National Drug Policy

2006–2011

Consultation Document

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How to Have Your Say

Your feedback is important in helping to develop the *National Drug Policy 2006–2011*. Please take this opportunity to have your say. You can provide comment by making a submission on your own behalf or as a member of an organisation. The final paper will be released after the consultation and analysis of submissions.

The Ministry welcomes all feedback. There are some key questions we would like you to think about and comment on. These questions are found on detachable pages at the back of this document.

There are three different ways you can make a submission.

1. Write down your comments on the detachable form at the back of this document and post them to:
   National Drug Policy
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2. Download the submission form in Word format from http://www.ndp.govt.nz, save it to your computer, fill it in and email it to: ndpreview@moh.govt.nz

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All submissions are due by 5 pm, Friday 9 June 2006.

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Introduction

New Zealand's National Drug Policy sets out the Government's policy and legislative intentions for tobacco, alcohol, illicit and other drugs for the period 2006 to 2011. This document builds upon the *National Drug Policy 1998–2003*, which was the first national policy document to consider all these substances within a single framework.

This document is a framework for identifying where the greatest drug-related harms are occurring and for guiding intersectoral decision-making about the best means for addressing those harms. The National Drug Policy for 2006–2011 is intended to aid government agencies and non-governmental organisations (NGOs) alike in developing organisational and intersectoral work programmes and action plans.

The second National Drug Policy has a strong intersectoral focus, which helps bring together health, justice, social development and education agencies that are working to a common goal. A number of specific strategies operate under the general auspices of the National Drug Policy.

- The *Crime Reduction Strategy*, by the Ministry of Justice, has an objective targeting organised crime, which relates in part to the production and sale of illicit drugs.
- The *Safer Communities: Action Plan to Reduce Community Violence and Sexual Violence*, also published by the Ministry of Justice, has alcohol-related violence as one of four major priorities.
- *Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand Mental Health and Addiction Plan*, a Ministry of Health document, includes the objectives of improving addiction services and the management of addiction and co-existing mental health problems.
- *Health and Physical Education in the New Zealand Curriculum*, published by the Ministry of Education, requires schools to provide students with opportunities to learn to make informed, health-enhancing decisions about drug use and misuse.
- *Strategy to Reduce Drug and Alcohol Use by Offenders 2005–2008,* by the Department of Corrections, has created a specific strategy to minimise harm related to drug use by offenders.
- *Youth Health: A guide to action*, a joint Ministry of Health and Ministry of Youth Development document, identifies tobacco, alcohol and drugs as specific health risks for young people.

Drugs defined

Reference to "drugs" in this policy is intended to cover a broad base of substances with psychoactive effects. These substances are divided into four categories: tobacco, alcohol, illicit and other drugs. Tobacco and alcohol are self-explanatory. "Illicit drugs" are those that are classified as a controlled drug under the Misuse of Drugs Act 1975, including some pharmaceuticals that can be used for psychoactive purposes. "Other drugs" are substances that may be regulated by the Misuse of Drugs Act, for example benzylpiperazine (BZP), which is covered by the Restricted Substances provisions. The term also includes products that are manufactured and marketed for domestic or industrial purposes but are capable of being used to achieve a psychoactive effect.

Overarching goal

To prevent and reduce the health, social and economic harms that are linked to tobacco, alcohol, illicit and other drug use.

Drug-related harm

Drug use can harm virtually every aspect of people's lives.

Drug use can result in harm to health, including death, illness, disease, mental health problems and injury. Harms may be chronic, such as depression or heart disease, or they may be acute, such as injuries from falls or car accidents.

Social harms are also associated with drug use. They can include interpersonal violence, family and relationship breakdowns, and child neglect. In addition, the use of illicit drugs inherently involves individuals in criminal activity. Of particular concern are situations where users commit property crime or supply illicit drugs to support their habit.

Economic harms can be the costs of health services, property damage, low productivity and work absenteeism.

As well as affecting the individual user, drug use harms the family and the community in which the individual lives. For example, alcohol use may be associated with domestic violence, and injecting drug use may result in blood-borne viruses spreading into the community as a whole.

Objectives

The following objectives have been identified for the second National Drug Policy to achieve the overarching goal:

- to prevent or delay uptake of tobacco, alcohol, illicit and other drug use, particularly in young people
- to reduce the prevalence of tobacco smoking, consumption of tobacco products and exposure to second hand smoke
- to reduce the risky consumption of alcohol
- to prevent or reduce the use of illicit drugs and other harmful drug use
- to minimise alcohol and other drug-related crime, crashes and anti-social behaviour, as well as associated injuries and other types of victimisation
- to reduce the availability of illicit drugs in the community by reducing the levels of importation, manufacture, cultivation and distribution of both illicit drugs and precursor substances
- to suppress the involvement of organised and transnational criminal groups in existing drug markets, and to stymie their involvement in any new drug markets
- to improve the quality of, and access to, alcohol and other drug treatment services
- to expand and refine data collection to support research into the size of the drug problem and emerging drug trends, and to create an evidence base for policy interventions and decision-making for service provision
- to strengthen links among government agencies, experts and NGO groups, and international organisations in the development and implementation of drug-related strategies and action plans.

Agencies will use these objectives to guide planning and prioritising in their work to prevent and reduce drug-related harms.

Harm minimisation

Drug policy in New Zealand is based on the principle of harm minimisation. The goal of harm minimisation is to prevent or reduce the harms related to the use of tobacco, alcohol, illicit or other drugs.

