

National Drug Policy

Part 1: Tobacco and Alcohol

Part 2: Illicit and Other Drugs

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MANATŪ HAUORA

Foreword

New Zealand has been protected from some of the worst drug problems which have affected other countries, particularly in relation to illicit drugs like heroin and cocaine. But no country is immune from such problems. Even now, drug use imposes unacceptably heavy health, social and economic costs on New Zealanders. Clearly, there can be no room for complacency.

In 1994, the Government released its National Mental Health Strategy. One of the five major directions of the strategy was to develop a national policy on drugs. This document represents the achievement of that direction, and a major step forward in the way in which we address drug-related harm in New Zealand.



Hon Roger Sowry

It brings together the two parts of the Government's National Drug Policy in one place, reproducing *Part 1: Tobacco and Alcohol* (which was first released in mid-1996) and publishing for the first time its companion policy, *Part 2: Illicit and Other Drugs*.

The policy is about improving the health and wellbeing of all New Zealanders by clearly setting out the Government's determination to prevent and reduce drug-related harm.

It emphasises the need for strong law enforcement (to control the supply of drugs), credible messages about drug-related harm (to reduce demand for drugs), and effective health services (to manage drug problems which do still occur). This is in line with the balanced approach to drug policy which is recommended by the United Nations and World Health Organization.

This is an intersectoral policy which relies on the efforts of different government and non-government agencies. It also recognises that communities need to be able to address drug-related issues at a local level. The Government has a role in encouraging and supporting such initiatives by providing leadership and resources, information and advice, and by ensuring that both community and government efforts are focused on a common goal and set of priorities.

The National Drug Policy establishes this strategic direction for the next five years, and sets out explicitly for the first time the Government's commitment to minimise drug-related harm. In partnership with the community, it is now time to turn this commitment into action.

Hon Roger Sowry
Associate Minister of Health

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Overview

Policy goal

The National Drug Policy's overall goal, as far as possible within available resources, is to minimise harm caused by tobacco, alcohol, illicit and other drug use to both individuals and the community.

National priorities

The following priorities for action have been selected for the first five years of the National Drug Policy's operation. These priorities may need to change over time.

Priority 1	To enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of tobacco, alcohol, illicit and other drug use
Priority 2	To reduce the prevalence of tobacco smoking and exposure to environmental tobacco smoke
Priority 3	To reduce hazardous and excessive consumption of alcohol, and the associated injury, violence and other harm, particularly on roads, in the workplace, in and around drinking environments, and at home
Priority 4	To reduce the prevalence of cannabis use and use of other illicit drugs
Priority 5	To reduce the health risks, crime and social disruption associated with the use of illicit drugs and other drugs which are used inappropriately.

Future directions

Strategies that work towards achieving the priorities of the National Drug Policy will be adjusted or developed as necessary, and will fit within the Government's overall strategic priorities. Major directions to be emphasised during the next five years include:

- information, research and evaluation
- health promotion
- assessment, advice and treatment services
- law enforcement
- policy and legislative development.

Strategies

The National Drug Policy aims to reduce the effects of harmful substance use through a balance of supply control measures (controlling or limiting the supply of drugs) and demand reduction measures (reducing individual demand for drugs). It recognises that there is a continuum of harm associated with drug use, and that no single approach or set of strategies can adequately address the possible range of harm. The policy allows for different approaches to be used, depending on the particular issue or the group being targeted. The overall aim, however, will always be to minimise drug-related harm.

Key groups

Desired outcomes are listed under each priority in the National Drug Policy, both for the whole population and specifically for key groups. The groups most at risk vary with the particular harm being addressed, and whether or not this harm is related to a single drug or a combination of drugs. Examples of groups which are at greater risk of a number of drug-related harms, and thus have desired outcomes listed under several priorities, are:

- young people
- Māori
- people with co-existing drug use and other mental disorders
- polydrug users
- pregnant women.

Key settings

There are a variety of environments or settings which need to be taken into account when minimising drug-related harm. Settings that warrant particular attention are:

- educational settings
- the community
- workplaces
- prisons and community correction settings.

Implementation, monitoring and review

Progress in implementing the National Drug Policy will be monitored and reviewed by:

- a special Ministerial Committee, which will meet twice yearly to review progress and decide which new policy initiatives should be recommended to the Government
- a monitoring group of officials, which will ensure that policies and programmes developed by government agencies are consistent and mutually supportive, and will make recommendations to the Ministerial Committee on new policy initiatives.

PART 1: Tobacco and Alcohol

Section 1: The Policy

Introduction

Part 1 of New Zealand's National Drug Policy sets out the Government's policy and legislative intentions for tobacco and alcohol for the next five years. It is the first time that all government policies to do with the harmful consequences of tobacco and alcohol have been brought together in one document.

This policy was developed over 18 months, following two rounds of consultation – the first on an issues paper, the second on a draft national policy on tobacco, alcohol and other drugs. It was originally published in June 1996 as *National Drug Policy, Part 1: Tobacco and Alcohol*.

Since the initial release of Part 1, there have been a number of important advances made towards achieving the desired outcomes of the policy, particularly in relation to tobacco. Highlights in the last 12 months include the continuation of the *Why start? / Hei aha te kai paipa?* multimedia campaign, increased smokefree sponsorship of sporting and cultural events, smokefree schools initiatives, increased enforcement of laws against the sale of tobacco products to under-age children, and new legislation to raise the minimum age at which young people can legally obtain cigarettes from 16 to 18 years of age.

As a result of these initiatives, anecdotal evidence suggests that young people are finding it more difficult to purchase cigarettes. There has also been a dramatic increase in the number of retail outlets which display signs advising customers of the ban on selling cigarettes to under-aged young people. Combined with the positive evaluations which have emerged from the *Why start?* multimedia campaign, it now remains to be seen whether these successes have translated into a reduction in the number of young people who smoke or who are exposed to environmental tobacco smoke.

Similarly, in relation to alcohol, it remains to be seen whether the efforts of the last year under the umbrella of Part 1 – for example, the launch of the Alcohol Advisory Council's three-year campaign to reduce teenage binge drinking – have resulted in a tangible reduction in the level of alcohol-related harm which is experienced by New Zealanders.

These are questions which will be addressed by the inaugural meeting of the special Ministerial Committee that will meet twice yearly to review progress under the National Drug Policy and to decide which new initiatives should be recommended to Government.

Purpose of the policy

This national policy:

- brings together a range of strategies and interventions which address a common goal
- forms a basis for coherent policy development across a wide range of settings and agencies
- assists future co-ordination of strategies and delivery through identification of any gaps and overlaps, and through establishing key linkages and co-ordination mechanisms
- provides for the development of measurable outcomes against which the impact of strategies may be assessed.

Policy goal

The goal of this policy is, as far as possible within available resources:

To minimise harm caused by tobacco and alcohol use to both individuals and the community

Underpinning this goal are five principles. They are:

- efficiency
- equity
- use of both harm prevention and harm reduction strategies
- upholding of individual rights where these do not unreasonably impinge on the rights of others
- ensuring the needs of Māori are addressed by enabling development of specific strategies acceptable to Māori.

National priorities

The following priorities for action have been selected for the first five years of Part 1 of the National Drug Policy. These priorities may need to change over time, especially as new research evidence becomes available, but they provide a clear starting point.

Priority one

To enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of tobacco and alcohol use.

Priority two

To reduce the prevalence of tobacco smoking and exposure to environmental tobacco smoke.

Priority three

To reduce hazardous and excessive consumption of alcohol, and the associated injury, violence and other harm, particularly on the roads, in the workplace, in and around drinking environments, and at home.

Outcomes and indicators

The National Drug Policy aims to provide a basis for making measurable progress towards achieving the priority policy objectives. For each priority, a set of desired outcomes is listed. Key groups within the population, whose members are at special risk of tobacco- and alcohol-related harm, and key settings for service delivery, have been identified. Where appropriate, these are reflected in the desired outcomes.

Measurable progress towards these outcomes will indicate that the priority objective is being achieved. In some cases, there are existing indicators to show whether the strategies being implemented have made a demonstrable difference. In other instances, the first step will be to capture baseline data. Targets will be set so that progress towards each outcome can be assessed.

Priority one

To enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of tobacco and alcohol use

Desired outcomes are:

- general acceptance by government agency staff of harm minimisation as an effective approach to reducing tobacco- and alcohol-related harm; and ongoing co-operation and collaboration among agencies involved in tobacco and alcohol issues
- increased involvement of the community, and particular subgroups in the community, in reducing tobacco- and alcohol-related harm
- more effective school policies and education in the school setting about healthy attitudes and practices for tobacco and alcohol use
- reduction in the rate of injury and loss of productivity in the workplace linked to the use of tobacco and alcohol
- improved range, quality and accessibility of effective treatment options for people with tobacco and alcohol problems
- improved expertise of health workers in the tobacco and alcohol field.

Priority two

To reduce the prevalence of tobacco smoking and exposure to environmental tobacco smoke

Desired outcomes are:

- reduction in the prevalence of tobacco smoking in the population
- reduction in the prevalence of tobacco smoking among people under 18
- reduction in prevalence of tobacco smoking among pregnant women
- reduction in the prevalence of tobacco smoking among Māori.

Priority three

To reduce hazardous and excessive consumption of alcohol, and the associated injury, violence and other harm, particularly on roads, in the workplace, in and around drinking environments, and at home

Desired outcomes are:

- increase in the proportion of the population who do not exceed maximum responsible drinking levels
- reduction in the prevalence of drinking among pregnant women and women planning pregnancy
- reduction in the prevalence of binge drinking and other harmful drinking patterns among young people, including young Māori and young Pacific people
- reduction in the rate of road crashes involving drivers who have consumed alcohol beyond prescribed blood alcohol content levels
- reduction in the rate of Māori death and injury caused by alcohol-related motor vehicle crashes
- reduction in the rate of alcohol-related crimes, including criminal assaults and public order offences
- reduction in the rate of alcohol-related drownings and other alcohol-related injuries.

