

National Drug Policy 2006-2011

**Report on Consultation Feedback**

Final 17 July 2006

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# Executive Summary

This document reports on feedback received during public consultation on the review of the National Drug Policy. It encompasses views expressed by stakeholders at the thirteen meetings, hui and fono throughout the country, and in the ninety-five written submissions on the Consultation Document.

The feedback received reflects a diverse range of individual and organisational beliefs on the role of government in relation to tobacco, alcohol and drug use. Comments on the policy direction set out in the Consultation Document were, however, for the most part positive.

The proposed overarching goal and harm minimisation approach were widely endorsed, and the four strategy areas generally accepted, although comment on the proposed actions within those four areas included a large number of suggested additions and amendments.

A notable amount of comment was directed at the policy development process as it appeared from the information presented in the Consultation Document, and on the form of the Consultation Document itself, rather than the proposed policy directions.

Many submitters felt strongly that the underpinning evidence base and analysis should have been more fully presented so that submitters could make informed comment on the document's proposals. Alongside this a clearer, and more clearly articulated, hierarchy encompassing the proposed goal, objectives, strategies and actions was called for.

Other comments suggested that the Consultation Document did not present a clear and compelling direction for drug policy over the next five years, or set out government's priorities in sufficient detail to inform organisational planning across the sector. Considerably more certainty about the development and implementation of action plans was sought.

The proposed strengthened approach to intersectoral collaboration was welcomed, but raised questions about how this would happen in practice. As with the action plans, the call was for a clearer picture of the way forward.

The omission of any reference to the Treaty of Waitangi was commented on with some surprise and concern.

Many submitters felt that the final Policy document should place more emphasis on particular population groups, particularly Māori and young people.

Two schools of thought were evident in relation to prohibition, especially but not solely in relation to cannabis. Some submitters wanted to see more emphasis on enforcement measures, while others argued that a harm minimisation approach ought to consider the harms resulting from prohibition as well as the harms from drug use.

There was a strong desire across the sector for involvement in the development and implementation of action plans, and for ongoing community and non-governmental organisation (NGO) engagement with public sector leaders and agencies.

# Introduction

This document reports on feedback received during public consultation on the review of the National Drug Policy. The report encompasses the views expressed by stakeholders at consultation meetings, hui and fono, and written submissions on the Consultation Document published by the Ministry of Health (MoH).

## Background

New Zealand's National Drug Policy sets out the Government's policy and legislative intentions for tobacco, alcohol, illicit and other drugs. The first National Drug Policy covered the period 1998-2003, and has continued to provide guidance for government activity through to 2006.

The National Drug Policy (NDP, or the Policy) is currently being reviewed by the Ministry of Health in collaboration with other government agencies. The second National Drug Policy, covering the period 2006-2011, will be published later this year.

## Consultation Process

The National Drug Policy Consultation Document (the Consultation Document) was published in April 2006, in hard copy and on the National Drug Policy website.<sup>1</sup> The consultation period ran from April to June 2006 and involved a series of meetings and hui for invited stakeholders, together with an opportunity for any interested parties to make a written submission.

### Meetings, Hui and Fono

Consultation meetings, hui and fono were held at the locations listed below. Each session was facilitated by an independent facilitator and the notes taken during the session form part of the raw material on which this report is based.

- Auckland (general meeting, hui and fono)
- Wellington (general meeting, hui and fono)
- Christchurch (general meeting and hui)
- Dunedin (general meeting)
- Whangarei (hui)
- Rotorua (hui)
- Gisborne (hui)

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<sup>1</sup> *National Drug Policy 2006-2011 Consultation Document* (2006), Ministry of Health: Wellington

- Palmerston North (general meeting).

Participants represented a cross section of the community. Representatives of a range of community groups and organisations with an interest in the National Drug Policy joined representatives of District Health Boards, health provider organisations and members of the wider community.

## Written Submissions

The Consultation Document sought feedback via a series of structured questions on aspects of the proposed policy and also provided the opportunity for submitters to comment on other matters or respond using their own format.

Ninety-five written submissions were received. Many of the most detailed submissions were from those that chose to write a submission to their own format rather than answering the structured questions. The 'yes/no' questions were answered by between fifty and sixty submitters.

The profile of the individuals and organisations that made written submissions is summarised below based on the information provided by submitters. Note that some submitters identified themselves as belonging to more than one type or sector.

<b>Profile of Written Submissions</b>		
<b>Variable</b>	<b>Description</b>	<b>Number of submissions (Total = 95)</b>
<b>Type</b>	Individual	23
	Group or organisation	63
	Both individual and group/organisation	2
	Other	4
	Not answered	3
<b>Sector(s) represented</b>	Non government organisation (NGO)	25
	Prevention/promotion	21
	Education	14
	District Health Board	11
	Consumer	10
	Provider	9
	Māori	8
	Family/whanau	8
	Academic/research	6
	Professional association	5
	Local government	3
	Pacific	2
	Other	8
Not answered <sup>2</sup>	33	

<sup>2</sup> Many of these submissions did, however, outline the activities and interest of the submitter.

# Consultation Feedback

## Key Themes

This section of the report outlines themes in the feedback received that spanned or lay outside of the specific questions posed in the Consultation Document.

### Process, form and direction

A notable feature of the feedback received was the amount and strength of comment that related to the policy development process and the type of information presented in the Consultation Document, rather than to the proposed policy directions.

Key elements that submitters had hoped or expected to see were a review of the effectiveness of the first NDP, a clear statement of the present situation, emerging trends and the problem to be addressed or purpose of the policy, and a hierarchy of goal, objectives and actions. Alongside this was the expectation that the analysis and decision-making underpinning that hierarchy would be clearly visible and firmly evidence based, so that the Policy document would be one that set out not only what would be done over the next five years, but also why, and how this would be achieved.

