National Drug Policy

2007–2012

Citation: Ministerial Committee on Drug Policy. 2007. *National Drug Policy 2007–2012*. Wellington: Ministry of Health.

Published in March 2007 by the
Ministry of Health
PO Box 5013, Wellington, New Zealand

ISBN 978-0-478-30751-1 (Book)
ISBN 978-0-478-30752-8 (Internet)
HP 4362

This document is available on the National Drug Policy website:
http://www.ndp.govt.nz

National Drug Policy
A Policy for New Zealand

Foreword

In New Zealand, we have taken decisive action and achieved significant advances in many areas of drug policy. Since the release of the first National Drug Policy, smoking has been banned from enclosed workplaces including bars and restaurants, and the Government has adjusted alcohol excise to better reflect the harms that were posed by cheap spirit-based drinks. We have faced a changing illegal drug environment, including a surge in the availability of methamphetamine and other amphetamine-type substances. Methamphetamine and its precursor substances have been made classified drugs and the Misuse of Drugs Act 1975 has been amended to provide for a new class of drugs that pose a low risk but are still worthy of some form of control. Twenty-four Community Action Youth and Drugs programmes are now established to work with communities to address drug-related harm particularly among young people.

While these are noteworthy accomplishments, there is still much to do in reducing harm from alcohol, tobacco and other drugs. I am pleased to introduce this second National Drug Policy, which reflects those achievements by building on the first National Drug Policy. It will serve as the basis for New Zealand's policy and practices aimed at preventing and reducing drug-related harm throughout the community over the next five years.

Drug policy is a complex area that requires input and participation from a wide range of government and non-government agencies. Across the sectors there is a substantial resource and expertise to progress the objectives of this policy. Initiatives range from work by law enforcement agencies to seize illegal drugs, education to highlight the dangers of taking drugs through to alcohol and drug treatment services. In the next five years, this second National Drug Policy will continue to act as a framework to guide funding decisions around drug policy.

The second National Drug Policy maintains the principles of the first, to minimise the harm from drugs but further broadens the intersectoral focus, with greater emphasis on social and economic harm from drug abuse. There is also a greater emphasis on the collection of, and access to, information in order to inform policy and measure the impacts of policy interventions.

As Minister responsible for this Government's illicit drug policy and Chair of the Ministerial Committee on Drug Policy, I will be working with my Ministerial colleagues to ensure that Government policy engages all sectors in the development of innovative, coherent, co-ordinated, and consistent policy that is informed by evidence of effectiveness.

With this plan the overarching direction for the next five years is being set. The next challenge for government agencies will be the development of action plans based on the principles set out in this policy aimed at focusing activity on the prevention and reduction of drug-related harm.

Hon Jim Anderton
Associate Minister of Health

Contents

Part One: **Introduction**

1. Context for the National Drug Policy

1.1 Legislative and strategic context

The *National Drug Policy 2007–2012* builds on the first *National Drug Policy 1998–2003* (Ministry of Health 1998). It sets out the Government's policy for tobacco, alcohol, illegal and other drugs within a single framework. It does this by establishing the goals, objectives and principles that will guide drug policy and intersectoral decision-making about the best way to address the harms caused by drug use, and identifies the population groups that require special attention.

The Government has identified three strategic themes – economic transformation, families – young and old, and national identity – which collectively provide the context for the implementation of this policy. A feature of these three themes is an integrated and co-ordinated whole-of-government or intersectoral approach to strategic issues.

The National Drug Policy will help central and local government agencies and non-governmental organisations (NGOs) to develop work programmes and action plans that fit into a national direction. Having a strong intersectoral focus brings together health, justice, enforcement, social development and education agencies that are working towards the common goal of preventing and reducing the health, social and economic harms that are linked to tobacco, alcohol and other drug use.

The National Drug Policy aims to reduce the effects of harmful substance use through a balance of measures that:

- control or limit the availability of drugs (supply control)
- limit the use of drugs by individuals, including abstinence (demand reduction)
- reduce harm from existing drug use (problem limitation).

The National Drug Policy recognises that there is a continuum of harm associated with drug use and that there is no single approach or strategy that can, on its own, address the problems. Instead, a range of strategies is needed. This will require the development of specific strategies that are responsive and culturally appropriate in addressing the needs of Māori, Pacific peoples and young people, given the over-representation of these groups in many drug-related problems.

Following are a number of strategies that operate under the general auspices of the National Drug Policy that reflect input from various sectors.

- The *Crime Reduction Strategy* (Ministry of Justice 2002) targets organised crime, which includes the production, distribution and supply of illegal drugs.

- *Safer Communities: Action plan to reduce community violence and sexual violence* (Ministry of Justice 2004) identifies alcohol-related violence as a major priority.
- *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health 2005) aims, among other things, to improve addiction services and the management of addiction and co-existing mental health problems.
- *Health and Physical Education in the New Zealand Curriculum* (Ministry of Education 1999) requires schools to provide students with opportunities to learn to make informed, health-enhancing decisions about drugs.
- *Strategy to Reduce Drug and Alcohol Use by Offenders 2005–2008* (Department of Corrections 2004) has a specific strategy to minimise harm related to drug use by offenders.
- *Youth Health: A guide to action* (Ministry of Health and Ministry of Youth Affairs 2002) identifies tobacco, alcohol and other drugs as specific health risks for young people.
- *The New Zealand Police Alcohol Action Plan* (New Zealand Police 2006) aims to improve the Police's ability to prevent and reduce alcohol-related harm.

1.2 Overarching goal

The overarching goal of the National Drug Policy is to prevent and reduce the health, social and economic harms that are linked to tobacco, alcohol, illegal and other drug use.

1.3 Objectives

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

- to prevent or delay the uptake of tobacco, alcohol, illegal and other drug use, particularly in Māori, Pacific peoples and young people
- to reduce the harm caused by tobacco by reducing the prevalence of tobacco smoking, consumption of tobacco products and exposure to second-hand smoke
- to reduce harm to individuals, families and communities from the risky consumption of alcohol
- to prevent or reduce the supply and use of illegal drugs and other harmful drug use
- to make families and communities safer by reducing the irresponsible and unlawful use of drugs
- to reduce the cost of drug misuse to individuals, society and government.

Government agencies will incorporate these objectives into the planning and prioritising of their drug policy work.

1.4 Principles

1.4.1 Harm minimisation

Drug policy in New Zealand is based on the principle of harm minimisation. The aim of harm minimisation is to improve social, economic and health outcomes for the individual, the community and the population at large.

A harm minimisation approach does not condone harmful or illegal drug use. The most effective way to minimise harm from drugs is not to use them. The harm minimisation approach does recognise that where eliminating high-risk behaviours is not possible, it remains important to minimise the personal, social and economic costs associated with those behaviours. Harm minimisation encompasses a wide range of approaches, including abstinence-oriented strategies and initiatives for people who use drugs. It also considers the impact of the illegal status of some drugs on the people who use them.

Strategies that support harm minimisation can be divided into three groups or 'pillars':

- supply control
- demand reduction
- problem limitation.

All three pillars will be used in various combinations.

Supply control

Supply control aims to prevent or reduce harm by restricting the availability of drugs. For legal drugs this will involve restricting the circumstances in which they can be sold, supplied or consumed. For illegal drugs, supply control activities will focus on controlling New Zealand's borders to prevent drugs being imported into the country and shutting down domestic drug cultivation, manufacturing, trafficking and selling operations.

