

# **A New National Drug Policy for New Zealand**

**Analysis of submissions**

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# Executive summary

The discussion document *A New National Drug Policy for New Zealand* was released for public consultation in December 2013. The consultation ran between 16 December 2013 and 28 February 2014, during which time a total of 120 submissions were received from a variety of groups. The information and views provided have been used to inform the development of the National Drug Policy (the Policy).

This document is a summary of the key themes that emerged from this consultation. Many of the submissions were complex. Given the volume of information received and the breadth of views expressed in the responses, and in the interests of clarity, this document does not include every response received for each question. Rather, we have sought to reflect all themes emerging from the responses.

The most common groups to submit, other than individuals, were health/treatment service providers (20) followed by interest groups (12), community organisations (11) and industry bodies (6).

In addition to responding to the questions in the discussion document, many submissions provided views that did not fit neatly under any of the individual questions, or commented on drug-related matters beyond the scope of the consultation. It is notable that a number of people wrote in support of the Wellington Declaration, with around a quarter of all submissions referencing either the Declaration specifically, or a significant number of its principles.

A further common theme beyond the scope of the consultation was the issue of either legalising or decriminalising cannabis, supported by around a third of submissions. A number of these submissions commented on the harms resulting from the black market; and several commented on the potential value of generating taxation income from cannabis. The majority of those who supported cannabis law reform explicitly supported legalising medical cannabis on prescription.



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# Keeping what works and making it better

## Question 1: What should we call our new Policy?

Fifty-one submissions responded to this question, of which around half were comfortable with the current name. The most common preferred change was to mention alcohol (16 submissions) and/or tobacco (3 submissions) explicitly in the title. Some respondents also wished to see a clearer distinction made between illegal drug use and safe and socially responsible drug use, including that of alcohol.

## Question 2: Where should we focus our efforts? Should these efforts be consistent or differ depending on the drug or substance?

Almost all submissions commented on this question. The majority of these were in support of the three existing pillars being treated more or less equally, with supply control, demand reduction and problem limitation strategies and activities reinforcing each other. However, a small number of submissions suggested that either demand reduction (9 submissions) or problem limitation (5 submissions) should be given greater emphasis than the other pillars. Further, around 20 submissions expressed concern that supply control, in their view, receives the bulk of available resources, some of which could perhaps achieve better outcomes if invested more equally across the other pillars.

Evidence suggests that enforcement efforts to control the supply of illicit drugs are effective up to a point, after which additional effort achieves ever-smaller returns ... in the case of cannabis, supply enforcement could be reaching a point of diminishing returns and we see it as an area to investigate for redistribution of spending to demand reduction and problem limitation. [Submission 95]

The majority of submissions did not identify a specific substance on which the policy should focus. A variety of views were expressed as to whether a specific drug – and if so, which specific drug – should be a key focus of the policy. Alcohol was named as the preferred key focus by 10 submissions; tobacco, cannabis, opiates, methamphetamines and synthetic drugs were each selected as a key focus by at least one submission.

Children and young people were the group most commonly identified as a key priority. Māori, Pacific peoples, lesbian, gay, bisexual, transgender and intersex (LGBTI), rural populations, the elderly and women were also each identified as a key focus by at least one submission. Ensuring that agencies work closely and collaboratively together, and that strategies across sectors do not conflict, was explicitly identified as a key priority by several submissions. Around 20 submissions also identified workforce development, particularly of the Māori and Pacific workforce, as a key priority for improving both prevention and treatment.

We recommend that the National Drug Policy is informed by and implements a health equity approach to reducing drug harm. 'Health equity' is the absence of systematic disparities in health (or in the societal determinants of health) between groups with differing levels of social advantage or disadvantage. Particular priority groups are Māori, Pasifika, LBGTI [LGBTI] and rural populations. [Submission 88]

There needs to be more consistency and cohesion in regards to how we respond to all drugs as a country. For those who really understand drug use and addiction, this has to include moves to respond to drug use and dependence within a health rather than a criminal justice framework. [Submission 39]

## **Supply control**

Within the supply control pillar, the most commonly identified focus for effort was reducing the availability of alcohol (24 submissions), with removing alcohol from supermarkets and raising the purchase age both mentioned. Three submissions called for tougher penalties for illegal drug use and misuse of legal drugs, two submissions for better enforcement of existing laws, and three submissions for less expenditure on cannabis enforcement. While out of scope, tobacco and synthetic drugs were both mentioned as candidates for prohibition.