Feedback included some forceful comment that the Consultation Document did not adequately meet these expectations, and some commented that the absence of the expected evidence base and analysis made it difficult to comment on the proposed policy direction. Some submissions went to the extent of proposing an alternative set of goals, objectives and/or actions. Comments included:

*“... there is a lack of any review of the impact of the previous policy on drug-related harm...”*

*“If the overall goal of a national drug policy is to prevent and reduce harms, it should be clear what the harms are in New Zealand which need preventing and reducing.”*

*“(We are) very concerned that the draft does not describe the evidence and analysis that the plan is built on... in the absence of adequate information and analysis (we) cannot support this draft policy.”*

*“The policy waivers between detailed recommendations in some cases and general statements in others.”*

*“...it is difficult to see what actions are needed in order to meet the goal of the policy.”*

Other comments conveyed a sense of disappointment and/or frustration that the Consultation Document did not present a clear and compelling direction for drug policy over the next five years, or set out government’s priorities in sufficient detail to inform organisational planning across the sector.

*“... the policy in its current form fails to provide the necessary leadership and direction required of a strategic document of this kind.”*

*“This document needs to give AOD services some priority areas, direction and ‘clout’ to argue from when competing for funding.”*

Submitters acknowledged that action plans were yet to be developed, but the non-committal language and lack of specifics about timeframes, opportunities for input, and what the plans would cover, combined with limited information on accountabilities and resourcing for implementation left many questions unanswered.

*“... with the current Policy wording there is a risk that much of the five-year span that this document covers will be spent developing plans, rather than delivering action...”*

*“...we get no hint of which groups may have action plans.”*

*“... the policy must be much more specific in identifying which sectors will be resourced to achieve which objectives and how progress and relationships between the sectors is to be monitored at ground level.... no indication of expected timelines within the five years for anything.”*

Other feedback related to the form of the final Policy document highlighted the importance of consistent and precise terminology, or suggested that a glossary would be a useful addition.

### **Intersectoral links**

The Consultation Document sets out a list of strategies that operate under the general auspices of the NDP. Submitters welcomed this but felt that the cross-referencing should encompass a much wider range of related strategies and plans. Some emphasised that acknowledgement of these links needed to extend beyond simple referencing to alignment of action plans where appropriate.

Specific documents mentioned were: *Te Rito: New Zealand Family Violence Prevention Strategy*; *Tobacco Control Research Strategy for New Zealand*; the *National Māori Tobacco Control Strategy 2003-2007*; *Seeing through the Smoke: Tobacco Monitoring in New Zealand*; the *Tobacco Youth Initiation Framework*; the *New Zealand Injury Prevention Strategy and Implementation Plan*; the DHB Toolkits; *TuHANZ*; *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)*; the *New Zealand Cancer Control Strategy*; the *Meth Action Plan*; the *New Zealand Transport Strategy*; the *Workplace Health and Safety Strategy for New Zealand to 2015*; the *HIV/AIDs Action Plan*; and the *Youth Development Strategy*.

Other areas where links were proposed included Māori and Pacific health strategies, gambling policy, nutritional policies, and the Ministry of Youth Development's Effective Drug project.

### **Treaty of Waitangi**

Feedback included some surprise that the Consultation Document does not mention the Treaty of Waitangi or make explicit reference to Treaty principles. Comments of this nature were made by a diverse range of submitters, including but by no means limited to those who identified themselves as Māori.

*“(Our organisation) further finds the omission of the Treaty of Waitangi and working with Treaty principles to improve the health of all New Zealanders is rather disturbing...”*

*“... a failure to acknowledge the Treaty of Waitangi as an underpinning document for a partnership approach to a raft of drug related health and social issues with respect to which Māori are over-represented in harm statistics.”*

## **Identified population groups**

There was a strong call for the final policy document to place more weight in both the analysis and the proposed actions on particular population groups. The two groups most widely mentioned were Māori and young people. Others included older people, Pacific people, Asian males, women, the gay community and polydrug users.

In relation to Māori, submitters highlighted the over-representation of Māori in many of the negative alcohol and other drug (AOD) statistics, but also the strengths of Māori communities and the importance of Māori involvement and control over responses to those problems.

*“(We are) advocating the necessity to retain and sustain Kaupapa Māori services and have these acknowledged and actioned under the auspices of the new national Drug Policy.”*

Feedback specific to young people and children emphasised the need for actions targeted at particular age groups, youth participation, and the importance of ensuring young people have access to alternative social and recreational opportunities.

*“...if we are able to alter young people’s drug taking behaviour we will alter their long-term behaviours, health and well-being.”*

## **Harm minimisation and prohibition**

Two schools of thought were evident in relation to policy around drug classification and prohibition. While some submitters wanted to see more support for enforcement agencies, others strongly believed that the government and policy-makers ought to consider the harms resulting from prohibition alongside the harms caused by substance use and abuse.

Comment of this type advocated for government control through regulation, education and health promotion rather than prohibition, with drug use viewed as a health issue rather than a criminal one. Submitters argued that prohibition is not working (and cannot be made to work), generates black markets and organised crime, and diverts law enforcement resources that could be better used elsewhere.

*“The term ‘harm’ must be defined holistically ... for most people who choose to use illegal drugs but are otherwise law abiding, the legal sanction associated with being caught using drugs is, almost certainly, the most significant and profound harm they will face”*

*“There is no type of legislation that can stop the attraction humans have for psychoactive substances. The best thing we can do is give guidance and information so as to minimise harms from abuse...”*

*“Where is harm minimisation when a child is thrown out of school for being found with cannabis?”*

Government policy on cannabis attracted a range of comment from both sides of the legalisation debate. Those in favour of decriminalisation argued that its medical benefits should be acknowledged, and that a regulatory approach could provide the government with control while avoiding the harms associated with prohibition. The opposing view was that cannabis is harmful and should remain an illegal drug.

## **Where to from here?**

A number of submissions made suggestions on the way forward for the NDP’s policy development process and implementation over the next five years.

A key theme was a desire from across the sector for involvement in the development and implementation of action plans, while the importance of providing opportunities for ongoing community and NGO engagement with public sector leaders and agencies was also emphasised.