Demand reduction

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

Problem limitation

Problem limitation seeks to reduce harm from drug use that is already occurring. This group of activities includes emergency services and treatment for problematic drug use and dependence. Some problem limitation interventions do not seek to eliminate or reduce drug use in the short to medium term, but instead aim to reduce the related harm to the individual and community.

1.4.2 Evidence-informed policy

Effective drug policy is based on a careful analysis of the most up-to-date information available. Strategies to prevent and reduce drug-related harm will be focused on substances that cause the most harm and, where appropriate, on the population groups that experience the highest levels of harm. Interventions will reflect practices that are informed by rigorous research, critical evaluation, professional expertise, and the needs and preferences of the community.

The evidence base for the underlying determinants of drug use and effective interventions will be continually built up, and where there is no robust information about the extent of the harm or where evidence is lacking about effective interventions, further research or evaluation programmes will be undertaken.

1.4.3 Whole-of-government approach

Work on drug policy needs a whole-of-government approach. The structures that support this are the Ministerial Committee on Drug Policy (MCDP) and the Inter-Agency Committee on Drugs (IACD). The membership and functions of these committees are set out in Appendix 1.

The whole-of-government principle is embodied in the multi-agency composition of the IACD and MCDP. All government agencies are committed to, and aware of, the work of these inter-agency groups and value the importance of participation in them. This allows agencies to know about each other's work, to plan and work together, and to set collective strategic directions. Agencies will also collaborate in specific areas to address drug issues. For example, the National Drug Intelligence Bureau (NDIB) is a jointly operated agency comprising police, customs and health officials focused on obtaining information about trends in illegal drugs.

A whole-of-government approach fits with the Government's approach to social policy as a whole. Reducing tobacco, alcohol and other drug abuse has been one of the five critical social issues identified by the Government in 2004 for interagency action in *Opportunity for All New Zealanders*.

Drug abuse is a causal or risk factor for many of the important social and economic issues identified under the Government's priority themes of economic transformation, families – young and old, and national identity.

1.4.4 Partnerships

Drug problems will not be solved by government alone. A wide range of individuals, communities, employers, industry, local and voluntary groups, service providers, and other NGOs are stakeholders in the effective development of drug policy. Government agencies will consult and work with these stakeholders to ensure they are able to contribute meaningfully and constructively to the drug policy development process. The IACD will develop mechanisms to ensure that formalised processes are developed to achieve a collaborative and engaged approach to strategic working groups and the development of action plans, including innovative ways to address drug issues.

1.4.5 Reducing inequalities

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

- achieving a minimum level of wellbeing for all people
  and
- ensuring a more equitable distribution of the determinants of wellbeing across society.

There are important socioeconomic, gender and geographical inequalities in New Zealand. Family background, ethnicity or disability should not be major determinants of an individual's life chances.

In New Zealand, ethnic identity is related to health and wellbeing outcomes. The health status of Māori and Pacific peoples is demonstrably poorer than that of other New Zealanders. Addressing these socioeconomic, ethnic, gender and geographic inequalities requires a whole-of-government approach that takes account of all the influences on health and wellbeing and how they can be tackled. Action to reduce inequalities in health has the potential to improve the health of all New Zealanders (Ministry of Health 2002).

It is a priority to reduce these inequalities by improving the availability of, and access to, drug prevention and treatment services for Māori, Pacific peoples and young people because these groups experience the highest levels of drug-related harm. Service planning needs to incorporate, within the whole-of-population approach, specific targeted strategies that take into account the social and cultural context of Māori, Pacific peoples and young people, and feature a suite of actions that will lead to reductions in the inequalities of health outcomes for these groups.

Because of the intersectoral and whole-of-government approach that the policy takes, government agencies, community groups and NGOs will have different strategic frameworks and responses underpinning their work with Māori and Pacific peoples to address health inequalities and responsiveness issues; for example, *Te Rito: New Zealand Family Violence Prevention Strategy* (Minister of Social Services and Employment 2002).

He Korowai Oranga: Māori Health Strategy (Minister of Health and Associate Minister of Health 2002) provides guidance to the health sector on ways to achieve Māori health improvements. He Korowai Oranga has an overarching aim of whānau ora: Māori families supported to achieve their maximum health and wellbeing. The range of approaches and interventions needs to be accessible, effective and culturally appropriate. The aim is to improve overall health outcomes and reduce disparities among groups at greater risk.

1.5 International commitment

New Zealand is a party to three United Nations conventions:

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

The first two of these conventions establish international control measures to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes and to prevent diversion into illicit channels. The third convention requires the New Zealand Government to co-operate with international measures to prevent drug trafficking. Ratification of these conventions imposes certain requirements on New Zealand to ensure that drugs are appropriately scheduled within domestic drug control legislation.

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

At the United Nations General Assembly Special Session on the World Drug Problem in 1998, commitments were made to address illegal drug cultivation and manufacture, and the diverting of precursor chemicals, and to reduce drug demand. New Zealand, along with other countries, will report on progress towards these commitments in 2008.

New Zealand has also ratified the World Health Organization's Framework Convention on Tobacco Control. This Convention sets out minimum standards parties must observe on such matters as price measures, tobacco advertising, sponsorship and promotion, packaging and labelling of products, and protection from exposure to tobacco smoke.

Currently, there are no international conventions relating to alcohol control. However, the New Zealand Government participates in regional and global World Health Organization activities related to public health problems caused by alcohol.

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

1.6 Recent achievements

A number of important advances in preventing and reducing drug-related harm were made over the life of the first National Drug Policy. Following are some examples of recent achievements.

The Smoke-free Environments Amendment Act 2003 placed further restrictions on smoking in workplaces by banning tobacco smoking from all indoor workplaces, including restaurants and bars. The aim of reducing exposure to second-hand smoke in indoor workplaces has been achieved, and the measure is strongly supported by the public.

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

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

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

1.7 Definitions

1.7.1 Drugs

Reference to 'drugs' in this policy is intended to cover a broad base of substances with psychoactive effects. These substances are divided into four categories: tobacco, alcohol, illegal drugs, and other drugs. Tobacco and alcohol are self-explanatory. 'Illegal drugs' are those that are classified as controlled drugs under the Misuse of Drugs Act 1975, including some pharmaceuticals that can be used for psychoactive purposes. 'Other drugs' include medicines that are diverted from their legitimate purpose, restricted substances listed in the Misuse of Drugs Act, and products (eg, volatile substances) that are manufactured and marketed for domestic or industrial purposes but are capable of being used to achieve a psychoactive effect.

1.7.2 Drug-related harm

Drug use can harm virtually every aspect of people's lives. Harms to health include death, illness, disease, mental health problems and injury. Harms may be chronic, such as depression or heart disease, or acute, such as injuries from falls or traffic crashes.

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

Economic harms include the costs to health services, property damage, low productivity and work absenteeism.

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

Part Two:
The Next Five Years

2. Policy and strategies

2.1 Policy foundations

As we have seen, this National Drug Policy builds on the first National Drug Policy. The principle of harm minimisation and the balance of supply control, demand reduction and problem limitation strategies will continue, as will the co-ordinating mechanisms, the Ministerial Committee on Drug Policy (MCDP) and the Inter-Agency Committee on Drugs (IACD). The Ministry of Health will continue its leadership role and the *National Drug Policy* will continue to be the umbrella document that guides agencies in their responses to drug-related harm.

