The Wellington Declaration on reshaping New Zealand's alcohol and other drug policy

27–28 August 2013

drugfoundation.org.nz/wellington-declaration

Background

Introduction

The government's National Drug Policy provides an overarching strategy and action plan for responding to drug issues. It informs the work and investments of all relevant government agencies and non-government organisations. The recent five-year plan expired in 2012 and the government has begun preparations for its replacement.

In order to proactively respond to this opportunity and ensure that civil society has a strong voice in the development of the new policy, the New Zealand Drug Foundation convened a national summit on reshaping New Zealand's alcohol and other drug policy. This was held in Wellington on 27-28 August 2013.

Attending this summit were a broad range of civil society representatives, who were tasked with finding consensus on key alcohol and other drug policy issues. The result of this consensus building is the Wellington Declaration, attached.

How the Wellington Declaration was drafted

Prior to the summit, participants provided input through an online survey. Among other things, they were asked about achievements under the previous National Drug Policy, as well as areas of concern. They also described a vision for drug policy success and the principles that should underpin our collective efforts. Based on this survey, the Drug Foundation compiled a draft declaration.

Then, over the two-day summit, participants worked their way through the draft and negotiated additions and amendments to the document. This process allowed people with different perspectives to negotiate their differences and find language everyone could agree with. At the end of the two days, what was produced was a collaborative vision for our National Drug Policy and an agreed set of recommendations for achieving it.

Navigating the Declaration

The Declaration opens with a brief explanation about what the document is, how it was developed and how it should be used. It then provides some context around drugs in New Zealand and highlights some of the impacts of current drug policy. This is followed by an overview of where our drug policy has been successful and where improvements are needed.

The Declaration provides a set of principles to guide the development of the next national drug policy. It then focuses on five key areas, with resolutions made in each:

- Prevention, early intervention and education (page 15)
- Harm reduction (page 20)
- Treatment and recovery (page 23)
- Legislation (page 29)
- New Zealand as a global citizen (page 32).

Implementing the Wellington Declaration

Our ultimate hope is that this declaration informs the development of the next National Drug Policy. It represents the collective wisdom of many in our community who, despite their 'coalface' expertise and experience with the National Drug Policy, have never had a chance to contribute to its development. These perspectives can only benefit our collective approach to such a complex issue as drugs.

We also hope that people who were not at the summit will see their own perspectives and priorities reflected in the declaration. Those who do can still sign up to it and use it to give weight to their own endeavours. Signing up to the declaration is a way to add your voice to calls for change to New Zealand's drug policy. It is also an opportunity to connect with others who have the same priorities and are keen to collaborate to create change.

This document was created with a spirit of good will and a desire for better cooperation and collaboration between everyone affected by drugs and drug policy. We trust that the Government and any other organisation with an interest in an Aotearoa/New Zealand free from drug harm, will accept it in the spirit it was created, and help us all to make it a reality.

If you want to help us do so, you can sign up to the declaration at:
www.drugfoundation.org.nz/wellington-declaration

Reshaping New Zealand's Alcohol and other Drug Policy

Declaration from Wellington national drug policy summit, 27-28 August 2013

We, the participants of the national summit on reshaping New Zealand's drug policy, drawn from 67 organisations and a range of communities from around Aotearoa New Zealand, including family members and whānau of those who have, or have had, issues with drugs, people who use drugs, health professionals, educators, researchers, policy specialists, community advocates, people in recovery, young people, Ngā Mokai, Māori and Pasifika peoples:

Welcome the opportunity to come together to find consensus on a new approach for New Zealand's National Drug Policy.

Note that the National Drug Policy provides the overarching strategy for responding to drug use and related harm, and as such, informs the work and investments of all relevant ministries, government agencies, and community organisations.

Recognise that drug policy is all too often a contentious and politically charged topic and are heartened by the fact that if we can find a shared vision among such a diverse group, then a national consensus is possible.

Recognise the need to address the social determinants that give rise to some people's participation in drug use and offending.

Recognise that in order for our drug policy to be effective, we need a cohesive and inclusive strategy with everyone working together to achieve a shared goal so we have a collective impact on these complex issues.

Note that this declaration focuses on alcohol, new psychoactive substances, volatile substances and illegal[1] drugs but acknowledge the important body of evidence, lessons learned and effective practices from the tobacco control field that are relevant to the statements in this document.