## **Demand reduction**

Within the demand reduction pillar, the importance of good education in schools to promote health and wellbeing, preferably linking to the wider school community, was a key theme, identified by 26 submissions. Some submissions emphasised that we need education for communities as well as youth, and preferably not just that which is provided by the Police. Building healthy, resilient and supportive communities – including by increasing local opportunities for youth and youth development, and supporting activities that foster community connection and cohesion – was identified as another key focus for activity under this pillar.

Demand reduction strategies should focus on creating environments and introducing systemic changes that make healthy choices easy, and enhance wellbeing for individuals and communities in the long term. [Submission 95]

## **Problem limitation**

The key themes for the problem limitation pillar were early intervention; research and evaluation of existing services, especially those centred on Māori, Pacific and youth populations; development of and support for new and innovative treatment services that involve the whole of whānau; and improving information on safer use of drugs. A number of submissions suggested that for purposes of clarity, this pillar could be better named 'Treatment and intervention' (or 'Intervention and treatment'). Two further submissions considered this pillar would be better named 'Harm reduction'.

## **Question 3: In what ways could our Policy support your community to reduce harm to others, such as whānau and friends?**

Forty-seven submissions addressed this question, including 10 health/treatment service providers, eight community organisations and seven interest groups. Around a quarter of these advocated either for treatment services to be more inclusive and supportive of family and whānau, or for specific free and confidential services (ranging from support services to peer support groups to education) for family and whānau. A number of these submissions also identified a need for services to make greater efforts to identify and assess family and whānau members in need of support. One submission, from a health service provider, wanted to see clearer clinical pathways developed that explain how care 'joins up' for users and their families, making it easy for users and those close to them to access services from a wide variety of entry points.

Statistics show that those who have alcohol and drug abuse issues are more likely to engage in treatment if their family and support people are receiving education and support. Addiction is a family issue ... more family inclusive [service] practice is needed. In order for family members to contribute effectively they require education, information, and support in their own right. [Submission 31]

Twenty-one submissions wanted to see a greater emphasis on, and appropriate resourcing for, treating people with an alcohol or drug use problem in the community where possible, rather than separating them from their family and whānau. A number of these submissions expressed a desire to see punitive responses for minor infractions of drug laws reduced. Around a third of submissions on this question wanted existing public health and treatment interventions strengthened by increasing community ownership of and leadership in reducing drug harm.

Several submissions felt the new Policy should offer a more holistic approach to harm reduction than has previously been taken. This approach includes increasing information sharing and collaboration across health and social services; ensuring greater policy coherence between sectors; and aligning the approach more closely with other initiatives that address the determinants of wellbeing.

Further ideas included:

Recognition of the gender differences in alcohol-related harm, and in particular that many of the harmful effects of alcohol on women are caused by others' drinking. [Submission 20]

It is also important to recognise the role [family and whānau] play in reducing the harm and setting parameters of acceptable behaviour. The model around road safety education, where the focus was on what speeding or drink-driving can do to others, could be a useful model. [Submission 37]

Strengthen the power of Medical Officers of Health to veto policies that have been unduly influenced by alcohol and hospitality industry lobbying. [Submission 39]

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# Outcomes and action plans

## Question 4: What outcomes should we be aiming for?

A wide number of outcomes were identified. The following were the key themes that emerged.

- **Social change.** Almost all submissions identified a change in social attitudes towards misuse of drugs as a key outcome to aim for. For some, an explicit goal was to have a society where drunkenness, smoking and other harmful drug use are not seen as acceptable. However, many also emphasised that cultural change needs to include destigmatising drug users, and fostering an understanding of problem drug use as a health issue rather than a personal failing. Several submissions also identified the need to respect personal choice, and not stigmatise non-harmful drug use (including moderate consumption of alcohol).
- **Better access to a wider range of treatment options.** Twenty-three submissions wanted a key outcome of the policy to be services that are:
  - relevant, accessible and culturally appropriate
  - the right mode of treatment for that individual at that time
  - available in all settings without prolonged waiting.

