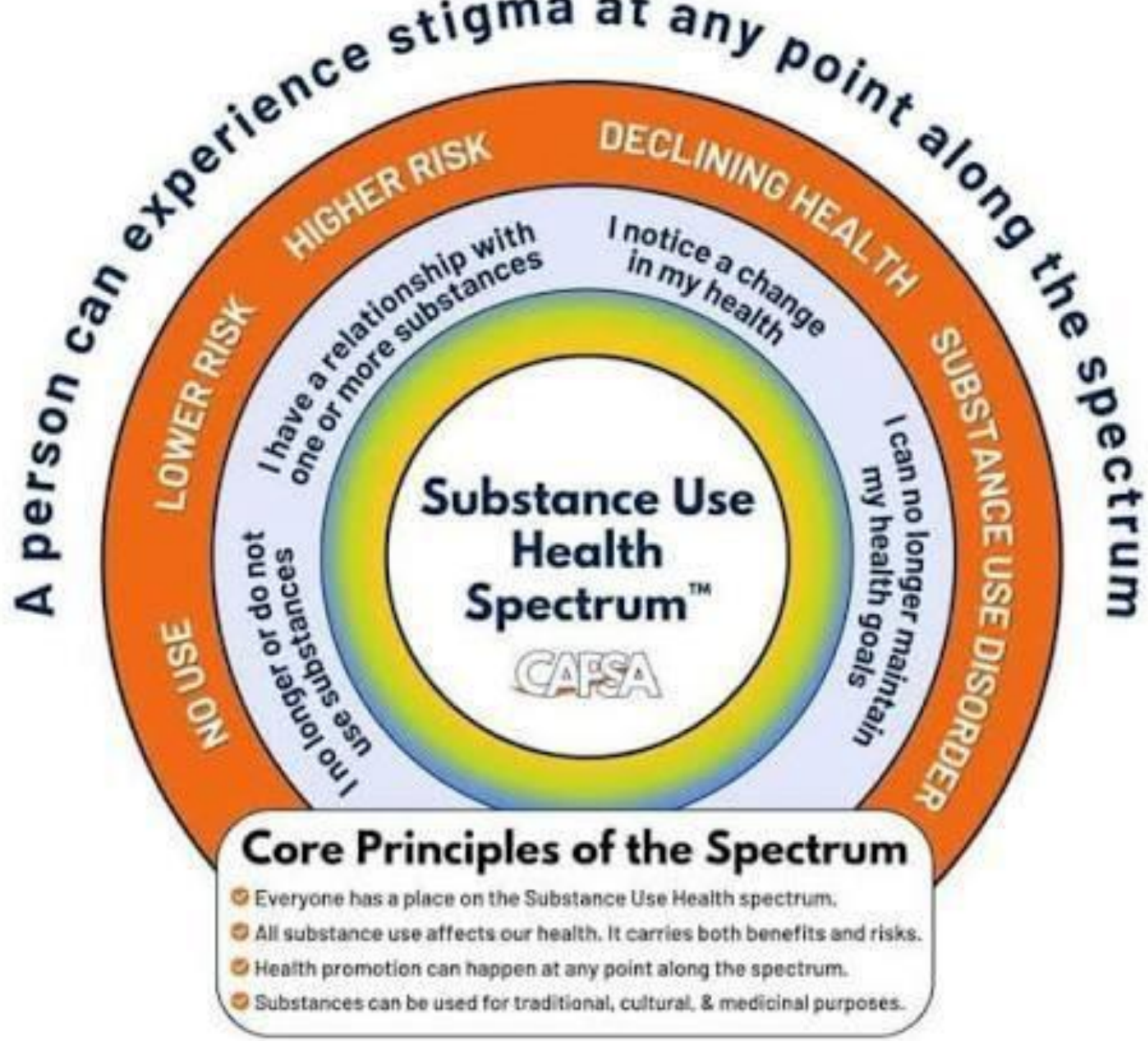
This is not their health. It is our health.

Substance Use Health does not divide people into:

“healthy people” and “people with substance use disorders.”

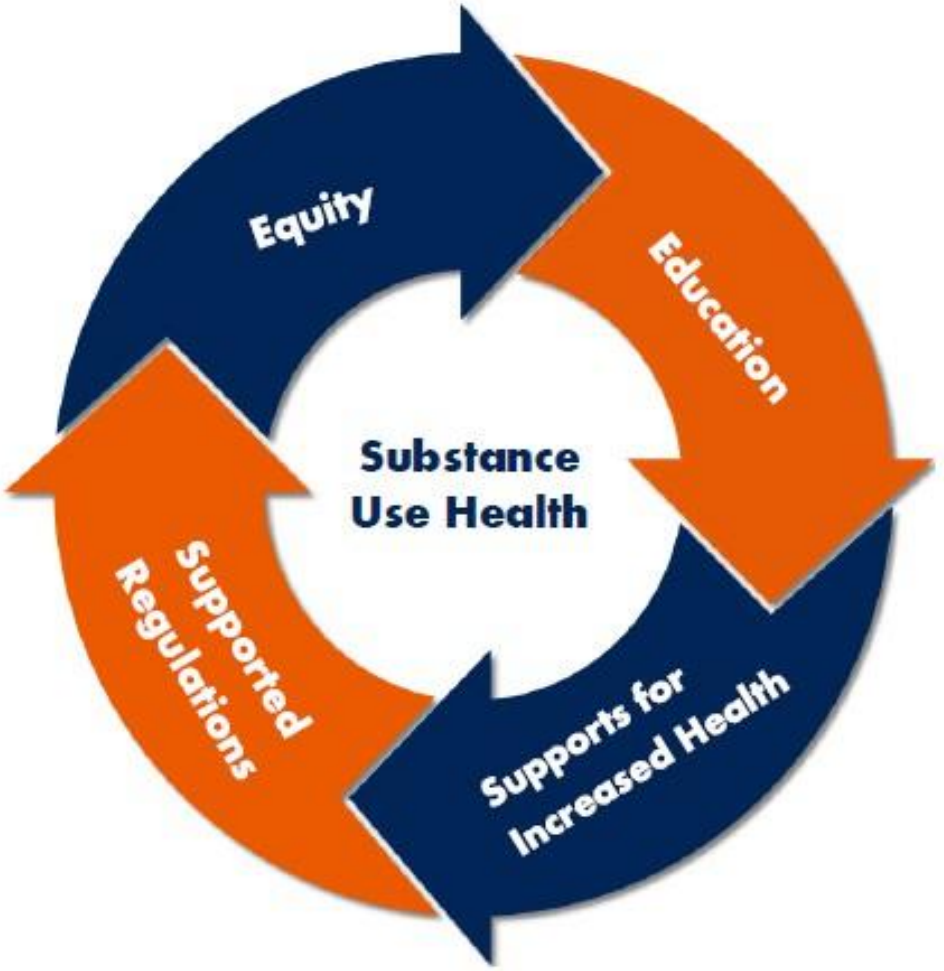
It recognizes that substance use: wellness, benefit, risk, coping, culture, medication, pleasure, stress, and healing… exist across all communities.

Substance Use Health places everyone inside the same conversation about health.


A person can experience stigma at any point along the spectrum
NO USE
LOWER RISK
HIGHER RISK
DECLINING HEALTH
SUBSTANCE USE DISORDER
I no longer or do not use substances
I have a relationship with one or more substances
I notice a change in my health
I can no longer maintain my health goals
Substance Use Health Spectrum™
CAPSA
Core Principles of the Spectrum
Everyone has a place on the Substance Use Health spectrum.
All substance use affects our health. It carries both benefits and risks.
Health promotion can happen at any point along the spectrum.
Substances can be used for traditional, cultural, & medicinal purposes.

Health Encompasses Everything

Substance Use Health is not a structure but is interconnected by equity, education, supports for increased health, and supported regulations to fully optimize wellness.



Substance Use Health

Substance Use Health is CAPSA's response to the false beliefs that lead to discrimination.

It interrupts stigma at every level by destabilizing *othering:*

- It treats all substance use as health
- It dismantles stigma in language and systems
- It rejects the line between "us" and "them"

All People. All Pathways.

Substance Use Health places the choice about substance use with the person.

CAPSA, CCSA, and the Mental Health Commission of Canada have brought this forward together. People want:

- To make their own choices about their relationship with substances
- Substance Use Health treated like any other condition of physical or mental health

CAPSA, MHCC, 2023 / CAPSA, CCSA, 2024 / CAPSA, CCSA, 2025

No Pathway Above Another

Substance Use Health does not validate or sanction one health choice over another.