Recognise Māori as tangata whenua of Aotearoa New Zealand and acknowledge their independent right and autonomy to lead discussions and processes, to identify, develop and propose priorities and contributions to the National Drug Policy that best represent the views of Māori.

Acknowledge that there is a range of evidence informing us of the prevalence of drug-related harm within Aotearoa New Zealand experienced by individuals, family/whānau and communities. We also acknowledge that there are specific areas of drug-related harm where Māori are disproportionately affected. Some of these areas are noted in this Declaration with the intention to share knowledge and evidence gained. We hope that this may inform the on-going growth of effective cultural, social and clinical prevention and treatment initiatives for and by Māori, inclusive of building capacity and capability of the Māori workforce.

Offer this Declaration to all Māori leadership and consultative forums as a contributory document to support the development and submission of Māori views and opportunities for action in reshaping the National Drug Policy.

Assert that the resolutions in this declaration are set out with the intention of a collaborative approach between Non-Government Organisations, community organisations, government agencies, and individuals, in the spirit of partnership. This Declaration and its Resolutions should be considered and implemented in collaboration with other government agencies and related organisations.

[1] In the context of this document, "illegal drugs" refers to any drug categorised under the Misuse of Drugs Act 1975 and includes any prescription drugs (particularly narcotics) when used for recreational reasons or without a prescription.

Context

Note that Aotearoa New Zealand has high rates of drug use in comparison to other countries, particularly for cannabis, amphetamine type stimulants and new psychoactive substances.[2]

Note that alcohol is by far the most important recreational drug in Aotearoa New Zealand, both in terms of its widespread use and misuse.

Note that a recent Ministry of Health study showed 95 percent of New Zealanders aged 16–64 had consumed alcohol at some stage in their lives.[3] Eighty percent of New Zealanders aged 16–64 consumed alcohol in the past year[4] and one in five past year drinkers had hazardous drinking patterns.[5]

Note that the consumption of alcohol among young people is also relatively high, although evidence suggests it has decreased in the last decade.[6] In a recent survey of Aotearoa New Zealand secondary school students[7] fifty-seven percent had tried alcohol, eight percent drink alcohol at least weekly and 23 percent reported having engaged in binge drinking (five or more alcoholic drinks within four hours) in the past four weeks.[8]

Note that at last count, nearly one in two adults (49 percent) had used an illegal drug for recreational purposes at some point in their lifetime, equating to about 1,292,700 people in the total population aged 16–64 years in Aotearoa New Zealand.[9] The same survey found that one in six (16.6 percent) of adults had done so in the past year.

Note that cannabis is currently Aotearoa New Zealand's most widely consumed illegal drug. In the most recent Ministry of Health survey available, almost one in two adults had ever tried it and around one in seven had used it in the past year.[10]

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[2] UNODC (2013). World Drug Report. UNODC: Vienna.
[3] Ministry of Health (2010). 2007/08 New Zealand Alcohol and Drug Use Survey. Ministry of Health: Wellington
[4] Ministry of Health (2013). *Hazardous Drinking in 2011/12: Findings from the New Zealand Health Survey.* Ministry of Health: Wellington
[5] Ministry of Health (2013). Op. cit.
[6] Ministry of Health (2013). Op. cit.
[7] Clark, T.C, Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., Fortune, S., Lucassen, M., Peiris-John, R., Robinson, E., Rossen, F., Sheridan, J., Teevale, T., Utter, J. (2013). *Youth'12 Overview: The health and wellbeing of New Zealand secondary school students in 2012*. Auckland, New Zealand: The University of Auckland.
[8] Clark, T.C, Fleming, T., Bullen, P et. al. Op. cit. pg. 23
[9] Ministry of Health (2010). *Drug Use in New Zealand: Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey.* Wellington: Ministry of Health
[10] Ministry of Health (2010). Op. cit.

Note that Aotearoa New Zealand has high rates of cannabis use among young people, with nearly 80 percent having used it by age 21.[11] The Youth 2012 survey highlights that cannabis use among secondary school students has declined over the past decade. It also showed that around one in eight are current users[12] and weekly cannabis use among secondary students was around 3 percent.