Several submissions mentioned that services across sectors need to be ‘joined up’, so that those seeking help are referred to the right people or service no matter where they have initially entered the system.

- **Communities and young people are better supported.** A focus on youth and community resilience was a key theme emerging across answers to many of the questions in the discussion document. Numerous submissions named as key priorities: increasing public awareness of and debate about drug issues and drug policy; empowering communities to actively engage in their own harm reduction strategies; and ensuring that young people have the knowledge and skills to make good decisions around drugs – and that they develop resilience and protective factors to delay or prevent the uptake of drugs.

Other outcomes identified included:

- more accurate, evidence-based classification of substances
- the socioeconomic determinants of drug use are clearly acknowledged and taken into consideration in the development of the policy
- an illicit drug policy shift from criminal justice to health-focused treatment and prevention.

## **Question 5: What issues should the first action plans try to tackle?**

The answers to this question followed similar themes to the outcomes identified above: destigmatisation, increasing community capacity and awareness, and increasing access to a broad range of treatment options were the most commonly named issues for action.

Alcohol was the single substance most commonly focused on, although most submissions seemed to assume that action plans would not be drug-specific or, if they were, that there should be action plans for all categories of drug. Half the submissions addressing this question felt that the first action plans should include a focus on vulnerable populations, such as youth, Māori, Pacific and new immigrant populations.

Other key themes were:

- improving integration, collaboration and consistency across sectors and between departments – including consistency of aims and messages, better collection and sharing of data, and greater coordination between (particularly) mental health services and alcohol/drug treatment services
- increasing workforce capacity, particularly of the Māori and Pacific workforce
- addressing the determinants of drug use, including health and social factors, and helping vulnerable groups to develop resilience and other protective factors to prevent problem drug use.

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# Measuring results

## Questions 6 and 7: Should the Policy contain performance targets? What should we measure?

Among the 31 submissions addressing these questions were ten health/treatment service providers, nine interest groups and four industry bodies. Most of these submissions (22) were broadly in support of performance targets, including the majority of the health providers that submitted on this question. However, many commenters also urged caution in setting these targets. Nine submissions expressed concern that performance targets are not well suited to measuring the treatment of a complex and chronic relapsing condition like problematic drug or alcohol use, and might focus providers and funders on the wrong place. It was also emphasised that changing social attitudes, beliefs and behaviour will take significant time.

[There is a] challenge around determining performance targets for people accessing treatment given the nature of addiction, where interventions need to be tailored to individual need ... recovery and wellbeing require a whole of systems-approach, eg, a recovery-oriented system of care, particularly if the outcome is to be a sustained reduction of problematic substance use and/or abstinence. [Submission 44]

Health providers were largely in support of performance targets as long as these are clear and measurable, with responsibility for delivery made explicit. Several submissions suggested that long-term targets, particularly those based on population health outcomes, may be the most appropriate way of measuring success.

Popular suggestions for performance measures were:

- **harm-based measures**, for example:
  - reducing drug/alcohol-related hospital admissions or emergency department presentations
  - reducing domestic violence rates
  - fewer drug/alcohol incidents in schools, including alcohol- or drug-related exclusions
  - recidivism rates on discharge from prison
- **more general population measures**, for example:
  - lowered rates of use, including rates of harmful use, in various settings and populations
  - increasing public awareness of the risks of drug use, and where help can be accessed
  - progress toward improved public health and social outcomes for populations where drug use is high
  - incorporating into targets the Health Promotion Agency's Impact Measures for Alcohol (which measure statistics such as the number of high-risk drinkers who seek help and the number of adults who are low-risk drinkers)
- **service-based measures**, for example:
  - the number of people accessing alcohol and other drug services, and the waiting time before they received services
  - the number of family and whānau being supported through alcohol and other drug services
  - user experience of alcohol and other drug services – a number of submissions suggested that the Health Quality and Safety Commission's Consumer Experience measures would be appropriate here.