Future directions

Within the next five years, strategies that work towards achieving the outcomes of the National Drug Policy will be adjusted or developed as necessary, and as further information becomes available. These strategies will be cost-effective and will fit with the Government's overall strategic priorities and the fiscal constraints it is operating under. Major directions to be emphasised include the following.

Information

Systems for collecting the information necessary to monitor and gauge the success of this policy will be developed. In the first two years of this policy, emphasis will be placed on ensuring baseline data and targets are developed for the desired outcomes.

Research and evaluation

In the next five years, research and evaluation will include emphasis on:

- assessing the prevalence of tobacco and alcohol use, including use by at-risk groups
- assessing the environmental and predisposing factors associated with tobacco and alcohol use
- assessing the impact of legislative changes (for example, if the Sale of Liquor Act 1989 is amended)
- assessing the impact of law enforcement interventions
- developing evaluation techniques and performance indicators for service providers
- determining which interventions have the greatest impact on drivers arrested with very high blood alcohol concentrations and repeat drink-drive offenders.

Health promotion

In the next five years, health promotion initiatives will include:

- strengthening of health warnings and information on tobacco packaging
- mass media education campaigns, including:
 - smoke-free campaign
 - drink driving campaign
 - alcohol moderation campaigns
- health promotion in schools which more closely meets the needs of particular school communities
- improved health promotion for at-risk groups, such as:
 - prison inmates and prison staff
 - sports people
 - young Māori
- provision of information and resources about tobacco- and alcohol-related harm, and how it can be reduced

- provision of information and advice about workplace policies and programmes to minimise tobacco- and alcohol-related harm
- provision of host responsibility training for people serving alcohol in licensed premises, sports clubs, other community venues and homes.

Health promotion initiatives may include:

- community development projects focused on reducing or preventing tobacco- and alcohol-related harm
- provision of training opportunities for health promotion workers.

Assessment, advice and treatment services

In the next five years, assessment, advice and treatment services will focus on:

- better addressing the needs of at-risk populations, such as:
 - children and adolescents
 - those with co-existing alcohol use disorders and other mental disorders
 - prison inmates
 - drink-drive offenders
 - Māori
 - Pacific people
- increasing the provision of advice by primary health workers and other community workers, especially for:
 - pregnant women and women planning pregnancy
 - people with emerging alcohol problems.

Training for service providers will focus on:

- training for primary health workers and other community workers in brief assessment and intervention
- training for specialist drug treatment workers in management of mental disorders
- training for mental health service workers in assessment and management of tobacco- and alcohol-related problems
- training for community workers and school personnel in recognition of tobacco- and alcohol-related problems, and how to manage and refer people at risk of harm.

Law enforcement

Within the next five years, there will be:

- enhanced enforcement of the Smoke-free Environments Act 1990, including increased prosecutions for sale of tobacco products to minors
- continuing enforcement of the Sale of Liquor Act 1989, including those provisions related to the minimum drinking age, intoxication and host responsibility
- further improvement of the compulsory breath testing programme administered under the Transport Act 1962.

Policy and legislative development

Within the next five years, policy and legislative review will include:

- investigating the feasibility of introducing photographic proof of age (for example, on drivers' licences) for use in licensed premises
- review of the provisions for compulsory assessment and treatment of people with alcohol use disorders
- review of the Sale of Liquor Act 1989, which focuses on the operation of the Act and whether it is meeting its objective and underlying principles, and which addresses the following issues:
 - the minimum drinking age
 - supermarket and off-licence sales on Sunday
 - Sunday trading in hotels and taverns
 - issues relating to different types of licences that can be granted
 - drinking hours
 - definition of intoxication
 - host responsibility
 - managers' certificates and training
 - the roles of the Liquor Licensing Authority and District Licensing Agencies
 - the position of licensing trusts
 - technical issues
 - consideration of the Potter Report on liquor advertising
 - health warnings.

Implementation, monitoring and review

Progress within the priority areas of the National Drug Policy will be monitored and reviewed in the following ways:

- A Ministerial Committee, chaired by the Minister of Health and including the Ministers of Corrections, Customs, Justice, Police, Māori Affairs, Youth Affairs, Transport and Education, will meet twice yearly to review progress and decide which new policy initiatives should be recommended to the Government.
- A monitoring group, chaired by a Ministry of Health official and including representatives of the Ministries of Education, Justice, Transport and Youth Affairs, Te Puni Kōkiri, the Department of Corrections, Police, Customs, Land Transport Safety Authority and the Alcohol Advisory Council, will ensure that policies and programmes throughout government are consistent and mutually supportive. The monitoring group will receive reports from individual government agencies on the progress made in implementing this policy, and will make recommendations to the Ministerial Committee on new policy initiatives. It will seek representations from other agencies as appropriate.
- All government agencies with responsibilities for drug-related policy initiatives will present six-monthly progress reports which outline progress with their areas of responsibility, give an update of resources devoted to the area, and report on any other strategies/interventions designed to impact on the national priorities and desired outcomes.

Section 2: Background Information

Major issues

Use of tobacco and alcohol results in considerable harm in New Zealand. Around 5000 deaths each year are attributed to the effects of tobacco and alcohol. The health, social and economic costs of harmful tobacco and alcohol use are borne by individuals, families and the wider community.

The harmful consequences of tobacco and alcohol use, or misuse, are of grave concern to many New Zealanders. However, alcohol when used in moderation and in non-hazardous situations can provide personal and social benefits. In developing this policy, then, the Government has not sought to prevent all use of tobacco and alcohol, but rather to minimise the harm which results from their use.

Of all drugs, tobacco and alcohol result in the most harm in New Zealand. This harm includes problems for the individuals using tobacco and alcohol, for those around them, and for society as a whole. Health problems may occur after long-term heavy use or more immediately, as in asthma due to passive smoking and injuries from alcohol-related road crashes. Also, with alcohol in particular, there may be follow-on social problems in the family or the community, caused by the behaviour of drinkers.

Alcohol is used by over four-fifths of the adult population, and tobacco by about a quarter of the adult population. While alcohol is widely used, and is embedded in New Zealand culture, there is also recognition that it can cause great damage in society, particularly through its association with street and family violence, injury and accident.

Although the overall use of tobacco has been falling, rates for young people, Māori and women have not changed significantly. Unless we continue our efforts and develop new strategies, disease and premature death caused by tobacco both to smokers and to others in their environment, like young infants, will continue to be unacceptably high – particularly among young women and Māori.

Harm that results from tobacco and alcohol use includes harm to health, violence and crime, and community disruption in different settings, such as homes and workplaces.

- **Harm to health:** Harm to health includes deaths associated with any drug use, illness and disease, accident and injury. Tobacco causes the most direct risk of premature death to the user, but alcohol is the highest contributor to mortality and illness among young people. Alcohol is a major contributor to road crashes. It has also been linked to other accidents and injuries, such as drownings, although there is a lack of data available in this area.
- **Violence and crime:** Violence and crime are associated with alcohol use in a number of ways. Alcohol is widely agreed to be a significant factor in violence, contributing to street violence and disorder, family violence and general antisocial behaviour.

- **Community disruption:** Tobacco and alcohol use affects the life of the family and the community in which the individual lives, as well as the individual user. Excessive use of alcohol can lead to reducing an individual's social functioning at home, with dysfunctional behaviour affecting the behaviour of other members of the family at school and in the community generally. It can also lead to industrial accidents and reduced productivity at work.

Because the range of harm associated with tobacco and alcohol use is so varied, and so diffused across the community, a large number of agencies are dealing with different aspects of the problems that arise. The co-ordination of activities across sectors, through a national policy, should increase the overall effectiveness of individual interventions. Also, because drugs are often used together, a national policy will foster development of strategies, for example for young people, that focus on multiple drug use as well as use of tobacco or alcohol alone.

In seeking to minimise the harm of tobacco and alcohol use for the community and the individual, Part 1 of the National Drug Policy will assist in addressing two of the Government's Strategic Result Areas – improved health status and crime reduction.

Principles for policy development

The following principles underpin the National Drug Policy.

Efficiency

Cost-effectiveness must be taken into account in decisions about what types of harm to reduce and how to reduce them. The national priorities for tobacco and alcohol use reflect this principle. These priorities were determined according to the most costly areas of harm, and where there is most research and evidence about effective strategies to reduce the harm. Where research or evidence about the most effective strategies – or even the extent of the harm – is lacking, the national policy recommends further research or evaluation programmes before policy decisions are made.

There are also a number of areas where there is insufficient evidence about the cost-effectiveness of possible interventions; and it is recommended that more work be done before policy decisions are made, and funding allocated.

Equity

Considerations of equity must also be taken into account in decisions about resource allocation, access to services, and outcomes for special populations and communities.

Use of both harm prevention and harm reduction strategies

This principle reiterates that harm minimisation allows for different approaches to be used. It recognises that an effective national policy must do two things:

- prevent harm from occurring, by preventing uptake and/or harmful use of tobacco and alcohol
- reduce harm which is already occurring.

Health education programmes to prevent people taking up tobacco smoking are an example of harm prevention. 'Host Responsibility' strategies, such as having party-goers stay overnight if they consume too much alcohol, are an example of harm reduction.

Upholding of individual rights where these do not unreasonably impinge on the rights of others

This principle requires a careful balance to be struck between the rights of the individual and the rights of others, or of society at large. Clearly, as a society, we hold that some types of harm (even to individuals) are always unacceptable, while other choices – which may be harmful to the individual – are legal and acceptable if the use does not impinge upon others. That is, weighting is given to individual choice where the costs of this choice are not borne by others.

Individuals are free to use tobacco and alcohol. This policy is designed to ensure that the effects of that use do not directly impinge on the rights of others, for example through smoking in enclosed public spaces, or through driving while impaired by alcohol.