A harm minimisation approach does not condone harmful or illicit drug use. The most effective way to minimise harm from drugs is not to use them. The harm minimisation approach does recognise that where eliminating high-risk behaviours is not possible, it remains important to minimise the personal, social and economic costs associated with those behaviours. The aim of harm minimisation is to improve health, social and economic outcomes for the individual, the community and the population at large. It encompasses a wide range of approaches, including abstinence-oriented strategies and initiatives for people who use drugs.

Strategies that support the overarching goal of harm minimisation can be divided into three groups or "pillars": supply control, demand reduction and problem limitation. A combination of all three of these approaches should be implemented to achieve the overarching goal.

Supply control

Supply control strategies attempt to prevent or reduce harm by restricting the supply of drugs. For licit drugs, supply control will relate to restricting the circumstances in which these substances can be legally sold, supplied or consumed. For illicit drugs, supply control strategies focus on controlling New Zealand's borders to prevent drugs being imported into the country and shutting down domestic drug cultivation, manufacturing, trafficking and selling operations.

Demand reduction

Demand reduction involves a wide range of activities that aim to reduce individuals' desire to use drugs. The focus for harm reduction is on initiatives that aim to delay or prevent uptake, encourage drug-free lifestyles or create awareness of risks involved with drug use.

Problem limitation

Problem limitation seeks to reduce harm from drug use that is already occurring. This group of strategies includes emergency services and treatment for problematic drug use and dependence. Some problem limitation interventions do not seek to eliminate or reduce drug use in the short to medium term but instead aim to reduce the related harm to the individual and community. An example of this kind of intervention is the needle and syringe exchange programme, which aims to prevent the spread of blood-borne viruses among the injecting drug using population and into the general community.

Recent achievements

A number of important advances towards achieving the overarching goal of preventing and reducing harm were made over the life of the first National Drug Policy. It should be noted that the initiatives described below are not intended to be a comprehensive report of those advances. Rather they are examples of recent achievements that have occurred under the auspices of the National Drug Policy.

The Smoke-free Environments Amendment Act 2003 placed further restrictions on the retail display of tobacco products and banned tobacco smoking from all indoor workplaces, including restaurants and bars. The primary goal of the legislation is to prevent the health harms caused by tobacco smoking and exposure to second hand smoke.

Fifteen new Community Action on Youth and Drugs (CAYAD) programmes were established throughout New Zealand in 2004 by the Ministry of Health. CAYADs involve partnership with communities and aim to address the harm from drugs experienced by young people. These programmes operate by increasing informed debate on drug issues, promoting safe behaviours, identifying or developing best practice programmes for school and student needs, and forging alliances among key community organisations.

The Effective Drug Education project commenced in 2002 and has been led by the Ministry of Youth Development. The project aims to identify best practice for alcohol and drug education for young people, families and communities that not only raises awareness but also results in sustained behavioural change. A literature review and analysis was undertaken and two booklets, *Strengthening Drug Education in School Communities* were produced in 2004 with principles of best practice for the design, delivery and evaluation of school-based drug education.

The Alcohol Advisory Council received an increase in its annual funding in 2004 to run a large-scale social marketing campaign with the goal of changing the culture of drinking in New Zealand. The campaign is intended to run for at least five years, and is targeted at all adult New Zealanders, with the aim of encouraging people to take greater responsibility for their drinking.

The National Drug Policy – The Next Five Years

Policy foundations

The general principle of harm minimisation and the balance of supply control, demand reduction and problem limitation strategies found in the first National Drug Policy continue to be sound and relevant to the current policy and operational environment. Accordingly, much of the previous National Drug Policy has been carried over into this second National Drug Policy.

The co-ordinating mechanisms established during the first National Drug Policy – the Ministerial Committee on Drug Policy (MCDP) and the Inter-Agency Committee on Drugs (IACD) – will continue (see the appendix for further details). The Ministry of Health will continue its secretariat role for these groups. As well, the Government intends that the National Drug Policy will continue its role as the umbrella document to guide agencies in their responses to drug-related harm.

Moving forwards

Drug policy in New Zealand has developed and matured since the first National Drug Policy was published in 1998. Consequently, the focus has been changed in some ways, and new planning mechanisms have been created. The strategy objectives have also been reviewed and, in some cases, updated to reflect new evidence and changes in the social and political environment.

Planning processes

The Government intends to issue a companion document containing more detailed information on prevalence and patterns of drug use and the related health, social and economic harms experienced by the population. In addition, it is envisaged that a number of action plans identifying specific targets and indicators will be developed under this policy. These action plans may be substance-based or related to a particular target group or setting, or may be generic. The MCDP will determine the focus and priorities of the action plans, which will be developed and monitored by IACD agencies.

Stronger intersectoral focus

The first National Drug Policy had a strong emphasis on health objectives and approaches to addressing the harms arising from tobacco, alcohol, illicit and other drug use. In the next five years, the Government will retain health-related objectives but will also aim for a greater intersectoral focus that encompasses both social and economic harms from drug use. This broadening of focus may require government agencies to refine their datasets and undertake research in new areas to ensure there is an adequate evidence base to work from.

Addressing emerging trends

In the next five years, the role of the National Drug Intelligence Bureau will be maintained and strengthened and more prominence will be given to forecasting future trends in drug use, illicit production and trafficking, and intervening proactively. This approach will require a strengthening of research into emerging drug trends.