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# Doing the right things

## **Question 8: How will we know if we are allocating the right balance of resources to each of the areas of supply control, demand reduction and problem limitation? What should we be looking for?**

Of the 17 submissions that commented on this question, 10 felt this could be achieved through systematically collecting and analysing data on a range of indicators measuring levels of harm, and comparing these with baseline data to determine if there is an improvement over time. Improvement across all indicators would suggest that the right balance has been found, whereas if some indicators did not show improvement they would highlight where more resources are needed. Proposed indicators include:

- number of referrals to services
- waiting time to access services
- uptake of services
- number of drug- or alcohol-related stand downs or exclusions from school
- number of drug- or alcohol-related emergency department admissions, and the number of these admissions involving minors
- street value of drugs.

A further three submissions felt that resources should be allocated according to cost-effectiveness of action within each pillar. Several submissions reiterated their preference for resources to be either shifted from enforcement toward prevention and/or treatment (four submissions) or more focused on supply control (one submission).

## **Question 9: What would you like to know about how well the different approaches taken under the Policy are working?**

Sixteen submissions answered this question. Many wanted to see regular, publicly available updates on outcomes and performance against targets; one submission mentioned that this reporting should include independent evaluation of progress toward targets. Two submissions wanted to see regular reporting on relevant statistics, and one submission wanted regular reporting on the allocation of resources between the three pillars.

Several submissions wanted to see information about the effectiveness and cost-effectiveness of the approaches being taken, both in terms of reducing harm overall and reducing harm for particular population groups; and wanted information about successful approaches, including intersectoral approaches, to be shared widely. One submission wanted to be able to see how well innovation and flexibility were incorporated into the approaches taken under the Policy.

## **Question 10: What have you seen working well in your community to reduce alcohol and other drug-related harm?**

Among the 23 submissions commenting on this question, a wide variety of examples was put forward.

The majority of submissions indicated that harm reduction worked best when there was prompt access to a range of quality treatment options across the whole continuum of treatment, from walk-in clinics, screening and assessment through to peer support and continuing care options. Several submissions also mentioned the importance of a client-centred approach that meaningfully engages consumers (and their family and whānau) in planning, implementing and evaluating their services.

There was also a strong feeling that the community should be actively engaged in developing harm minimisation policies and strategies. Almost all submissions mentioned the value of building community capability and engagement, and encouraging local leadership (backed by supportive, evidence-based national policy).

More specific examples of programmes or approaches that submissions said worked well included:

- the Community Action Youth and Drugs (CAYAD) approach, currently operating in 25 communities, which is designed to make lasting environmental changes through paid coordination. The CAYAD approach includes:
  - building strong local relationships and raising public awareness of drug-related issues
  - engaging communities in developing policies and practices to minimise harm
  - mobilising community stakeholders to build capacity
  - Kaupapa Māori service provision
  - whole-of-community access to funding
- the specific intervention service in Christchurch for those aged over 65 years who have been identified as having a problem with alcohol consumption that is impacting on their lives
- the alcohol industry-funded 'Cheers' programme
- the alcohol and drug courts being piloted in Auckland
- fetal alcohol spectrum disorder diagnosis and intervention.

Where we have been able to facilitate team training to apply a comprehensive assessment and care plan for affected individuals and whānau, matters relating to the child health and wellbeing within families, schools, courts improve and preventive awareness of this alcohol related harm roll[s] out across the region served by these teams. Diagnosis and intervention lead effectively and seamlessly to prevention.  
[Submission 47]

## **Question 11: If you are a provider of alcohol or other drug services, do you think there is a way government could better work with you or support you through non-financial means?**

Again, among the 33 submissions commenting on this question, a wide variety of suggestions was put forward.

Almost half wanted government to consider social, political and cultural realities when developing policy and approaches toward drug harm. This includes considering the relationship between social determinants of health and drug harm, and recognising that some communities and populations are therefore at higher risk and need to be supported via positive, strengths-based approaches. Several of these submissions also highlighted the need for government to involve a diverse range of people and groups when formulating and implementing drug policies.

Around a quarter of submissions wanted to see more effort put into ensuring access to services. One submission suggested that the development of flexible, cross-agency, long-term contracting for treatment services would allow for more rapid access to appropriate services.

A similar number wanted to see a greater emphasis on a true intragovernmental approach, with better coordination between agencies in terms of both policy approach and information sharing. Several submissions mentioned the need to ensure that responses to a range of different health and social issues consistently take drug and alcohol issues into account, and do not create arbitrary barriers to people accessing the appropriate help. One submission suggested a remit in service specifications requiring the sector and organisations to work collaboratively. Another suggested that all ministries should sign off policy together.