Ensuring the needs of Māori are addressed by enabling development of specific strategies acceptable to Māori

Under the Treaty of Waitangi, the Government has a particular responsibility to address Māori health status issues. This principle establishes a specific focus of the national policy on meeting Crown objectives in relation to Māori health; namely, to ensure that Māori have the opportunity to enjoy at least the same level of health as non-Māori.

The principle acknowledges that Māori are suffering disproportionate harm from the use of tobacco and alcohol, and that strategies designed for the general population have had limited effect in reducing that harm among Māori.

Problems in Māori communities may be addressed more effectively when targeted approaches are developed by and for Māori, because of the need for in-depth knowledge of the Māori community, and for acceptable and effective approaches to use when advocating changes in behaviour and lifestyle.

The National Drug Policy therefore reflects this principle. It does so in two ways: first, by the inclusion of outcomes for Māori under many priorities; and second, by advocating strategies through which Māori identify their own needs, and the most appropriate and effective interventions to reduce harm.

Strategies

Part 1 of the National Drug Policy aims to reduce the effects of harmful tobacco and alcohol use, using a balance of supply control and demand reduction measures. It recognises that there is a continuum of harm associated with the use of tobacco and alcohol, and that no single approach or limited set of strategies can adequately address the possible range of harms.

The policy allows for different approaches to be used, depending on the particular issue or the group being addressed. Prevention of use and the promotion of abstinence will be appropriate in certain circumstances, and the promotion of moderation, or risk-awareness, in others. The overall aim will always be the reduction of harm.

Strategies for the prevention and reduction of tobacco- and alcohol-related harm, which contribute towards meeting each priority area, need to take into account three interacting components:

- the characteristics of individual smokers or drinkers (for example, their age, gender and ethnicity)
- the environment in which the tobacco or alcohol use occurs (for example, the social, physical and economic context)
- the characteristics and effects of the tobacco or alcohol they are using (for example, its psychoactive properties, type and amount, its dependence-producing effect).

Different strategies are needed to target:

- the whole population, or particular at-risk groups within it
- all drug use, including that of tobacco and alcohol, or misuse of tobacco or alcohol specifically
- all settings, or particular environments where misuse occurs.

Strategies need to operate in the three different areas of:

- supply control (controlling or limiting the supply of tobacco and alcohol)
- demand reduction (reducing individual demand for tobacco and alcohol)
- problem limitation (limiting the problems that arise from tobacco and alcohol use).

Part 1 of the National Drug Policy represents an important step in New Zealand in the co-ordination of policies and strategies across the many government agencies that share responsibilities to do with tobacco and alcohol. Each agency will continue to implement and manage the policies and programmes within its area of responsibility. For instance, the Alcohol Advisory Council is co-ordinating development of a national strategic plan to promote safety in the use of alcohol and to minimise the harm. This policy sets an overall direction, providing a framework for this work, and for resource allocation and co-ordination among government agencies.

To be successful, the policy needs the support and participation of non-governmental organisations, including local and voluntary groups, service providers, individuals, employer and industry groups, and the community at large. It is hoped that, by setting a framework and a direction, this policy will assist them to participate in an overall approach to reducing tobacco- and alcohol-related harm.

The policy is intended to reinforce and further develop strong intersectoral linkages at both a national and local level.

Key groups

In the National Drug Policy, desired outcomes are listed under each priority, both for the whole population and specifically for key groups affected. The groups most at risk vary with the particular harm being addressed, and whether or not this harm is related to tobacco or alcohol alone, or use of a combination of drugs.

For example, under tobacco, desired outcomes are listed for young people (since the teenage years are those in which people most commonly start smoking), pregnant women (since tobacco smoking during pregnancy retards the growth of the unborn child, and exposure to tobacco smoke during infancy increases the risk of sudden infant death) and Māori (since a higher proportion of Māori smoke than of the general population, and Māori suffer disproportionately from lung cancer and heart disease, diseases for which the risk is increased by tobacco smoking).

Some groups are already experiencing greater harm to health resulting from tobacco and alcohol use. Use of tobacco and alcohol, and harm associated with this use, needs to be monitored for other groups that are also at potential risk, such as Pacific people and recent immigrant groups.

Examples of groups that are at greater risk of a number of tobacco- and alcohol-related harms, and thus have outcomes listed under several priorities, are given below.

Young people

Young people, from primary school age through to young adulthood, are a major focus for prevention of tobacco- and alcohol-related harm. Personal decision-making and other life skills need to be developed and fostered, so that young people feel able to make healthy decisions about the use of tobacco and alcohol.

The particular age group focused on may vary from one strategy to another. For example, strategies to prevent uptake of tobacco smoking may focus on people under the age of 18 years, whereas those to prevent alcohol-related harm may focus on teenagers and adults under 25 years of age, or more specifically on young men.

For young people not using any drugs, a message that co-ordinates information about all drugs and emphasises a general healthy lifestyle may be most appropriate. For the young people who are already using tobacco and alcohol, it is important to focus on use that will minimise health risks and other risks. For example, young people should be encouraged not to drink to excess. Young women who are smokers should be encouraged to stop smoking before contemplating having a child.

School health policies and drug education in schools are avenues to reach young people of school age. However, many in this age group are not in school for a variety of reasons, and those who are truants are at high risk of tobacco- and alcohol-related problems. A community focus is therefore necessary to reach some members of this target group. A community focus is important even when young people are reached through the school: school-based education must be supported by family and community messages, so that young people do not receive conflicting messages.

A particular concern is the shortage of specialist treatment and support services for young people with tobacco- and alcohol-related problems, and especially the shortage of appropriate services for young Māori.

Māori

Māori as a group suffer harm from tobacco and alcohol disproportionately to the rest of the population. For example, Māori women have a high rate of smoking that has not fallen as much as in the rest of the population, and Māori have a high rate of death and injury from alcohol-related road crashes. Before these problems can be addressed, more detailed information is needed, for example, about drinking patterns among Māori.

Māori cultural components should be offered in all services available to Māori, particularly in health promotion and treatment services. In addition, it is essential that programmes to address tobacco- and alcohol-related problems among Māori are developed and implemented by Māori. General programmes have often not proved effective for Māori communities. Some providers of alcohol and drug treatment services advocate abstinence as a particular treatment goal for Māori whose lifestyle choices have detrimental effects on themselves, their families and their communities. An increasing number of Māori service providers are using a continuum of care approach which incorporates health promotion, intervention and treatment.

Other factors that will assist Māori-managed programmes are an emphasis on increasing the knowledge, skills and support available to Māori workers in the voluntary sector as well as to professionally trained Māori workers, and recognition of the need for a variety of local approaches rather than for a single national approach. Local approaches will be dependent both on the particular needs of local hapū and iwi, and on the degree of involvement in health services by different hapū and iwi.

People with both alcohol disorders and other mental disorders

A group which has been identified as being in need of targeted assistance within treatment options is those people who experience both mental health and drug (including alcohol) problems. The prevalence of co-existing mental health and drug disorders is high. Surveys of mental health service users have indicated that between 20 and 70 percent also have a drug disorder. Likewise, high proportions of people with drug, especially alcohol, dependence also have a mental disorder.

Health outcomes for this group are much poorer than those for people with either disorder alone. There is some evidence that this group may not be adequately treated by either specialist mental health or specialist drug treatment services. Integration of treatment services for people who have both disorders is vital if people are to manage their disorders in in-patient or community settings. Better integration of mental health and drug treatment services, and development of specific treatment protocols for people with these co-existing disorders, is needed to improve services for this group.

Polydrug users

The most serious harms are often suffered or caused by those who use more than one substance (for example, drink alcohol and smoke cannabis). These people are referred to as polydrug users. When a 'substance by substance' approach is taken to addressing drug-related problems, the needs of polydrug users can be overlooked. Treatment providers suggest that most of their clients use more than one drug.

Pregnant women

The unborn child is at particular risk of harm from exposure to tobacco and alcohol. When used in an ongoing way during pregnancy, tobacco and alcohol are associated with low infant birthweight and other signs of developmental problems. Alcohol consumption during pregnancy, particularly when this is ongoing and at high levels, can result in fetal alcohol syndrome, which includes both intellectual impairment and physical irregularities.

Key settings

There are a variety of environments or settings which need to be taken into account when minimising tobacco- and alcohol-related harm. Often, different government agencies will be involved in different environments.

For example, in the school setting, the Ministry of Education will take a lead role, while in prisons, the Department of Corrections will have the major responsibility. Clearly also, a range of non-governmental agencies will have an important part to play in a variety of activities such as research, advocacy, support and service provision. Individuals, whānau and the wider community also have vital parts to play, and it is hoped that they will also support this national policy.

Some settings that warrant particular attention are set out below.

Educational settings

The school environment is a major setting for developing skills to make healthy choices about drugs, and both the Ministry of Education and local boards of trustees have key roles to play in ensuring school policies and education are effective. The Ministry of Education guidelines on drug education and policies within schools have proved useful; and the new national curriculum statement on Health and Physical Education currently under development will ensure that education about tobacco and alcohol is integrated into everyday learning and teaching within the classroom setting, the approach that research shows is most effective.

A number of voluntary and private providers also offer drug education in the school setting, and it is important that schools and boards of trustees can assess the relative effectiveness of their programmes.

The Ministry of Health is working with the health and education sectors to promote a *Healthy Schools: Kura Waiora* approach in schools. Applied to drugs, this approach includes development of school policies on tobacco, alcohol and other drugs, involvement of the community and provision of accepting school environments, as well as enhancing the skills required to make healthy choices about drugs.

There is also opportunity in the school setting for early intervention with young people who are experiencing problems with drugs. Training for school personnel, to assist in identifying and referring people at high risk of drug-related harm, is needed.