*“... strengthening of links amongst government agencies must be seen to be implemented and operationalised within a community setting.”*

## **Consultation Questions**

Feedback in response to the structured questions set out in the Consultation Document is outlined on the following pages. The summary also includes comments made at the consultation, meetings, hui and fono, and those in written submissions that did not follow the question and answer format, where these related to the topics covered in the structured questions.

### **Q1 Overarching goal**

The Consultation Document sets out the following overarching goal for the National Drug Policy 2006-2011:

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

The feedback received generally endorsed this goal.

The most frequent change suggested was a focus on harmful use, misuse, or abuse, rather than use. Submissions making this suggestion typically argued either that aiming to preventing all use is unrealistic, or that not all use is harmful. One submission commented that trying to prevent use, and failing to do so, increases rather than reduces harm, while another suggested that government resources could more usefully be focused on treatment rather than pursuit of what was perceived as the unattainable goal of prevention. Other suggested changes included:

- Rewording as ‘... prevent and/or reduce...’

- Replacing 'prevent' with 'discourage'
- Replacing 'reduce' with 'minimise'
- Acknowledging that harms can in some cases include death
- Adding environmental harm alongside health, social and economic
- Adding reference to building the community resources needed to address the environmental setting in which harmful use occurs
- A more positive emphasis: '... to improve health and prevent and reduce...', or 'to improve the health and wellbeing of all New Zealanders by preventing and reducing...'
- Adding reference to enhancing the benefits of drug use, alongside preventing and reducing harm
- Recognising individuals' right to inflict harm upon themselves, or upon others with their consent
- Replacing the word 'drug' with 'substance'.

Responses to the 'yes/no' question posed in the Consultation Document are set out below and reflect the general support for the proposed goal.

<b>Q1 Do you agree with the overarching goal of the Policy?</b>	
Yes	50
No	9
Total responses to this question	59

## **Q2 Proposed objectives**

As discussed earlier in this report, the list of objectives set out on page three of the Consultation Document attracted some criticism in the context of comment on the flow of logic through the document.

A common theme was that the objectives were not specific enough to clearly guide other agencies and NGOs in their own planning activity. One commented that the objectives needed 'more bite and direction', and several queried whether the ordering of objectives indicated prioritisation, or alternatively suggested that some prioritisation was needed. Specific suggestions reflected a range of attitudes towards AOD use and included:

- Amend the use of 'delay' in the first objective as this is not appropriate for tobacco use
- Add the word 'nicotine' where tobacco is mentioned, or replace 'tobacco' with 'nicotine'
- Remove the link between 'prevent' and 'alcohol' in the first objective (assuming the prevention of all alcohol consumption is not what is intended)

- Focus on discouraging harmful use or misuse rather than preventing all use
- Amend objective two to include ‘... non-prescribed consumption...’ to allow the use of substitutes for heavily addicted smokers
- Reword objective three to read ‘to reduce the risky per occasion consumption ...’
- Reword objective three to read ‘to reduce risky and problem use of alcohol across all ages especially teenagers’
- Add ‘to reduce the incidence of intoxication ‘ to objective three
- Remove the word ‘risky’ from objective three
- Replace ‘illicit’ with ‘harmful’ in objective four
- Remove ‘reduce’ in relation to illicit drugs in objective four
- Replace ‘minimise’ with ‘prevent’ in objective five
- Replace the word ‘stymie’ (objective seven) with ‘prevent’, ‘thwart’ or ‘hinder’
- Strengthen objective seven with the words ‘... and where possible eliminate...’
- Consider the capacity as well as quality of treatment services (objective eight)
- Data collection (objective nine) has an important role but should not become an objective in its own right
- Rephrase objective nine to acknowledge the benefits as well as the problems associated with drug use
- Amend objective nine to encompass evaluation as well as research
- Amend objectives nine and ten to emphasise environmental prevention strategies as opposed to individual prevention
- Amend objective ten to include community and consumer input, and links to schools.

Among those who answered the direct ‘yes/no’ question, the objectives were generally well supported, though often with some qualifying comment as discussed above.

<b>Q2 Do you agree with the proposed objectives of the Policy?</b>	
Yes	47
No	9
Total responses to this question	56

### Q3 Additional Objectives

As shown below, around three quarters of the submissions which addressed the 'yes/no' question relating to additional objectives did see a need for additions (though not necessarily for a longer list in total).

<b>Q3 Are there any other objectives you believe should be included?</b>	
Yes	44
No	14
Total responses to this question	58

Suggestions for additional objectives included:

- Objectives specific to population groups, specifically Māori, youth, the elderly and Pacific people
- Tikanga based interventions for Māori
- Greater emphasis on young people, namely: issues related to parental control and responsibility, alcohol in homes and supply to minors; reducing social supply; a stronger focus on prevention; better quality and provision of health promotion, harm reduction and treatment programmes, including in schools; and creation of a national AOD document as part of the school curriculum to ensure consistency nationwide
- Community development, including: development to underpin community action; clinician engagement in community action and community development activities; building community resilience against drug-related pressures; and 'whole community' initiatives encompassing alcohol, crime, injury and Community Action on Youth and Drugs (CAYAD)
- New approaches to education and counselling; prioritisation of education
- Regulation of advertising and other promotion including: bans or greater control on advertising, marketing and promotion; and an end to public promotion of alcohol
- Workforce development, including: attracting and training clinicians in AOD and co-existing disorders; education across disciplines at undergraduate and post-graduate level; and improving the capability of health and social services workforces to identify and respond to AOD dependence, misuse and abuse
- Reducing inequalities: gender; ethnicity; and socio-economic background
- Greater emphasis on treatment, including: a range of evidence-based treatment options; detoxification; better quality and access to treatment services, including in schools; more residential treatment facilities; rehabilitation programmes, particularly where this may reduce criminal offending; and broadening acceptance of alternative AOD treatments