Many submissions stated that drug policy needs to be based on solid empirical, scientific and experiential evidence. Several made further mention of research and evaluation; their concerns were either that all current New Zealand evidence and research be made publicly available, or that government invests in more research and evaluation of effectiveness of services.

Further suggestions were to:

- change and challenge the language used when talking about drugs and alcohol – in order to promote policies that are treatment-oriented, and decrease emphasis on criminalisation and marginalisation of users
- minimise and streamline reporting requirements, and minimise the additional screening required by the Ministry of Health
- provide greater support and resources for health practitioner education and training on identifying and addressing problem use issues
- strengthen alcohol leadership by agencies, including the Ministry of Health and district health boards, so that they take more action to address health relating to alcohol, and alcohol-related harm, not just addictions service. One submission wanted the Ministry to take a more aggressive stance in support of tobacco cessation
- review the Misuse of Drugs Act 1975 and the Alcoholism and Drug Addiction Act 1966
- review all mental health and addictions funding, and ensure that there are services available that accept those in need of addictions treatment who do not have a concurrent mental health condition
- require all schools to develop drug policies that focus on prevention and referral
- implement a policy that makes all schools alcohol free.

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# Making sure we're not interfering too much

## **Questions 12 and 13: Can you think of instances whereby supply control, demand reduction, or problem limitation interventions have been inconsistently applied across New Zealand? If so, do you think it has influenced the amount of harm that users or the people around them have suffered?**

Thirty-eight submissions answered one or both of these questions, including ten treatment/health service providers, five industry bodies and eight community or interest groups. The following three key themes emerged.

- **Regional variability in action around alcohol**

Nearly a third of submissions that commented on this issue considered that a potential source of undesirable inconsistency stems from giving local councils sole control over alcohol licensing decisions, and local action to prevent harm from alcohol. Several submissions expressed concern that some councils have shown little interest in developing local alcohol policies (LAPs), and that some of the districts most in need of strong action on alcohol have appeared unable to withstand lobbying from industry.

With alcohol licensing being conducted by District Licensing Agencies/Committees, regulations have been inconsistently applied across New Zealand. An example of this is the recent apparently inconsistent decisions made by the Dunedin Licensing Agency and the Canterbury District Licensing Committee regarding whether alcohol can be sold at school fairs or not. [...] Local Alcohol Policies (LAPs) are being created in some districts but not in others. These are designed in legislation as an opportunity to empower communities to have policies which reflect their need. However, there is a poor understanding of the impact of alcohol in most communities and the alcohol sector is playing a disproportionate role in the formulation of many of these policies through direct lobbying of councillors during the drafting process. [Submission 104]

- **Regional variability in access to, and quality of, harm reduction and problem limitation services (including both specialist treatment services and primary care early interventions)**

Submissions were concerned that the lack of national oversight of what services are provided in each district health board area has led to some areas having significantly less support available for people seeking help.

People have to jump through hoops to access treatment in some places. They go from pillar to post before getting to where they need to be and even then there is no guarantee they will be accepted by the service. This is ludicrous. Services need to open their doors wide to anyone who might need or want help – any door is the right door. The single point of entry model only works for those close to that point; it also means people have to access services which are not the services that can help them. [Submission 114]

- **Inconsistency in resource allocation between substances**

While this subject was addressed in more detail in response to questions in the next section, here several submissions mentioned their belief that resources were inconsistently allocated between substances when the actual risks or harms inflicted by particular substances were taken into account. Four submissions specifically stated that not enough resources were dedicated to reducing harm from alcohol.

The political will to take appropriate action across any of the pillars is inconsistent – particularly in regards to the actual risk posed by different substances. More time and effort is often spent grandstanding on less harmful substances while insufficient action is taken to reduce harm from more harmful substances. This has an effect on the public's responses to different drugs as well as shaping New Zealand's response more generally. [Submission 39]

A number of submissions reiterated their concern that there is a resource imbalance between the three pillars. In their view, supply control (and particularly punitive measures) receives funding out of proportion to its ability to deliver reduced harms.