The Government will ensure that legislation is kept up to date in order to address new trends and increase understanding of the risks associated with drug use.

Opportunity for All New Zealanders

The Ministry of Social Development's document *Opportunity for All New Zealanders* outlines the Government's expectation that agencies will work to reduce tobacco, alcohol and other drug use. Agencies are required to consider whether outcomes could be enhanced by:

- improved interagency collaboration
- further problem definition and research to identify causal factors
- joint definition of a desired outcome
- further analysis of evidence of "what works" to make a difference
- building on existing work, and developing new ways to work together.

These factors will inform policy development by agencies working under the National Drug Policy over the next five years.

Strategies

A comprehensive range of strategies will be used to achieve the objectives of this policy, utilising a combination of supply control, demand reduction and problem limitation approaches.

Strategies need to take into account five interacting components:

1. the physical, economic, social and legal environment in which drugs are produced, marketed, distributed and used
2. the characteristics of individual drug users (e.g. their age, gender and ethnicity)
3. the setting in which the drug use occurs and/or in which interventions can be implemented (e.g. schools, workplaces, public places)
4. the characteristics and effects of the drug in question (e.g. its psychoactive properties, dependence-producing effect and legal status)
5. the need to reduce health, economic and social inequalities.

For this second National Drug Policy, four broad strategy areas for action have been identified as important means for achieving the overarching goal and objectives of the policy:

1. supply control
2. demand reduction
3. problem limitation
4. information collection, research and evaluation, and monitoring.

Supply control

Regulation and law enforcement have been identified as the focus for supply control initiatives for the next five years.

Regulatory intervention is a powerful tool for controlling the environment within which drug use occurs. The focus and goals of regulation necessarily differ for licit and illicit drugs.

Regulation of licit drugs usually focuses on:

- controlling sale or supply to certain people
- restricting sale and consumption to certain locations
- controlling advertising and display
- requiring warnings to be placed on product packaging.

Regulation of people's actions, such as limitations on drinking and driving, can also affect the situations in which licit drugs are used.

Regulation of illicit drugs generally prohibits importation, manufacturing, supply, possession and use. The aims of such regulation include preventing illicit drugs from reaching users and deterring individuals from choosing to use illicit drugs. Enforcement of illicit drug regulations often involves initiatives to prevent the establishment of extensive and enduring drug distribution networks and to disrupt the activities of existing organised crime groups.

Action points for 2006–2011

- Keep the current legislative and regulatory framework for drugs up to date, and develop regulations where needed.
- Enhance enforcement of legislation regulating licit drugs, such as inhalants and legal highs.
- Identify other areas where enforcement of regulation requires strengthening.
- Proactively target organised and transnational crime groups involved in the New Zealand illicit drug trade.
- Identify, develop and implement new and enhanced drug enforcement techniques and strategies as further supply control measures.
- Continue to undertake joint/interagency responses to drug trafficking both domestically and internationally.
- Strengthen capability within monitoring and enforcement agencies through effective workforce development initiatives.

Demand reduction

For the demand reduction area, education and health promotion have been highlighted as strategic directions to be pursued.

The 1986 Ottawa Charter defined health promotion broadly, as the process of enabling people to increase control over and improve their health. It included a focus on economic, social and cultural factors and the impact of these factors on health.

Health promotion strategies cover a wide variety of interventions designed to build healthy public policy, strengthen community action, re-orient health services, create supportive environments, and develop personal skills. Relevant strategies include use of pricing and tax policy, attention to the nature of advertising and marketing of products, community action, social marketing and health education. Effective health promotion programmes often involve a comprehensive approach using a number of these strategies together.

Action points for 2006–2011

- Undertake community action projects focused on reducing or preventing drug-related harm.
- Undertake mass media education to raise awareness of the risk of drug use.
- Conduct social marketing campaigns to reduce or prevent drug-related harm.
- Undertake policy work on potential restrictions on marketing of alcohol and legal non-pharmaceutical drugs, such as legal highs.
- Conduct health promotion in schools and other educational settings.
- Disseminate information and resources about drug-related harm, and how it can be prevented or reduced.
- Continue work on pricing and tax policy.

Problem limitation

Assessment, advice and treatment services are the core areas for development in the problem limitation arena.

Treatment interventions are vital to limit the problems arising from substance use. In June 2005 the Ministry of Health released *Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand Mental Health and Addiction Plan.* One of its 10 strategic directions focuses on addiction, and aims to improve the availability of and access to quality addiction services. Most of the other strategic directions are also relevant to alcohol and drugs, including the directions on promotion and prevention, primary health care, and Māori mental health. *Te Tāhuhu – Improving Mental Health 2005–2015* will be followed by an action plan as part of its implementation.

Action points for 2006–2011

- Improve access to and quality of alcohol and other drug treatment services.
- Improve service delivery for people with co-existing mental health, alcohol and other drug-related problems.
- Improve access to and quality of primary mental health services for people with, or at risk of developing, an alcohol or other drug problem.
- Improve access to opioid substitution or maintenance treatment programmes for people who are opioid dependent.
- Improve access to the needle and syringe exchange programme for injecting drug users at risk of contracting blood-borne viruses.

Information collection, research and evaluation, and monitoring

Successful implementation of the above strategies requires:

- data collection, monitoring and research concerning the impact, risk factors, patterns of use and related harms
- the evaluation of the effectiveness of policy interventions for tobacco, alcohol, illicit and other drug use.