It removes and decamps silos between recovery, abstinence, treatment and harm reduction:

- All pathways are health information
- No pathway is favored or discouraged

This is why the language of Substance Use Health holds higher value than what came before.


dapaanz
Cutting Edge 2019

manaaki

CARE

pono

INTEGRI-
TY

pukenga
ahurea

SKILFUL-
NESS

CODE OF ETHICS DAPAANZ 2025

TANGATA WHAIOVA :
person seeking wellness

2SLGBTQIA+ Match

Global Leadership Exchange
June 2026, Ottawa, Canada

Romy Lee

National Manager – Child and Youth Mental Health

Principal Advisor – Lived Experience

Asian Family Services

Together enriching lives

2SLGBTQIA+ Match

2nd Collaborative Gathering | Global Leadership Exchange

Dates June 1–2, 2026

Venue Kind Space 2SLGBTQIA+ Community Centre —400 Cooper Street, Suite 9001, Ottawa, Canada

Who Addiction, mental health & disability sector leaders across NGO, government and education

Turning Ideas into Action: Inspiring Leaders to Mobilize Collective Solutions

Strengthen 2SLGBTQIA+ leadership, influence systems, and accelerate equity across mental health, addiction, and disability sectors through international collaboration, lived experience expertise, and collective action

Key Themes

1. Leadership is a Collective Responsibility
2. Inclusion and Visibility Drive System Transformation
3. Equity and Human Rights Are Foundational to Quality Care
4. Relentless Incrementalism Creates Sustainable Change

The 2026 GLE Declaration

Turning Ideas into Action

What is it?

An international declaration developed by participants of the 2026 GLE 2SLGBTQIA+ Leadership Collaborative Match, setting out a shared commitment to advance equity across the mental health, addiction and disability sectors.

It captures the collective learning, priorities and commitments that emerged from leaders with lived experience, community leaders, policy influencers and organisational decision-makers.

Why was it created?

Because 2SLGBTQIA+ people continue to experience:

- Disproportionate harms in mental health, addiction and disability systems
- Barriers to affirming care
- Systemic discrimination
- Underrepresentation in leadership and decision-making

It moves beyond conversation into practical commitments for individuals, organisations and GLE itself.

CORE PURPOSE

To turn ideas into action by creating systems where 2SLGBTQIA+ people can thrive, lead, and help shape the future of health and social services.

Commitments for Individuals: 2SLGBTQIA+ Community Members, Allies, and Accomplices

Why This Matters

Individual leadership shapes culture, disrupts stigma, and creates safer environments. Every person in these sectors has a role in advancing equity.

Short-Term Actions (0–12 months)

- Practice visible allyship through pronoun use, inclusive language, and affirming behaviours.
- Interrupt discrimination and microaggressions using trauma-informed approaches.
- Engage in self-reflection to identify biases and areas for growth.
- Amplify 2SLGBTQIA+ voices by sharing platforms and credit.

Medium-Term Actions (1–3 years)

- Be a visible, authentic leader.
- Build competency in intersectionality, inclusion, and cultural safety.
- Participate in mentorship and peer-support networks.
- Model progressive disruption by challenging outdated norms in teams and communities.

Long-Term Actions (3+ years)

- Sustain leadership pipelines by supporting 2SLGBTQIA+ representation in governance and executive roles.
- Champion systemic change through policy advocacy and community partnership.
- Commit to lifelong learning and accountability as systems evolve.

Commitments for Organizations in Mental Health, Substance Use Health, and Disability Sectors

Why This Matters

Organizations shape the conditions under which 2SLGBTQIA+ people receive care, work, and lead. Organizations have a responsibility to create environments that are safe, affirming, and equitable — and to repair harms caused by historical exclusion.

Short-Term Actions (0–12 months)

- Adopt explicit 2SLGBTQIA+ inclusion and anti-discrimination policies, including within the hiring process.
- Implement trauma-informed workplace practices that support psychological safety.
- Ensure visibility by integrating 2SLGBTQIA+ identities into training, communications, and values.
- Collect inclusive demographic and qualitative data (voluntary, confidential, ethically governed) and responsibly report on data collected, acknowledging that 2SLGBTQIA+ live full and complete lives.
- Acknowledge the personal investment of time, energy, and advocacy for 2SLGBTQIA+ experiences in employment spaces.

Medium-Term Actions (1–3 years)

- Develop employment and leadership pathways for 2SLGBTQIA+ staff, including mentorship and equitable promotion processes.
- Appropriately compensate individuals for expertise gained through lived experience - including transitioning from informal advisory roles to formal, employed positions.
- Embed inclusive design into service delivery and program development.
- Invest in workforce education on intersectionality and cultural safety.
- Establish accountability mechanisms, such as equity dashboards or advisory councils.

Long-Term Actions (3+ years)

- Transform organizational culture by consistently including 2SLGBTQIA+ leadership at all levels.
- Align strategy, governance, and funding with equity and human rights principles.
- Partner with community organizations to co-design programs and policies.
- Sustain progressive disruption by continuously challenging systemic barriers.

Commitments for the Global Leadership Exchange (GLE)

As the convenor, catalyst, and steward of global learning

Why This Matters

GLE is uniquely positioned to mobilize leaders, amplify marginalized voices, and accelerate change across systems. GLE must model the leadership it seeks to inspire: to build a 2SLGBTQIA+ inclusive environment at GLE and through the GLE communities.

Short-Term Actions (0–12 months)

- Embed 2SLGBTQIA+ leadership across all GLE activities and Matches.
- Create trauma-informed, culturally safe spaces for dialogue and shared learning.
- Document and disseminate promising practices.

Medium-Term Actions (1–3 years)

- Continue to support the global 2SLGBTQIA+ Leadership Collaborative network to promote collaboration, mentorship, and knowledge exchange.
- Develop tools, frameworks, and guidance for organizations advancing inclusion.
- Integrate 2SLGBTQIA+ perspectives across all GLE thematic areas and future Exchanges.

Long-Term Actions (3+ years)

- Influence global policy and system reform by elevating evidence and lived experience.
- Sustain a global movement that champions progressive disruption and persistent incrementalism.
- Ensure long-term visibility of 2SLGBTQIA+ leadership within GLE governance, strategy, and partnerships.

2SLGBTQIA+ Match

Global Leadership Exchange
June 2026, Ottawa, Canada

romy.lee@asianfamilyservices.nz

Asian Family Services
Together enriching lives

National Committee
for Addiction Treatment

Paramanawa | Morning tea

Workshop: Same Side of the Coin? Behavioural Addictions

Jenny Wolf, Addictions & LE Council Lead, Global Leadership Exchange

National Committee for Addiction Treatment

Workshop Session

“Same sides of the Coin?” Behavioural Addictions

Which Behavioural Addictions?

- Gambling
- Gaming
- Compulsive sexual behaviours*
- Shopping
- Problematic digital technology use

*Compulsive sexual behaviours:

- Aotearoa Services that support compulsive sexual behaviours, internet porn and harmful sexual behaviours:

- "STOP" in the South Island; "Wellstop" lower half of North Island; "Safe Network" top half of the North Island

- Note not all compulsive behaviours = addiction

- Could consider interventions (MI and CBT) or refer

- Mindful of 'sbos' and how CEP continues to 'ping pong' tāngata whai ora

Note also:

- Some Aotearoa Youth Addiction services are already treating t ā ngata whai ora with behavioural addictions

- AND…we look forward to hearing about Touchgrass today ☺

Key Points (refresh)

- To see addictive behaviours from an addictions framework
- Behavioural addictions involve repetitive, maladaptive behaviours with craving, loss of control, and persistence despite harm
- Evidence based treatments (EBTs) include:

  CBT (strongest evidence)

  MI + CBT - improves motivation & engagement –(limited behavioural trials)

  skills / psychoeducation, mindfulness (emerging with promising results)

Some additional info…

- There are screening tools for a range of behavioural addictions – need consistently used agreed tools
- Dr Kim is to write a manual of the ‘nuances’ of behavioural addictions from July 2027
- Fertile ground for data capture and research

Systematic Review of Addiction Substitution in Recovery (Kim et al 2021)

- Synthesised literature examining addiction substitution during recovery from substance use or behavioural addictions
- 96 studies sample sizes 6 –14,885
- Of these, 17.65% found support for addiction substitution
- 52.94% found support for recurrent recovery

- Overall, male gender, younger age, greater substance use severity, and presence of mental health disorders were associated with addiction substitution. Addiction substitution was associated with poorer treatment outcomes

Table Discussions:

- Agree a Scribe
- One question each with allocated time to discuss
- Final feedback from tables 15 minutes

1. How does what you have just heard resonate from tā ngata whai ora stories you have heard from your work / own experience? (8 mins)

2. What would it take to embed this into our practice from the following perspectives:

- Workforce development (knowledge and skills)
- Systems and frameworks and data capture
- Resourcing
- Interface with specialist providers
- Other

(10 mins)

3. If you were to adjust the draft Position Statement, what would this look like?

Are there any gaps in what we have presented / discussed so far?