Tertiary education settings are also important venues for provision of health promotion messages regarding drug use. Many young people undertaking tertiary education are away from home for

the first time. That new sense of freedom and independence, coupled with hazardous drinking cultures (including drinking games and binge drinking) that have built up over many decades, poses particular problems for young people. Steps need to be taken to change the culture.

Community

Reducing harm from tobacco and alcohol requires a co-ordinated series of strategies that deal with the beliefs and behaviours of individuals and the social and cultural structures around them. Resourcing local communities to work on the issues, using local community networks, and intersectoral co-operation at a local level – that is, harnessing the energy and the knowledge of the community – can be a powerful way to change attitudes and behaviour. Indeed, strengthening community action was recognised by the *Ottawa Charter for Health Promotion* (1986) as one of the major strategies required to achieve equity in health. The community development approach empowers local communities to tackle issues in a way that suits them and their particular physical, social and cultural environment. It can co-ordinate the efforts of many different people and organisations, including local authorities, police, community workers, schools, marae, resident groups, retailers and so on.

Working with whole family groups within a community, rather than just individuals, can also enhance the effectiveness of health promotion or treatment initiatives, and, within the community setting, this policy also includes strategies that look at families. As mentioned above, community strategies can also complement school programmes, and ensure that children and their families are getting similar information and health measures.

Workplace

In the workplace, individuals who have problems with tobacco and alcohol use can affect not only their own productivity and safety, but also that of others. Employers are responsible for ensuring workplace drug policies exist. These include policies covering provision of smoke-free environments, and host responsibility practices for all occasions when alcohol is served in the workplace.

The Health and Safety in Employment Act 1992 has formalised employer responsibility to provide a safe work environment. This responsibility includes taking steps to remove risks to the health and safety of employees and others. Where such risks may be posed by tobacco and alcohol use, workplace programmes to identify and address tobacco- and alcohol-related problems should be developed as part of an overall health and safety plan.

Effective workplace programmes incorporate prevention, early intervention, treatment and rehabilitation components for tobacco- and alcohol-related problems. They will almost certainly include a written policy statement, supervisor training, employee education, and employee assistance programmes. They may also address the issue of testing for alcohol, particularly in safety-sensitive occupations such as in the transport, forestry and power industries. Such workplace programmes operate best when developed in full consultation with the workforce.

Prisons and community correction settings

Convicted drink drivers and others with community-based sentences for alcohol-related offences can be targeted with education and treatment programmes. However, available treatment regimes have not always been well matched to the needs of offenders. It is evident that excellent national and local co-ordination between the justice, police and health sectors is necessary to ensure effective strategies.

Types of intervention

Types of intervention to implement the National Drug Policy are as follows.

Health promotion

Health promotion strategies cover a wide variety of interventions designed to facilitate change and improve the health of the whole community and particular groups within it. Health promotion therefore includes strategies to do with pricing policy, tax rates, understandable and enforceable legislation, the nature of advertising and marketing of products, building supportive and healthy environments, developing healthy public policy, community development, social marketing and education. Effective health promotion strategies involve a number of interventions in the different areas listed above, which need to be introduced and implemented as an integrated package, in order to achieve the desired goals.

Legislation and regulation

Regulatory intervention is a powerful tool for setting a framework and for controlling the environment within which tobacco and alcohol use occurs. For example, legislation can control the supply of substances by prohibiting them altogether, or to some people (for example, those under a certain age), or restricting them to certain locations. Legislation can also affect the way alcohol is used through regulating the actions of people while they are affected by it (for example, the legislation relating to driving a vehicle while impaired by alcohol).

The main pieces of legislation in this area are:

- Smoke-free Environments Act 1990
- Sale of Liquor Act 1989
- Transport Act 1962.

Other relevant legislation is:

- Accident Rehabilitation and Compensation Insurance Act 1992
- Alcoholism and Drug Addiction Act 1966
- Broadcasting Act 1989
- Health and Disability Services Act 1993
- Health and Safety in Employment Act 1992
- Local Government Act 1974
- Māori Community Development Act 1962

- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Resource Management Act 1993.

It is important to review the legislative framework from time to time, to ensure that it is working as intended, and to identify amendments which would improve it. For example, the Smoke-free Environments Act 1990 has recently been amended, to change to 18 the age at which a person can buy tobacco. During the timeframe of this national policy, the effect of that change will be able to be monitored. In other areas, the provision of legislation is found to be working less well than expected because enforcement needs to be strengthened, as is discussed in the next section.

Enforcement

Enforcement is an important part of the overall policy. Within the tobacco and alcohol area, there are different agencies responsible for administering and enforcing the major pieces of legislation. The list below gives the main enforcement agencies for each Act:

- Smoke-free Environments Act 1990 (Ministry of Health)
- Sale of Liquor Act 1989 (Police, District Licensing Agencies, Ministry of Health)
- Transport Act 1962 (Police).

There are several areas where enforcement of legislation can be strengthened, for example the Smoke-free Environments Act 1990 in relation to selling tobacco to under-age persons.

Enforcement measures can also include training for staff in relevant industries in understanding and complying with the law, for example liquor licence holders and their staff understanding the provisions of the Sale of Liquor Act 1989 as it relates to refusing to serve intoxicated patrons.

Enforcement measures and their consequences (in convictions) can be very expensive, so it is essential to evaluate the cost-effectiveness of enforcement in particular areas.

Treatment

Treatment interventions are vital to limit the problems arising from tobacco and alcohol use. The National Drug Policy emphasises the need for a variety of treatment services.

- There is a special focus on primary care, with the early diagnosis of problems and hence intervention at an early stage. Where early enough, advice and assistance to stop harmful tobacco and alcohol use and promotion of healthier lifestyles by primary care health professionals has proven very effective.
- Also effective are interventions by workers other than health professionals, for example community workers and school personnel. For that reason, training in recognition and response to tobacco and alcohol issues is important for other primary care workers.
- Services need to include, as well as screening and early intervention, consistent assessment to direct clients to the treatment regime appropriate for them.
- Treatment programmes need to be tailored for:
 - Māori, and members of other cultural groups
 - people who are not highly motivated to change behaviour, such as some of those referred from the justice system

- people with both alcohol use problems and mental disorders, who need services that recognise all their treatment needs
- polydrug users.

Research

The National Drug Policy highlights the need for further research in many areas associated with tobacco and alcohol use. Although there is a considerable information base nationally and internationally, there are significant gaps in our knowledge, even at the most basic level. These gaps need to be addressed before the most effective interventions can be determined for certain problems.

For example, the extent and patterns of use of tobacco and alcohol are not well known within New Zealand's Pacific communities. The extent of tobacco- and alcohol-related harm among young people also needs to be researched on an ongoing basis. Evaluations of many existing interventions would also be useful.

This national policy encourages research funding organisations like the Health Research Council, the Foundation for Research, Science and Technology, and other research funding bodies, to include research on key information gaps and evaluations in the tobacco and alcohol area as priorities for funding.

Glossary

- Drug:** Unless otherwise stated, ‘drug’ or ‘drugs’ refers to tobacco, alcohol, illegal drugs, volatile substances (such as petrol, solvents and gases such as LPG), and other substances used for psychoactive effects, recreation or enhancement, as well as prescription and pharmacy-only drugs used outside medical or pharmaceutical advice. ‘Drugs’ should be read as synonymous with ‘tobacco, alcohol and other drugs’.
- Drug-related harm:** ‘Drug-related harm’ refers to all harms (as defined below) that are direct or indirect consequences of drug use. These consequences may affect those who use drugs as well as others.
- Harm:** ‘Harm’ includes all adverse effects or outcomes, including harm to health as well as detrimental effects on social and family relationships, loss of actual or potential enjoyment or livelihood, and economic or financial costs.
- Harm minimisation:** ‘Harm minimisation’ is an approach that aims to minimise the adverse health, social and economic consequences of drug use, without necessarily ending such use for people who cannot be expected to stop their drug using immediately. The primary goal of this approach is a net reduction in drug-related harm rather than becoming drug-free overnight, although harm minimisation strategies often lead to a reduced number of people who use drugs over time. Examples of harm minimisation approaches to alcohol include promotion of low-alcohol drinks and ‘Host Responsibility’ training for people who serve alcohol. There is also potential for harm minimisation measures for tobacco smokers, including the promotion of low-tar cigarettes and nicotine chewing gum used to minimise smoking, although such strategies are limited by the fact that there is no proven way to ensure a safe level of any tobacco smoking.
- Mental disorder:** As used in this document, ‘mental disorder’ refers to a disorder that is not directly related to drug use and which is recognised by psychiatrists and other health professionals as a mental disorder. In general, the term as used in this document refers to more serious psychiatric problems including psychotic disorders (such as schizophrenia) and moderate to severe mood disorders (such as depression), anxiety disorders and personality disorders.

PART 2: Illicit and Other Drugs

Section 1: The Policy

Introduction

Part 2 of New Zealand's National Drug Policy has been developed over more than two years with input from many different organisations and individuals.

This is the companion policy to *National Drug Policy, Part 1: Tobacco and Alcohol*, which was publicly released in 1996. The decision was taken to release Part 1 earlier than Part 2 because it was important that national policy on tobacco and alcohol – the two drugs which cause the most harm to the most people in New Zealand – was developed before a national policy on illicit and other drugs.

It is important to note, however, that the two parts form a single National Drug Policy. For this reason, there are a number of similarities between the two parts. Most notably, the structure and purpose of Part 2 is similar to Part 1. In addition, the principles that underpin the National Drug Policy's goal of harm minimisation are reiterated in Part 2. These points of similarity underscore the importance of a consistent national policy on all drug use.

The drugs covered by Part 2 are all substances, other than tobacco and alcohol, which are used for psychoactive effects, recreation or enhancement, as well as prescription and pharmacy-only drugs used outside medical or pharmaceutical advice. The policy also covers volatile substances such as petrol, solvents and inhalants, which are occasionally abused for psychoactive effect.