Information gained through data collection, research and evaluation supports policy interventions and service development in a number of ways. First, it enables agencies to accurately identify the scope and nature of particular drug issues and to prioritise policy responses in a way that will prevent or reduce the harm most effectively. Further, it helps build the evidence base for determining which policy interventions will be most effective. Finally, it provides data to monitor and measure the results of specific local interventions.

Although the national and international knowledge base is growing, there are still substantial gaps in our knowledge. Further, there is little information available related to social and economic costs arising from alcohol use and some other types of drug use.

Action points for 2006–2011

- Identify, prioritise and fill gaps in current data collection to support work towards the overarching goal of this policy.
- Identify and prioritise research needed to fill gaps in our knowledge, with a focus on the dynamics, nature and structure of the illicit drug scene, particularly for emerging drugs.
- Build understanding of the underlying determinants of drug use.
- Gather baseline data to develop indicators for action plans supporting this second National Drug Policy.
- Continue research on prevalence and incidence of drug-use and drug-related harm.
- Co-ordinate and collate data collected by different agencies working to reduce drug-related harm into an accessible resource.
- Ensure that high quality evaluation of initiatives, projects and programmes, including evaluation of cross-cutting policy programmes, is undertaken.

Monitoring progress

Action plans will be developed by government agencies to implement the strategies and to achieve objectives outlined in the National Drug Policy. These plans will:

- specify the types of activities to be undertaken
- contain specific outcomes and targets
- identify ways to resource the activities
- nominate which government agency will take the lead in each area.

As these plans are generated, an intersectoral work programme to advance the National Drug Policy's objectives will be developed.

The development of indicators will be a significant component of the action plans. In some cases indicators already exist but in other instances it will be necessary to collect baseline data before meaningful indicators can be developed.

Progress within the priority areas of the National Drug Policy and implementation of action plans will be monitored and reviewed in the following ways.

- The MCDP will meet at least twice yearly to review progress and decide which new policy initiatives should be recommended to the Government.
- The IACD will ensure that policies and programmes throughout government are consistent with this policy and are mutually supportive. It will receive reports from individual government agencies on progress made in implementing this policy, and will make recommendations to the MCDP on new policy initiatives. It will seek representations from other agencies as appropriate.

Funding

Drug policy is a highly complex area that requires input and participation from a wide range of government and non-governmental agencies. Substantial resource is put into initiatives that progress the objectives of the National Drug Policy. These initiatives range from work by law enforcement agencies to seize illicit drugs, through to education in schools, to alcohol and other drug treatment services. In the next five years, the second National Drug Policy will continue to act as a framework to guide funding decisions in the broad range of sectors that contribute to drug policy.

In addition, a National Drug Policy Discretionary Grant Fund was established in 2004. This fund is managed by the MCDP and administered by the IACD, and provides a supplementary pool of funding for initiatives that advance the goals of the National Drug Policy.

Features of the New Zealand Approach

The core tenet of the National Drug Policy is harm minimisation, supported by a balance of supply control, demand reduction and problem limitation strategies and the overarching goal of preventing and reducing harm. However, drug policy in New Zealand has a number of other distinguishing features.

Evidence-informed practice

Policy interventions to prevent and reduce drug-related harm will be focused on substances that cause the most harm and, where appropriate, on the population groups that experience the highest levels of harm. The objectives for preventing and reducing drug-related harm identified in the National Drug Policy were determined according to this principle.

The specific priority targets contained in the action plans that are developed to support the National Drug Policy will also be informed by evidence. In developing these action plans, reference should be made particularly to the companion document summarising data about drug use and related harm that will be released during the life of this policy.

Where there is no robust information about the extent of the harm or where evidence is lacking about effective interventions, further research or evaluation programmes should be undertaken to inform future policy decisions.

Reducing inequalities

The Government aims to reduce disadvantage and promote equality of opportunity in order to achieve a similar distribution of outcomes across different groups, and a more equitable distribution of overall outcomes within society. This means both:

- achieving a minimum level of wellbeing for all people
- ensuring a more equal distribution of the determinants of wellbeing across society. Family background, ethnicity or disability should not be major determinants of an individual's life chances.

In New Zealand, ethnic identity is an important dimension of health inequalities. The health status of Māori and Pacific peoples is demonstrably poorer than that of other New Zealanders. In addition, there are important socioeconomic, sex and geographical inequalities.

In terms of health inequalities, it is a priority to improve the availability of and access to drug prevention and treatment services for those currently at risk of poor health outcomes. A population health approach should be used when planning all services and programmes so that the impact of the proposed intervention on specific groups, as well as on the total population, is considered. The Health Equity Assessment Tool and the Reducing Inequalities Intervention Framework can assist with this. The aim is to improve overall health outcomes and reduce disparities among groups.

Links with the NGO sector

The Government recognises that an effective National Drug Policy needs the support and participation of NGOs, including local and voluntary groups, service providers, individuals, employer and industry groups, and the community at large. It is envisaged that NGOs will have an important role in informing the development of action plans under this policy over the next five years.

International contribution and co-operation

New Zealand contributes to the United Nations International Drug Control Programme and participates in the annual meetings of the United Nations Commission on Narcotic Drugs (CND). The purpose of the CND is to analyse the world drug situation and develop proposals to strengthen the international drug control system.