2.2 Moving forward

Drug policy in New Zealand has developed and matured since the first National Drug Policy was published in 1998. Objectives have been reviewed and updated to reflect new evidence and changes in the social and political environment. The Government will continue to address drug-related harm through approaches known to be effective. The Government will also seek new and innovative approaches to these issues.

2.2.1 Evidence online

An online information source will be developed and maintained. This will co-ordinate and collate up-to-date research and survey data, information on emerging issues, and annual position reports. It will also include detailed information on the prevalence and patterns of drug use and the related health, social and economic harms experienced by the population.

2.2.2 Action plans

Action plans will be developed under the Policy. These plans may be substance-based or related to a particular target group or setting, or may be generic. Action plans that have already been developed include: *Clearing the Smoke: A five-year plan for tobacco control in New Zealand 2004–2009* (Ministry of Health 2004a) the *National Alcohol Strategy 2000–2003* (Ministry of Health and the Alcohol Advisory Council 2001) the *Methamphetamine Action Plan* (Ministerial Action Group on Drugs 2003) and the *Action Plan on Alcohol and Illicit Drugs* (Ministry of Justice 2003).

Agencies represented on the IACD will work together to develop action plans to achieve the objectives outlined in the National Drug Policy. These plans will:

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

In developing new action plans, the process followed will include:

- a systematic review of the evidence
- involvement of topic experts
- consultation with stakeholders.

As these plans are generated, individual agency work programmes to advance the National Drug Policy's objectives will be developed and built on.

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

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

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

2.2.3 A stronger intersectoral focus

The first National Drug Policy had a strong emphasis on health objectives and approaches to addressing the harms arising from tobacco, alcohol, illegal and other drug use. Over the next five years the Government will retain health-related objectives but will also develop a greater intersectoral focus, which will encompass both the social and the economic harms from drug use.

All government agencies will be held accountable by the MCDP for achieving the objectives of the National Drug Policy, delivering effective policies and programmes, and collaborating with other agencies to achieve a co-ordinated approach to reducing drug-related harm. This broadening of focus may require government agencies to refine their data sets and undertake research in new areas to ensure there is an adequate evidence base to work from.

2.2.4 Addressing emerging trends

The Government expects that in the next five years there will be changing patterns of drug use, and that new trends will emerge in the nature and extent of the drug problems faced in New Zealand. For this reason it is important that the National Drug Intelligence Bureau, ALAC, the Health Sponsorship Council, and government agencies maintain vigilance over legal and illegal drug trends. The National Drug Intelligence Bureau will be reviewed to ensure that it can provide a strong, proactive and prominent capability to forecast future trends in drug use.

2.2.5 Contribution to social wellbeing

The Government's theme, families – young and old, has five sub-themes:

- strong families
- healthy confident kids
- better health for all
- strong and safe communities
- positive ageing.

Drug abuse underlies many social issues and concerns, and tackling it will help to address issues such as family violence, crime, safety, educational under-achievement, unemployment, road safety and family cohesiveness. A strong and cohesive National Drug Policy and resulting action planning will contribute significantly to all of these sub-themes.

2.3 Strategies

Strategies will be developed, as necessary, to achieve the objectives of the National Drug Policy taking into account five interacting components:

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

There will be a focus on the following three strategic areas over the next five years: regulation and law enforcement; health promotion and education; and assessment, advice and treatment services.

2.3.1 Regulation and law enforcement

Regulatory intervention is a powerful tool for controlling the environment within which drug use occurs. However, the focus and goals of regulation necessarily differ for legal and illegal drugs.

Legal drugs

Legislation controlling legal drugs includes the Smoke-free Environments Act 1990, Sale of Liquor Act 1989, Customs and Excise Act 1996, and Part 3 of the Misuse of Drugs Amendment Act 2005.

Regulation of legal drugs can be applied to:

- the purchaser or consumer (eg, setting a minimum purchase age, degree of acceptable intoxication and location of use)
- the product (eg, restrictions on content, volume, packaging and labelling; requirements for warnings and product information; and controls over price, distribution and marketing)
- consumption facilities (eg, licensing regimes, controls over hours of operation, location and density of outlets, restrictions on marketing promotions, requirements for staff training and security systems).

The focus for the next five years will be to review the enforcement and adequacy of these regulations and to identify areas for more efficient and effective controls, especially for volatile substances and other restricted substances.

Illegal drugs

Where drugs are illegal, regulation generally involves measures aimed at preventing them from reaching users and deterring individuals from choosing to use them. This includes prohibiting importation, manufacturing, supply, possession and use. The enforcement of illegal drug regulations involves initiatives to prevent the establishment of extensive and enduring drug distribution networks and to disrupt the activities of existing organised criminal groups.

The focus of the next five years will include reducing the availability of illegal drugs in the community by reducing the levels of importation, manufacture, cultivation and distribution of both illegal drugs and precursor substances. It will also include working proactively to suppress the involvement of organised and trans-national criminal groups in existing drug markets, and to stymie their involvement in any new drug markets. This will involve the development and use of new and enhanced enforcement techniques and strategies. Enforcement agencies will continue to undertake joint/interagency responses to drug trafficking, both domestically and internationally. There will also be a strengthened capability within monitoring and enforcement agencies through effective workforce development initiatives.

Legislation controlling illegal drugs includes the Misuse of Drugs Act 1975, Medicines Act 1981 and Customs and Excise Act 1996.

2.3.2 Health promotion and education

The 1986 Ottawa Charter defined *health promotion* as the process of enabling people to increase control over and improve their health. It includes the impact of economic, social and cultural factors on health. Health promotion strategies include interventions designed to build healthy public policy, strengthen community action, reorient health services, create supportive environments, and develop personal skills. Relevant drug health promotion intervention includes:

- the use of the regulatory tools available for legal drugs, including pricing and tax policy

- working with industry on the nature of advertising and marketing of products
- community action and resiliency programmes
- social marketing.

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

Health education strategies involve providing information about drugs and their effects to inform people's choices about drug use. The focus for the next five years will be to continue to fund Community Action on Youth and Drug (CAYAD) programmes, social marketing (including tobacco control and alcohol culture change), and other health promotion initiatives.

The Government will review the scope and funding of drug-related health promotion and education to ensure that the best and most effective mix is achieved.

2.3.3 Assessment, advice and treatment services

Over the next five years the Government will continue to improve the quality of, and access to, drug treatment services. Treatment interventions are vital to the limitation of problems arising from substance use.

In June 2005 the Minister of Health released *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan.* One of its 10 leading challenges focuses on addiction, and aims to improve the availability of, and access to, quality addiction services including maintenance treatment programmes and opioid substitution. Most of the other leading challenges, including service delivery for people with co-existing mental health and drug-related problems, are also relevant to alcohol and drugs, including the directions on promotion and prevention, primary health care, and Māori mental health. *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Minister of Health 2006) is the implementation plan for *Te Tāhuhu – Improving Mental Health 2005–2015*.

Access to, and the quality of, primary mental health services for people with or at risk of developing drug problems will be improved. The needle and syringe programme for injecting drug users at risk of contracting blood-borne viruses will be maintained and access will be improved. There will be a systematic review of the interface between addiction and mental health treatment and criminal justice systems, including implications for Māori and Pacific peoples, women offenders and youth offenders.

There will also be work on minimising alcohol and other drug-related crime, crashes and anti-social behaviour, as well as associated injuries and other types of victimisation.