One of the special features of this policy is that it includes illicit drugs – drugs which are controlled under the Misuse of Drugs Act 1975. This statute distinguishes between the seriousness of the harm that could be caused by the misuse of different types of drugs, scheduling them as either Class A, Class B, or Class C controlled drugs. Class A controlled drugs include 'hard drugs' like heroin and LSD. Class B controlled drugs include substances with a high abuse potential, such as morphine, opium and various amphetamine-type stimulants. Class C controlled drugs include various pharmaceutical drugs like codeine, as well as 'designer drugs' and the less potent forms of cannabis.

By scheduling these drugs as 'controlled drugs', lawmakers have sent a clear message that the possession and use of these types of drugs is against the public interest and is therefore illegal.

This is the first time that all government policies to do with the harmful consequences of illicit and other drug use have been brought together in one document. Many different government agencies, as well as many other groups and organisations in New Zealand, are involved in addressing these consequences, and trying to prevent them. This national policy provides a common goal and the means to co-ordinate these efforts.

Purpose of the policy

In New Zealand, the lack of intersectoral decision-making about drug use issues has meant that consistent strategies to minimise drug-related harm have not been developed. No sector or agency has had overall responsibility for priority setting or co-ordination. As a result, interventions to reduce the harm caused by drug use within New Zealand have grown up in a largely haphazard manner, reflecting historical factors rather than the current state of knowledge about the patterns of drug use or levels of drug-related harm.

Isolated interventions do not take advantage of synergies between different interventions, and may even be counter-productive where there is a conflict of interest between sectors. For example, fear of police involvement can sometimes deter people from contacting emergency medical services when a person they are with has overdosed on illicit drugs. Any delay in calling an ambulance in such situations may lead to poorer health outcomes for the person who has overdosed, and in serious cases it could even lead to death. On the other hand, probation and community police officers who have wanted to refer people with drug abuse or dependence problems for early intervention by health services (before they engage in more serious drug-related offending) have sometimes found that appropriate services for such people are not readily accessible.

Another result of isolated interventions is that the information needed to choose the best overall strategies to reduce drug-related problems has not been systematically collected. Agencies have tended to collect only the information they need for their own purposes.

In short, past interventions by government agencies have not been strategically aligned. There has been no framework for intersectoral decision-making about where the greatest drug-related harms are occurring and what are the best means of addressing those harms.

Against this backdrop, Part 2 of the National Drug Policy:

- brings together a range of strategies and interventions which address a common goal
- forms a basis for coherent policy development across a wide range of settings and agencies
- assists future co-ordination of strategies and delivery through identification of any gaps and overlaps, and through establishing key linkages and co-ordination mechanisms
- provides for the development of measurable outcomes against which the impact of strategies may be assessed.

Policy goal

The goal of this policy is, as far as possible within available resources:

To minimise harm caused by illicit and other drug use to both individuals and the community

Underpinning this goal are five principles. They are:

- efficiency
- equity
- use of both harm prevention and harm reduction strategies

- upholding of individual rights where these do not unreasonably impinge on the rights of others
- ensuring the needs of Māori are addressed by enabling development of specific strategies acceptable to Māori.

National priorities

Identifying national priorities helps to provide a focus for co-ordinating a range of different strategies, programmes and activities to achieve the overall goal of the policy.

The following priorities for action have been selected for the first five years of Part 2 of the National Drug Policy. These priorities may need to change over time, especially as new research evidence becomes available, but they provide a clear starting point.

Priority one

To enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of drug use.

Priority two

To reduce the prevalence of cannabis use and use of other illicit drugs.

Priority three

To reduce the health risks, crime and social disruption associated with the use of illicit drugs and other drugs which are used inappropriately.

Outcomes and indicators

The National Drug Policy aims to provide a basis for making measurable progress towards achieving the priority policy objectives. For each priority, a set of desired outcomes is listed. Key groups within the population, whose members are at special risk of drug-related harm, and key settings for service delivery, have also been identified. Where appropriate, these key groups and settings are reflected in the desired outcomes.

Measurable progress towards these desired outcomes will indicate that the priority objective is being achieved. In some cases, there are existing indicators to show whether the strategies being implemented and resources being deployed have made a difference. In other cases, the first step will be to develop such indicators and capture baseline data. The range of performance indicators that will be used is likely to include a mix of quantitative and qualitative measures, as well as specific measures of change in the costs of drug-related harm. Each relevant government agency will be responsible for including such performance indicators in the detailed implementation plans which they develop.

Priority one

To enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of drug use

Desired outcomes are:

- general acceptance by government agency staff of harm minimisation as an effective approach to reducing drug-related harm; and ongoing co-operation and collaboration among agencies involved in drug issues
- increased involvement of the community, and particular subgroups in the community, in reducing drug-related harm
- more effective school policies and education in the school setting about the harms and hazards of drug use
- reduction in the rate of injury and loss of productivity in the workplace linked to the use of drugs
- improved range, quality and accessibility of effective treatment options for people with drug problems
- improved expertise of health workers in the drug field.

Priority two

To reduce the prevalence of cannabis use and use of other illicit drugs

Desired outcomes are:

- reduction in the prevalence of cannabis use in the population
- reduction in the prevalence of cannabis use among people under 25
- reduction in the prevalence of cannabis use among Māori
- reduction in the prevalence of cannabis use among pregnant women
- reduction in the prevalence of other illicit drug use, including opioids, psychostimulants and hallucinogens
- reduction in the prevalence of illicit drug use among prison inmates.

Priority three

To reduce the health risks, crime and social disruption associated with the use of illicit drugs and other drugs which are used inappropriately

Desired outcomes are:

- preventing a 'hard drug' market becoming established in New Zealand
- reduction in the availability of other drugs which are illegally imported into New Zealand, particularly those imported by organised crime groups
- reduction in crime and violence associated with manufacture, trafficking and use of illicit drugs, including property crime and crimes against the person
- reduction in the transmission of blood-borne viruses through injecting drug use
- reduction in the prevalence of unauthorised pharmaceutical drug use and associated harm
- reduction in the prevalence of non-medical use of anabolic substances and associated harm
- reduction in the prevalence of volatile substance abuse and associated harm.

Future directions

Any policy which extends over five years must have the capacity to be flexible over time. Strategies that work towards achieving the desired outcomes of the National Drug Policy will thus be adjusted as necessary, and as further information becomes available.

These strategies will always be cost-effective, however, and will be consistent with the Government's overall strategic priorities and the fiscal constraints it is operating under.

Specific strategies to minimise drug-related harm will be set out by individual government agencies in the implementation plans that they will develop for each of the priority areas in the policy. Major directions to be emphasised will include the following.

Information

Systems for collecting the information necessary to monitor and gauge the success of this policy will be developed. In the first two years of this policy, emphasis will be placed on ensuring baseline data and targets are developed for the desired outcomes.

Research and evaluation

In the next five years, research and evaluation will include an emphasis on:

- assessing the prevalence of drug use, including use among at-risk groups
- assessing the environmental and predisposing factors associated with drug use
- assessing the impact of any amendments to drug-related legislation
- assessing the impact of law enforcement interventions and harm minimisation strategies
- developing evaluation techniques and performance indicators for service providers.

Health promotion

In the next five years, health promotion initiatives will include:

- programmes promoting the value of remaining drug-free
- provision of information and resources about drug-related harm, and how it can be prevented or minimised
- health promotion in schools, notably the *Healthy Schools: Kura Waiora* approach, which more closely meets the needs of particular school communities
- provision of information and advice about workplace policies and programmes to minimise drug-related harm
- improved provision of health information and advice to at-risk groups, such as:
 - injecting drug users
 - young people
 - prison inmates and staff
 - sports people.

Health promotion initiatives may include:

- community development projects focused on preventing or minimising drug-related harm
- provision of training opportunities for health promotion workers.

Assessment, advice and treatment services

In the next five years, assessment, advice and treatment services will focus on:

- better addressing the needs of at-risk populations, such as:
 - children and young people
 - Māori
 - Pacific people
 - people with co-existing drug use disorders and other mental disorders
 - prison inmates
- improving the delivery and accessibility of methadone treatment services
- increasing the provision of advice by primary health workers and other community workers, especially for:

- pregnant women and women planning pregnancy
- people with emerging drug problems.

Training for service providers will focus on:

- training for primary health workers and other community workers in brief assessment and intervention
- training for specialist drug treatment workers in the assessment and management of people with co-existing mental disorders
- training for mental health workers in the assessment and management of people with co-existing drug use problems
- training for community workers and school personnel in recognition of drug-related problems, and how to manage and refer people at risk of drug-related harm.

Law enforcement

Within the next five years, there will be:

- increased co-operation between the Police, Customs and overseas law enforcement agencies to identify and prosecute people who bring illicit drugs into New Zealand
- continued operations by the Police and Customs to target illicit drug suppliers and distributors, including proactive identification and response to emerging drug threats
- continued community policing initiatives aimed at preventing drug-related crime and reducing recidivism by first-time drug offenders
- further development of drug intelligence systems to counter the availability of illicit and other drugs, including use of technology and new drug interdiction techniques
- increased investigation of the supply of illicit and other drugs to at-risk populations, such as young people and prison inmates
- increased use of statutory powers to seize assets from illicit drug manufacturers and large-scale cannabis cultivators.

Policy and legislative development

Within the next five years, policy and legislative review will include:

- legislative amendments to allow the use of electronic interception powers during investigations of large-scale cannabis cultivators or distributors
- development of legislative and other proposals to prevent the diversion of precursor and essential chemicals into the illegal manufacture of controlled drugs
- review of the classification of chemical drugs such as methamphetamines under the Misuse of Drugs Act 1975, and the addition to the Act of controlled drug analogues
- review of current legislative and other responses which aim to prevent the unauthorised use and illegal sale of prescription drugs, including anabolic substances
- refinement of legislative and other proposals to reduce drug use by prison inmates
- refinement of the regulatory framework within which the needle-exchange programme for injecting drug users operates

- review of drug education and treatment programmes for children and young people
- review of the compulsory assessment and treatment of people with drug disorders.

