How New Zealand has supported people with addictions has changed

Write other important markers on this timeline

Did you know that providing treatment and support for people experiencing addictions is a relatively recent addition to New Zealand's history?

This timeline is a selection of events and legislation that have changed how New Zealand supports people with addictions.

It outlines our attempts to use only fines and imprisonment to make people change, our history of prohibition areas, the changes in the ages and ethnic groups that were most impacted by alcohol and other drugs, the emergence of new models in the 60s and 70s to address the new drugs coming into our shores, and the creation of addiction treatment as a specialist sector.

Our sector has always seen health approaches as the best way to support people with addictions. Over 100 years of effort from organised groups of passionate people have got us to where we are now. And the journey continues.

This is our story.

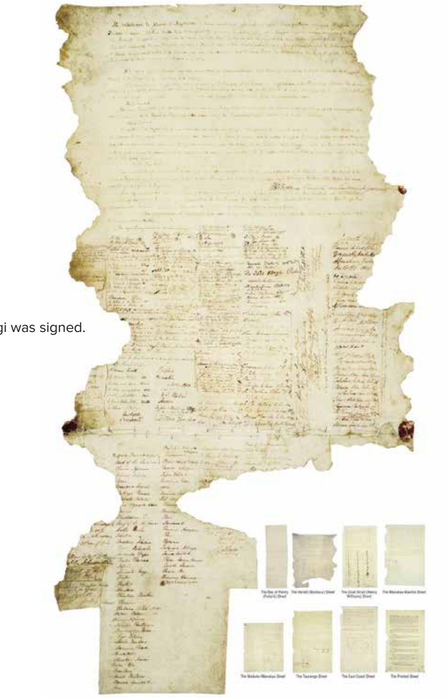
1800

Early 1800's
A British Issue
"There is sufficient information to recognise that in New Zealand for almost as long as there has been European settlement there has been some use of drugs to the point of dependence and abuse."

"drunkenness was a major social characteristic of the young British colony. Not until 1870 did drunkenness comprise less than half of all causes of convictions. However, in the 264 cases of drunkenness brought before the Police and Magistrate's Court at Wellington for the period 1844-48, only one was for "Natives". The court records note that, "The native population is remarkably free from drunkenness – indeed from any use of ardent spirits"."

1834
A Temperance Society was formed in the Bay of Islands to promote abstinence from alcohol. The site where many new settlers were based.

1840
Te Tiriti ō Waitangi was signed.



1842
A regulated market for alcohol
New Zealand's first liquor licensing system was introduced. People who were 'disorderly drunks' could be arrested, tried, and fined or imprisoned for up to two days.

1856
A group of Waikato and Waipa chiefs sent the following letter to Parliament:
"This is our word to you – do not let any intoxicating drinks come to this land to Waipa, but let it be kept there [Auckland] at the inns. Let the Maori law, which has been asserted to by all the chiefs of this place [Waipa] and Waikato, be sacred, namely that the Natives be not allowed to drink spirits … This [alcohol] is the worst thing hitherto brought to New Zealand … we have determined, therefore, not to allow it to be used."

1866
Opium is added to the regulated market
Sale of Poisons Act laid down the conditions of sale and included opium (mentioned as opium laudanum, which had been used as a tincture for pain relief and as a sleeping aid).

1866
Punishing the habitual drunkards
The Vagrant Act introduced the term habitual drunkards – someone who had been convicted of drunkenness three times within twelve months. They could be imprisoned with or without hard labour for up to three calendar months.

1871
Registering people who can sell poisons
Sale of Poisons Act established a process to register who could sell 'poisons'.

1884
New Zealand's alcohol prohibition areas
Alcohol was prohibited in the King Country area after a Ngati Maniapoto petition requested the ban. This ban lasted until 1954.

1901
No search warrants required if the premises are occupied by Chinese
The Opium Prohibition Act 1901 specified that a search warrant could be requested if there was suspicion that opium was being smoked in a premises, but that "search warrant shall not be required in the case of any entry on premises occupied by Chinese."

1906
Just fining and imprisoning doesn't help people change. Another option is created
The Habitual Drunkards Act aimed to make better provision for the care and detention of habitual drunkards. It essentially was a three strikes law, where 'habitual drunkards' (now classified as three convictions of drunkenness within nine months) could be committed to an institute for proper care and detention (not less than 12 months unless the Governor directed an earlier discharge). Escape from this institution would be treated the same as escape from prison.

1907
Our first residential centre
The Salvation Army opened an Inebriates' Retreat on Pakatoa Island. This was negotiated between the Salvation Army and the Government to be the first institution for the treatment of people under the Habitual Drunkards Act.