2.4 Information collection, research, evaluation and monitoring

The successful implementation of drug harm minimisation strategies will involve:

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

Information gained through data collection, research and evaluation supports policy interventions and service development in a number of ways. First, it enables agencies to accurately identify the scope and nature of particular drug issues and to prioritise policy responses in a way that will prevent or reduce the harm most effectively. Second, it helps build the evidence base for determining which policy interventions will be most effective. Finally, it provides data to monitor and measure the results of specific local interventions. Data collection to support research into the size of the drug problem and emerging drug trends, and to create an evidence base for policy interventions and decision-making for service provision, will be refined and expanded.

Although the national and international knowledge base is growing, there are still substantial gaps in our knowledge. For example, there is little information available on the social and economic costs arising from alcohol use and some other types of drug use. The IACD will be specifically tasked with addressing these issues and ensuring that researchers from each agency (and independent researchers) undertake a stocktake of existing knowledge and identify what further information is needed.

Research into drug issues will continue to be funded, as appropriate, through the Health Research Council, Cross-Departmental Research Fund, National Drug Policy Discretionary Grant Fund and individual agency budgets.

2.5 National Drug Policy Discretionary Fund

The National Drug Policy Discretionary Grant Fund (NDPDGF), established in 2004, provides government ministers involved with drug policy with access to a pool of funding for new initiatives or projects that fill gaps in drug policy work. The NDPDGF will continue to fund:

- high-quality cross-departmental projects that support the advancement of the National Drug Policy
- projects that fill a gap which would otherwise remain unfilled due to not meeting a particular agency's funding criteria
- projects that allow for forward planning and fast response by government agencies to changes in current and emerging drug trends.

The fund is jointly managed by the IACD and MCDP.

The NDPDGF has funded research into benzylpiperazine (BZP), a substance for which there was little knowledge world wide. It is expected that the NDPDGF will continue to be a source of funding for cutting-edge research and interim support for innovative approaches to drug issues.

3. Issues relating to population groups

The relationship between drug use and social factors such as unemployment, low income, poor housing and low social cohesion is clear. However, individual risk and protective factors can mediate this relationship so that some individuals will do better than others. The groups most at risk vary, depending on the particular harm being addressed and whether or not this harm is related to single drug or poly-drug misuse.

At a population level, low socioeconomic status is associated with an increased risk of drug-related harm from tobacco, alcohol and illegal drugs. In addition, three specific population groups have been identified as being at greater risk of many drug-related harms than other New Zealanders: Māori, Pacific peoples and young people. These groups are an important target for initiatives to reduce drug-related harm because they have a higher need and require specific approaches to ensure that efforts to reduce harm are effective.

3.1 Māori

Māori suffer disproportionate harm from the use of drugs, especially tobacco, alcohol and cannabis. Strategies designed for the general population have been less successful in reducing harm among Māori. The Government recognises the importance of consolidating gains in Māori development and accelerating Māori participation.

He Korowai Oranga, the Māori Health Strategy (Minister of Health and Associate Minister of Health 2002), is a government strategy developed to address health issues affecting Māori. The overall vision of He Korowai Oranga is whānau ora, which emphasises whānau health and wellbeing and places whānau at the centre of public policy. The strategy strongly supports Māori holistic models and wellness approaches to health and disability.

There is a clear association between high smoking prevalence, ethnicity and low socioeconomic position in New Zealand. Overall, Māori smoking rates remain high (see section 1.1) and have declined at a slower rate than for non-Māori. Smoking is a significant contributing factor to the health inequalities seen between Māori and non-Māori.

Data from large-scale New Zealand surveys show that while Māori are less likely to drink alcohol and drink less often, they drink more heavily on a typical drinking occasion when compared with non-Māori *(Reference to A 2003 Study for the Alcohol Burden of Disease and Disability Group*). Thus Māori are more likely than non-Māori to have potentially 'hazardous' drinking patterns (see section 1.2.2).

The National Drug Policy recognises that drug problems in Māori communities may be addressed more effectively when targeted approaches are developed by and for Māori. This has implications for the way services are provided for Māori to minimise the drug-related harm they experience. Some ways in which services might be organised to better meet the needs of this group are outlined below.

3.1.1 Mainstream services for Māori

Access for Māori clients to the full range of mainstream drug treatment services – including rehabilitation, detoxification and drug education services – should not be limited by socioeconomic factors or geographical isolation. Programmes and interventions should be appropriate for Māori across the continuum of care from health promotion, early intervention and treatment.

3.1.2 Kaupapa Māori services

Kaupapa Māori services are predominantly provided and delivered by Māori within a framework of Māori concepts of health and wellbeing. Such services can be delivered either by Māori groups within mainstream services or by Māori community/hapū/iwi services.

3.1.3 Māori advocacy and peer support services

Māori advocacy and peer support workers who work in and with mainstream and kaupapa Māori services to meet the needs of Māori clients, their whānau and hapū will be encouraged.

3.1.4 Māori with co-existing disorders

Māori present for treatment with dual diagnosis more often than non-Māori. Anecdotal evidence suggests that Māori with both drug and other mental health problems present to drug and alcohol services rather than to mental health services because they do not want to be associated with the perceived stigma of mental health services. Drug and alcohol workers therefore need training in how to assess and manage people with dual diagnosis. Drug and alcohol services should ideally have access to Māori drug and alcohol counsellors, and be in consultation with whānau, hapū, iwi and liaison support from kaupapa Māori mental health services.

3.2 Young people

Young people, from primary-school age through to young adulthood, are a particular concern and warrant a strong focus for the prevention of drug-related harm. Information for young people about the effects of drugs and ways to prevent and reduce harm needs to be appropriate. For young people who are already using drugs, it is important to focus on effective interventions to help them to stop their use (eg, smoking cessation services) or minimise the risk of harmful effects (eg, reducing excess or binge drinking).

School-based health promotion initiatives work best when supported by consistent family and community-based approaches. A community focus will also be necessary to reach members of this target group who are at higher risk, including those who may not regularly attend school. 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, alcohol and other drugs.

3.3 Pacific peoples

The increasing prevalence of tobacco and alcohol consumption, combined with low rates of tobacco, alcohol and drug service utilisation, are growing concerns for Pacific communities (prevalence data for Pacific peoples are summarised in section 1). In addition, the largely youthful structure of the Pacific population points to the possibility that rates of drug use may continue to increase in future.

Tobacco smoking and hazardous drinking patterns are leading causes of preventable deaths for Pacific peoples. The prevalence of smoking for Pacific males is higher than the national average, while that for Pacific females (which was low in the past) is now similar to the national average. Pacific adult males have higher rates of hazardous drinking patterns than other ethnic groups (see section 1.2.3).

Receiving suitable and timely treatment is vital to reducing the harms linked to tobacco, alcohol and other drug use. It is therefore important to include a Pacific focus in efforts to improve the access and quality of services. There are two areas for development to further meet the needs of Pacific peoples: improved data collection and improved service utilisation.

3.3.1 Improved ethnicity data collection

Pacific communities in New Zealand are made up of a number of separate ethnic groups, so ethnic-specific data are required to ensure health services are targeted at areas of need. For example, Cook Island female adolescents have a smoking rate of 42%, compared to Samoan adolescents with a rate of 24% (Scragg 2005). Effective interventions may therefore require ethnic-specific programmes. Improved ethnicity data collection will enable agencies to accurately identify problems and target initiatives more effectively.