(8 mins)

Feedback

Thank you! ☺

Any other comments please email
jenny@gle.world

Next Steps: Deb

Touchgrass: Responding to increasing levels of problematic screen use among youth

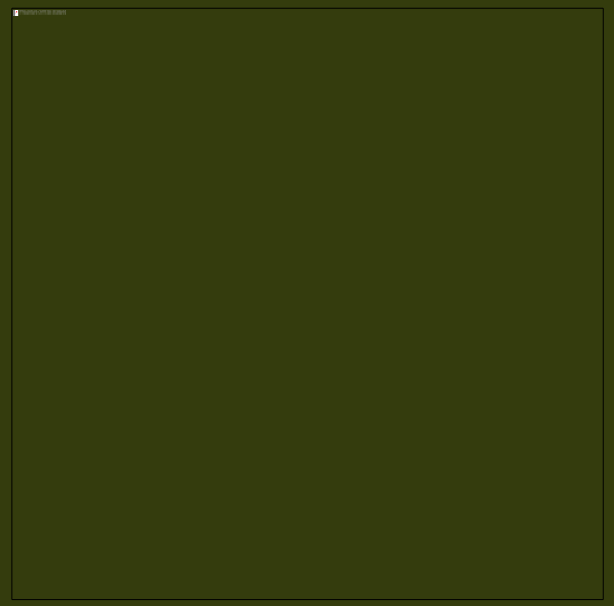
Frances Russell, Clinical Lead/Kaihaumanu Matua, Touchgrass

National Committee for Addiction Treatment


touchgrass
Responding to increasing levels of problematic screen use among youth.

Responding to increasing levels of problematic screen use among youth.
Self-help, digital tools, and personalised support.

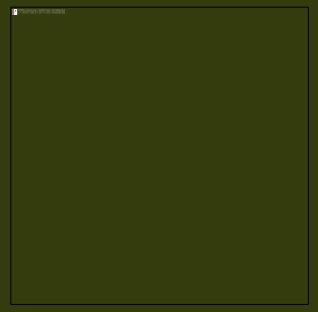
How many hours on average do young people spend online per week in Aotearoa?



42 hours per week

(Cullen, et al., 2024)

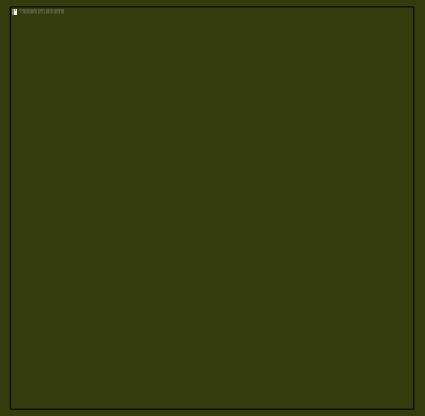
What percentage of rangatahi in Aotearoa would meet criteria for problematic social media use?

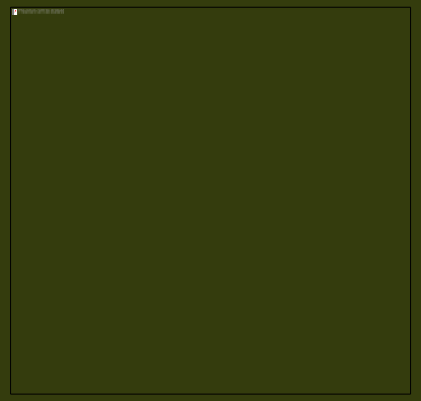


22% of young people

(Marsh, et al., 2025)

What percentage of adolescents in Aotearoa have gambled?





43.7% of young people

(Ministry of Social Development, 2026)

Youthline State of Generation Report 2026

Rangatahi aged 12-24 years of age

66%

Identify screen addiction and social media as an issue

touch grass

Youthline State of Generation Report 2026

Rangatahi aged 12-17 years of age

More than

40%

Say it is the most common issue they face, above relationship issues, drug use, violence and abuse.

touch grass

Youthline State of a Generation Report 2026

“We’re not living life — we are just living through our phones.”

“It prevents us from actually living, it also makes anxiety worse because the screen time is so addictive that we can't function properly without it”

touch grass

What are parents telling us?

‘It’s a real battle, it really is. It’s sucking the life out of our children. They struggle to do activities that are not online anymore’

‘It becomes very easy to normalise screen time and as a parent who uses their phone for work it can become a grey area about what's too much time and what's unhealthy.’

‘I would like to have transparency with my child and their activities on line’

Benefits

Community for rangatahi

Communication tool

Space for mental health support

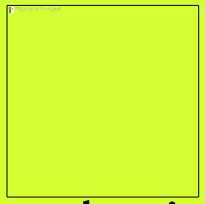
Social and enjoyable

Development of new skills

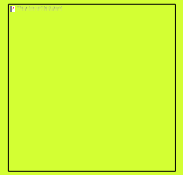
touch grass

Impacts of Problematic Screen Use

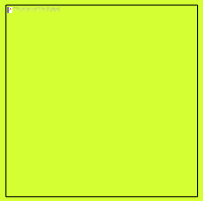
Social



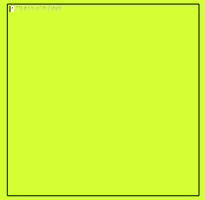
Academic



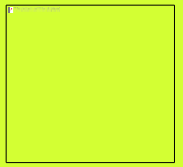
Brain changes



Sleep



Mental Health

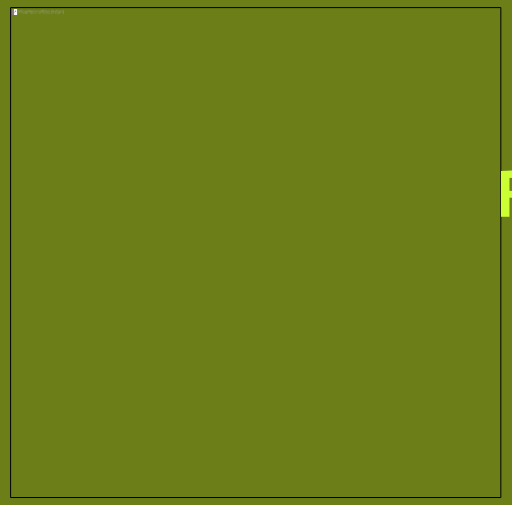


Physical Health

Cullen, et al. 2024 & Dresp-Langley, 2020)

The Convergence of Gaming and Gambling

Shared Reinforcement Mechanisms



Variable rewards

Gaming mechanics
Loot boxes
Cosmetic purchases
Microtransactions

Dopamine release

Risk/reward decisions

Gambling Mechanics
Betting systems
Chance-based outcomes
Monetary rewards

touch grass

Whilst different screen dependencies frequently co-occur, they are treated as separate clinical problems, without a specialist service to meet their needs

touch grass

touch grass

Aotearoa's first integrated early intervention service to address online gambling, gaming and social media harm in a single clinical framework.

touch grass

How research informed our Service Design

- Rapid access
- Self referral
- Confidential and youth friendly
- Stepped care approach
- Online self help and digital resources
- Whānau centred
- Ongoing youth co-design
- Trauma informed, clinically robust

(Pryjmachuk, et al 2024, Ollendick, et al, 2018, Te Pou, 2024, Park, et al, 2021)

touch grass

Youth Insights that informed Service Design

- Privacy is central
- Support is invisible and hard to name
- Gambling is normalised and widespread
- Shame and self blame is a common experience of rangatahi experiencing gambling harm
- Relatability and lived experience matters to young people

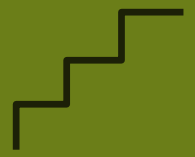
1
BUMP INTO

Young people encounter Touchgrass in their own spaces - Reddit, Discord, TikTok, Instagram. Through content that feels native, not marketed. No action demanded.

2
FIRST TOUCH

Anonymous, AI-enabled information and self-reflection via the Touchgrass platform. Nothing saved. Explicit permission to leave at any time.

3
FIRST STEP



Multiple valid options with no hierarchy.
DIY tools, digital or human chat.
Leaving is valid.
The young person chooses.

4
CLINICAL SUPPORT AND COMMUNITY

Clinical services, counselling, whānau therapy, youth services, peer support,and intensive treatment.

touch grass

Touchgrass Eligibility Criteria: Clinical Pathway

Age range: 13-24	
Inclusion criteria	**Exclusion Criteria**
Positive screen for gambling harm Positive screen for gaming harm Positive screen for problematic screen use Whānau affected included	Problematic porn use Digital harm (primary presenting issue) Alcohol or drug use only Mental Health concerns only

Touchgrass Model of Care

Age Range: 13-24

Digital Gateway	Peers	Clinical	Hoake	Follow up only
Online resources Self help tools	Dedicated peer support worker providing mentioning, community connection and goal setting	Full clinical assessment and treatment: Individual Couple Group Whānau	Funded care package (criteria must be met)	Monitoring and check-in only; no active treatment

Touchgrass: The Long Term Vision

Touchgrass meets young people wherever they are and goes with them as far as they need to go

- Online content, social media & content creation internships.
- Digital self-help tools & anonymous AI-guided advice.
- Education & workshops. Community activations.
- Peer support Community based groups.
- Advocacy
- In-person & online individual & whānau counselling.