- Activity related to long-term use: identifying the consequences of such use; and services for the elderly
- Smoking cessation, including: nicotine reduction; provision of effective smoking cessation services and programmes
- Activity related to the link between alcohol and drugs, and road accidents, including: further research into the effects of drugs on driving; awareness raising campaigns and development of roadside testing capabilities for drug driving; consideration of compulsory vehicle insurance for all vehicles driven by under 25s, with premiums that reflect the real cost of alcohol and drug related accidents; and alternatives including access to public transport and recreational opportunities
- An overall objective of reducing consumption for each category of drugs
- Reducing demand for drugs (as a specific objective)
- An objective related to the needle and syringe exchange programme
- The concept of 'brief intervention' in relation to alcohol
- Banning pills containing piperazine compounds
- Reducing harm to society (acknowledging that a range of substances including tea and coffee can have beneficial as well as harmful effects)
- Ensuring that drug policy strategies do not override or disregard civil, legal and human rights
- Policy development and evaluation including: emphasis on a broad range of information sources including academia and the advertising industry; greater emphasis on intersectoral policy activity; evaluation of policy interventions
- More research into the link between 'tagging' and solvent use from spray cans
- Responses to the misuse of prescription drugs
- Leadership in the sector
- Maintaining and increasing trust between drug users and health professionals.

#### **Q4 Harm minimisation approach**

Comments on the principle of harm minimisation reflected a wide range of attitudes towards drug use and the role of government in controlling or influencing this. These ranged from those who felt that the term 'harm minimisation' does not send a sufficiently strong message, through those who were strongly supportive of the concept as described in the Consultation Document, to those who felt that the document's interpretation of 'harm minimisation' was too narrow in that it does not consider the harms resulting from policies of criminalisation.

There was some criticism that the groups of strategies or ‘pillars’ set out in the Consultation Document are not consistent with the internationally recognised definition of harm minimisation which was described as normally encompassing ‘supply reduction’, ‘demand reduction’ and ‘harm reduction’. The reasons for this departure were queried and clarification of the terms used was sought.

Other submitters were comfortable with the terminology used but stressed that the term ‘harm minimisation’ needs to be carefully and consistently explained to increase understanding across the sector and within communities. It was suggested that the use of examples within the policy document might help to achieve this.

Other feedback included:

- Important to understand what the harms are – the Consultation Document does not do this
- Important to recognise the potential harms from products considered to be less harmful alternatives, such as low-tar cigarettes
- Harm minimisation should be based on a neutral stance of neither condemning nor condoning drug use
- Wouldn’t like it to be seen as an accepted process of tolerance
- The concept needs to be contextualised and public health emphasised
- Potential for contention about what constitute ‘high-risk behaviours’
- Good to see recognition of a place for abstinence
- A focus on abstinence can prevent users accessing help
- Replace ‘prevent’ with ‘discourage harmful use’
- Should focus on teaching people how to have healthy relationships with drugs (including alcohol), as well as on harm minimisation
- Reference to harm minimisation as the ‘overarching goal’ on page four of the Consultation Document is incorrect.

Most of the submissions that answered the question posed in the Consultation Document were supportive of a harm minimisation approach.

<b>Q4 Do you agree with the harm minimisation approach as described on page 3?</b>	
Yes	50
No	8
Total responses to this question	58

## Q5 Prevention and harm reduction

As shown below, the Consultation Document's inclusion of both prevention and harm reduction activity was widely endorsed.

<b>Q5 Do you agree that the National Drug Policy should cover both the prevention and reduction of harm from drugs?</b>	
Yes	52
No	5
Total responses to this question	57

Submitters who did not support the dual approach felt that the focus should be primarily or solely on harm reduction. The reasons for this were either a concern at the perceived ineffectiveness of prevention strategies (including that they may actually cause harm), or a belief that preventing drug use is not a realistic aim.

Other comments included:

- A query about whether funding for the Policy's implementation will come from public health or clinical AOD funds, or if both, where the balance would lie
- Consider the potential for different strategies to work together, and for them to work against each other
- More could be achieved by separating prevention and harm reduction, but capacity constraints mean coverage of both is pragmatic.

## Q6 Companion document

There was widespread support for a companion document, along with some strong criticism that such a document had not been published before or at the same time as the Consultation Document, so that feedback could have been informed by this additional material.

<b>Q6 Do you think a companion document as outlined on page 6 would be useful?</b>	
Yes	53
No	7
Total responses to this question	60

In addition to informing policy development, submitters envisaged that a companion document, updated at regular intervals, would be useful to inform stakeholder organisations' short-term and strategic planning and contracting.

One submitter expressed concern, however, that there was potential for the information in a companion document to be misused by the media or those opposed to a harm minimisation approach. Another suggested that substantial documents tend to sit on shelves, whereas regular updates and fact sheets would be more easily used.

Suggestions relating to the content of a companion document covered:

#### Patterns of use

- Additional statistics and data to support policy development, including current issues, trends and projections into the future
- Detailed statistics and research findings on the patterns, prevalence and impact of drug use for various substances, including variables such as age, social factors, ethnicity, gender and different environmental settings, and local level information
- Information on disparities between Māori and non Māori, and on other population groups such as older people and young people
- Information on the social, cultural and environmental determinants and context of drug use in New Zealand
- Consumption trends correlated with the parameters of drug policy, including a measure of lawfully available supply
- Information on 'legal highs' including their impact and usage trends.

#### Effects

- Information on drug related health, social and economic harms (including those potentially generated by policy), incorporating medical evidence on the health effects of various substances
- Information on the social and economic harms associated with early use of alcohol
- Causality data on alcohol-related medical treatment and hospital admissions
- Balanced information on beneficial uses of drugs as well as harmful abuse, with input from users
- Information on the benefits of recreational and performance drug use.

#### Best practice examples

- Information on evidence-based 'best practice', including successful overseas policies and programmes and examples of local partners working in collaboration

#### Planning information

- Present and planned resource allocations for each of the four strategy areas
- Analysis of potential risks and possible responses.