Other issues raised include:

- a belief that the Government's stance on psychoactive substances is inconsistent with that on tobacco and alcohol (and, in the case of tobacco, actively undermines efforts to reduce harm from tobacco)
- concern about the disproportionate levels of drug-related harm in certain populations, such as LGBTI populations, and Māori and Pacific communities
- concern that police misuse their powers when enforcing drug laws
- concern that police diversion is unavailable, or near unavailable, in some areas.

Among the submissions that identified inconsistent application across the country, all but one felt that this inconsistency has had negative impacts. Most of these impacts centred on increasing inequalities among population groups; for example, those from socioeconomically deprived neighbourhoods are more likely to report unmet treatment needs and have less stringent alcohol licensing policies in their area. The criminalisation of drug users was also cited as an effect of inconsistency that increases harm by creating real or perceived barriers to people's recovery. Those who felt alcohol is under-resourced believed that this prevents New Zealand from acknowledging and addressing the true level of harm associated with alcohol.

The remaining submission, from an industry body, felt that periods of inconsistency were inevitable given that priorities differ over time. However, in this view, assessment over the medium term would reflect greater consistency (and if it did not, this would indicate a need for reprioritisation).

## **Questions 14 and 15: In what circumstances should local bodies be able to decide how the Policy is implemented in their district? For what issues or approaches should the policy be consistent across the country?**

Among the 37 submissions commenting on these questions were seven health/treatment service providers, five community organisations, five interest groups and four industry bodies. Despite the concerns about regional variation discussed above, the majority of submissions on this topic considered that there needs to be an opportunity to take the local situation into account, and that a degree of local control over how some aspects of the Policy are implemented in their region would be appropriate. Around half wanted the Policy to more expressly recognise the role of local government in dealing with drug and alcohol use and consequences, and the responsibility of local bodies to reflect this across a broad range of council functions. Only five submissions considered that local government should not be able to, or should not need to, tailor implementation for its area.

A common theme (for two-thirds of the submissions on this topic) was that there should be a national 'baseline' or default standard for implementation that all councils are required to meet, while having the freedom to implement measures over and above this baseline as they see fit. Several submissions suggested that local bodies should have the flexibility to implement strategies consistent with their specific issues, provided these are supported from central government by clear guidance and guidelines on priorities and priority groups, as well as by evidence-based advice on best practice. Three submissions emphasised the importance of allowing local bodies flexibility to adapt national guidelines to local needs, given that certain substances are a bigger issue in some parts of the country than others.

We strongly support giving local authorities much greater powers to set local priorities, and to regulate and enforce the supply of legal drugs in their areas. This would be an effective way to target resources, as the limited evidence available indicates major variations in drug preferences and use patterns in different cities or regions. However, such powers need to be within a transparent and well-monitored legislative framework, to avoid local regulation based on moral panic, or regulation and enforcement which may discriminate against a particular community or population group. [Submission 96]

Commonly suggested issues or approaches that should be consistent across the country were:

- population-level interventions like social marketing, drug and alcohol education, and advice on standard drinks
- access to and quality of services, including for prisoners
- data collection – around half of submissions wanted all district health boards to be required to collect consistent data on use, and the harm and injury related to use, in their area
- the number of licensed premises and off-licences that can operate within an area
- the approach to children and young people (eg, programmes in schools, positive youth development initiatives).

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# Looking to the future

## **Question 16: Are there any particular substances or classes of drugs that you think will be a concern in the future?**

Forty-seven submissions commented on this question, including eleven health/treatment service providers, eight interest groups and seven community groups. Most of these submissions named more than one substance as being of particular concern. The following were the most commonly cited substances.

- **Alcohol**

Thirty submissions considered alcohol to be a particular concern for the future. Points raised included that alcohol is the most commonly used co-drug, the drug most destructive to the brain and the drug currently responsible for the greatest proportion of harm; and that violence is the major alcohol-related harm to women and children. Numerous submissions reiterated that the social and environmental factors surrounding alcohol – discussed further in the next question – were the key reasons why it was likely to be a continuing concern.

Alcohol ... will continue to contribute to costs in justice, welfare and health until there is a strong commitment to interventions aimed at pricing, accessibility, marketing and advertising. [Submission 116]

- **Psychoactive substances**

For 30 submissions, psychoactive substances were a particular concern. Points raised included that no drug can be safe for every individual; that unknown health, mental health and social costs may arise from their use; that new substances will continue to be developed on an ongoing basis; and that their popularity among young people is a particular concern.