THANK YOU

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Marsh S, Young A, Reid C, Chu J. Problematic social media use common among NZ teens as government examines age limits. ***Public Health Expert Briefing*. 2025**

Ministry of Social Development. ***Youth Health + Wellbeing Survey 2025 Findings*. 2026.**

Smith M SL, Gage R, D' Souza A. *Children's exposure to gambling and gambling marketing: a report on the key findings for the* ***New Zealand Ministry of Health.* . 2025.**

National Committee
for Addiction Treatment

Tina | Lunch

Lived Experience Addiction Leadership Group Update

Lived Experience Addiction Leadership Group

National Committee
for Addiction Treatment

LEALG UPDATE

HOLD ON TO YOUR SEATS

LIVED EXPERIENCE WHANAU PROJECT LEAD

TE POU

COMPETENCIES

STRATEGY & ACTION PLAN

ORGANISATIONAL READINESS GUIDE, ADDICTIONS WORKFORCE

SECTOR KŌRERO

CONTACT THE TEAM

Livedexperience@tepou.co.nz

Leadership – Lessons along the way

Lt Col Lynette Hutson, Mission Projects Officer Mission Department, The Salvation Army | Territorial Headquarters

National Committee
for Addiction Treatment

Lessons Along The Way

we define leadership as a social process that enables individuals to work together to achieve results that they could never achieve working alone

- My story in a nutshell
- Christchurch Bridge Volunteering then working in the AOD sector
- And ongoing

Winnipeg Canada
Lots of snow

Wealth and Poverty

Frostbitten legs

Fighting, blood and violence

To be a leader you have to have people following you

Authentic

Working in AOD walking the talk

Not copycat models

Truthful

Do what you say you will do

The power and release of apology

Lead with kindness


Lynette

You don’t have to always be right

Be brave and courageous

Don’t be afraid to change your view or opinion

Mongrel Mob
Unexpected challenge

A group of people who are totally outcast

What does it feel like to be on the outside?

To be shut out

To be hated by ordinary people

Ask for help and admit when you don't know

Be brave and courageous

Praise success and don't shame failure

Don't try and go it alone

Working in the Pacific

Dapaanz

Sam White, CEO

National Committee
for Addiction Treatment

[redacted]

Dapaanz update

Addiction Leadership Day

23 July 2026

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Updating Te Kōwhao, the dapaanz Te Tiriti o Waitangi policy

Te Kōwhao reaffirms our commitment to ensuring that the **intent and aspirations of Te Tiriti o Waitangi are visible in the mahi we do as an organisation and as an addiction workforce.**

Te Kōwhao sits alongside *Tikanga Matatika* | the dapaanz Code of Ethics, *Te Anga Pūkenga* | Addiction Intervention Competency Framework and *Aronui* | Supervision guide as one of the **foundational and guiding documents for the organisation and for the addiction workforce.**

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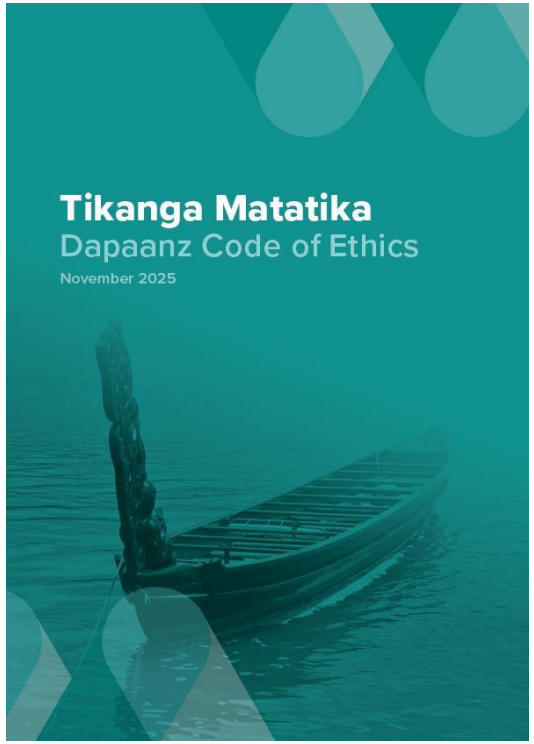
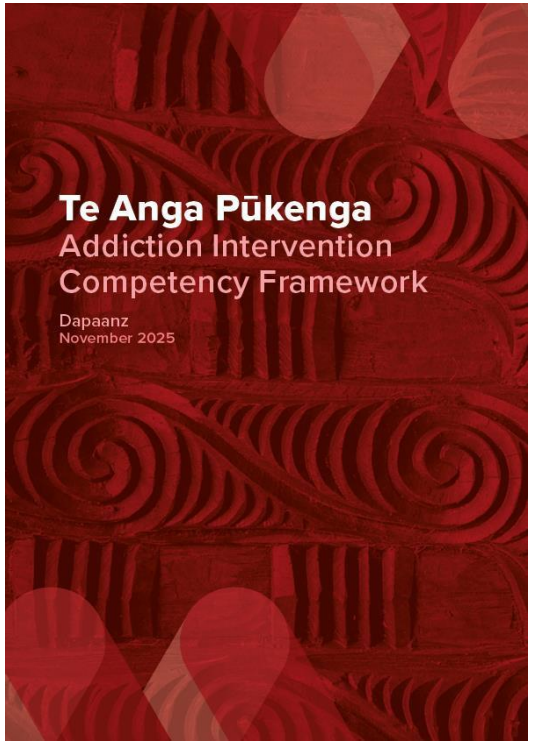
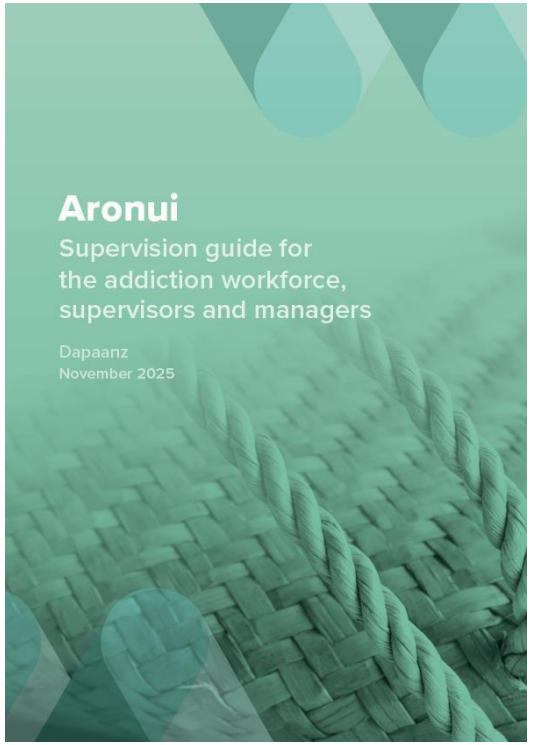
Our other guiding documents – a 2025 refresh







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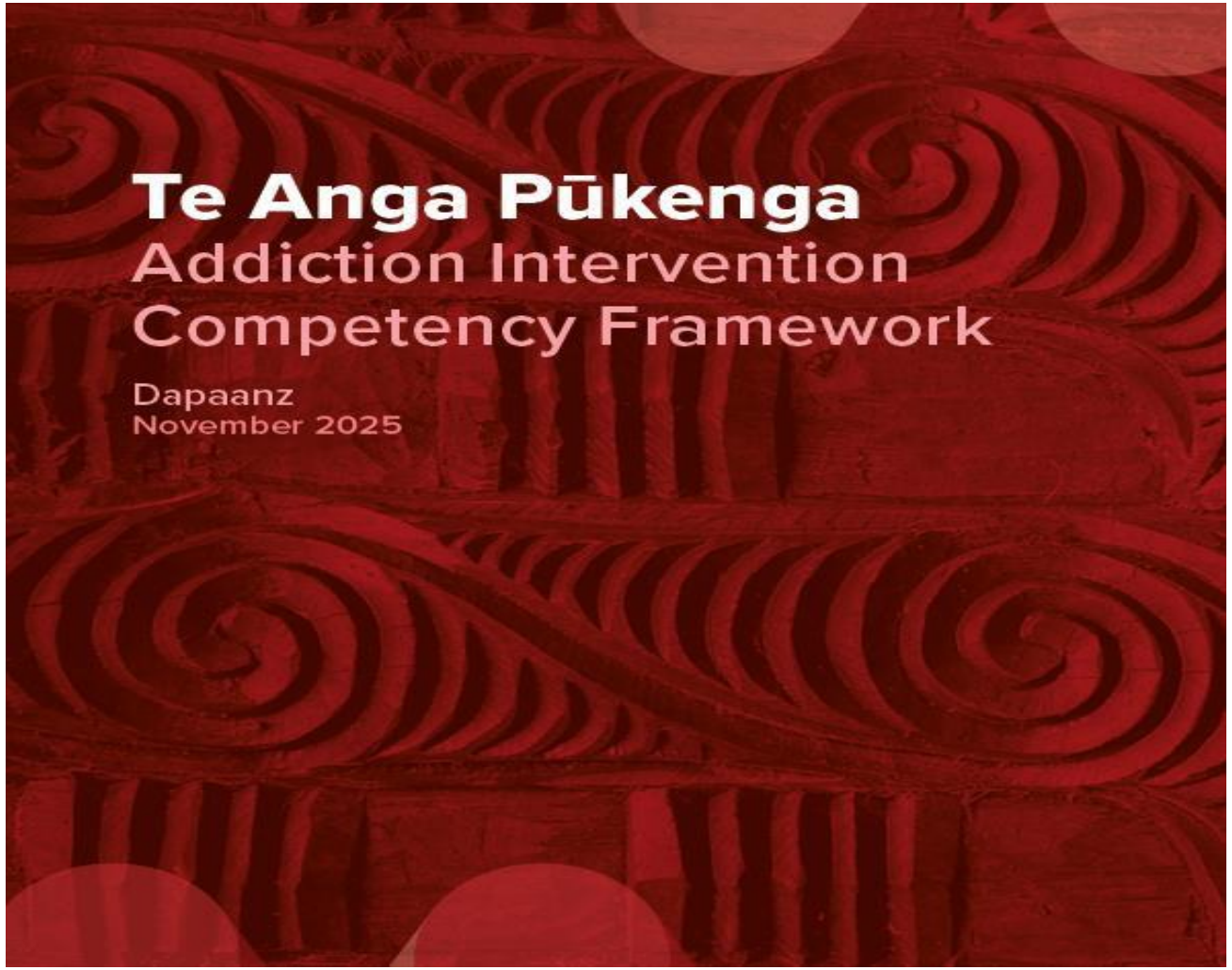
Te Anga Pūkenga