#### Other information

- A definition of obligations under the Treaty of Waitangi
- Data on patterns of sale and supply of controlled substances to minors

- Statistics on drug advertising
- Statistics on demand for treatments
- Illustration of how a cost/benefit analysis of the use of particular drugs, by particular people, in particular settings might be carried out
- Material to support 'shock tactics' including photographs.

## **Q7 Stronger intersectoral focus**

The stronger intersectoral focus outlined in the Consultation Document was for the most part welcomed by submitters and seen as appropriate across all four strategy areas. Government sectors mentioned in submissions included corrections, justice, education and social welfare in addition to health.

This section of the document also raised questions about how an intersectoral approach would be given effect, including comment that care will be needed to ensure resources are not spread too thinly or in a way that dilutes effectiveness in relation to health objectives. It was also noted that an intersectoral approach could turn into a 'talk-fest' at the expense of real on-the-ground progress.

Other cautious comments included that there are difficulties with refining datasets within the health sector, let alone across sectors, and that while economic impact is discussed in this section of the Consultation Document, this is not carried through to other sections.

Submitters noted that while the document talks about improved collaboration between government agencies and other stakeholders including DHBs, non governmental organisations, providers and communities, it doesn't provide any detail on the mechanisms by which this will happen.

Several submitters noted the need for collaboration between health, corrections and justice agencies in relation to alcohol and drug treatment services for prison inmates and people on probation, which was seen as a gap in current service provision.

Comments in submissions that did not support, or sought limits on, an intersectoral approach included:

- All harms to the individual should remain a health objective
- Drug abuse is primarily a health problem so this should be a larger focus; social and economic harms are secondary
- Do not agree with any movement of drug policy away from the health umbrella as it is too easy for general talk about social and economic harm to become a smokescreen for puritanical attitudes.

Other comments on the proposed intersectoral focus included:

- Intersectoral collaboration should be part of the 'policy foundations' section of the document and a key principle in the way the Policy works
- There is a need for a shift in organisation culture within government departments, and intersectoral leadership at the highest level

- The range of agencies contributing to the working group that finalises the NDP should be widened to include the Policy, ACC, OSH, LTNZ, local authorities and employers' representatives
- The description in the Consultation Document operates from a damage perspective and should instead reflect a strength based focus
- Cultural harm should be considered along with health, social and economic – this aligns with the four aspects of community wellbeing set out in the Local Government Act 2002
- From a health perspective, it is not acceptable to consider the theoretical economic benefits of any of the drug industries or to offset income from these industries when considering economic harms
- Intersectoral collaboration requires not just refining datasets but also incorporation of AOD assessment questions into standard assessment tools
- Community pharmacists are a valuable but under-utilised resource with a range of attributes such as accessibility, existing patient relationships, expertise, and computerised dispensing records
- AOD harm is symptomatic of wider social issues and should be addressed as part of a health strategy of a wider community-determined development plan.

Responses from those who answered the Consultation Document's question on this area are set out below and show strong support for a stronger intersectoral focus.

<b><i>Q7 Do you agree with the broader focus on social and economic harms (not just health objectives) described under 'Stronger International (sic) Focus' on page 6?</i></b>	
Yes	52
No	7
Total responses to this question	59

## **Q8 Strategy areas**

As discussed earlier in this report, some submitters felt strongly that more work was needed to align and show the linkages between the different levels of the policy framework. It was suggested that the four strategy areas should be clearly linked to the evidence and analysis that led to their selection so that stakeholders could understand the rationale for inclusion.

The addition of a strategy area focused on information collection, research and evaluation and monitoring was welcomed, though some submitters suggested that these activities could be encompassed within the other three areas.

Other comments on the four strategy areas were:

- How will the four areas be prioritised?
- Health promotion is a process of working and should be incorporated into all areas, not confined to Demand Reduction

- Concern at skewed resourcing in favour of enforcement rather than treatment and especially education, given that minimising early uptake is such a priority
- Include workforce development
- ‘Enforcement’ could be an additional pillar
- The first point in the list of interacting components on page seven should include ‘institutional environment’ alongside physical, economic, social and legal.

Responses to the question asked in the Consultation Document are set out below and reflect general agreement with the four areas.

<b>Q8 Do you agree with the four broad strategy areas?</b>	
Yes	48
No	9
Total responses to this question	57

### **Q9 Supply control action points**

As shown below, around two thirds of those who responded to the question on this area felt that additional action points were needed in relation to supply control.

<b>Q9 Would you add anything further to the action points for 2006-2011 for supply control?</b>	
Yes	36
No	18
Total responses to this question	54

Almost all of the suggested changes either addressed perceived gaps in the set of action points set out in the Consultation Document, or added detail to those already there; few simply disagreed with the proposed actions.

The absence of supply control action points specific to alcohol and tobacco was queried with some concern. It was suggested that separate supply control action points for tobacco, alcohol and other drugs would allow greater specificity.

Several submissions called for stronger or additional measures to control the supply of tobacco, particularly to minors. These included stronger controls on promotion, removal of branding on packages, a requirement for stronger warnings on packages, a requirement for all sellers to be licensed, a ban on sales in venues accessible to minors, expansion of smokefree environments, removal of duty-free cigarette allowances, a public information campaign or other measures aimed at discouraging social supply to minors, regular increases in excise tax, higher taxation rates for tobacco companies, holding the tobacco industry accountable for its actions, a regulatory framework based on a public health model rather than a business one, investigation of full government control of distribution, and a transparent strategy for how any breaches will be dealt with.

A further suggestion was that the tobacco related action points should be clearly linked with the WHO Framework Convention on Tobacco Control.

Suggestions in relation to alcohol supply included a call for stronger enforcement in relation to supply to minors, an action point around planning and monitoring supply at local level, tighter regulation of alcohol licenses, including making alcohol available only in 'pubs', more host responsibility training for licensed premises, efforts to reduce social supply, and the need for new ways of influencing supply.