3.3.2 Improved treatment service utilisation

Research suggests that there is a relatively low level of treatment service utilisation by Pacific peoples. One approach to address this is to improve and formalise the linkages between primary health organisations and community organisations that provide alcohol and drug treatment services (Ministry of Health 2001), given that the enrolment rates at primary health organisations for Pacific peoples are high (Ministry of Health and Ministry of Pacific Island Affairs 2004). Improving the quality of Pacific and mainstream services through cultural competence frameworks and Pacific models of care are also emerging responses to managing disparities in service utilisation and health outcomes.

Appendices

Appendix 1: **Drug Use in New Zealand**

There has never been a time, place, or culture where some psychoactive drug has not been used, and it is highly unlikely there will ever be (Ryder et al 2006).

Drug-related problems can have a significant impact on individuals, families and whānau, communities and society as a whole. The costs – including treatment, education, service provision, enforcement and custodial care – can be measured in financial terms, but the personal and emotional costs on the lives of individuals and the people around them are immeasurable. This is why the Government believes it is critical to continue to progress an agenda of prevention and reduction of drug-related harm affecting the wellbeing of all New Zealanders.

This section provides a background to the development of the National Drug Policy (NDP) by presenting an overview of tobacco, alcohol, illegal and other drug use in New Zealand and the harms caused by their misuse. It presents a rationale for continuing to develop the NDP. Note that the amount and quality of information differ considerably depending on the substance in question. In general, the data are more comprehensive for alcohol and tobacco than for illegal and other drugs, and there is more information about health harms than social and economic harms.

1.1 Tobacco

Tobacco smoking is the single biggest cause of preventable death and ill health in New Zealand. It is estimated that smoking is currently responsible for nearly one in five (approximately 5000) deaths per year in this country. Health effects include cancers (mouth, lung, throat, pancreas and kidney), blindness, chronic respiratory disease, heart disease, stroke, and sudden infant death syndrome (SIDS). Tobacco use causes the highest mortality rate of all recreational drugs in New Zealand.

In addition, second-hand smoke is now recognised to be a substantial health hazard. Exposure to second-hand smoke is estimated to be responsible for about 300 deaths per year in New Zealand.

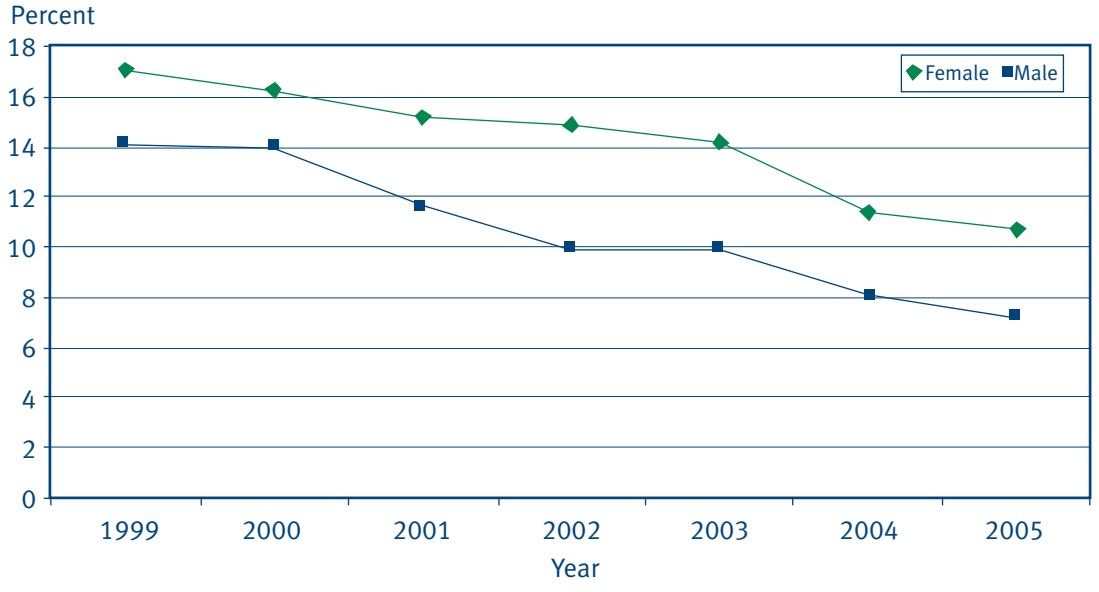
Smoking is strongly associated with socioeconomic status, with the highest prevalence among people with low incomes. The proportion of smokers in the most deprived areas is two to three times greater than the proportion of smokers in the least deprived areas (Crampton, Salmond, Woodward et al 2000).

The prevalence of cigarette smoking has decreased over the last 10 years, from 27% in 1995 to 23.5% in 2005 (Ministry of Health 2006). Other notable findings on tobacco use are as follows.

- Smoking rates among Māori and Pacific peoples are comparatively high: the age-adjusted prevalence of smoking among Māori is 46% and for Pacific peoples it is 36%. European/other ethnic groups have a prevalence of 20%.
- Māori women (50%) have higher smoking rates than Māori men (40%).
- The prevalence of smoking among Pacific males is 39%, while the prevalence among Pacific females is 33%.
- Higher smoking prevalence is seen among young and middle-aged groups (15 to 49 years) compared with people aged over 50 years. Smoking prevalence generally declines with age as more people quit after the age of 40.
- The prevalence of smoking among people aged 15 to 19 years is 27%. In this age group, males (25%) and females (29%) have similar smoking rates.
- The prevalence of smoking among Māori and Pacific youth (15–19 years) is 46% and 36% respectively.
- Among Māori youth, females have a higher smoking prevalence (60%) than males (32%). The reverse is true among Pacific youth, with 28% of females currently smoking compared with 46% of males.

According to the Year 10 Smoking Survey (Scragg 2006), the prevalence of smoking in year 10 students has decreased from 11.4% to 10.7% in girls and from 8.1% to 7.2% in boys over 2004 and 2005. This is consistent with a continuing downward trend since 2000, when the prevalence was 16.3% among girls and 14.0% among boys (see Figure 1).

Figure 1: Prevalence of daily smoking (year 10 students), by sex, 1999–2005



Source: National Year 10 Smoking Survey (Scragg 2006)

The Year 10 Smoking Survey indicates a decreasing trend in the prevalence of daily smoking across all ethnic groups from 1999 to 2005. The decline over this period has occurred among European, Māori, Pacific and Asian year 10 students, although large relative inequalities persist (Table 1).

Table 1: Prevalence of daily smoking (%), year 10 students, by sex and ethnicity, 1999–2005

Female							
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Māori	36.2	37.1	34.3	34.3	34.2	29.1	26.5
Pacific	23.0	19.4	19.5	17.6	18.1	13.2	14.5
Asian	5.9	5.1	3.2	3.9	4.5	2.9	2.9
European/Other	13.1	12.2	11.4	10.8	9.8	7.2	7.3

Male							
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Māori	23.6	24.2	19.1	16.8	19.4	16.2	14.0
Pacific	16.6	16.8	14.3	10.8	12.5	11.8	10.2
Asian	7.9	9.4	7.2	7.5	6.4	3.8	5.3
European/Other	12.6	12.1	10.0	8.6	7.6	5.9	5.4

Source: Year 10 Smoking Survey (Scragg 2006)

1.2 Alcohol

Alcohol is the most commonly used recreational drug in New Zealand, with over 80% of New Zealanders reporting that they have drunk alcohol in the last year. While most people drink without harming themselves or others, the misuse of alcohol by some results in considerable health, social and economic costs. These costs are borne by individuals, families and the wider community. Alcohol-related harm includes:

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

(Alcohol Advisory Council of New Zealand 2005.)