1908
New Zealand's first consumer protection legislation for drug information
The Quackery Prevention Act made it illegal to publish false information about whether a drug was effective at treating health conditions or not. This also suppressed the practice of Rongoā Māori.

1909
Avoid the stigma of a conviction by volunteering yourself for detention
The Reformatory Institutions Act 1909 made provision for the establishment and control of reformatory institutions for the reception and detention of habitual inebriates and of fallen women. People could now avoid the stigma of being convicted by volunteering themselves for detention in an inebriates home (or having a relative volunteer them).

Under this act people could be ordered to be detained in an Inebriates Home, and "any woman or girl who is or appears to be over the age of fourteen years" could be ordered to be detained in a Reformatory Home without consent if there was evidence or testimony that she was "a common prostitute or habitually leads an immoral life."

1911
Our first women's residential centre
The Salvation Army opened the Rotoroa Sanatorium on Rotoroa Island (previously Ruthe's Island). Negotiations to acquire the island began in 1908 when the facilities on Pakatoa Island became full. The programme on Pakatoa Island continued to operate, and with the men on Rotoroa Island, it was now able to house women.

1927
Regulating drugs that used to have free reign as over-the-counter medicines or home-made remedies.
Dangerous Drugs Act was introduced to "regulate the importation, exportation, manufacture, sale, distribution, use, and possession of certain dangerous drugs." This included opium, diacetylmorphine (heroin), coca-leaf, and Indian hemp (cannabis).

1946
A new option
Alcoholics Anonymous was brought to New Zealand, with the first groups happening in 1947.

1947
Tightening up prescriptions and exploring substitution therapy
The Drug Supervisory Board of the United Nations asked New Zealand for an explanation about why heroin consumption was increasing at a fast rate. NZ was reported to be the third or fourth highest country in the world for consumption of heroin per capita. Investigations suggested that this was due to high prescription rates and lack of monitoring or control over prescriptions. As greater control over prescriptions was explored, medical practitioners were invited to use another drug as a substitute to help people overcome a narcotic dependence.

1951
The schedule of Dangerous Drugs expands and people with addictions are recorded on a register
The Dangerous Drugs Regulations allowed a medical officer of health to prohibit a named person from obtaining or seeking to obtain any dangerous drugs (now a wider schedule than in the Dangerous Drugs Act 1927)

1953
New horizons – alcoholism can be treated and is a public health problem
The National Society on Alcoholism was created to increase public understanding that alcoholism can be treated and is a public health problem, and to establish or promote better support facilities and education.

1956
The momentum builds – A call to change outdated and counterproductive penal approaches and move to a more compassionate, treatment orientation
Conference on the care of alcoholics and the need for more modern policy towards them was convened by the Minister of Justice (he was also the former Minister of Health). Several resolutions and programmes emerged that aimed to change attitudes away from a penal approach towards a more compassionate, treatment orientation.

The conference declared that the penal provisions of existing legislation were outdated and counter-productive to getting alcoholics into effective treatment.

1959
The Salvation Army's first mainland Bridge programme was opened in Wellington.

1962
New positions to prevent drunkenness – the Māori wardens
The Māori Community Development Act created the positions of Māori Wardens. A large part of their role and the legislation that give authority to the role is preventing drunkenness.

1963
Cannabis was found at the scene of Auckland's Bassett Road murders, entering NZ's criminal records for the first time and prompting Deputy Police Commissioner Robert Waton to say, "Marijuana is the thin edge of a revolting wedge into the vice underground, a trade that festers deep in the social flesh but leaves little mark on the surface."

1965
People who deal and people who use substances are differentiated
The Narcotics Act 1965 followed a United Nations approach that distinguished between dealing and possession of substances.

1966
New approaches – Hospitals provide more support
The Alcoholism and Drug Addiction Act came into force. This act was "to consolidate and amend the Reformatory Institutions Act 1909 and its amendments, and to make better provision for the care and treatment of alcoholics and drug addicts." This provided for compulsory treatment of "drug addicts" in designated institutions. The Department of Health indicated that Oakley Hospital in Avondale was intended to be the designated institution of choice with special security accommodation for this group. The medical superintendent of five other hospitals (Kingseat, Tokanui, Porirua, Sunnyside, and Seacliff) could also accept a person under this act.

1967
The Sale of Liquor Amendment Act extended the closing time for licenced premises from 6PM to 10PM, abolishing the "six o'clock swill".