Comments relating to supply control measures for cannabis were mixed, with some calling for continued control and promotion of its adverse effects, and others for a move away from prohibition in favour of regulatory control.

The importance of keeping legislative and regulatory frameworks up to date was endorsed, though there were several comments that the Misuse of Drugs Act which was enacted in 1975 needs a full review rather than updating. Submitters noted that it was important that such frameworks could respond quickly when emerging evidence indicated a need for reclassification from licit to illicit.

Other comments and suggestions in relation to supply control included:

- Enforcement needs to be properly resourced and roles clearly defined across agencies (law enforcement agencies don't see themselves as social workers) - enforcement agencies could be supported through education, A&D liaison positions and formal liaison agreements
- Point seven (strengthening monitoring enforcement capability) should emphasise interagency alliances through workforce development
- The Policy needs to be more explicit about ways in which enforcement agencies can test for use of drugs
- The Policy doesn't have much about community involvement in supply control – communities often know things like where the 'tinny houses' are
- Want to see industry held accountable – tobacco, alcohol, pharmacies
- A section of the policy document setting out supply control legislation would be useful
- Supply control could be improved by tighter legislation, for example requiring mandatory checking of proof of age
- A more sophisticated set of procedures for managing and controlling unknown drugs in the early stages of their appearance is needed
- Manufacturers and importers of any new drugs should be required to prove that they are not harmful

- Comments on drug classification, including that pseudoephedrine should be reclassified prescription only, cannabis/marijuana should be available on prescription for medical purposes, tighter controls are needed on opiate and methadone prescribing and monitoring of sales of pseudoephedrine containing medicines, a more restrictive legislative/regulatory framework is needed for legal highs, and a suggestion that a select committee inquiry into the reclassification of all drugs is needed
- Encouraging economic development and giving young people a role in that would make a huge difference in communities with an established cannabis growing industry
- Nicotine should be identified as a drug separate from tobacco
- A review and/or tighter controls on prescription and dispensing practices for pharmaceuticals with abuse potential is needed
- Supply control in schools is an issue for school management and needs to consider student rights and legalities
- Supply control by Public Health Units is inconsistent and under-resourced – a nationally consistent process is needed
- The term ‘supply control’ is misleading in relation to policy around illicit drugs
- Increasing access to methadone increases the drug supply and therefore the number of opiate addicts
- The reference to regulation controlling advertising and display might be better placed in the demand reduction section of the Policy.

## **Q10 Demand reduction action points**

As with supply control, the demand reduction action points set out in the Consultation Document were generally accepted, but a high proportion of submissions contained suggestions for additional actions or suggested further detail and specificity.

<b>Q10 Would you add anything further to the action points for 2006-2011 for demand reduction?</b>	
Yes	34
No	22
Total responses to this question	56

A small number of submissions were sceptical about the effectiveness of the proposed actions, for the reason that similar activities were already in place or had been implemented in the past with little or no effect. Other submissions were strongly supportive of demand reduction strategies.

Many submissions discussed education and health promotion in schools. Different views were evident in relation to the respective roles of teachers and health or AOD specialists, the extent to which health promotion and AOD education should be integrated into school culture and activities, and the place for speakers such as treatment workers or former users.

Several submissions commented on the distinction between education and health promotion, with education seen as only a small part of health promotion. Effective health promotion was variously described as being carried out with community involvement, collaborative and intersectoral, action-based, and carried out in a range of community and workplace settings and through existing structures such as marae and churches, not just schools and educational institutions.

Other comments and suggested changes to the demand reduction action points included:

- The proposed action points are unbalanced - too much weight on education and promotion
- There is a need for ongoing professional development for trained health education teachers – designated professionals should be accessible to deliver health education and promotion programmes, as well as counselling services, and available to support teachers
- Develop capacity among non AOD staff to deliver brief interventions
- Drug education in primary and secondary schools needs to be strengthened through implementation of the health and physical education curriculum
- Education is currently under-resourced and under-emphasised
- Education aimed at young people needs to target different age ranges, well before secondary school
- Education needs to look at the cause of the problem and instil values, not simply 'drug scare' programmes
- Schools need good guidelines (as for suicide)
- School based cessation programmes are needed
- Investigate ways to end expulsion from school for minor offences
- There is a need to provide greater support for individual families at risk of alcohol or drug abuse so that these behaviours are not taken up by children
- Improved co-ordination is needed in the production of AOD resources – suggest awaiting the findings of the Ministry's resource stocktake before disseminating further information
- A lot of effort went into the Effective Drug Education resource material but it has been very unevenly promoted and implemented
- Some resources should be focused on illiterate young people
- Education and information resources on P/methamphetamine

- Planning for a social marketing campaign should consider the costs of resources in languages other than English
- Targeted campaigns are more effective than mass media – risk of adding to stigmatisation of drug users where mass media is used, or of increasing use
- Promotional activities need to include information on how users can reduce harm to themselves, as well as prevention
- Include community development as well as community action
- A range of actions to reduce demand for tobacco: ‘denormalisation’; taxation policy; pricing policy to remove the price advantage for loose tobacco; promotion and funding for cessation programmes; education (including the risks to unborn children); considering ways to prevent marketing that portrays smoking as glamorous; banning retail displays of tobacco products; and improved resourcing to support the implementation and enforcement of the Smokefree Environments Act
- Widespread advertising of legal highs should be prevented
- Restrict alcohol marketing and sponsorship, particularly messages aimed at children and young people - make a stronger statement about limiting alcohol marketing
- The drinking age needs to go back up
- Promote a moderate and responsible drinking culture
- Prohibit direct consumer advertising by pharmaceutical companies
- Work on pricing and tax policy should examine tobacco, alcohol and licit drugs and could consider its role in reducing demand for BZP products
- Provide incentives for employers to offer drug education programmes
- How does the plan intend to influence corporate practice among the licit drug industries, in line with the Bangkok Charter for Health Promotion – this charter should be referred to
- There should be compulsory education programmes in prisons
- United Nations days on health subjects e.g. World Tobacco Day should be promoted
- The safest drugs under the Misuse of Drugs Act should be legalised to provide alternatives to more harmful substances.