The 2025 refresh of *Te Anga Pūkenga* is based on the 2011 Addiction Intervention Competency Framework.

It introduces a new competency **"Working with tāngata whai ora under the care and management of Corrections"**

*__watch this space__: tools for reflective practice and development coming soon



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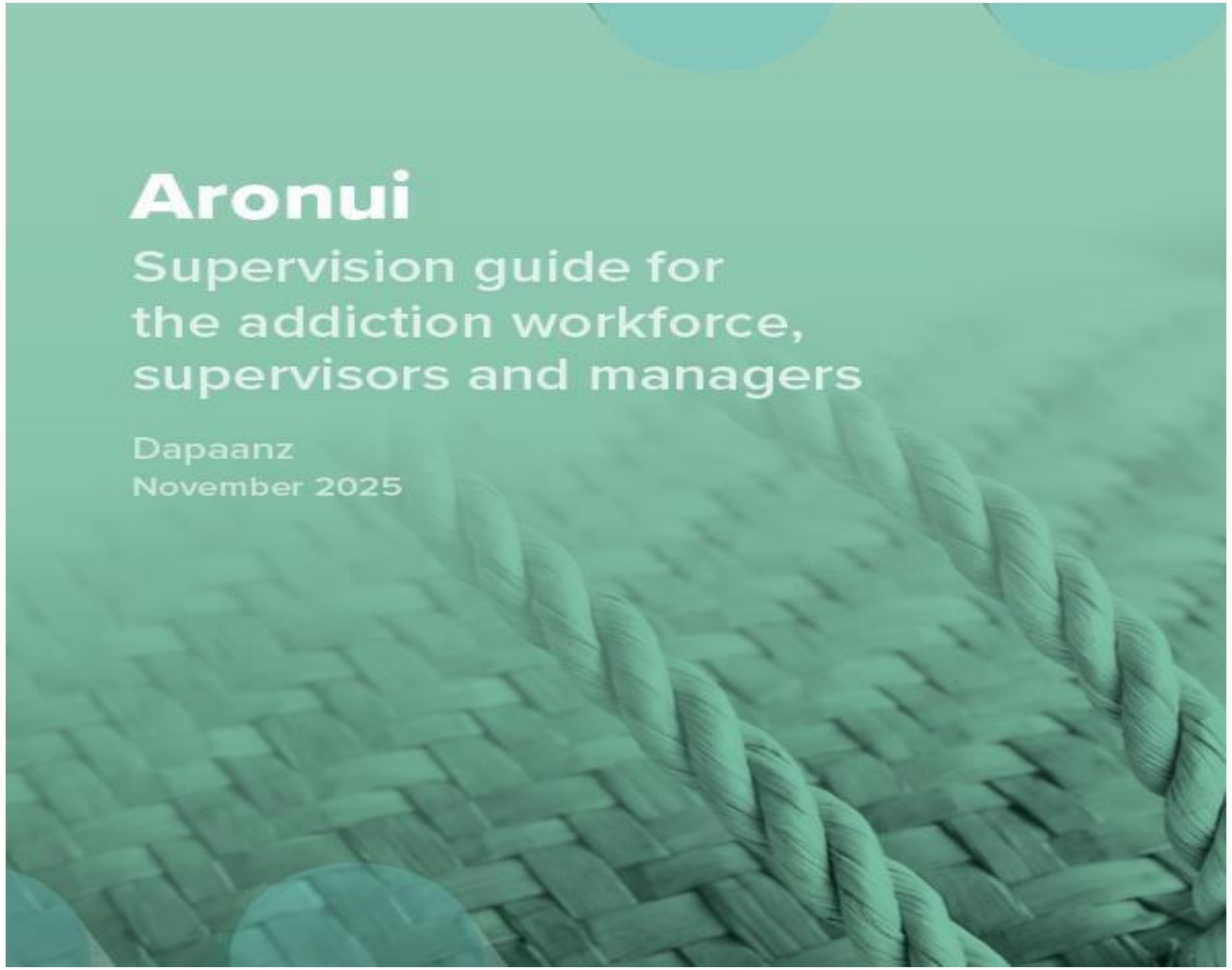
Aronui

Supervision guide for the addiction workforce, supervisors and managers

The refreshed version of Aronui includes a range of new content, including:

- Trauma-informed practice and supervision
- Technology and supervision
- Lived experience and supervision

In 2026, our CPD programme has included **several online roundtables** and **workshops** to support supervisors and supervisees to **deepen their understanding of Aronui** and get the most out of supervision



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2025 Member Survey

- Every two years we conduct a membership wide survey
- Listening to what our members say

- 2025 feedback has resulted in:
  - Refining renewal and CPD process to make admin easier for members
  - Doing our best within our technical scope to streamline our processes
  - Enhancing our CPD offering

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Listening to what our members say – CPD

- New topics, new formats
- More lower cost and free options
- Two in-person workshops in South Island recently
- Over 80 CPD events this year
- Sharing Cutting Edge presentations online

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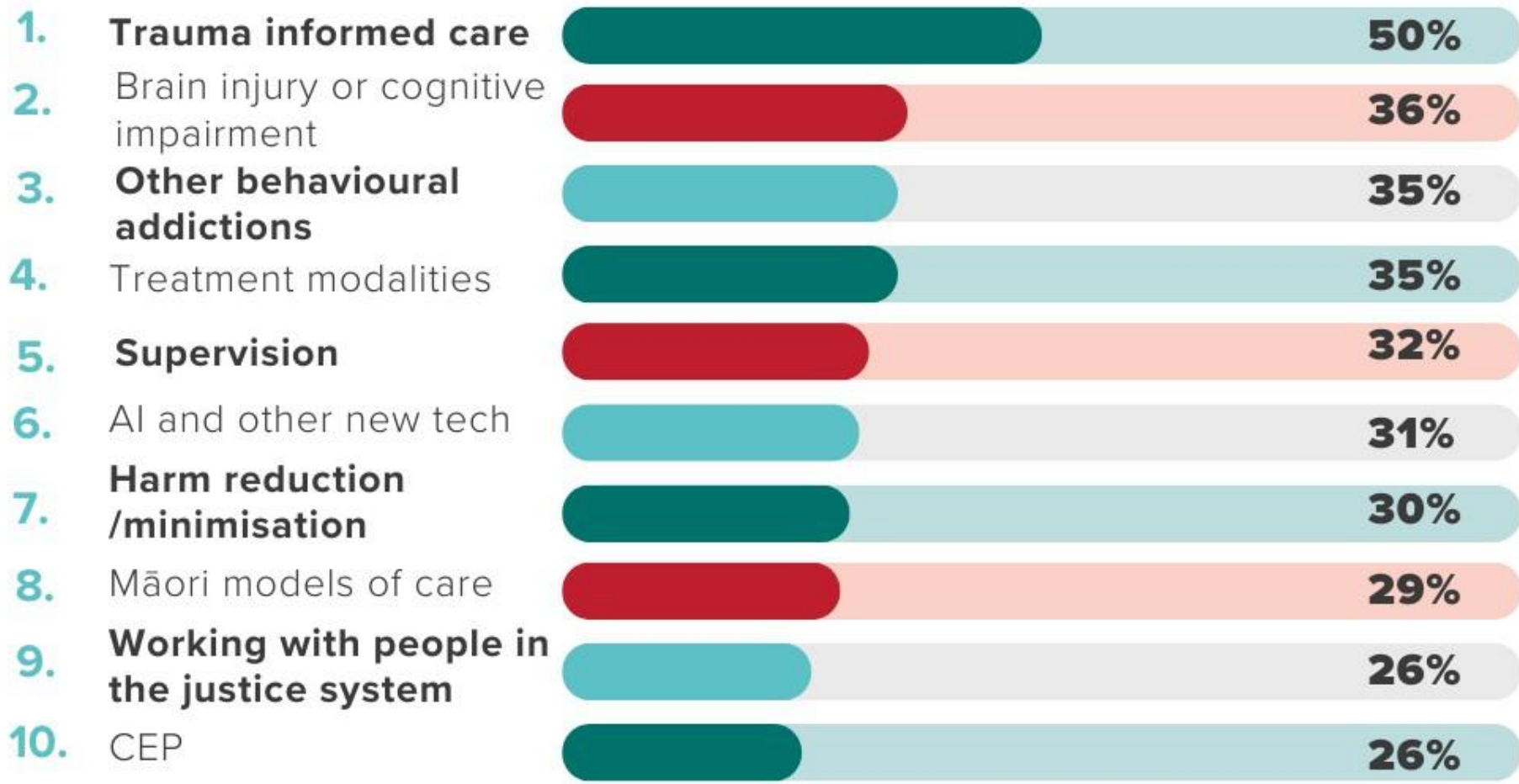
Top 10