1969
Narcotics Anonymous became available in New Zealand, instigated by James K. Baxter.

Write other important markers on this timeline

A snapshot of the addictions sector in 1970

Several "striking and highly significant changes" occurred in drug use in NZ in the 1960s. Aside from alcohol, there had been few noticeable problems from other drug use in the mainstream population in New Zealand. Opium was seen as a distinct problem among Chinese immigrants, who were dealt with differently under the law.

The Department of Health reviewed what was happening and made several recommendations, including that "facilities be provided for the adequate assessment of all those charged with drug offences, and that all those charged on whom no recent assessment is available be referred for assessment before their case is determined by the Court."

Here are some quotes and graphs from the report:

"For as long as records have been kept by the Department of Health, well over 90 percent of the "known addicts" have been over 35 years of age, and women have predominated among them. Since 1964, however, the percentage under 25 has increased slightly…and the sex ratio has been reversed."

"Excluding the Chinese opium smokers, the large majority of drug abusers who now come to official notice in New Zealand are New Zealand born Europeans. While a few Maoris, other Polynesians, Chinese, and European immigrants are involved, their numbers are at present small and proportionately not significantly higher than in the population as a whole."

"At present there appears to be comparatively little trafficking or "pushing" drugs for profit, and that little is mostly unorganised and on an individual basis. The younger users in particular share what they have, on the understanding that the recipients return the favour later. The more deeply committed users take care to have a reserve supply hidden away against times of shortage."

"To date any increase in crime as a result of drug abuse has been confined largely to forgery of prescriptions and to burglary of places where drugs are held. As yet comparatively little crime can be traced to drug abusers seeking money to pay for their habit."

"Drug abuse is essentially a human problem, with effects on both individuals and society as a whole. To deal with it justly and effectively it is necessary to know and understand not only the properties and effects of the drugs but as much as possible about the people involved; to try and see through their eyes and listen to what they have to say."

"We feel that it is desirable that the police should continue to exercise discretion in dealing with drug offenders who, not being involved in any other crime, have come under their notice. This may arise when parents or some responsible persons seek advice from the police, or when a drug taker has volunteered for medical treatment, and is under an acceptable form of control or is no longer involved in the misuse of drugs. It is essential that parents, or drug offenders themselves, can seek advice for the rehabilitation of a user without fear or unnecessary repercussions."

"The Committee notes with approval that psychologists and social workers are participating increasingly, along with doctors, in the assessment situation, and recommends extension of this move. It considers that there is need for the provision of more assessment facilities outside hospitals in centres other than Auckland."

"Particular attention needs to be given to the problem of dealing with the large number of drug abusers who have not yet developed any 'degree of dependence but are either on the way to or in danger of doing so. Abusers in this category are not usually considered to require 'hospital treatment, especially in view of the pressure on hospital accommodation. Their main needs are counselling, sometimes but not necessarily from a physician or general practitioner with qualifications, experience or interest in psychological medicine, and help with personal problems, especially finding something to take the place of drugs in their lives. While existing counselling centres have already proved their value in dealing with abusers of this type, they are limited in number and size, they can deal only with those who come or are brought to them, they have no supervisory powers, and they are severely restricted in their capacity to follow up cases. To 'meet this particular need, the existing centres should be encouraged to extend their work, and others established, first in Wellington, and later in Christchurch."

"It is not necessary to accept that the overall misuse of drugs must increase in New Zealand, but it would be reckless to assume that the problem can be contained at about its present level simply by strengthening the present measures of control and treatment along the lines recommended in this report. This assumption completely ignores the importance of the psychological and social factors which have contributed towards the recent upsurge in serious drug misuse, and which must be expected either to remain as potent in the foreseeable future as they have been over the past few years or to grow in importance."

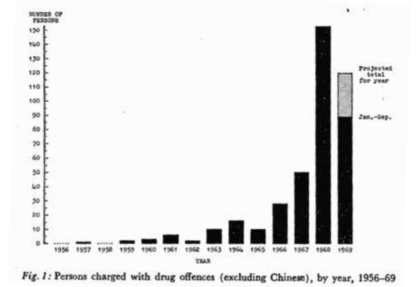


Fig. 1: Persons charged with drug offences (excluding Chinese), by year, 1956–69

1972
Opioid Substitution Therapy is available
Wellington and Christchurch methadone clinics established.

1972
The Salvation Army opens the Bridge programme in Parnell, Auckland.

1975
Drugs are grouped into three classes
The Misuse of Drugs Act updated the Narcotics Act 1965 and aimed to make further provision for the prevention of misuse of drugs. It introduced three classes of substances Class A, Class B, and Class C.

1975
A peer voice
An addiction and consumer peer group was formed in Christchurch to "improve treatments and services and to provide low-level support for consumers in hospital receiving alcohol and other drug service."