Implementation, monitoring and review

Since the purpose of the National Drug Policy is to provide a strategic framework and general direction for efforts to minimise drug-related harm over the next five years, it is envisaged that more detailed implementation plans will be developed for each of the priority areas in the policy. These plans will specify the types of activities to be undertaken, contain specific performance indicators, identify ways to resource the activities, and nominate which government agency will take the lead in each area.

Once these plans have been generated, an intersectoral work programme to advance the National Drug Policy's desired outcomes will be developed by the Ministry of Health. It is intended that this intersectoral work programme will be agreed to by all relevant government agencies by January 1999. This is included as a target in the Ministry's recent publication, *Moving Forward*, which provides national objectives and targets for the remaining years of the Government's National Mental Health Strategy.

More generally, progress within the priority areas of the National Drug Policy will be monitored and reviewed in the following ways.

- A Ministerial Committee, chaired by the Minister of Health and including the Ministers of Corrections, Customs, Justice, Police, Māori Affairs, Youth Affairs, Transport and Education, will meet twice yearly to review progress and decide which new policy initiatives should be recommended to the Government.
- A monitoring group, chaired by a Ministry of Health official and including representatives of the Ministries of Education, Justice, Transport and Youth Affairs, Te Puni Kōkiri, the Department of Corrections, Police, Customs, Land Transport Safety Authority and the Alcohol Advisory Council, will ensure that policies and programmes throughout government are consistent and mutually supportive. The monitoring group will receive reports from individual government agencies on the progress made in implementing this policy, and will make recommendations to the Ministerial Committee on new policy initiatives. It will seek representations from other agencies as appropriate.
- All government agencies with responsibilities for drug-related policy initiatives will present six-monthly progress reports which outline progress with their areas of responsibility, give an update of resources devoted to the area, and report on any other strategies/interventions designed to impact on the national priorities and desired outcomes.

Section 2: Background Information

Major issues

The use of drugs results in considerable harm in New Zealand. Around 5000 deaths each year are attributed to the effects of drug use, although they are mainly related to the use of tobacco and alcohol. Use of illicit and other drugs also results in serious harm to many New Zealanders' health, as well as crime and other forms of social disruption.

- **Harm to health:** Harm to health includes deaths associated with drug use, illness and disease, and accidents and injuries. Intravenous injection of drugs can result in the transmission of blood-borne viruses, such as hepatitis and HIV, which potentially threatens the whole community through the risk of infectious diseases being spread throughout the population.
- **Crime:** Crime is also associated with drug use in a number of ways. Illicit drugs involve individuals in criminal activities – users by obtaining the drug and sometimes in criminal activities to support their drug use, and other individuals through involvement in supplying the drug to the user.
- **Social disruption:** Drug use affects the life of the family and the community in which the individual lives, as well as the individual user. Excessive use of drugs can lead to reduced social functioning at home, with dysfunctional behaviour affecting the behaviour of other members of the family, at school and in the community generally. It can also lead to accidents as well as reduced productivity at work.

In developing this policy, the Government aims to minimise these types of harm which result from illicit or other drug use.

Implicit in this approach is the acceptance that some people, for whatever reason, will use drugs illegally or inappropriately. These people are often highly resistant to 'just say no' messages about drug use, even when they are aware of the health, legal and other risks associated with such use. Innovative strategies are needed to communicate to them the value of staying drug-free.

Cannabis is the most commonly used illicit drug in New Zealand, and the Government is particularly concerned to reduce the harmful effects of its use. Risks to the user from cannabis include respiratory harm, possible cognitive impairment, and other mental health effects. Cannabis use can also pose a risk of injury to others, can have a negative impact on social and personal relationships, and may cause problems if used during pregnancy.

A major issue which relates to drugs like cannabis is the level of criminal activity associated with the market for illicit drugs. Members of the public can often become victims of crime which is committed to fund a drug habit.

For example, a recent survey of people waiting to enter the methadone programme in Christchurch found that, in order to sustain their opioid drug dependence, on average each person generated over \$1000 every week from various types of criminal activity.

Enforcing drug control laws and investigating drug-related offending also account for a significant amount of public resources. A significant amount of public money is spent on controlling New Zealand's borders to prevent drugs coming into the country, and shutting down domestic drug cultivation, manufacturing and trafficking operations. The Police and Customs Service are committed to preventing organised crime groups with drug connections from becoming established in New Zealand. We need to be vigilant in the area of narcotic drugs, as well as the new generation of chemical drugs (for example, Ecstasy) which are causing alarm overseas. This is a key priority for the Government.

Because the range of harm associated with drug use is so varied, and spread so widely across the community, a large number of agencies are dealing with different aspects of problems that arise. Until now, the efforts of these agencies have not been co-ordinated on a national basis. The National Drug Policy seeks to develop partnerships between government and non-government agencies working to minimise drug-related harm, provides a common vision for their efforts, and establishes a means to co-ordinate them. This should help increase the overall effectiveness of interventions by individual agencies.

Since different drugs are often used together, the National Drug Policy will also foster strategies which focus on polydrug use, as well as use of particular drugs on their own. This is important because the most serious drug-related harms are often suffered or caused by polydrug users – for example, people who drink alcohol and take minor tranquillisers (such as benzodiazepines).

Another group which has been identified as being in need of targeted assistance are those people who experience both drug problems (such as cannabis dependence) and mental health problems (such as schizophrenia). Research evidence suggests that the prevalence of co-existing drug use and mental health disorders is extremely high. For example, a recent survey of New Zealand's acute inpatient mental health services found that 48 percent of clients admitted to psychiatric units had a substance abuse issue. Similarly, many people with drug use problems are also found to have a co-existing mental disorder. The management of such 'dual diagnosis' clients poses special challenges.

At the macro level, it is also important to see how the National Drug Policy fits within the Government's wider strategic objectives. Its goal of minimising the harm caused by drug use to individuals and the community helps to address the Government's Strategic Result Areas of improved health status, crime reduction, community security, and enabling individuals and families to improve their ability to participate in society.

The National Drug Policy can also be seen to fit within the context of the Government's *New Zealand Crime Prevention Strategy* (1994). Within this strategy, the Government has identified seven crime prevention areas for priority action, including: 'developing an approach for the management of programmes that address the misuse and abuse of both alcohol and drugs'.

Principles for policy development

The following principles underpin the National Drug Policy.

Efficiency

Cost-effectiveness must be taken into account in decisions about what types of harm to reduce and how to reduce them. The national priorities for illicit and other drug use reflect this principle. These priorities were determined according to the most costly areas of harm, and where there is most research and evidence about effective strategies to reduce the harm. Where such research or evidence is lacking, or there is no robust information about the extent of the harm, this policy recommends that further research or evaluation programmes be undertaken before policy decisions are made.

There are also a number of areas where there is insufficient evidence about the cost-effectiveness of possible interventions. Here, also, it is recommended that more work be done before policy decisions are made and funding allocated.

Equity

Equity means fairness. Considerations of equity must be taken into account in decisions about resource allocation. It involves improving equity of access for all New Zealanders to public health, assessment, advice and treatment services, as well as decreasing disparities in the outcomes for key population groups such as Māori and Pacific people.

Use of both harm prevention and harm reduction strategies

This principle reiterates that harm minimisation allows for different approaches to be used. It recognises that an effective national policy must do two things:

- prevent harm from occurring, by preventing uptake and/or harmful drug use
- reduce drug-related harm which is already occurring.

Examples of harm prevention are health education programmes designed to discourage people from taking up cannabis use. Examples of harm reduction are programmes for people with opioid dependence, such as the needle exchange programme and methadone treatment services, which attempt to minimise harm to the users and the community, even if some drug use continues and drug-related harm cannot be totally avoided.

Upholding individual rights where they do not unreasonably impinge on the rights of others

This principle requires a careful balance to be struck between the rights of the individual and the rights of others or society at large. As a society, we hold that some types of harm are always unacceptable, while other choices – which may be harmful to the individual – are legal and acceptable if the use does not unreasonably impinge upon others. That is, individual choices are respected where the costs of the choices are not borne by others.

Another way to think about this principle is that, all other things being equal, it favours the strategy which is least intrusive on individual rights. For example, if two strategies could be used equally effectively to reduce the use of a certain drug – such as a health promotion campaign or a targeted law enforcement campaign – and only one strategy could be implemented, then this principle would give preference to the strategy which would least interfere with the rights of individuals. In this scenario, the health promotion campaign would be preferred as the strategy to reduce the use of the particular drug, because it would be less intrusive than a targeted law enforcement campaign on the lives of the individuals who were using the drug in the community.

Ensuring the needs of Māori are addressed by enabling the development of specific strategies acceptable to Māori

Under the Treaty of Waitangi, the Government has a particular responsibility to address Māori health status issues. This principle establishes a specific focus of the policy on meeting Crown objectives in relation to Māori health – namely, to ensure that Māori have the opportunity to enjoy at least the same level of health as non-Māori.

The Government also recognises the importance of consolidating gains in Māori health development and accelerating Māori participation in the health sector workforce.

More directly, this principle acknowledges that Māori are suffering disproportionate harm from the use of several substances covered by the policy, and that strategies designed for the general population have often had a limited effect in reducing that harm among Māori.

This principle also acknowledges that problems in Māori communities may be addressed more effectively when targeted approaches are developed by and for Māori. This is because of the need for in-depth knowledge of the Māori community, and of acceptable and effective approaches to use when advocating changes in behaviour and lifestyle.