TRAINING TOPICS REQUESTED



Peer Support Professional Development series

- **Five half-day online workshops,** delivered by **Ka Rere Te Manu**
- Dapaanz has subsidised this event series to **maximise equitable participation for our peers & endorsed support workers.**
  - Peer support is / Peer support is not
  - Boundaries in peer practice
  - Responding to risk while staying peer
  - Reflective practice and sustainability
  - Peer drift and system pressures

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Provisional Practitioner (Graduate)

- **Advocacy by educators**
- Available for **recent graduates who are seeking employment** within an addiction service and undertaking clinical work.
- **First step** toward becoming a fully registered Addiction Practitioner.
- Once graduates begin working in a clinical role within an addiction service and are supervised by a dapaanz ACS, they should apply for the next stage of provisional registration.
- This next stage is held for a minimum of 12 months and a maximum of 36 months from there they can **work toward meeting the requirements for full registration.**

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Earn as you learn

- The programme offers:
  - Paid employment in an intern addiction practitioner role (at minimum, the living wage, based on 12-months FTE)
  - Funded training for a dapaanz-recognised clinical practice qualification
  - Paid study leave for block courses and assessments
  - Supervised practice and mentoring and structured learning supports

- Internships in this first round are available in the following locations:
  - Northland –Kaitaia and Kaikohe
  - Tair ā whiti, Rotorua, Southern Waikato
  - Hawke' s Bay
  - Invercargill

Earn-as-you-learn

Addiction practitioner internships

- Especially seeking applications from:
  - New entrants to the addiction workforce
  - Students part way through their studies
  - Support and peer workers transitioning into practitioner roles
  - Culturally diverse and Kaupapa M ā ori workforce pathways.

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Membership milestone

- In February this year, the number of members who whakapapa Māori passed 600 for the first time
- We now have 643 Māori members (at 20 July 2026), representing 30% of our membership ~half are registered practitioners
- We offer regular communities of practice online hui for Māori practitioners and also supervisors
- We remain focused on supporting our members to **practise in a way that enhances Māori wellbeing.**

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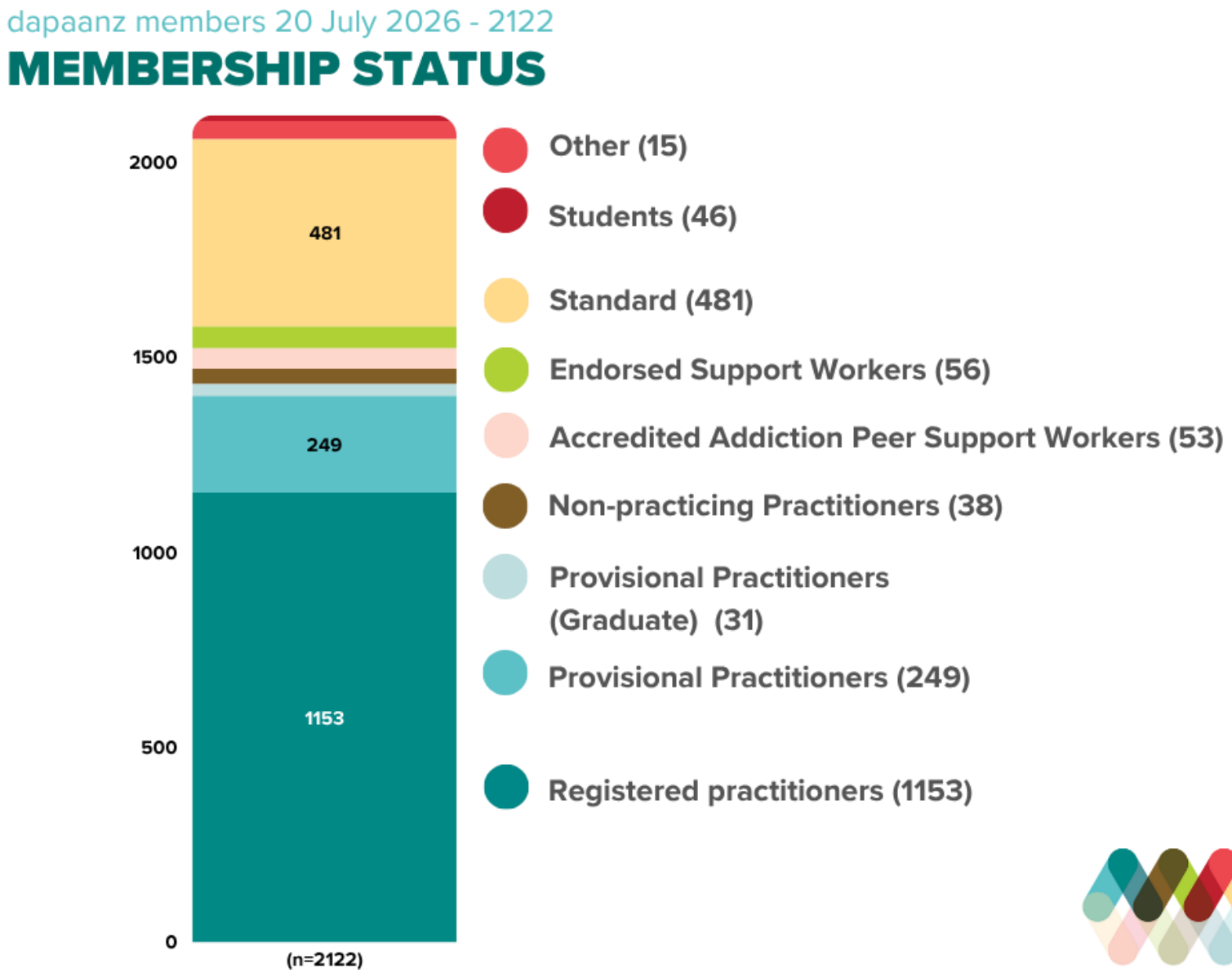
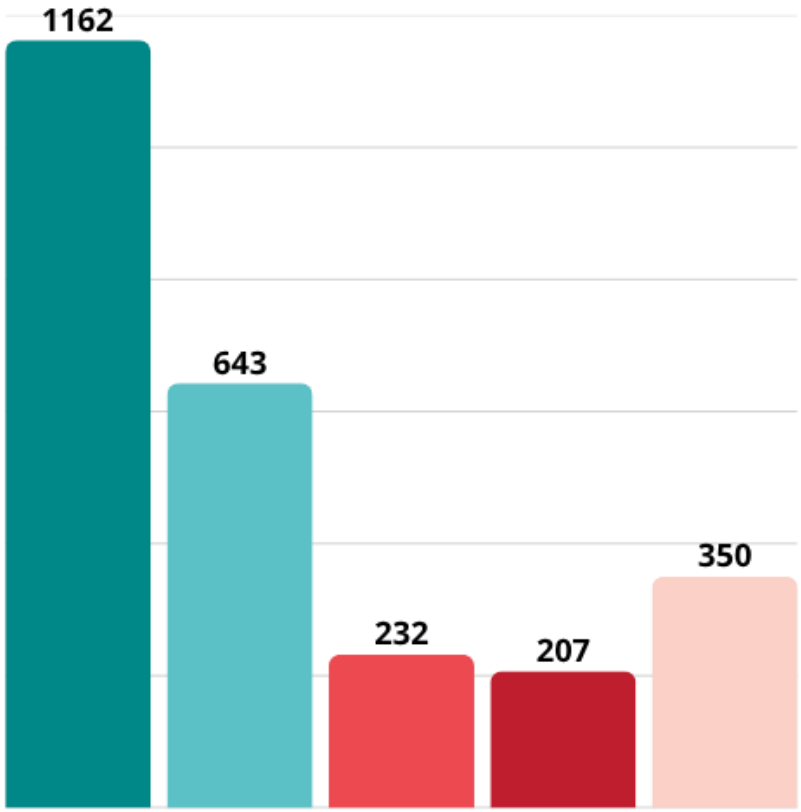
Dapaanz: by the numbers