1976
ALAC is created, which facilitates the development of many services.
Following a report by the Royal Commission of Inquiry into the Sale of Liquor, the Alcohol Advisory Council was set up. It's primary objective was "the encouragement and promotion of moderation in the use of liquor, the discouragement and reduction of the misuse of liquor, and the minimisation of the personal, social, and economic harm resulting from the misuse of liquor." The council's activities were funded by means of a levy on liquor imported into, or manufactured in, NZ.

1978
Mason Durie joined the Alcohol Advisory Council and was the first person on the council representing Māori.

1979
Aspell House opened.

1980
Alcoholism services are now available in a third of New Zealand hospital boards
10 out of the 29 hospital boards had services established to treat alcoholism.

Early 1980's
Creating a movement to create better support for Māori
The South Auckland Alcohol and Drug Committee was formed - a small group of Māori people with an interest in alcohol and other drug issues. Te Ara Hou (NZ's first Māori residential AoD treatment service) and Te Atu Rama (a residential programme for women) emerged from this group.

1982
The Māori Support Group was established at Queen Mary Hospital.

1984
ALAC established a National Māori Coordinator position to support better Māori responsiveness within the AoD treatment sector.

Mid 1980's
Social activism creates our first community harm reduction service
The Needle Exchange Programme was generated through social activism, supported by a number of pharmacists. The legislation to allow these services to legally occur was enacted in legislation in 1987.

1985
The movement builds – national networks facilitate Māori development within AoD services
Te Ara i Rauhanga was established. This was a national network to connect centres of excellence for Māori development within AoD services.

Late 1980's
ALAC supported the development of several new AoD treatment services

Creating professional training in alcohol and other drug studies
Central Institute of Technology (CIT) began providing a level 5 Certificate in Alcohol and Drug Studies.

1987
Moana House opens in Dunedin

Kua Makona campaign released. This can be considered one of the first Māori specific alcohol resources.

1988
Te Utuhina Manaakitanga Trust opened in Rotorua, driven by concerns from the Māori community about the closure of local hospital-based services.

1988
The law catches up
An exemption in Section 13 of the Misuse of Drugs Act 1975 was added to permit the possession of needles that were obtained through authorised needle exchange programmes.

Organising support for Problem Gambling begins
The Compulsive Gambling Society (later became the Problem Gambling Foundation) is established with funding from the NZ Lottery Grants Board.

1990
Te Aroha Hau Angi Angi – the Taha Māori programme at Queen Mary Hospital was established.

1990 -
A shift towards community services
A number of residential facilities close.
Bridge Haven, Upper Hutt, 1994
Miranda House, Stratford, mid 1990s
Aspell House, Plimmerton, late 1990s
Clairmont House, Timaru, late 1990s
Belmont, Nelson, late 1990s
Queen Mary, Hanmer, 2003
Queen Mary Taha Maori, 2003
NSAD, Marton, 2003
Argosy House, Auckland, 2004
Kahunui, Opotiki, 2005

1992
Ara Te Whakaaro Pai programme opened in Te Tai Tokerau. It did not remain open for long, but helped the Northern AOD network Ngā Manga Puriri to be established.

Gambling support is available.
The Compulsive Gambling Society launches a telephone service.

1993
Oasis centres for gambling addiction opened

1995
Nga Punawai Aroha programme was established. This was a specific approach for Māori within the Hawkes Bay Addiction Service.

1996
A new centre to improve treatment and prevention
National Centre for Treatment Development (now the National Addictions Centre at the University of Otago) was established to improve the treatment and prevention of addiction and related problems for people in New Zealand.

The first Cutting Edge conference
The National Addictions Centre hosted the first Cutting Edge conference and continued to do so until handing the conference over to dapaanz in 2009.

1998
A degree in Alcohol and Drug Studies
A bachelor in Alcohol and Drug Studies first started to be taught at CIT (which became WelTec). Students could exit with qualifications throughout this training with a level 5 Certificate in Alcohol and Drug Studies, level 6 Diploma in Alcohol and Drug Studies, or complete the whole Bachelor's degree.

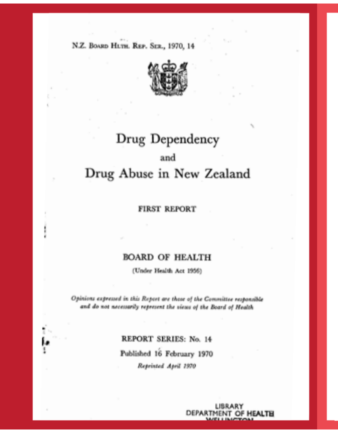
1999
Dedicated roles for consumer advisors
The Health Funding Authority contracted the Christchurch Community Council on Alcohol and Drugs to create a dedicated consumer advisor position.