1.2.1 Alcohol consumption

The results of the 2004 New Zealand Health Behaviours Survey – Alcohol Use show that 81.2% of New Zealanders had consumed alcohol at least once in the last 12 months (Ministry of Health 2007). However, further analysis shows markedly different drinking patterns for different age groups, in terms of both the frequency and amount of alcohol consumed. For example, although people aged 18–24 years did not consume alcohol as frequently as people aged 55–65 years, they were significantly more likely to consume large amounts of alcohol on a typical drinking occasion.

Among New Zealanders aged between 12 and 65 years who had consumed alcohol in the last 12 months, about 14.7% consumed more than the recommended upper limits for responsible drinking on at least a weekly basis. The Alcohol Advisory Council (ALAC) recommended upper limits are six standard drinks for men and four standard drinks for women on any one occasion.

Males (82.5%) were significantly more likely to have consumed alcohol than females (78.4%) in the last 12 months. Among past-year drinkers, males (53.9%) were significantly more likely than females (39.9%) to consume alcohol four or more times a week on average.

The heaviest 9.5% of drinkers reported consuming enough alcohol to feel drunk at least once a week, with males (14.3%) significantly more likely than females (6.4%) to drink enough to feel drunk at least weekly. Two in five drinkers reported that more than once in the last 12 months they had felt the effects of alcohol the day after drinking. About 15% of drinkers had felt the effects of alcohol from the night before while at work, study or doing housework.

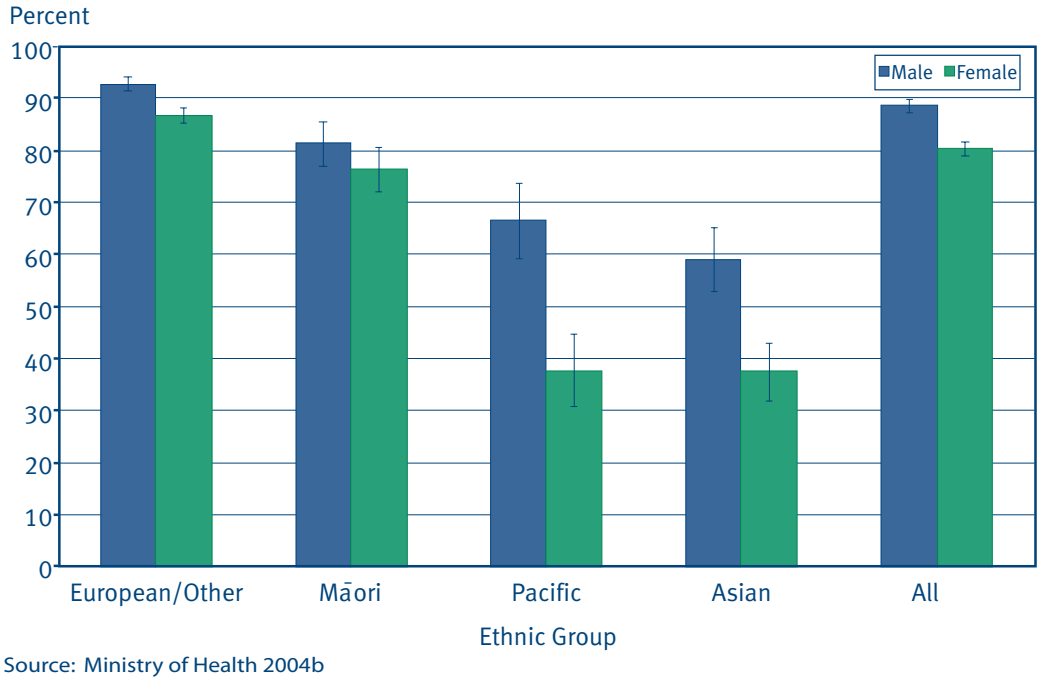
1.2.2 Alcohol and Māori

Non-Māori (81.3%) were significantly more likely than Māori (74.2%) to have consumed alcohol in the last 12 months. However, Māori drinkers (50.3%) were significantly more likely than non-Māori drinkers (23.3%) to consume a large amount of alcohol on a typical drinking occasion. Māori drinkers (21%) were also more likely than non-Māori drinkers (14.7%) to consume a large amount of alcohol at least weekly.

1.2.3 Alcohol and Pacific peoples

Pacific adults (46%) are more likely to be non-drinkers than the total population (19%). They are also less likely to have started drinking early in life or to be regular drinkers, and have lower rates of alcohol dependence compared with the New Zealand population overall. However, Pacific adult males in particular appear to have higher than average rates of hazardous drinking patterns. Current Pacific drinkers (27%) are more likely than other New Zealanders (8%) to have consumed more than 10 glasses on their previous drinking occasion (Ministry of Health and Ministry of Pacific Island Affairs 2004).

Figure 2: Past-year alcohol use in adults, by ethnic group and sex (age-standardised), 2002/03



Source: Ministry of Health 2004b

1.2.4 Alcohol and youth

Over half (55.7%) of youth aged 12–17 years had consumed alcohol in the last 12 months ('youth drinkers'), and about one in eight of these, or 12.4% of all youth drinkers, said they had consumed large amounts of alcohol at least once a week. Over three-fifths (62.5%) of youth drinkers reported that someone else had purchased alcohol for them in the last 12 months.

1.2.5 Alcohol-related harms

The national alcohol use survey found that alcohol consumption causes a wide range of self-reported problems and harms for drinkers, including affecting work or study, and results in actions regretted later, such as having unprotected sex.

The survey found that people had also experienced problems as a result of someone else's drinking, including physical assault, sexual harassment and impacts on their family life, social life and financial position. More than one in 20 New Zealanders aged 12–65 years had suffered physical assault (5.7%) and sexual harassment (5.3%) as a result of someone else's drinking during the last 12 months.

A study of New Zealand data from 2000 found that 51% of alcohol-attributable deaths and 72% of years of life lost[1] in 2000 were due to injuries. Young people were more likely to experience alcohol-related injuries than older drinkers (Alcohol Advisory Council of New Zealand 2005).

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

Among New Zealanders aged 12–65 years who had wanted to reduce their alcohol consumption during their lifetime, 2.2% had received help to reduce their alcohol consumption, and 1% had wanted help but had not received any.

1.2.6 Alcohol and pregnancy

Four out of five (82.4%) of pregnant female drinkers reported stopping drinking during their pregnancy, and 79.2% of female drinkers who were planning a pregnancy reported that they had stopped drinking alcohol.

1.2.7 Transport-related harm from alcohol

Alcohol consumption degrades driving performance, and the risk of a crash increases as the driver's alcohol level increases. For example, a driver aged over 30 years with an alcohol level of 50 mg/100 ml is six times more likely to be involved in a fatal crash than a sober driver aged over 30 years. The same driver with a level of 80 mg/100 ml is 16 times more likely to be involved in a fatal crash. The national alcohol use survey found that approximately one in five drinkers reported having done at least some of their driving under the influence of alcohol in the last 12 months.

In 2005 driver alcohol impairment was a contributing factor in 100 fatal traffic crashes, 390 serious injury crashes and 940 minor injury crashes (Ministry of Transport 2006). Between 2003 and 2005 driver alcohol impairment was a contributing factor in 30% of fatal crashes, 18% of serious crashes and 11% of minor injury crashes. For every 100 drunk drivers or riders killed in road crashes, 55 of their passengers and another 35 sober road users die with them. People with a high blood alcohol level are more likely to be injured or die as a result of a crash than those who are sober.