Dapaanz: by the numbers

dapaanz members, 20 July 2026

ETHNICITY



source: dapaanz member data 15 July 2025, (n=2122)

*members could choose multiple ethnicities

Number of members identifying as

- Pākehā/NZ European
- Māori
- Asian
- Pasifika
- Other

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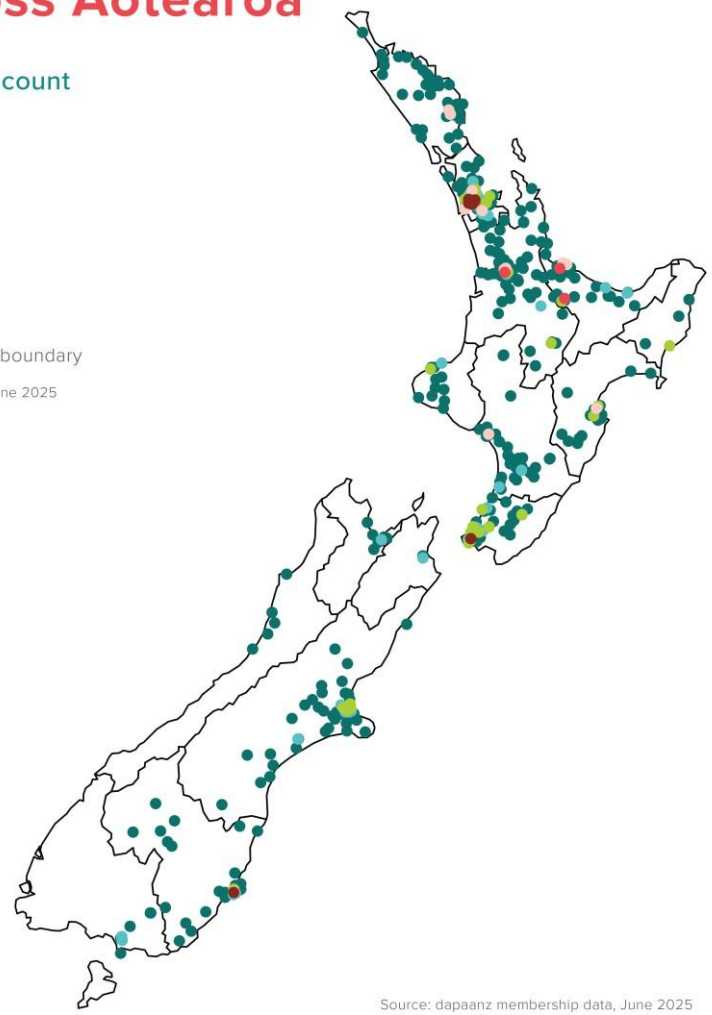
Dapaanz members across Aotearoa

Member count

- 1 - 5
- 6 - 10
- 11 - 15
- 16 - 20
- 21 - 25
- 26 - 32
- Region boundary

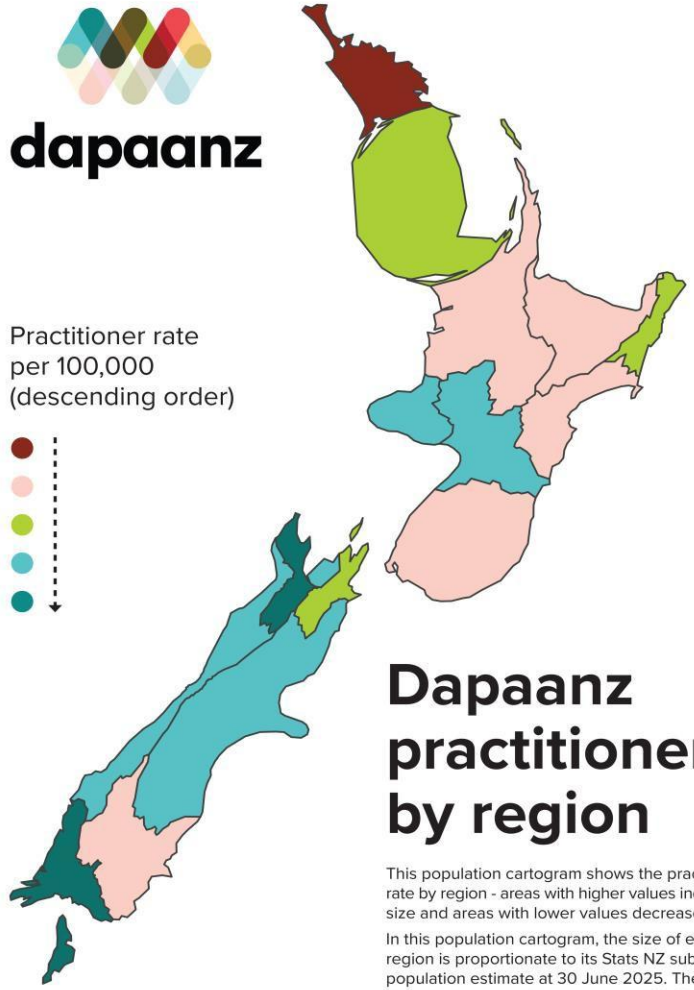
n=1877, June 2025



Source: dapaanz membership data, June 2025

dapaanz

Practitioner rate per 100,000 (descending order)



Dapaanz practitioners by region

This population cartogram shows the practitioner rate by region - areas with higher values increase in size and areas with lower values decrease in size.

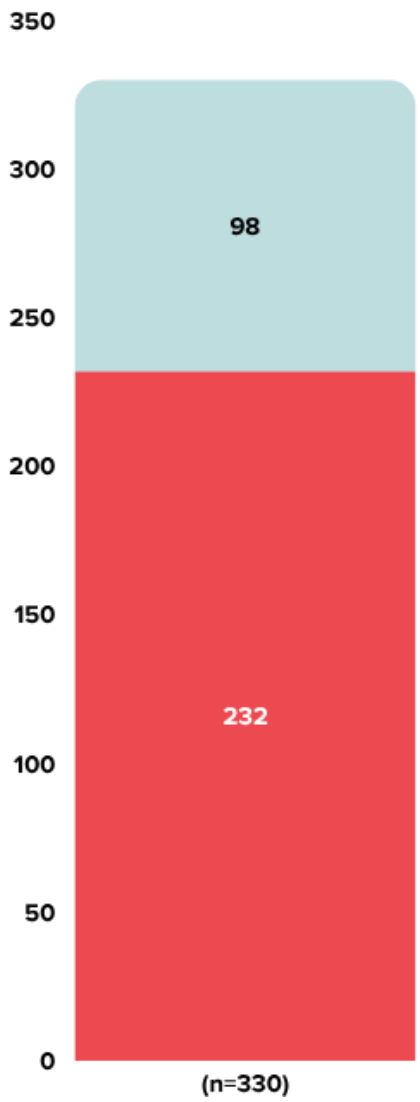
In this population cartogram, the size of each region is proportionate to its Stats NZ subnational population estimate at 30 June 2025. The colours show highest practitioner rate per 100,000 from deep red in Northland through to the lowest rate (dark cyan-teal) in Southland and Tasman.

anz
iction practice

Dapaanz: by the numbers

dapaanz members, 20 July 2026

PRIVATE PRACTICE OR SELF-EMPLOYED*



*Only includes those members who identified as private practice or self-employed on registration or renewal

Registered elsewhere

Registered with dapaanz

*20% of dapaanz-registered practitioners work in private practice or are self-employed

(The number of practitioners working in private practice has increased by 21% since December 2025)

Private practice: recent activity

- Dapaanz Communities | Private Practice zui (3 this year so far)
- Private practice-specific CPD opportunities
- ACC engagement
- Developing private practice guidelines
- MOJ engagement – increase in qualified pracs delivering reports

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In 2027 we turn 25 years old!

- **Evolution of dapaanz** as an organisation and **addiction practice as a profession**
- We are **considering how membership and practice has changed over time**
- **Richness** in education, practice, career development and membership types
- **Join us in celebrating** this important milestone!
- Watch this space!

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Ngā mihi

- **Thank you** to the staff team for their expertise, support and care they extend across their mahi and to members.
- **Biggest thank you** to our members for your professionalism, dedication, and efforts to build the addiction sector
- For **supporting tāngata whai ora, your communities and dapaanz.**

Join us on

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Reducing Methamphetamine Harm in Te Tai Tokerau

Debbie Jordan, System Design Manager PFO, Northern Mentally Well, Mandi Cross, Methamphetamine Harm Reduction Programme, Northern Regional Commissioning, TWO, Maria Baker, CEO, Te Hiku Hauora

National Committee
for Addiction Treatment

Reducing Demand for Methamphetamine Programme

Building an Integrated Recovery System in Te Tai Tokerau

Working together to strengthen prevention, early intervention, treatment and recovery across Te Tai Tokerau.