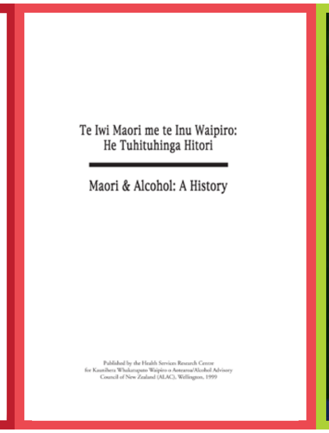
2000
Te Ātea Marino established in the Auckland region.

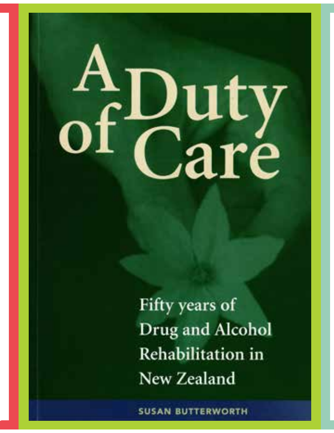
2001
Waitemata District Health Board created a position for a dedicated consumer advisor

The beginnings of a formal addictions workforce
Practitioner competencies for alcohol and drug workers in Aotearoa New Zealand were developed by the sector and released.

For more information check out the source material!







2002
A new professional association
dapaanz was established to oversee the practitioner competencies and promote excellence in addiction practice. Members were first invited to join at the Cutting Edge conference in 2002

The CADS Auckland Consumer Team is created

2004
Ethical practice is formalised
The Code of Ethics for alcohol and other drug workers was created and reviewed by the sector throughout 2004. A final version was released in 2005.

Addiction practitioners can become registered
A registration process for alcohol and other drug practitioners that was based on the practitioner competencies and code of ethics was launched.

An addiction workforce programme
The Ministry of Health contracted the National Addictions Centre to lead a National Addiction Workforce Development programme. Matua Raki developed out of this.

Co-ordinating action
The National Training Providers Network was established to provide a forum for addiction training to connect and develop across New Zealand. Matua Raki created the National Treatment Forum (now called the National Committee for Addiction Treatment, NCAT).

2005
The Salvation Army's Rotoroa Island programme closed.

Organising professional development for the addictions workforce
The Addiction Summer Schools started. These were led by Joel Porter with the support of Matua Raki and later were hosted by dapaanz.

2007
The Deputy Director-General of the Mental Health Directorate in the Ministry of Health wrote to all the District Health Boards endorsing dapaanz registration, stating that the registration "should provide DHBs with the assurance that their addictions practitioners are working within nationally recognised competency guidelines" and cautioning against interpreting the Health Practitioners Competency Assurance Act as meaning that all health care must be provided with direct oversight of a health professional registered under that act.

Increasing development of peer support
Counties Manukau Alcohol and other Drug Consumer Network is created. This network facilitated the development of many peer support groups.

2008
Creating a Pasifika workforce
Le Va was established as the Pacific-focused workforce development programme within Te Pou ō te Whakaaro Nui.

2010
Problem gambling practitioners were invited to register under dapaanz.

2011
The Addiction Intervention Competency Framework was released after development and consultation with the sector. This replaced the 2001 practitioner competencies, and included specialist competencies for problem gambling, alcohol and other drug, and smoking cessation workers.

dapaanz introduced a process for recognising the contribution of Kaumatua to the addictions sector.

2014
Peer workforce competencies developed
Te Pou led a process to develop competencies for a new part of the sector – the peer workforce.

2017-18
Updated legislation
The Substance Addiction (Compulsory Assessment and Treatment) Act was launched. This enabled people to receive compulsory treatment if they have a severe substance addiction and their capacity to make decisions about treatment for that addiction is severely impaired.
The Ministry of Health approved dapaanz registered practitioners as Health Professionals and therefore able to apply to be Approved Specialists under this act.

2018
The Waitangi Tribunal commissions historian Barry Rigby to prepare a report on issues of alcohol, tobacco and substance abuse for Māori. This report is due on the 30th of August 2019.

Addiction should be viewed as a health and social issue.
He Ara Oranga – the Report of the Government Inquiry into Mental Health and Addiction is released. Among other recommendations, this calls for addiction to be viewed as a health and social issue that requires care and support, acting on recommendations to reduce the impact of harmful alcohol use, and replacing criminal sanctions for the possession of drugs with civil responses (e.g. treatment).

2020

What does the future hold?

dapaanz
fostering excellence in addiction practice