Note that in recent years, international studies show levels of key psychoactive components in cannabis have changed.[13]

Note that we have insufficient data on the use of new psychoactive substances. Research has not been able to keep up with the rapid creation of these substances.

Note that Aotearoa New Zealand has a history of misuse of prescription drugs – particularly opioids – dating back to the early 1980s.[14]

Note that gaps exist in Aotearoa New Zealand's knowledge base including empirical data on prescription medicines diversion, type, use and reasons for their diversion. This includes steroids, psychostimulants and central nervous system depressants such as opioids. The different risk factors, both in type and magnitude, and behavioural profiles of the people who use these drug types need to be investigated more thoroughly; particularly as diverted opioids remain a leading cause of poisoning deaths among young people.[15]

Note that within the United States of America, pharmaceutical opioid deaths now outnumber deaths due to heroin and cocaine combined[16].

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[11] Fergusson D. and Boden J., "Cannabis use in adolescence". Prime Minister's Chief Science Advisor (2011). *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*. Office of the Prime Minister's Science Advisory Committee: Wellington pg. 257

[12] Students were considered current users if they had reported they had smoked cannabis but did not report that they no longer used it. Youth 2012 Overview Report, pg. 23

[13] Di Forti, M. et al "High potency cannabis and the risk of psychosis." *The British Journal of Psychiatry* (2009), 195, 488-491 and Knight G, Hansen S, Connor M, Poulsen H, McGovern C, Stacey J. "The results of an experimental indoor hydroponic Cannabis growing study, using the 'Screen of Green' (ScrOG) method-Yield, tetrahydrocannabinol (THC) and DNA analysis." *Forensic Sci Int*. (2010) Oct 10;202(1-3):36-44. doi: 10.1016/j.forsciint.2010.04.022. Epub 2010 May 13.

[14]Sellman JD, Hannafin J, Deering D, Borren P. (1996*) "Delivery of treatment for people with opioid dependence in New Zealand: Options and Recommendations*." A commissioned paper for the Ministry of Health, New Zealand. Christchurch, New Zealand: National Centre for Treatment Development (Alcohol, Drugs & Addiction), September 1996.

[15] Child and Youth Mortality Review Committee, Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi (2013). *Special Report: Unintentional deaths from poisoning in young people*. Wellington: Child and Youth Mortality Review Committee pg. 16

[16] Centre for Disease Control (2011) *Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008*. MMWR 2011; 60: 1-6. For similar international findings see Degenhardt L. et. al. (2013) Global burden of disease

Note that we have insufficient data on the use of volatile substances despite these being one of the leading causes of poisoning deaths among disadvantaged, marginalised and disenfranchised young people.[17] Ministry of Health estimates put the age standardised lifetime prevalence of recreational inhalant use at 2.5 percent.[18]

Are concerned that for some people, using drugs will cause them significant harm –including death. The risk of harm tends to increase as use increases, but can also come from a single instance of use. The risk of harm also increases with a lower age of onset. These harms are more likely to come from some drugs than others.

Recognise drug-related harm is inclusive of the impact that law enforcement can have on peoples' finances, liberty and future employment and travel options. We note that arrest and convictions occur disproportionately in Māori and young populations.

Understand that an individual's drug use can also cause harm to others. It is estimated that for every person with a drug issue, three others are affected.[19]

Note that children can be particularly harmed by parents who use drugs. For those children whose mothers consume alcohol while pregnant, the effects can be both devastating and lifelong.[20] Note that we have insufficient data about drug-related harm to others, in particular the impact of prenatal exposure.

Note that where people have co-existing problems, including mental health, physical health and cognitive issues, they are at particular risk from drug-related harm.

Note that the improved mental health and wellbeing of all New Zealanders is everyone's responsibility.

Acknowledge that drug use is not always harmful and most people's drug use will not create significant, if any, issues for themselves or others. We also acknowledge drug use can have a beneficial effect for some people.

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attributable to illegal drug use and dependence: findings from the Global Burden of Disease Study 2010. *The Lancet* Early Online Publication 29 August, 2013

[17] Child and Youth Mortality Review Committee (2013) Op. cit. pg. 19

[18] Ministry of Health (2010). Op. cit. Note that this is for people aged 16-64 and VSA tends to happen among younger people.