1.3 Cannabis

Cannabis smoking has adverse effects on the respiratory and cardiovascular systems and increases the risk of major psychological problems. Cannabis is the most widely used illegal drug in New Zealand and the third most widely used recreational drug after alcohol and tobacco. The 2003 New Zealand Health Behaviours Survey – Drug Use showed that one in seven New Zealanders (13.7%) had used cannabis in the last year, and that 15.1% of past-year users smoked cannabis frequently (10 or more times per month on average) (Ministry of Health forthcoming).

Other findings from the 2003 New Zealand Health Behaviours Survey – Drug Use included:

- among past-year users, males (21.3%) were significantly more likely than females (6.3%) to smoke cannabis frequently (10 or more times per month on average)
- people aged 18 to 24 years were most likely to have smoked cannabis in the last 12 months (40.8% of males and 27.1% of females)
- similar proportions of males (19.6%) and females (21.3%) aged 13 to 17 years report cannabis use in the past 12 months

- Māori (20.8%) were significantly more likely than non-Māori (14.0%) to have smoked cannabis in the last 12 months.

1.4 Stimulants

Stimulants include amphetamine, methamphetamine, crystal methamphetamine, ecstasy (MDMA),[2] cocaine and crack. Earlier surveys have shown a significant increase in illegal stimulant use between 1998 and 2001: in 2001 5.3% of those surveyed reported having used an illegal stimulant in the last year, compared with 3.2% in 1998. In the New Zealand Health Behaviours Survey – Drug Use 2003 report (Ministry of Health forthcoming) amphetamines (including methamphetamine) were the second most commonly reported illegal drug ever used (6.8%) or used in the past 12 months (2.5%). Past-year ecstasy (MDMA) use was reported by 1.9% of New Zealanders, making ecstasy the second most commonly used stimulant.

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

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

1.5 Hallucinogens

Hallucinogens include LSD and 'magic mushrooms'. In the New Zealand Health Behaviours Survey – Drug Use 2003 report, 1.2% and 1.1% of people reported past-year use of LSD and mushrooms.

1.6 Opiates

Opiates include morphine, codeine, opium, heroin and a wide range of pharmaceutical drugs such as methadone and buprenorphine. Due to New Zealand's geographic isolation it is difficult to import heroin and raw opium in bulk, so the majority of opiates abused in New Zealand have been prescription medicines (eg, morphine sulphate tablets and methadone), poppies and 'home bake'.

The prevalence of opiate use remained relatively stable throughout the 1990s, with 0.6% of those surveyed in 2001 being current opiate users compared with 0.5% in 1990. Prevalence of use reported in the New Zealand Health Behaviours Survey – Drug Use 2003 remained low: around 0.1% of people reported last-year use of poppies, homebake and/or morphine.

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

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

1.7 Inhalants and volatile substances

Solvents include petrol, glue, butane gas and liquefied petroleum gas (LPG). These substances are contained in readily available products such as adhesives, thinners, petrol, aerosol sprays, gas, paint and anti-freeze and are inhaled by recreational users. In 2003 0.1% of people surveyed had used solvents in the previous year.

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

1.8 Performance and image-enhancing drugs

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

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

1.9 Diverted pharmaceuticals

Currently there is no way to measure the volume of diverted pharmaceutical drugs on the illicit drug market. The only surveys conducted on the recreational use of pharmaceuticals have focused on tranquilliser use.

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

1.10 Legal highs

Legal highs are substances such as 'party pills' that have psychoactive effects and are sold for recreational use. There has been a dramatic increase in the availability of products containing benzylpiperazine (BZP) in the last five years, with an estimated 1.5 million capsules being manufactured for sale in 2003. One concern about legal highs is the lack of information provided to users about health risks – in particular poly-drug interactions – associated with their use.

BZP was made a 'restricted substance' by the Misuse of Drugs Amendment Act 2005. The sale of products containing BZP is confined to those over 18 years of age, and restrictions have been placed on the way in which products containing BZP may be advertised or distributed.

A recent survey (Wilkins et al 2006) of 2010 people aged between 13 and 45 years found that 20% of the sample had ever tried legal party pills and 15% had used them in the last year. The highest use was reported by people aged 20–24 years. The survey also found that Māori were more likely than non-Māori and males more likely than females to have used legal party pills in the last year.

In November 2006, the Expert Advisory Committee on Drugs (EACD) considered research into BZP and related substances. Based on the evidence considered, the EACD made recommendations to the Associate Minister of Health including that BZP, phenylpiperazine and related substances be classified as 'class C1' controlled drugs under the Misuse of Drugs Act 1975.