New Zealand is also a party to a number of United Nations conventions related to the Drug Control Programme, including:

1. the *Single Convention on Narcotic Drugs 1961*, as amended by the 1972 Protocol
2. the *Convention on Psychotropic Substances 1971*
3. the *Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*.

The first two of these conventions codify internationally applicable control measures to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes and to prevent diversion into illicit channels. The third convention requires the New Zealand Government to co-operate with international measures to prevent drug trafficking.

New Zealand has also ratified the *World Health Organization Framework Convention on Tobacco Control*. This convention requires countries to impose restrictions on tobacco advertising, sponsorship and promotion; establish new packaging and labelling of products; and establish clean indoor air controls. Currently, there are no international conventions related to alcohol control. However, the New Zealand Government participates in regional and global World Health Organization activities related to public health problems caused by alcohol.

Finally, New Zealand is a party to the *World Anti-Doping Code*, which provides for international uniformity in anti-doping regulatory regimes. It includes provisions on prohibited substances, testing, laboratory procedures and sanctions.

Drug Use in New Zealand

This section of the National Drug Policy provides a broad overview of the current situation in New Zealand with respect to use of tobacco, alcohol, illicit and other drugs. The volume, quality, type and recentness of data about the prevalence of drug use and resulting harms differs considerably depending on the substance in question. In general, the volume of available data is larger for alcohol and tobacco than for illicit and other drugs, and larger for health harms than for social and economic harms.

For more detailed information about drug use in New Zealand, please consult the companion document to this policy, which will be published subsequently.

Tobacco

Tobacco smoking is the greatest cause of preventable death and ill health in New Zealand. Health effects include cancers (mouth, lung, throat, pancreas and kidney), blindness, chronic respiratory disease, heart disease, stroke, and sudden infant death syndrome. Tobacco use causes the highest mortality rate of all recreational drugs in New Zealand. Smoking is currently responsible for 18 percent of all deaths (i.e. approximately 4300–4600 per year) in New Zealand. In addition, second hand smoke is now recognised to be a substantial health hazard. Past exposure to second hand smoke is estimated to be responsible for about 347 deaths per year in New Zealand.

The prevalence of cigarette smoking has not significantly decreased in the last 10 years, although consumption levels have dropped.

Other trends include the following.

- The levels of smoking among Māori, especially young Māori women, are very high.
- In the 1990s there was a sustained decrease in the prevalence of tobacco use in people aged 55 years and older and in people of European descent.
- The highest smoking prevalence is in the group aged 25 to 34 years. Smoking prevalence generally decreases with age as more people quit and fewer start smoking as they grow older.
- Of the ethnic groups surveyed in 2002/03, Māori were most likely to be current smokers, followed by Pacific, European/other and Asian ethnic groups.
- The prevalence of smoking in 2002/03 was significantly higher for people in the most socioeconomically deprived areas than for those in the least deprived areas.
- In 2002/03 one in 15 adult non-smokers reported being exposed to cigarette smoke inside their home.

Alcohol

Alcohol is the most commonly used recreational drug in New Zealand. In 2002/03, 83.5 percent of people responding to the New Zealand Health Survey had consumed a drink containing alcohol in the previous 12 months.

The New Zealand Health Survey 2002/03 found 19.1 percent of adults over 15 years had a pattern of hazardous drinking. Hazardous drinking was defined as an established pattern of drinking that carries a high risk of future damage to physical and mental health. Overall, males had a higher prevalence of hazardous drinking patterns compared to females (27.1 percent and 11.7 percent respectively). Of the ethnic groups surveyed, Māori had the highest prevalence of hazardous drinking patterns followed by European/other and Pacific. Between 1998 and 2001 the frequency of consumption and amount of alcohol consumed per occasion increased significantly for young people aged 15 to 17 years.

Alcohol-related harms include:

- haemorrhagic stroke, cancers of the mouth, throat, breast and liver, and cirrhosis of the liver
- mental health conditions, such as dependence and depression
- birth defects including fetal alcohol syndrome and other permanent disabilities
- economic and social harms such as poverty, unemployment, low productivity, family breakdown and child neglect
- non-fatal and fatal injuries, either intentional (e.g. from violence or self-harm) or unintentional (e.g. from road traffic crashes).

A study of New Zealand data from 2000 found that 51 percent of alcohol-attributable deaths and 72 percent of years of life lost[1] in 2000 were due to injuries. Young people are more likely to experience alcohol-related injuries than older drinkers.

Cannabis

Cannabis is the most widely used illicit drug in New Zealand and the third most widely used recreational drug after alcohol and tobacco. In 2002/03, of those adults responding to the New Zealand Health Survey, one in seven (14.2 percent) had used cannabis in the last year and one in 19 (5.3 percent) smoked cannabis regularly (i.e. daily, weekly, fortnightly).

Cannabis smoking has adverse effects on the respiratory and cardiovascular systems and increases the risk of major psychological problems.

Other trends include the following.

- In 2002/03, males were significantly more likely than females to smoke cannabis regularly (8.3 percent and 3.6 percent respectively).
- Of the age groups surveyed in 2002/03, those aged 15 to 24 years were most likely to smoke cannabis regularly.
- Between 1998 and 2001 there was a trend towards more women aged 15 to 17 using cannabis (from 20 percent in 1998 to 30 percent in 2001) and reporting current use (from 10 percent to 18 percent).

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[1] Years of life lost are a measure of premature mortality. They measure deaths in units of time (life years) rather than by events (mortality).