[19] NCAT (2011). *Addiction is a family issue. Position Paper* pg. 1. Wellington: NCAT

[20] Popova S, Stade B, Lange S, Bekmuradov D and Rehm J (2012). *Economic Impact of Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorders (FASD): A Systematic Literature Review*. Centre for Addiction and Mental Health: Social and Epidemiological Research Department. Toronto, Canada.

Note that commercial interests, such as alcohol and other drugs producers, retailers, and marketers profit from the use of drugs. We recognise that many of these organisations seek to influence the content and implementation of drug policy for their own interests.

Acknowledging recent successes in Aotearoa New Zealand

Appreciate that harm minimisation has been the key objective of Aotearoa New Zealand's National Drug Policy for many years. We also applaud the prioritisation that reducing inequalities was given in the previous National Drug Policy.

Are impressed by the implementation of the Psychoactive Substances Act and the government's willingness to try a new approach and regulate these drugs based on robust evidence of each product's harm profile. We support the move away from criminalising people for possession, under age purchase and social supply and the Act's requirements to collect and share information on both approved and unapproved products with the wider public.

Are heartened by the decline in tobacco use and attribute it to a comprehensive, evidence-based approach focussing on greater regulation, including restrictions on advertising and marketing, steady price increases, measures to increase public understanding around tobacco harms and making treatment options easily accessible to all.

Note the contribution of the Prime Minister's Methamphetamine Action Plan and the impact it has had on rates of methamphetamine consumption. This highlights how gains can be made when drug policy has full governmental support, strong political leadership, agencies are well resourced and held accountable for achieving results and investment is balanced between enforcement, treatment, public education and community action interventions.

Acknowledge that the alcohol reform process helped to engender a long-overdue public conversation about Aotearoa New Zealand's relationship with alcohol and encouraged communities to get involved in making changes locally. We support the inclusion of Local Alcohol Policies in the new legislation as well as new rules around the provision of alcohol to minors and restrictions around where alcohol can be sold.

Applaud the Ministry of Health's community action on youth and drugs funding stream to support communities to reduce drug-related harm.

Are thankful that Aotearoa New Zealand was one of the first countries in the world to have a government sanctioned national needle exchange programme and acknowledge this has ensured our rates of HIV among people who use drugs (and the wider public) are some of the lowest in the world.[21] Although our rates of Hepatitis C are still too high, they are significantly lower than they would be without this service. We also note that this public health-based approach is exceptionally cost-effective.

Are also thankful that New Zealanders who become dependent on opioids have access to opioid substitution therapy and that this is available at no cost to the client. Opioid substitution therapy is an exceptionally well-evidenced treatment option and has helped a significant number of New Zealanders stabilise their lives and further their recovery from opioid dependence. We also support the recent inclusion of *Suboxone* as a fully subsidised treatment option for those with opioid dependence.

Acknowledge the incredible initiative of the Notorious Chapter of the Mongrel Mob, who, with the collaboration of the Salvation Army, are addressing methamphetamine use within a gang community. Initial results are extremely positive and highlight the importance of communities being supported to solve their own problems in their own way. This joint venture provides a model for future initiatives, particularly those focussed on addressing drug use within gang and other marginalised communities.

Support the work of the Alcohol and Drug Courts currently being piloted in the Auckland region. Although these courts have not been running long enough to be adequately evaluated, we are heartened by the move to recognise drug dependence as a driver of crime and the need to address it through therapeutic rather than purely punitive interventions. We also acknowledge the pioneering work of the Christchurch Youth Drug Court.

Applaud the Department of Corrections for initiating alcohol and drug screening upon people's entry into prison and developing a suite of interventions designed to cater for those with drug issues and short sentences.

[21] Aitken C (2002). New Zealand Needle and Syringe Exchange Programme Review. The Centre for Harm Reduction pg. 5

Are impressed by the Alternative Resolutions project developed by the New Zealand Police and the organisation's increasing focus on keeping low-level drug offenders out of the criminal justice system.

Applaud New Zealand Police and District Health Boards for providing mental health nurses in Police watch houses. Co-morbid mental health and drug issues are extremely common – particularly within the criminal justice sector – and there is a need to focus on harm reduction rather than criminalisation.