New psychoactive substances should be given priority under the new policy. No drug can be safe for every individual, and it would be prudent to consider enabling excise taxes to be collected to help balance these. [Submission 95]

- **Volatile substances**

In 21 submissions, volatile substances/solvents were considered to be a particular concern. Points raised included the high mortality rate associated with solvent abuse; the particular use of these substances among young teenagers and children; and their ready availability.

Poisoning from gases and volatile liquids is more common in younger teenagers, with some deaths occurring in children. For both these and prescription medicines, children and young people can more readily access them due to their wide availability.

Addressing these issues may require more emphasis on educating children and young people about the risks involved, and the available care for those experiencing substance abuse problems with these drugs. [Submission 120]

- **Prescription medicines**

Seven submissions felt misuse of prescription medicines, especially opioids, was a particular concern for the future. Points raised included that prescription medicines (along with volatile substances and alcohol) are one of the most common causes of poisoning in young people in New Zealand; that an ageing population is likely to exacerbate the increasing misuse of

prescribed medication; and that it is relatively easy for prescribed but unused medications to be diverted for recreational use.

- **E-cigarettes**

Six submissions considered e-cigarettes to be a substance of concern for the future. Points raised included that the long-term effects of sustained e-cigarette use are largely unknown; and that the devices undermined the no-smoking message and had the potential to become a gateway to cigarette smoking by hooking young people on nicotine.

We are aware that many off shore companies including the tobacco industry have begun to invest heavily in the growth industry of e-cigarettes. We are also aware that without clear evidence that shows these products are safe to use and significantly effective as a cessation device, as a health workforce we are not to promote their use among New Zealanders who smoke. [Submission 85]

Other substances that were each mentioned by at least one submission were:

- cannabis (especially its increasing use by young people)
- tobacco and oral snuff
- party pills
- pre-workout supplements
- methamphetamine (particularly in regard to contaminated housing)
- crack cocaine and home-bake heroin.

## **Question 17: Are there any society-wide trends and pressures that you think will be a concern in the future?**

Twenty-eight submissions commented on this question, many identifying more than one social trend or pressure of concern. The following were the key themes that emerged.

- **Alcohol culture**

Twelve submissions considered the culture around alcohol in New Zealand is a significant concern for the future. Comments included that binge-drinking is still seen as ‘cool’ among some demographics; that overconsumption is so normalised that the health consequences no longer register; and that this normalisation is reducing the effectiveness of harm reduction strategies. Several submissions expressed concern about alcohol companies’ sponsorship of sporting and other popular events, seeing this as a poorly regulated form of mass marketing.

The continual bombardment of young people to alcohol promotion, particularly the well-funded viral method utilising social media. Continual sponsorship of events especially those that attract the attention of children and young people – and heavy drinking adults – actually all sponsorship needs to be gone from our environments. It is drug promotion and thus unacceptable. [Submission 45]

- **The internet and social media**

Seven submissions considered the growing use of the internet and social media to be a source of concern for the future. Comments included that social media is a vector for spreading harmful drug practices, and that it allows marketing, especially of alcohol, to the young. Several submissions mentioned the influence of ‘viral marketing’ of legal drugs. Concerns relating to the internet more broadly included the ease of availability of both illegal and legal drugs online, and the relative lack of options for regulatory monitoring of this market.

The availability of legal drug products online including pharmaceuticals and psychoactive substances may create fewer opportunities for regulatory monitoring of sale and supply of these products. This may result in purchase and supply to minors, as well as the sale of unapproved and potentially harmful products in unapproved quantities. [Submission 116]

- **The ongoing criminalisation and stigmatisation of drug users**

Four submissions believed that the criminalisation and stigmatisation of drug users will continue to be a concern in the future, as it constitutes a barrier to people accessing treatment, engaging in employment and education, and being a valued member of society.

Submissions also commented on:

- the impact of changing demographics – for example, the growing number of older people – on patterns of drug use
- contaminated housing
- ease of cannabis cultivation and other illegal drug manufacture, and undetected drug use, in rural areas
- drunk driving in rural areas.