Health New Zealand
Te Whatu Ora

Te Hiku Hauora

Rākau Ora

Leadership Hui
July 2026

Introduction

Te Hiku Hauora

Maria Baker
Te Hiku Hauora

Te Hiku Hauora

Teina Piripi
Te Hiku Hauora

Rākau Ora

Vanessa Kite
Rākau Ora

Te Whatu Ora
Health New Zealand

Mandi Cross
PFO | Northern | Mental Health & Addiction

From National Strategy to Regional Delivery

The Reducing Demand for Methamphetamine Programme is part of the Government's Methamphetamine Action Plan, building on the strong regional foundations established through Te Ara Oranga to strengthen prevention, early intervention, treatment and recovery across Te Tai Tokerau.

Methamphetamine Action Plan

National strategy to reduce methamphetamine harm through coordinated cross-sector action.

Te Ara Oranga Foundation

Established strong regional recovery partnerships and service integration.

Reducing Demand for Methamphetamine Programme

National investment strengthening prevention, early intervention, treatment, recovery and workforce.

Integrated Regional Delivery

Delivering together across Mid and Far North, Te Tai Tokerau.

Strengthening the pathway of care

STRENGTHENING THE PATHWAY OF CARE

Earlier engagement

Better prepared clients

Improved retention

Stronger step-down pathways

More integrated system response

Improved cultural responsiveness

WHAT THIS MEANS IN PRACTICE

Fewer people falling through the gaps between services, because support is easier to find and access.

More coordinated care around the person and their whānau, with services working together.

Greater support for clinicians through training, specialist input and resources for complex cases.

A pathway that supports recovery beyond treatment, including whānau, housing, wellbeing and connection.

Stronger use of local knowledge and leadership to design solutions that fit our communities.

Better outcomes for tāngata whai ora and whānau, including improved wellbeing and quality of life.

Earlier engagement → **Better access to treatment** → **Sustained recovery**

$4 MILLION INVESTMENT (2026–2029)

What does this look like in Te Tai Tokerau?

Kaitaia

FAR NORTH

- Te Puarangi – Te Hiku Hauora
- Pou Whānau Connector
- Clinical AOD Treatment
- Medical & Specialist Support
- Indigenous Practitioners
- Peer Recovery – Rākau Ora
- Hospital SBIRT + HSS

Kaikohe

MID NORTH

- Te Ara Oranga Expansion – Integrated AOD Recovery Service
- Community SBIRT (HSS)
- Pou Whānau Connector
- Clinical Nurse Practitioner
- Peer Recovery – Arataki Ministries

Stronger together for better outcomes
for tangata whai ora and whānau.

Working Together

Relationships First	Communities at the Centre
Collaborative Partnerships	Shared Expertise
Building on Strong Foundations	Local Leadership
Learning Together	Investing in Local Solutions

Te Hiku Hauora

Corrections – Ongoing Challenges and Evolution

Terry Huriwai, Kaitohutohu Matua, AOD Services Team, Te Ara Poutama

National Committee for Addiction Treatment

Addiction Leadership Day July 2026 - Updates

Community Residential AOD treatment

- We have contracts with seven providers for 38 packages of care.
- Provides prioritised access for 99 individuals over the year.

Challenges include:

- triage and assessment processes; wait-list management;
- Change in referral processes has created challenges contributing to current under-utilisation.
- New service –delays due to required community engagement processes

Addiction Leadership Day July 2026 - Updates

Prison-based AOD treatment or interventions

- AOD Harm Minimisation sessions delivered at 14 sites –2071 people have attended these sessions over the past year!
- Low, moderate and/or high intensity programmes delivered at 15 of the 18 sites –650 people have attended these programmes over the past year!

Challenges include:

- Under-utilisation of low and moderate programmes

Comprehensive AOD assessments – understanding our data

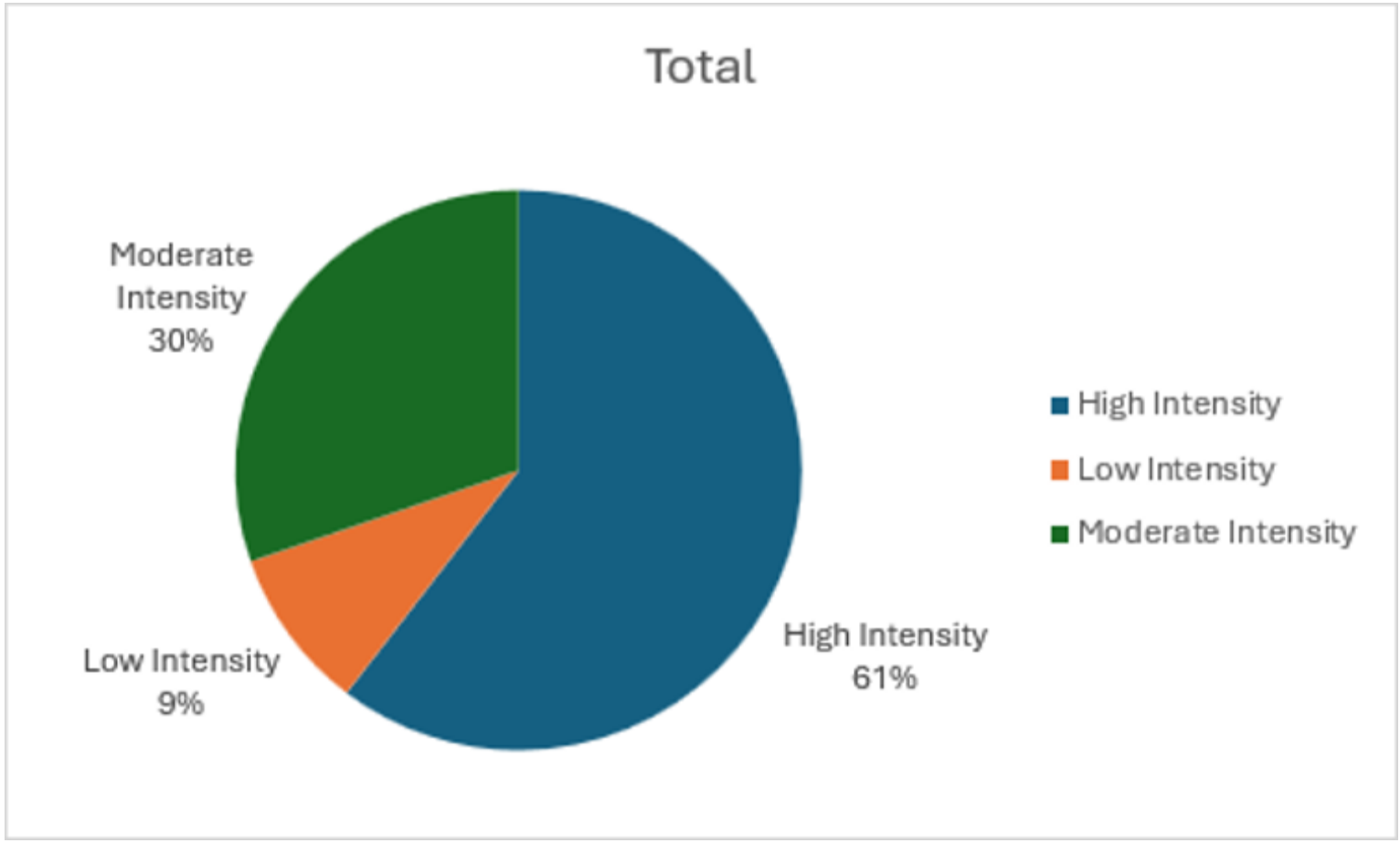
Highlights:

92% of target starts for high intensity

90% completion rates across low, moderate and high intensity

What we have learned:

We need more high spaces



Challenges:

50% of target starts for low intensity

54% of target starts for moderate intensity

What we have learned:

We have too many low and moderate spaces

The future

Prison population	Current (Feb 2026)	1-yr projection (June 2027)	5-yr projection (June 3031)	10-yr projection (June 3036)
Remand	4,677	4,900	5,700	6,900
Sentenced	6,563	7,100	8,200	8,300
Total	**11,240**	**12,000**	**13,900**	**15,200**

- Fewer cases are projected to come to court, but cases are projected to become more serious
- Although women make up a smaller portion of the prison population than men, the number of women entering remand has continued to increase over the last year and is projected to increase by 82% over the next 10 years.
- Average time spent in remand has increased substantially over the past two decades, from around 44 days in 2005 to approximately 91 days currently.
- Time in remand is projected to increase by 24% over the next 10 years to approximately 110 days by 2036.
- No treatment options currently available in remand due to transient nature of remand.
- People being convicted whilst in remand but then released on time-served.

Remand population – challenges and opportunities

Challenges:

- How do we provide treatment that matches people's identified need when we don't know until they are sentenced, how long they will stay in prison?
- Can we provide treatment when people are only accused of the crime, not convicted?

Opportunities:

- Innovative solutions.
- Health promotion, harm reduction, *and* options for assessment and treatment as required.

National Committee
for Addiction Treatment

Closing Remarks and Evaluation

National Committee
for Addiction Treatment

Whakakapē | Closure and farewell