In summary, the National Drug Policy reflects this principle in two ways. Firstly, by the inclusion of specific desired outcomes for Māori under many national priorities. Secondly, by advocating strategies through which Māori identify their own needs, and the most appropriate and effective interventions to minimise drug-related harm.

Strategies

This policy aims to minimise the harmful effects of drug use by using a balance of supply control and demand reduction measures. It recognises that there is a continuum of harm associated with drug use, and that no single approach or set of strategies can adequately address the possible range of harm. It allows for different approaches to be used, depending on the particular issue or the group being addressed. However, the overall aim will always be to minimise drug-related harm.

Strategies to prevent and reduce drug-related harm, which contribute towards meeting each priority area, need to take into account three interacting components:

- the characteristics of individual drug users (for example, their age, gender and ethnicity)

- the environment in which the drug use occurs (for example, the social, physical and economic context)
- the characteristics and effects of the drug which is being used (for example, its psychoactive properties, type, amount and dependence-producing effect).

Different strategies are needed to target:

- the whole population, or particular at-risk groups within it
- all drug use, or use of specific substances
- all settings, or particular environments where misuse occurs.

Strategies need to operate in the three different areas of:

- supply control (controlling or limiting the supply of drugs)
- demand reduction (reducing individual demand for drugs)
- problem limitation (limiting the problems that arise from drug use).

Across these areas there will be various types of intervention included among the strategies, from law enforcement to health promotion to drug treatment. By developing priorities and specific desired outcomes, and providing a general overview of strategies to be undertaken by agencies, singly or in conjunction with others, this policy will assist agencies with their individual priority setting. Moreover, many issues will need to be addressed on a range of fronts, with input from sectors such as health, education, justice and law enforcement.

Part 2 of the National Drug Policy represents an important step in the co-ordination of policies and strategies across the many government agencies which share responsibilities to do with illicit and other drugs. Each agency will continue to implement and manage the policies and programmes within its own particular area of responsibility. This document sets an overall direction, providing a framework for this work, and for resource allocation and co-ordination among government agencies.

To be successful, the National Drug Policy also needs the support and participation of non-governmental organisations, including local and voluntary groups, service providers, individuals, employer and industry groups, and the community at large. It is hoped that, by setting a framework and a direction, this policy will assist them to participate in an overall approach to minimising drug-related harm.

The policy is intended to reinforce and further develop strong intersectoral linkages at both a national and local level.

Key groups

In the National Drug Policy, desired outcomes are listed under each priority, both for the whole population and specifically for key groups affected. The groups most at risk vary with the particular harm being addressed, and whether or not this harm is related to a single drug or a combination of drugs.

For example, in the case of cannabis, desired outcomes are listed for young people (since this is the time people most commonly start using cannabis), pregnant women (since cannabis use during pregnancy retards the growth of the unborn child) and Māori (since current evidence suggests that there is high use of cannabis by Māori in some areas, particularly where cannabis cultivation forms a major part of the local economy).

Some groups are already experiencing greater harm to health resulting from drug use. For example, the use of doping agents by sports people is specifically recognised in a separate statute, the New Zealand Sports Drug Agency Act 1994. Drug use, and drug-related harm, also needs to be monitored for other groups which are at potential risk, such as Pacific people and recent immigrant groups.

Examples of groups which are at greater risk of a number of drug-related harms, and thus have desired outcomes listed under several priorities, are given below.

Young people

Young people, from primary school age to young adulthood, are a major focus for preventing drug-related harm. Personal decision-making and other life skills need to be developed and fostered, so that young people feel able to make healthy decisions about drug use. The particular age group focused on may vary from one strategy to another.

School health policies and school-based drug education are avenues to reach young people of school age. However, many in this age group do not regularly attend school, and those who are truants are at high risk of developing drug-related problems. Interventions which are aimed at school age children in their particular communities are therefore necessary to reach some members of this target group.

A community focus is also important even when young people are reached through the school. It is vital that school-based drug education is supported by family and community messages so that young people do not receive conflicting messages.

A particular concern is the shortage of specialist treatment and support services for young people with drug-related problems, and especially the shortage of appropriate services for young Māori.

People with co-existing drug use and other mental disorders

A group which has been identified as being in need of targeted assistance within treatment options are those people who experience both drug problems and mental health problems (sometimes called 'dual diagnosis' clients). Research evidence suggests that the prevalence of co-existing substance use disorders and mental health disorders is extremely high.

Health outcomes for this group are much poorer than those for people with either disorder alone. There is some evidence that this group may not be adequately treated by either specialist mental health services or specialist drug treatment services. Integration of treatment services for people who have both disorders is vital if people are to manage their disorders in community or inpatient settings. Better integration of mental health and drug treatment services, and development of specific treatment protocols for people with co-existing disorders, is needed to improve services for this group.

Polydrug users

The most serious harms are often suffered or caused by those who use more than one substance (for example, drink alcohol and smoke cannabis). These people are referred to as polydrug users. When a 'substance by substance approach' is taken to addressing drug-related problems, the needs of polydrug users can sometimes be overlooked. Treatment providers suggest that most of their clients often use more than one drug.

Pregnant women

The unborn child is at particular risk of harm from exposure to drugs. When used in an ongoing way during pregnancy, many drugs, including cannabis, cocaine and opioids, are associated with low infant birthweight and other signs of developmental problems. Women who use opioid drugs are at particular risk of poor pregnancy outcomes, but their health and that of their unborn children can be improved substantially by provision of appropriate health services, including methadone treatment where indicated.

Māori

Although a number of information gaps still exist, and further research is called for, current evidence suggests that there is a significantly higher prevalence of cannabis and other drug use problems among the Māori population than the general population.

This has a number of implications, for example on the way in which services are provided for Māori to minimise the drug-related harm which they experience. Ways in which services might be organised to better meet the needs of Māori are outlined below.

Ideally, Māori should have the choice of access to the full range of mainstream drug and alcohol services and, where possible, kaupapa Māori or Māori-provided services. Limited resources and the shortage of Māori drug and alcohol workers, however, mean it will not always be possible for Māori with drug use problems to access such services.

Mainstream services for Māori

Mainstream services have often not proved effective for Māori. Some providers of drug treatment services advocate abstinence as a particular treatment goal for Māori whose lifestyle choices have detrimental effects on themselves, their whānau and community. An increasing number of Māori service providers are using a continuum of care approach for Māori clients, which incorporates health promotion, intervention and treatment. Mainstream service staff should also respect the health and cultural needs of Māori and, where appropriate, be trained in the use of cultural assessment tools.

Kaupapa Māori services

Kaupapa Māori drug and alcohol services can be delivered within mainstream services or as separate services. In both cases, the service works to a Māori kaupapa on behalf of their clients, their whānau and hapū. Such services offer a range of treatment and support services, including whanaungatanga, whakapapa, turangawaewae, te reo Māori, tikanga Māori, koroua and kuia guidance, access to traditional healing, and the use of quality assessment and outcome measures relevant to Māori.

Māori advocacy and peer support services

Māori advocacy and peer support workers can work in and with mainstream and kaupapa Māori services. They work with providers, funders and other agencies to assist them to meet the needs of Māori clients, their whānau and hapū. Their principal role is to work with Māori clients and whānau so that they know and understand their rights.

People with co-existing disorders

Māori present for treatment with dual diagnosis more often than non-Māori. In a recent study, for example, admissions for drug-induced psychosis made up 21 percent of all admissions for Māori, as compared with 5 percent for non-Māori. Anecdotal evidence suggests that Māori with dual diagnosis present to drug and alcohol services rather than to mental health services, and do not want to be associated with the perceived 'stigma' of mental health services. Drug and alcohol workers therefore need training on how to assess and manage people with dual diagnosis, and drug and alcohol services should ideally have access to consultation with whānau, hapū, iwi, and liaison support from kaupapa Māori mental health services.

Key settings

There are a variety of environments or settings which need to be taken into account when minimising drug-related harm. Often, different government agencies will be involved in different environments. For example, in the school setting, the Ministry of Education will take a lead role, while in prisons, the Department of Corrections will have the prime responsibility. Clearly, a range of non-governmental agencies will also have an important part to play in a variety of activities such as research, advocacy, support and service provision. Individuals and the wider community also have a vital part to play, and it is hoped that they will also support this national policy.

Some settings which warrant particular attention are set out below.

Educational settings

The school environment is a major setting for developing skills to make healthy choices about drugs. Both the Ministry of Education and local boards of trustees have key roles to play in ensuring school policies and education are effective. Health agencies also support schools by providing advice. The Ministry of Education guidelines on drug education and policies within schools have provided some guidance. The draft national curriculum statement on health and physical education, when finalised, will help to ensure that education about drugs is integrated into everyday learning and teaching within the classroom setting, the approach that research shows is most effective.

The Ministry of Health is working with the health and education sectors to promote a *Healthy Schools: Kura Waiora* approach in schools. Applied to drugs, this approach includes development of school policies on drugs and involvement of the community, as well as enhancing students' skills to make healthy choices about drugs and opportunities to receive assistance and support where needed.

A number of voluntary and private providers also offer drug education in the school setting, and it is important that schools and boards of trustees can assess the relative effectiveness of these programmes.

There is also opportunity in the school setting for early intervention with young people who are experiencing problems with drugs. Training for school personnel is needed to assist in identifying and referring people at high risk of drug-related harm. How schools deal with students caught using, possessing or selling drugs also has the potential to assist young people make healthy decisions about drug use. The Ministry of Education has recently produced guidelines on school suspensions. It is important that schools also develop a policy on drug-related suspensions as part of an overall policy on drug use.

Tertiary education settings are another important venue for health promotion initiatives regarding drug use. Many young people undertaking tertiary education are living away from home for the first time. The new sense of freedom and independence this brings can pose problems for young people, and appropriate advice and support structures need to be provided for those students who engage in risk-taking behaviour that involves drug use.