Recognise the efforts of some schools to retain students as demonstrated by falling rates of exclusion and expulsion, and the success of behaviour initiatives such as restorative practice and Positive Behaviour for Learning.

Areas of concern

Remain concerned that many actions identified in the previous National Drug Policy have not been delivered. We are particularly concerned that the 'Evidence Online' priority was never implemented.

Are concerned by continued inconsistency in our national approach to different drugs. All drugs have the potential to be harmful, whether they are legal or not. In fact, the evidence increasingly shows that two of the legal drugs (tobacco and alcohol) are more harmful than many of the drugs currently criminalised under the Misuse of Drugs Act.

Are deeply concerned about the continued imbalance between the three pillars of the National Drug Policy in regards to prioritisation and resourcing and the emphasis placed on supply control through enforcement-related approaches. We note there is an increasing body of evidence to support a greater emphasis on demand reduction and harm reduction measures and this has not been reflected in the relative funding of the three pillars for illegal drugs.

Are concerned that public health measures are not given adequate priority or resourcing despite being the most cost-effective approach to minimising drug-related harm. Comprehensive preventative measures do not seem to exist in Aotearoa New Zealand except through law enforcement.

Are disappointed that, with the exception of the Drug Courts and the Psychoactive Substances Act, the government has taken no action on the Misuse of Drugs Act reforms proposed by the Law Commission in 2010. The Law Commission's recommendations were based on robust evidence and a remarkable amount of public consultation.

Are disappointed that the Alcohol Reform Bill did not contain the Law Commission's recommended regulations around price, advertising and sponsorship. We are also disappointed about the lack of progress on lowering the drink driving limit for adults.

Are gravely concerned about the continuing discrimination towards people who use drugs, including those in recovery, and the political and media rhetoric that increases stigma. Given that political and media discourses are two of the main sources of information around drug use and dependence, it is unsurprising that public attitudes are often unhelpful. We are convinced such stigma is a barrier to people seeking and receiving help and to the successful recovery of those who have had an issue with drugs.

Are convinced the ongoing criminalisation of people who use drugs not only adds to the stigma they face but further acts as a barrier to people seeking help for their own or other's drug use. Given that possession of certain drugs remains a criminal act under our current law, people are often scared to admit that they, or a loved one, have an issue with drugs. Fear of prosecution and a criminal record that will follow them for the rest of their lives and restrict their work and travel opportunities is of particular concern for young people and those who are in or aiming for leadership positions.

Are concerned that little has been done to create pathways that improve access from wherever people first access services, to obtaining the services they need.

Are deeply disappointed the review of the Alcoholism and Drug Addiction Act 1966 has not been given political priority and continues to be under review.

Are concerned that current prescription monitoring and processes to contain aberrant prescribing are inadequate. Mechanisms need to be improved to more rapidly feed information on diverted medication back to those who have the ability to modify process and practice.

Are gravely concerned that we are not systematically evaluating our approaches to reducing drug use and related harm. Despite some of the approaches being extremely cost-intensive, we have no idea whether they are actually cost-effective. Attempts to quantify this are often hampered by a lack of data collection.

Insist more needs to be done to identify and protect children whose families use drugs problematically. We are especially concerned about mothers who use drugs, particularly alcohol, during pregnancy. Aotearoa New Zealand has relatively high rates of alcohol consumption during pregnancy. It has been estimated that foetal alcohol spectrum disorder affects one in 100 live births[22]. However, recent international epidemiological studies of young, school-age children suggest the prevalence is much higher.[23] We note that no studies have been conducted in Aotearoa New Zealand.

Acknowledge our approach to the treatment of drug issues remains siloed and that services have historically been underfunded. Of the 150,000 people per year requiring addiction treatment only 34,000 people receive it.[24] Although there has been some progress in this area, co-existing problems remain a barrier to effective treatment and people with alcohol and drug issues are unable to access services available to other mental health clients (e.g. employment support). We are also concerned about access to services in rural areas. Consideration for dependent children must also be a priority.

Are concerned that despite positive evaluations of pilot programmes placing mental health nurses in Police watch houses in Counties Manukau and Christchurch[25], further deployment is constrained by funding reductions.