- Māori were significantly more likely than other ethnic groups to smoke cannabis regularly, for both males and females in 2002/03.

Stimulants

Stimulants include amphetamine, methamphetamine, crystal methamphetamine, cocaine and crack. There has been a significant increase in stimulant use over the last five years: in 2001, 5.3 percent of those surveyed reported having used a stimulant in the last year, as compared to 3.2 percent in 1998. In 2001 amphetamine and methamphetamine were reported as being by far the most commonly used stimulants, with current amphetamine/ methamphetamine users making up 3.5 percent of the 3.7 percent of all current stimulant users.

Methamphetamine is a particularly problematic stimulant. It is the only stimulant that is commonly manufactured in New Zealand and its manufacture and sale are closely linked to organised criminal groups. Methamphetamine is also the stimulant most commonly identified with violence, anti-social behaviour and mental health problems in New Zealand.

A 2004 study found that stimulant users are disproportionately male and aged 18–29 years, with heaviest use among 20–24-year-olds. Stimulant users typically are in full-time employment, come from a range of occupational (including professional) backgrounds, earn mid-level incomes, and have relatively high levels of educational achievement.

Hallucinogens

Hallucinogens include ecstasy (MDMA)[2], LSD and 'magic' mushrooms. In the 2001, 4.3 percent of those surveyed were current users of hallucinogens compared to 3.6 percent in 1998 and 1.5 percent in 1990. Ecstasy was the hallucinogen that the most people reported using in the last year (3.4 percent), followed by LSD (2 percent), magic mushrooms (1.8 percent) and other hallucinogens (0.2 percent). It is also notable that use of ecstasy more than doubled between 1998 and 2001. These increases were found primarily among those aged 20–29 years.

Opioids

Opioids include morphine, codeine, opium, heroin and a wide range of pharmaceutical drugs such as methadone and buprenorphine.

The prevalence of opioid use remained relatively stable throughout the 1990s, with 0.6 percent of those surveyed in 2001 being current opioid users compared to 0.5 percent in 1990. Due to New Zealand's geographic isolation, it is not easy to import heroin and raw opium in bulk; thus the majority of opioids abused in New Zealand have been prescription medicines (e.g. morphine sulphate tablets, methadone), poppies and home bake.

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[2] In most New Zealand and international studies ecstasy is classified as an amphetamine type stimulant rather than a hallucinogen (due to its chemical structure).

While the prevalence of opioid use is relatively low, the associated social and health harms (e.g. crime and potential blood-borne viruses) are serious. There is strong evidence from other Western countries that high rates of crime are associated with the injecting of illicit opioids. As a result of low rates of employment among injecting drug users (IDUs), combined with the high costs of illicit drugs, many IDUs turn to crime as a way of funding their drug use. Reduction in property crimes have been demonstrated among IDUs retained in opioid substitution treatment in Europe, North America, Australia and more recently New Zealand.

Further, in the period 1990–1996 there were 156 opioid-related conditions or poisonings perceived to be underlying cause of death. During the three years from 1996 to 1998 there were 3955 publicly funded hospitalisations where one or more opiate-related conditions or opiate poisoning were given as the reason for admission or as an additional diagnosis. Opioids that are taken through unsafe injecting practices increase the risk of harm through the transmission of blood-borne diseases such as HIV and hepatitis C.

Inhalants and volatile substances

Solvents include petrol, glue, and liquefied petroleum gas (LPG). These substances are contained in readily available products such as adhesives, thinners, petrol aerosol sprays, gas, paint and anti-freeze and are inhaled by recreational users. In 2001, 0.1 percent of those surveyed were current users of solvents and 0.2 percent had used solvents in the previous year.

Solvent use has been associated with a number of deaths. Over the three years from 1996 to 1998 there were 35 deaths specifically due to solvents. These deaths were related to drug dependence, abuse, accidental poisonings and suicide. During 2004 and 2005, the Wellington Coroner investigated six solvent-related deaths of young people that occurred from 2003 to 2004.

Performance and image enhancing drugs

Performance and image enhancing drugs (PIEDs), in particular anabolic agents, can assist in muscle growth and athletic performance. Anabolic agents are not psychoactive. However, their use carries serious health risks, including heart disease, cancer (liver, prostate and kidney), jaundice, and blood filled liver cysts.

To date, PIEDs have not been included in national drug use surveys in New Zealand. Hence, there is a lack of information about the prevalence of their use. The New Zealand Sports Drug Agency (NZSDA) carries out a drug testing programme on athletes involved in competitive sports under the New Zealand Sports Drug Agency Act 1994. Between 1994 and 2003 the NZSDA carried out a total of 9350 tests, with 97 (or 1.04 percent) positive results or refusals to provide a sample. In 2002/03 there were seven doping infractions under the NZSDA drug testing programme.

Diverted pharmaceuticals

Currently, there are no mechanisms in place to measure the volume of diverted pharmaceutical drugs on the illicit drug market. The only surveys conducted on the recreational use of pharmaceuticals have focused on tranquilliser use.

Other pharmaceuticals of particular concern include morphine, methadone and other opioid-based pharmaceuticals, amphetamine, benzodiazepines, methylphenidate (Ritalin) and ketamine. In addition, there is evidence of large-scale diversion of prescription and pharmacy-only ephedrine and pseudoephedrine products into the illicit manufacture of methamphetamine.