Community

Minimising harm from drugs requires a co-ordinated series of strategies that deal with the beliefs and behaviours of individuals and the social and cultural structures around them.

Resourcing local communities to work on the issues, using local community networks, and intersectoral co-operation at a local level, can be a powerful way to change attitudes and behaviour. Indeed, strengthening community action was recognised by the *Ottawa Charter for Health Promotion* (1986) as one of the major strategies required to achieve equity in health. The community development approach empowers local communities to tackle issues in a way which suits them and their particular physical, social and cultural environment. It can help to co-ordinate the efforts of different people and organisations.

Working with whole family groups within a community, rather than just individuals, can also enhance the effectiveness of health promotion or treatment initiatives; and, within the community setting, this policy includes strategies that look at families. As mentioned above, community strategies can also complement school programmes, and ensure that children and their families are getting consistent information and health measures.

Workplace

In the workplace, individuals who have problems with drug use can affect not only their own productivity and safety, but also that of others.

The Health and Safety in Employment Act 1992 has formalised the responsibility of employers to provide a safe work environment. This responsibility includes taking steps to remove risks to the health and safety of individual employees and others. Where such risks may be posed by drug use, workplace programmes to identify and address drug-related problems should be developed as part of an overall health and safety plan.

Effective workplace programmes incorporate prevention, early intervention, treatment and rehabilitation components for drug-related problems. They will almost certainly include a written policy statement, supervisor training, employee education and employee assistance programmes. They may also address the issue of drug testing, particularly in safety-sensitive occupations such as in the transport and industrial sectors.

It should be noted, however, that there are aspects of workplace drug testing which could potentially breach provisions of the New Zealand Bill of Rights Act 1990, Privacy Act 1993 and Human Rights Act 1993. Nonetheless, an employer's overlapping statutory and common law duties to provide a safe workplace can be seen to mandate such testing programmes. As such, the issue of employee drug testing illustrates the need within the National Drug Policy to balance the rights of individuals (to privacy and freedom from unreasonable search and seizure) and the rights of others (notably the right of co-workers and members of the public to be free from harm caused by the actions or omissions of a drug-impaired employee).

Such programmes operate best when developed in full consultation with the workforce. The most effective programmes are those which are included in a comprehensive plan which proactively seeks to address the overall health and well-being of employees.

Prisons and community correction settings

There is a high rate of problematic drug use among prison inmates, which makes prisons an obvious setting for some targeted strategies. Comprehensive strategies will include assessment, a variety of appropriate treatment services, and education programmes; and may also include interventions to prevent secondary health risks, for instance the provision of bleach to limit the spread of blood-borne viruses such as HIV. They will also include measures to reduce the supply of drugs into prisons and policies that discourage people from initiating or continuing drug use while in prison.

Dealing with drug use and dependence problems which occur in prisons prevents them from being transferred to the wider community. Such strategies can also help with crime reduction, since there is a strong association between drug use and crime.

People serving community-based sentences can be targeted with education and treatment programmes. However, available treatment regimes have not always been well matched to the needs of offenders. It is evident that better national and local co-ordination between the justice, police and health sectors is necessary to ensure effective strategies.

Types of intervention

Types of intervention to implement the National Drug Policy are as follows.

Legislation and regulation

Regulatory intervention is a powerful tool for setting a framework and for controlling the environment within which drug use occurs. For example, legislation can establish the basis for controlling the supply of substances by prohibiting them altogether, prohibiting their supply to certain people, or restricting them to certain locations. Legislation can also affect the way drugs are used through the regulation of people's actions if they are affected by them (for example, the laws about driving a vehicle while impaired by drugs).

Legislative controls, particularly on illicit drugs, also work within the context of international agreements on drug control, to which New Zealand is a party.

The main pieces of legislation in this area are:

- Misuse of Drugs Act 1975
- Medicines Act 1981
- New Zealand Sports Drug Agency Act 1994
- Transport Act 1962.

Other relevant legislation is:

- Accident Rehabilitation and Compensation Insurance Act 1992
- Alcoholism and Drug Addiction Act 1966
- Health and Disability Services Act 1993
- Health and Safety in Employment Act 1992
- Local Government Act 1974
- Māori Community Development Act 1962
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Resource Management Act 1993
- Toxic Substances Act 1979 (superseded over time by the Hazardous Substances and New Organisms Act 1996).

New Zealand is also bound by several international drug control conventions, for example the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Following the Special Session of the United Nations General Assembly on the World Drug Problem in June 1998, New Zealand has also committed itself to make progress towards a number of specific goals in relation to illicit drugs, for instance to establish new or enhanced drug demand reduction strategies and programmes by the year 2003.

Other international treaties which are relevant to this policy include the United Nations Convention on Rights of the Child. Article 33 of this Convention states that: 'Children have the right to protection from use of narcotic and psychotropic drugs and from being involved in their production or distribution'.

It is important to review the legislative framework from time to time to ensure that it is working as intended, and to identify needs for strengthened enforcement or amendment.

Enforcement

Enforcement of legislation is an important part of the overall policy. In the drug area, there are different agencies responsible for administering and enforcing the major statutes. The list below gives the main enforcement agencies for each Act:

- Misuse of Drugs Act 1975 (Police and Customs)
- Medicines Act 1981 (Ministry of Health, with Police)
- New Zealand Sports Drug Agency Act 1994 (New Zealand Sports Drug Agency)
- Transport Act 1962 (Police).

Law enforcement personnel need to be trained about the health risks and consequences of drug use, so that their work does not conflict with that of health sector staff using harm minimisation approaches, for example in relation to injecting drug users. The concept of harm minimisation need not be incompatible with modern policing practices if appropriate training is provided to law enforcement officers. Effective liaison between the police and primary care workers is important, especially when dealing with first-time drug offenders.

Treatment

Treatment interventions are vital to limit the problems arising from drug use. The National Drug Policy emphasises the need for a variety of treatment services.

- There is a special focus on primary care, with the early diagnosis of problems and hence intervention at an early stage. Where it is able to be provided early enough, advice and assistance to stop harmful drug use and promotion of healthier lifestyles by primary care health professionals has proven very effective.
- Also effective are interventions by workers other than health professionals, for example community workers and school personnel. For that reason, training in recognition and response to drug issues is important for other primary care workers.
- As well as screening and early intervention, services need to include consistent assessment to direct clients to the treatment regime appropriate for them.
- Appropriate opioid dependence treatment services need to be provided, as they can be effective in preventing many of the crime-related harms of injecting drug use.
- Treatment programmes also need to be tailored for:
 - people with co-existing drug disorders and other mental disorders
 - Māori, and members of other cultural groups
 - people who are not highly motivated to change their drug-using behaviour, such as some of those people who are referred from the justice system
 - polydrug users.

Health promotion

Health promotion strategies cover a wide variety of interventions, designed to facilitate change and improve the health of the whole community and particular groups within it.

Health promotion includes strategies such as building supportive and healthy environments, developing healthy public policy, community development, social marketing and health education.

Effective health promotion programmes often involve a comprehensive approach using a number of strategies together.

Research

The National Drug Policy highlights the need for further research in many areas associated with drug use. There are significant gaps in our knowledge about drug use, even at the most basic level. These gaps need to be addressed for many drug use problems before the size of the problem and the most effective interventions can be determined. For example, at a national level, the current prevalence and trends of cannabis use in New Zealand are unknown, as is the prevalence of use and incidence of harm from several other drugs, such as psychostimulants, hallucinogens, benzodiazepines and anabolic substances. The extent and patterns of drug use are also not well known within particular ethnic communities, for instance New Zealand Asian communities. In addition, the extent of drug-related harm among young people needs to be researched on an ongoing basis. Evaluations of many existing interventions would also be useful.

This policy encourages research funding organisations like the Health Research Council, the Foundation for Research, Science and Technology and other bodies to include research on information gaps and evaluations in the drug area as priorities for funding. A number of individual strategies propose research topics for key areas of this policy.

Glossary

- Drug:** Unless otherwise stated, 'drug' or 'drugs' refers to tobacco, alcohol, illegal drugs, volatile substances (such as petrol, solvents and inhalants), and other substances used for psychoactive effects, recreation or enhancement, as well as prescription and pharmacy-only drugs used outside medical or pharmaceutical advice. 'Drugs' should be read as synonymous with 'tobacco, alcohol and other drugs'.
- Drug-related harm:** 'Drug-related harm' refers to all harms (as defined below) that are direct or indirect consequences of drug use. These consequences may affect those who use drugs as well as others.
- Harm:** 'Harm' includes all adverse effects or outcomes, including harm to health as well as detrimental effects on social and family relationships, loss of actual or potential enjoyment or livelihood, and economic or financial costs.
- Harm minimisation:** 'Harm minimisation' is an approach that aims to minimise the adverse health, social and economic consequences of drug use, without necessarily ending such use for people who cannot be expected to stop their drug using immediately. The primary goal of this approach is a net reduction in drug-related harm rather than becoming drug-free overnight, although harm minimisation strategies often lead to a reduced number of people who use drugs over time. Examples of harm minimisation strategies include providing information to particular groups (such as school students) about drug-related harm, how it can be prevented, and how it can be reduced if they continue to use drugs (for example, not driving a motor vehicle after drinking alcohol and smoking cannabis). Another well-established example of harm minimisation is the needle and syringe exchange programme for injecting drug users, which attempts to prevent the use of 'dirty' needles and needle-sharing, which can pose a risk of the transmission of blood-borne viruses such as HIV and hepatitis.
- Mental disorder:** As used in this document, 'mental disorder' refers to a disorder that is not directly related to drug use and which is recognised by psychiatrists and other health professionals as a mental disorder. In general, the term as used in this document refers to more serious psychiatric problems including psychotic disorders (such as schizophrenia) and moderate to severe mood disorders (such as depression), anxiety disorders and personality disorders.