## **Question 18: Are we doing the right things to prepare for and respond to these concerns?**

Among the 22 submissions responding to this question, almost all felt that there was more we could do to prepare for future challenges. Suggestions for what we should be doing included:

- conducting more evaluations of alternative nicotine-dispensing devices, and establishing a balanced regulatory framework for these
- focusing more strongly on the drivers of drug use
- strengthening controls around alcohol, including by implementing more of the Law Commission's recommendations for reducing harm from alcohol
- putting policies in place to address the needs of older people with addictions, including training for rest home workers/caregivers on the particular needs of this client cohort
- strengthening control over legal highs
- implementing housing 'warrants of fitness' to address methamphetamine contamination
- being willing to look at reforming drug laws, and working towards significant reform of the United Nations drug control treaties
- ensuring policies are evidence-based, being mindful of unintended consequences and focusing on the right balance of policy measures.

## **Question 19: How many years should the next National Drug Policy be in effect for?**

Of the 42 submissions responding to this question, the majority wanted the Policy to be in effect for five years. Comments included that five years would provide sufficient time to incentivise action and allow good evaluation, but would not be so long as to limit flexibility to respond to new substances of concern or changing drug use patterns. A number of submissions stated that five years would be an appropriate timeframe provided the Government commits to reviewing all relevant legislation to determine its effectiveness and is willing to tweak legislation as necessary to respond to new trends in drug use.

Five submissions felt the policy needs a shorter timeframe (three or four years). Two of these submissions wanted to see either targets evaluated and reviewed, or results reported, annually. Two submissions wanted a 5- to 10-year timeframe, and a further three submissions a 10-year timeframe similar to that used in local government Long Term Plans, with regular interim review dates.

Two submissions felt that as the Policy's goal of minimising drug harm is a long-term challenge, a timeframe for the Policy is inappropriate. Rather, it should be a 'living document' with no end date, but with regular review dates and measuring and reporting of results.

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# Other comments

In addition to responding to the questions in the discussion document, many submissions provided views that did not fit neatly under any of the individual questions, or commented on drug-related matters beyond the scope of the consultation. The key themes emerging from these comments are summarised below.

A number of people wrote in support of the Wellington Declaration, with around a quarter of all submissions referencing either the Declaration specifically, or a significant number of its principles. Most of these submissions suggested that its principles should be at the heart of the refreshed Policy.

Around a third of submissions wanted cannabis to be either legalised or decriminalised. A number commented on the harms resulting from the black market and/or on the potential value of generating taxation income from cannabis. The majority of those in favour of cannabis law reform supported the legalisation of medical cannabis on prescription. Several commented on the need for more support for research into medical cannabis and other cannabis products, including clinical trials.

Several submissions felt we should decriminalise all drugs, all naturally occurring psychoactive substances or all 'harmless drugs'. One submission indicated that the Misuse of Drugs Act should be reviewed, and another that it should be repealed. However, one submission, coming from an enforcement perspective, reiterated the potential harms and costs of decriminalisation, citing the amount of police time and resources currently taken up by alcohol-related incidents.

A number of submissions offered more general comments on what they saw as important elements to include or retain in the refreshed National Drug Policy: the existing Policy's focus on populations, and polydrug users as a population at particular risk; a focus on youth as a priority population; recognition of the holistic view of Māori health; the involvement of Māori in developing the Policy's priorities; explicit reference to the Treaty of Waitangi; and the inclusion of gender analysis. Several submissions mentioned the importance of interagency collaboration and/or integration with existing initiatives and strategies. One submission suggested that the Policy needs to be informed by those who have personal experience of drug-related issues. In another submission, an industry body reiterated that while it supported the articulation of harm to others, it is also important that consumer needs are not ignored.

A number of submissions spoke about their concerns with the discussion document itself or the wider process of redeveloping the Policy – principally, concerns about the lack of further opportunities for input or feedback. One submission was concerned that there was not more engagement with industry, while another felt that further time is needed to engage in more consultation with the parties to the Wellington Declaration. One submission wanted the phrase 'evidence-informed' to be replaced with 'evidence-based' throughout; and two submissions were concerned that references to research and comparative statistics be used only with care and caution, to ensure that these are not taken out of context.