Legal highs

Legal highs are substances that have psychoactive effects and that are sold for recreational use but that are not regulated under drug or medicines regulations. While no data exist on prevalence of legal high use, there are some data on the size of legal high markets in New Zealand. In particular, there has been a dramatic increase in the use of products containing benzylpiperazine in the last five years, with an estimated 1.5 million capsules being manufactured for sale in 2003. One concern about legal highs is the lack of information provided to users about health risks, in particular polydrug interactions, associated with their use.

This overview of drug use in New Zealand has been informed by the following sources.

Alcohol Advisory Council of New Zealand. 2005. *The Burden of Death, Disease and Disability due to Alcohol in New Zealand*. Alcohol Advisory Council of New Zealand. Wellington.

Expert Advisory Committee on Drugs. 2004. *The Expert Advisory Committee on Drugs (EACD) Advice to the Minister on: Benzylpiperazine (BZP)*. Ministry of Health. Wellington.

Ministry of Health. 2003. *Tobacco Facts 2003.* Ministry of Health. Wellington.

Ministry of Health. 2004. *A Portrait of Health: Key results of the 2002/03 New Zealand Health Survey*. Ministry of Health. Wellington.

Drug Free Sport NZ.

New Zealand Health Information Service. 2001. *New Zealand Drug Statistics*. Ministry of Health. Wellington.

Wilkins C, Casswell S, Bhatta K, Pledger M. 2002. *Drug Use in New Zealand: National Surveys Comparison 1998 and 2001*. Alcohol and Public Health Research Unit, University of Auckland. Auckland.

Wilkins C, Reilly J, Rose E, Roy D, Pledger M, Lee A. 2004. *The Socioeconomic Impact of Amphetamine Type Stimulants in New Zealand: Final report*. Centre for Social and Health Outcomes Research and Evaluation, Massey University. Auckland.

National Drug Policy Advisory Structures

Since the first National Drug Policy was released in 1998, structures for coordinating intersectoral decision-making and monitoring progress towards policy objectives have been established. These are the Ministerial Committee on Drug Policy and the Inter-Agency Committee on Drugs.

Ministerial Committee on Drug Policy

The Ministerial Committee on Drug Policy (MCDP) is chaired by the Minister of Health and includes the Ministers of Corrections, Customs, Justice, Police, Māori Affairs, Youth Affairs, Transport and Education. The MCDP meets, on average, twice yearly to review progress and decide which new policy initiatives should be recommended to the Government.

Inter-Agency Committee on Drugs

The Inter-Agency Committee on Drugs (IACD) is a monitoring group of officials chaired by the Ministry of Health and includes the Ministries of Education, Justice, Transport, Youth Development, and Pacific Island Affairs; Te Puni Kōkiri; the Departments of Corrections, and the Prime Minister and Cabinet; New Zealand Police; New Zealand Customs Service; Land Transport New Zealand; Local Government New Zealand; and the Alcohol Advisory Council of New Zealand.

Expert Advisory Committee on Drugs

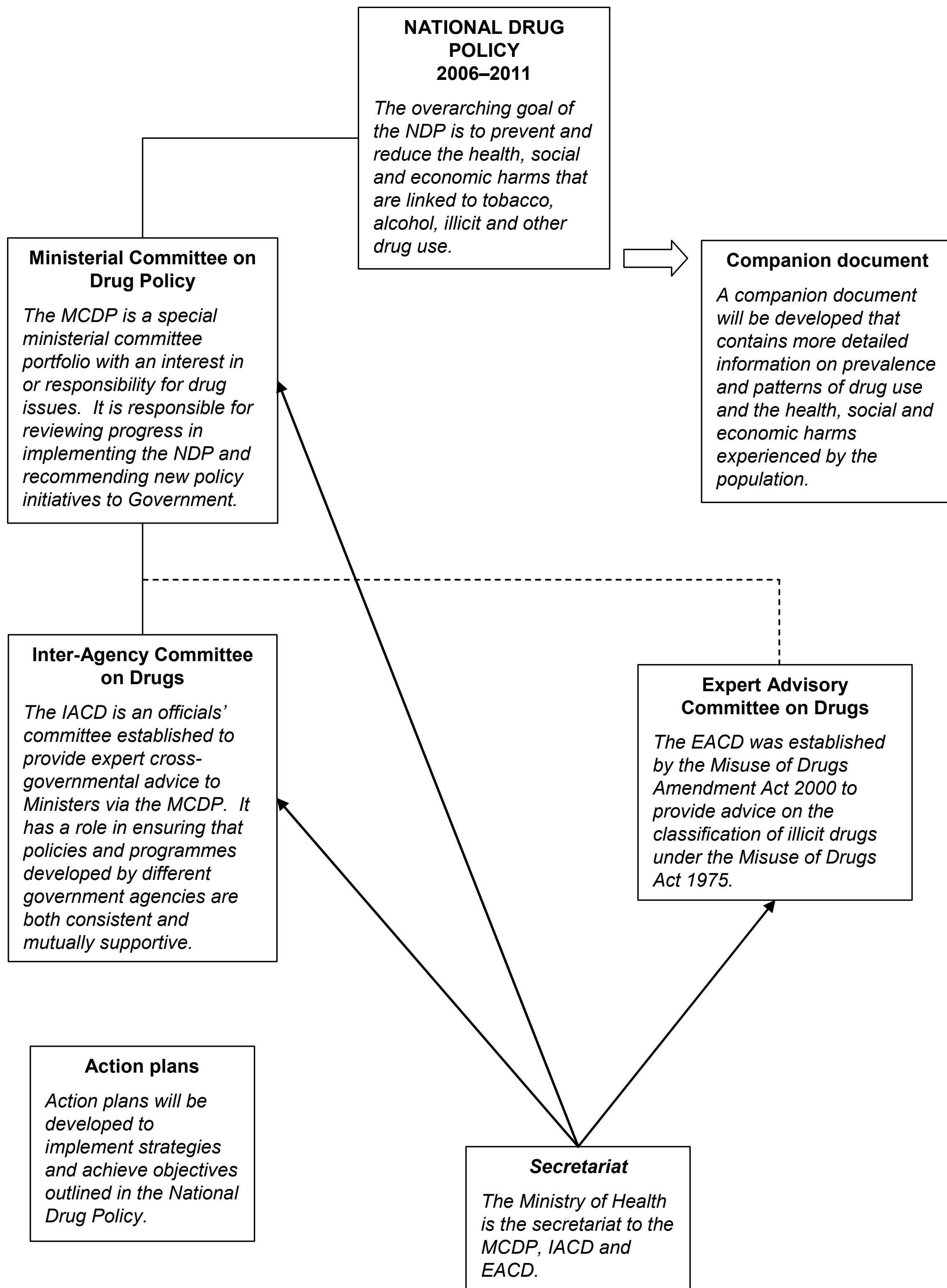
In 2000 the Misuse of Drugs Act 1975 was amended to establish the Expert Advisory Committee on Drugs (EACD). The EACD provides the Minister of Health with expert advice on the risk of harm to individuals and society from any particular drug or substance and on drug classification issues.