Appendix 2: **National Drug Policy Co-ordinating Structures**

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

Ministerial Committee on Drug Policy

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

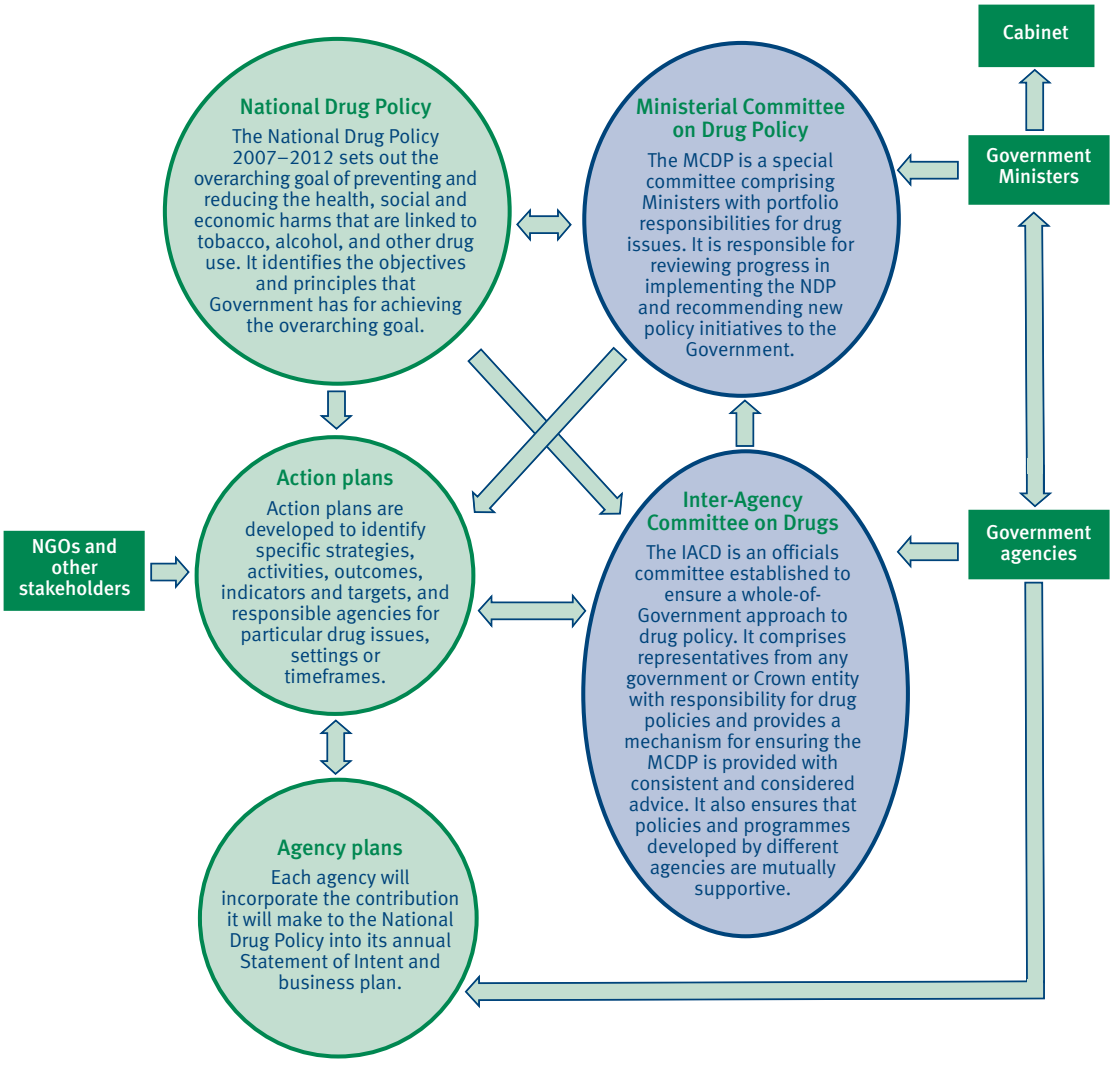
Inter-Agency Committee on Drugs

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

Expert Advisory Committee on Drugs

In 2000 the Misuse of Drugs Act 1975 was amended to establish the Expert Advisory Committee on Drugs (EACD). The EACD provides the Minister of Health with expert advice on the risk of harm to individuals and society from any particular drug or substance and on drug classification issues. The Ministry of Health provides secretariat support for the Ministerial Committee on Drug Policy, the Inter-Agency Committee on Drugs and the Expert Advisory Committee on Drugs.

Appendix 3: **The National Drug Policy in Context**



Abbreviations

ALAC	Alcohol Advisory Council of New Zealand
BZP	benzylpiperazine
CAYAD	Community Action on Youth and Drugs
CND	Commission on Narcotic Drugs
EACD	Expert Advisory Committee on Drugs
IDU	injecting drug user
IACD	Inter-Agency Committee on Drugs
MCDP	Ministerial Committee on Drug Policy
MDMA	methylenedioxymethamphetamine
NDIB	National Drug Intelligence Bureau
NDP	National Drug Policy
NDPDGF	National Drug Policy Discretionary Grant Fund
NGO	non-governmental organisation
NZSDA	New Zealand Sports Drug Agency
PIED	performance and image-enhancing drug
SIDS	sudden infant death syndrome

References and Bibliography

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

Bramley D, Broad J, Harris T, et al for the Alcohol Burden of Disease and Disability Group. 2003. Differences in patterns of alcohol consumption between Māori and non-Māori in Aotearoa (New Zealand). *New Zealand Medical Journal* 116 (1184).

Crampton P, Salmond C, Woodward A, et al. 2000. Socioeconomic deprivation and ethnicity are both important for anti-tobacco health promotion. *Health Education and Behaviour* 27: 317–27.

Department of Corrections. 2004. *Strategy to Reduce Drug and Alcohol Use by Offenders 2005–2008*. Wellington: Department of Corrections.

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

Jarvis MJ, Wardle J. 1999. Social patterning of individual health behaviours: the case of cigarette smoking. In: M Marmot, RG Wilkinson (eds). *Social Determinants of Health*. New York and Oxford: Oxford University Press.

Kypri K. 2003. Māori/non-Māori alcohol consumption profiles: implications for reducing health inequalities. *New Zealand Medical Journal* 116 (1184).

Minister of Health. 2005. *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan*. Wellington: Ministry of Health.

Minister of Health. 2006. *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015*. Wellington: Ministry of Health

Minister of Health, Associate Minister of Health. 2002. *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.

Minister of Social Services and Employment. 2002. *Te Rito: New Zealand Family Violence Prevention Strategy*. Wellington: Ministry of Social Development.

Ministerial Action Group on Drugs. 2003. *Methamphetamine Action Plan*. Wellington: Ministry of Health.

Ministry of Education. 1999. *Health and Physical Education in the New Zealand Curriculum*. Wellington: Learning Media Limited.

Ministry of Health. 1998. *National Drug Policy 1998–2003*. Wellington: Ministry of Health.

Ministry of Health. 2001. *A National Strategic Framework for Alcohol and Drug Services*. Wellington: Ministry of Health.

Ministry of Health. 2002. *Reducing Inequalities in Health*. Wellington: Ministry of Health.

Ministry of Health. 2004a. *Clearing the Smoke: A five-year plan for tobacco control in New Zealand 2004–2009*. Wellington: Ministry of Health.

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

Ministry of Health. 2005. *Tobacco Facts 2005*. Wellington: Ministry of Health.

Ministry of Health. 2006. *Tobacco Trends 2006*. Wellington: Ministry of Health.

Ministry of Health. 2007. *Alcohol Use in New Zealand: Analysis of the 2004 Health Behaviours Survey – Alcohol Use*. Wellington: Ministry of Health.

Ministry of Health (forthcoming). *Drug Use in New Zealand: Analysis of the 2003 Health Behaviours Survey – Drug Use*. Wellington: Ministry of Health.

Ministry of Health and the Alcohol Advisory Council. 2001. *National Alcohol Strategy 2000–2003*. Wellington: Ministry of Health and Alcohol Advisory Council.

Ministry of Health and Ministry of Pacific Island Affairs. 2004. *Tupu Ola Moui: Pacific Health Chart Book 2004*. Wellington: Ministry of Health.

Ministry of Health and Ministry of Youth Affairs. 2002. *Youth Health: A guide to action*. Wellington: Ministry of Health.

Ministry of Justice. 2002. *The Crime Reduction Strategy*. Wellington: Ministry of Justice.

Ministry of Justice. 2003. *Action Plan on Alcohol and Illicit Drugs*. Wellington: Ministry of Justice.

Ministry of Justice. 2004. *Safer Communities: Action plan to reduce community violence and sexual violence*. Wellington: Ministry of Justice.

Ministry of Transport. 2006. *Alcohol Factsheet*. Wellington: Ministry of Transport.

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

New Zealand Police. 2006. *The New Zealand Police Alcohol Action Plan*. Wellington: New Zealand Police.

Ryder D, Salmon A, Walker N. 2006. *Drug Use and Drug-related Harm: A delicate balance. 2nd edition*. Melbourne: IP Communications.

Scragg R. 2005. *Report of 1999 to 2004 National Year 10 Smoking Surveys*. Auckland: University of Auckland/Action on Smoking and Health (ASH).

Scragg R. 2006. *Report of the 1999–2005 National Year 10 smoking surveys.* Auckland: University of Auckland/Action on Smoking and Health (ASH).

Wilkins C, Casswell S, Bhatta K, et al. 2002. *Drug Use in New Zealand: National surveys comparison 1998 and 2001*. Auckland: Alcohol and Public Health Research Unit, University of Auckland.

Wilkins, C, Girling, M, Sweetsur, P et al. 2006. *Legal party pill use in New Zealand: prevalence of use, availability, health harms and 'gateway effects' of benzylpiperazine(BZP) and trifluoromethylphenylpiperazine* (TFMPP). Centre for Social and Health Outcomes Research and Evaluation (SHORE), Massey University.