### **Q11 Problem limitation action points**

As with the other strategy areas, feedback on the problem limitation action points included a large number of comments and suggestions.

<b>Q11 Would you add anything further to the action points for 2006-2011 for problem limitation?</b>	
Yes	36
No	20
Total responses to this question	56

Many submissions said that the action points needed to provide more detail about actions to improve the quality of and/or access to a range of treatment services.

Comments focused on the type of services to be supported (prevention/intervention, assessment, counselling, residential treatment, outpatient etc), the need for the final policy document to be clear about which substances the action points were intended to apply to, and responsiveness to particular population groups. The groups mentioned were Māori, children and young people, Pacific people, those with problems associated with long-term use, older people, women (including those with dependent children), children of people with AOD issues (breaking the cycle), and prison populations and those on probation.

Submissions also supported a strengthened role for primary care services in providing assessment and non-specialist treatment – for example better brief intervention at emergency departments (with follow-up), early response to alcohol and smoking problems, and allowing pharmacists to prescribe nicotine replacement therapy patches.

As discussed earlier in this report (see Q4 Harm minimisation approach), there was some disquiet about the Consultation Document's use of the term 'problem limitation' rather than 'harm reduction'. 'Harm reduction' was described as being the accepted term and supported by an international research base. 'Harm reduction' was also considered to differ from 'problem limitation' in that it encompasses activity to bring about safer and healthier use for those drug users for whom cessation of use is not a realistic short-term option, and in its relevance to first time users as well as those who have become drug dependent.

Other specific comments and suggestions included:

- Need to identify the level of demand for various types of AOD treatment services – provision must reflect the numbers in need
- Encourage collaborative working, for example between health promotion units and Primary Health Organisations (PHOs), and improved relationships between community providers and clinical services
- Ensure responsiveness and clarity around agency roles and responsibilities for people with co-existing AOD and mental health problems
- Provide funding for workforce development in relation to specialist AOD services
- Add an action point(s) focused on tobacco cessation programmes – evaluation, continuation, improving uptake, and access to programmes in hospitals and schools

- There's a lack of treatment and rehabilitation services for methamphetamine users, especially for Māori and Pacific people
- Good to see alignment with Te Tāhuhu - the addiction action plan from Te Tāhuhu should be the priority in this area
- Add an action point on developing and encouraging innovative treatments
- Note that needle and syringe exchange programmes have other benefits – not just preventing the spread of blood-borne viruses – improve usage as well as access to these programmes
- Involve consumers in the planning and delivery of AOD treatment services
- Encourage responsible use of medicines by ensuring consumers are well-informed
- Action related to opioid programmes needs to improve quality and effectiveness as well as access - encourage more general practitioners (GPs) to prescribe methadone treatment - modify funding mechanisms so that people don't have to pay for the appointment
- Opiate users and their families are not adequately informed of the risks associated with methadone – objective of increasing access should be abandoned
- Include funding for schools for random drug testing of students with known problems
- Acknowledge the sometimes vicious cycle of abuse/drug use/abuse
- Ensure awareness and access to Foetal Alcohol Syndrome assessments for babies
- Support housing/shelters for people on the street with AOD problems
- Consider other options for managing drug related crime, given the over-representation of Māori and Pacific people in the penal system
- The diversion scheme should be given a legislative basis
- Efficacy of drug courts should be analysed and reviewed
- Ensure privacy for applications to the Minister for medical use of cannabis.

## **Q12 Information collection, research, evaluation and monitoring action points**

Feedback on the fourth strategy area also included a large number of comments and suggested additions.

**Q12 Would you add anything further to the action points for 2006-2011 for information collection, research, evaluation and monitoring?**

Yes	30
No	24
Total responses to this question	54

Information was clearly seen as valuable in a number of ways, including to inform planning, funding decisions, service provision, programme development and evaluation, and benchmarking performance internationally.

The importance of encouraging information flows in both directions between communities/grass roots providers and policy makers/researchers was a common theme across a number of submissions.

Other general comments and suggestion on this area included:

- Use the information already available to inform policy and practice
- Add an action point on the dissemination and utilisation of research/evaluation findings
- Data collection opportunities need to be managed in a cohesive way - ensure links to existing processes where possible to prevent duplication - acknowledge the resource implications of asking providers to collect additional information
- There's a need for better data collection e.g. emergency department and treatment statistics
- Need a mechanism for identifying emerging trends and new products/substances
- Data collection tools must be culturally appropriate
- Include 'for Māori by Māori' research using a kaupapa Māori framework
- Acknowledge the limitations of surveys relating to illicit drug use (users' reluctance to participate)
- Confidentiality is important for school-based surveys of students
- Building capacity at grass roots level is critical
- Local level data is important – communities need templates/tools to support data collection
- The government should support a stable research infrastructure with continuity of funding
- Place the same emphasis on illicit drugs as on alcohol and tobacco

- Evaluation of initiatives, projects, programmes, policies and legislative changes is important (though a small number of submissions felt that it is already clear that existing interventions have failed) – a role for cost/benefit analysis
- Research and evaluation should be independent and follow scientific methods
- Research on controlled drugs should be done in an independent academic context, in a controlled setting
- Action points on evaluating the effectiveness of policy interventions for tobacco and alcohol should be added
- Information should be used to inform prioritisation of policy responses using a burden of disease model
- Research should be solution focused, not problem focused
- The NDP Discretionary Fund is a solid start.