The Ministry of Health provides secretariat support for the MCDP, IACD and EACD.

Abbreviations

CAYAD	Community Action on Youth and Drugs
CND	Commission on Narcotic Drugs
EACD	Expert Advisory Committee on Drugs
HIV	human immunodeficiency virus
IDU	injecting drug user
LSD	lysergic acid diethylamide
IACD	Inter-Agency Committee on Drugs
MCDP	Ministerial Committee on Drug Policy
MDMA	methylenedioxymethamphetamine
NDP	National Drug Policy
NGO	non-governmental organisation
PIED	performance and image enhancing drug

Appendix: The National Drug Policy in Context



Submission Form for the Draft National Drug Policy 2006–2011

Submissions close at **5 pm on 9 June 2006**.

Please detach and return to:

Please use the following detachable pages or the electronic form available online at www.ndp.govt.nz when making a submission.

Note: you do not have to answer all the questions or provide personal information if you do not want to.

This submission was completed by:

Name:..

Address:..

Email: ....

Organisation: ....

Position:...

Are you submitting this as:

- ☐ an individual
- ☐ on behalf of a group or organisation
- ☐ other (please specify) ....

Please indicate which sector(s) your submission represents:

- ☐ Consumer
- ☐ Academic/research
- ☐ Pacific
- ☐ Education
- ☐ Provider
- ☐ Non-government organisation
- ☐ Professional association
- ☐ Family/whānau
- ☐ Māori
- ☐ District Health Board
- ☐ Local government
- ☐ Funder
- ☐ Prevention/promotion
- ☐ Other (please specify) ....

Questions

1. Do you agree with the overarching goal of the Policy (page 2)?

☐ Yes ☐ No

If not, please provide reasons..
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2. Do you agree with the proposed objectives of the Policy (page 3)?

☐ Yes ☐ No

If not, please provide reasons..
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3. Are there any other objectives you believe should be included?

☐ Yes ☐ No

If so, please explain below..
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4. Do you agree with the harm minimisation approach as described on page 3?

☐ Yes ☐ No

If not, please provide reasons..
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5. Do you agree that the National Drug Policy should cover both the prevention and reduction of harm from drugs?

☐ Yes ☐ No

If not, please provide reasons...
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6. Do you think a companion document as outlined on page 6 would be useful?

☐ Yes ☐ No

If yes, please indicate what you would like the document to contain.......................
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7. Do you agree with the broader focus on social and economic harms (not just health objectives) described under 'Stronger Intersectoral Focus' on page 6?

☐ Yes ☐ No

Comment:...
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8. Do you agree with the four broad strategy areas (as described on page 7)?

☐ Yes ☐ No

Comment:...
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9. Would you add anything further to the action points for 2006–2011 for supply control (page 8)?

☐ Yes ☐ No

Comment:...
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10. Would you add anything further to the action points for 2006–2011 for demand reduction (page 9)?

☐ Yes ☐ No

Comment:...
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11. Would you add anything further to the action points for 2006–2011 for problem limitation (page 10)?

☐ Yes ☐ No

Comment:...
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12. Would you add anything further to the action points for 2006–2011 for information collection, research, evaluation and monitoring (page 11)?

☐ Yes ☐ No

Comment:...
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13. Do you agree with the method for monitoring progress?

☐ Yes ☐ No

If not, do you have suggestions for improvement:..
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14. Does the 'Features of New Zealand approach' adequately reflect the New Zealand situation?

☐ Yes ☐ No

If not, what else would you include? ....
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15. Does the 'Drug use in New Zealand' section provide a fair overview?

☐ Yes ☐ No

If not, what else would you include? ....
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16. Any other comments/feedback?...
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