Suggested topics for research or data collection included:

- The impact of drug related harm on family/whanau - information on the children of families with AOD problems
- The factors contributing to a progression from 'use' to 'abuse'
- The impact of alcohol or illicit drug use on criminal behaviour leading to imprisonment
- Pharmacotherapy (including for amphetamine and opiate dependence) and cognitive behavioural therapies
- Improving the reliability and validity of clinical indicators
- Tobacco use and control including retaining smoking questions in the Census, continued support for the New Zealand Tobacco Use Survey, the formation of international research partnerships and the inclusion of New Zealand in the International Tobacco Control Policy Evaluation Project
- Research/data collection to inform improved alcohol interventions and tobacco control
- Trends in drug advertising and research into effective controls on alcohol and tobacco industries
- Licensing information nationally
- Research to inform interventions to reduce inequalities
- Information on gender and ethnicity differences
- Data on 'kids and drugs'
- Environmental design and place management to ensure young people are not alienated from public spaces

- The economic costs of interventions, for example border control, and enforcement
- An evaluation of the existing legislative framework and whether prohibition is working
- A review of the evidential base for prohibition
- A comprehensive audit of harms that recognises wellbeing and civil rights
- A list of AOD service providers in each town and city.

### **Q13 Monitoring progress**

Fewer submissions made specific comment on the method for monitoring progress. As shown below, most of those who addressed the question set out in the Consultation Document were comfortable with the proposed method for monitoring progress.

<b>Q13 Do you agree with the method for monitoring progress?</b>	
Yes	40
No	15
Total responses to this question	55

Some submissions, however, sought more specificity about how the success of the Policy will be determined on completion of the five-year period, and wanted to see monitoring and reporting frameworks for the Policy as a whole rather than individual action plans.

Comments emphasised:

- The importance of translating the proposed theory into practice
- The need to link NDP monitoring to existing activities and processes
- The need to provide an opportunity and sufficient time for affected agencies and NGOs to contribute to the development of indicators and monitoring mechanisms
- The role of community feedback in assessing progress
- The need for adequate resourcing for monitoring activity
- Advocacy for local, regional and youth representation on the Inter-Agency Committee on Drugs (IACD) and the Ministerial Committee on Drug Policy (MCDP).

## Q14 Features of the New Zealand approach

Responses to the question on this section of the Consultation Document are shown below.

<b>Q14 Does the 'Features of New Zealand approach' adequately reflect the New Zealand situation?</b>	
Yes	37
No	17
Total responses to this question	54

Comments included:

- The information to be included in the companion document should have been presented and analysed as part of the consultation process to underpin the revised Policy
- Strong concern in some submissions at the document's use of the term 'evidence-informed practice' rather than the more usual 'evidence-based'
- The Treaty of Waitangi and the Treaty principles should be included
- Reducing inequalities isn't adequately covered
- There should be more information on Māori and Pacific populations, including the strengths of these communities
- More attention should be given to kaupapa Māori AOD treatment and supporting the effectiveness of kaupapa Māori approaches
- Geographical differences aren't sufficiently recognised
- The opportunities for equal health outcomes for some marginalised groups such as prison inmates may be limited
- Acknowledge New Zealand's high suicide rates and the links between mental health and A&D abuse
- Note the decline in volunteer input to social and community issues
- The Local Government Act 2002 gives significant role and influence to local authorities in promoting the social, economic environmental and cultural wellbeing of their communities, making them an important stakeholder group for the NDP
- Add more analysis of the public versus private, and for-profit versus not-for-profit aspects of prevention and service provision.

## Q15 Drug use in New Zealand

Responses relating to the overview of drug use in New Zealand are shown below.

<b>Q15 Does the 'Drug use in New Zealand' section provide a fair overview?</b>	
Yes	36
No	17
Total responses to this question	53

Many submissions made very positive comments about the usefulness of this summary, though others felt that considerably more detail was required. Other comments and suggestions included:

- Some of the data quoted is out of date and should be updated in the final policy document
- Expand information on prevalence and harms, such as the number of alcohol related presentations to emergency departments, and smoking rates among young people
- Add explicit reference to the long-term implications of early onset alcohol use
- The document understates the harms directly or indirectly attributable to alcohol
- The Policy should recognise the circumstances of smaller towns and rural communities, where alcohol and drunk driving are a major cause for concern
- Query methamphetamine being described as particularly problematic given the far greater prevalence of alcohol and tobacco
- Information on polydrug use would be useful (including the combined use of alcohol and legal highs by young people)
- Expand on the abuse of prescription drugs
- The impact of tobacco use on the Māori population needs further detail
- Mention 'roid rage' when discussion anabolic steroids
- Evidence is available to contradict the statement that cannabis smoking has adverse effects on the respiratory system
- Pseudoephedrine is now a controlled drug, not a pharmacy only medicine.

## Other comments

This final section of the report sets out comments on matters not closely related to the Consultation Document's question areas or encompassed in the discussion of key themes.

### NDP policy development

- Grouping alcohol, tobacco and other drugs into one document is too broad – individual policies would allow a more detailed and comprehensive treatment
- Consider whether the final Policy should be delayed until information arising from the Sale of Liquor (Youth Alcohol Harm Reduction) Amendment Bill 2005 and the New Zealand Drug Foundation Policy in Action Workshops is available
- A query about the basis for identifying *Strengthening Drug Education in School Communities* as a recent achievement, in the absence of information on its usefulness for schools
- Reference to the Discretionary Grant Fund is inconsistent as it wasn't established until after the end date for the first NDP
- It would be useful for the NDP to reinforce increased industry interest in workforce and transport safety issues since the passing of the Health and Safety in Employment Amendment Act 2002.

### Policy issues

- All schools regardless of decile require funding assistance
- NGOs need to be funded for advocacy and lobbying (to counter the effects of industry); all alcohol and tobacco lobbyists should be banned from parliament
- Introduce legislation enabling litigation against the tobacco industry
- Repeal the law against the sale of items such as vapourisers and bongs.

### Other comments

- Allocation and applications mechanisms for the Discretionary Grant Fund should be promoted
- Will the New Zealand government be playing a role in developing international instruments for global control of alcohol trade and marketing strategies (similar to its role in relation to tobacco)?
- Unclear how the Health Equity Assessment Tool is to be used
- Give people the freedom to make choices through legalisation, and also personal responsibility for the consequences.