Are gravely concerned at the lack of continuity of care for someone moving between prison and the community, and the inability of prisoners (particularly those on remand) to access services both while incarcerated and upon release. This is a population with high health needs and a concentration of drug-related issues. Co-morbidities are common including

[22] May, P.A. and Gossage, J.P., (2001) "Estimating the prevalence of fetal alcohol syndrome. A summary. *Alcohol Res Health* 25 (3): 159-67

[23] May PA. et al. (2011) Prevalence of Children with Severe Fetal Alcohol Spectrum Disorders in Communities Near Rome, Italy: New Estimated Rates are Higher than Previous Estimates. International Journal of Environmental Research and Public Health, 8 2331-2351.

[24] National Committee for Addiction Treatment (2011). *Addiction treatment is everybody's business* pg. 2

[25] Paulin J. and Carswell S. (2010) *Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative.* New Zealand Police: Wellington

disproportionately high rates of mental health issues, traumatic brain injuries and Hepatitis C.[26]

Insist more needs to be done to support and engage family members/whānau of those with or who have had a drug issue, including the children of those with or who have had drug issues. Caring for or living with someone with a drug issue can be a highly stressful and intensive experience – there is limited help available in regards to information and support. When things become too much, many families feel the Police are the only option for help, but are often concerned about the risk of criminal penalties.

Urge the government to appoint a lead agency that will take immediate action around volatile substance use. Despite repeated warnings from the Chief Coroner and other agencies, no government agency appears to be accountable for addressing the harm use of these substances is causing our young people.

Are deeply saddened that despite a commitment to reducing inequalities, some clusters within Māori and Pasifika communities are still disproportionately affected by drug-related harms. This includes being overrepresented in those receiving punishment for their drug use, through arrests, prosecutions and convictions, and school exclusions and expulsions. This requires urgent attention.

Find it unacceptable that given inadequate addiction prevention, some people also have to wait to access an opioid treatment service; some for over six months. Delayed access and unnecessary barriers to opioid substitution therapy is inhumane and can result in overdose, family/whānau breakdown, imprisonment and suicide. We are concerned with the inconsistent delivery of Opioid Substitution Therapy across the country, and note more punitive approaches lead to greater loss from treatment and act as a barrier to people who use opioids seeking treatment.

Are concerned that, despite the adoption of the Alternative Resolutions project by Police, drug arrest rates remain high by international standards. Police are often the only contact that people who use drugs have with authorities, yet they receive no training in identifying and helping those with drug issues, and continue to prosecute many people who have no drug issues.

[26] National Health Committee (2010). *Health in Justice: Improving the health of prisoners and their families and whānau.* Wellington: NHC Appendicies I and II.

Guiding principles

Are convinced that the primary goal of our national drug policy needs to be the reduction of drug-related harm and the promotion and protection of health and wellbeing. This includes minimising the harm that arises from responding to drug use via the criminal justice system.

Acknowledge the need to get better at evaluating the effectiveness, including cost-effectiveness, of our policies and practices for reducing drug-related harm. This also requires the robust evaluation of the work we do, the decisions we make and the projects that we commit resources to. Where possible, policies should be designed and implemented to allow for later programme evaluation. For example, piloting programmes as randomised control trials can facilitate programme evaluation.

Recognise that there needs to be an accurate assessment of drug-related harm, separating the costs of drug use from the costs of enforcement. While we commend the New Zealand Police for the development of the Drug-related harm Index we note that it is mainly comprised of the cost of law enforcement rather than the costs of drug use.

Insist that drug use needs to be understood and responded to as a health and social issue not primarily a criminal justice one.

Recognise that everyone shares accountability and responsibility for reducing drug-related harm.

Acknowledge that entrenched drug use (within individuals, families/whānau and communities) needs to be understood and addressed within its social, cultural and economic context including inequality and social exclusion. Protective strategies need to focus on building upon strengths to increase resilience, increase inclusion and reduce inequalities. Not only will this have an impact on drug-related harm but also a range of other social issues.

Understand that children and young people are particularly vulnerable to harm from their own and other's drug use and that some of these harms are permanent. We note the benefits of programmes addressing the needs of children of parents with mental illness and/or addictions (Children of Parents with Mental Illness or Addiction). While there is some evidence that drug use among young people is declining, there are some young people who

are starting to use drugs at a very early age.[27] Early, evidence-based interventions, including those that are universal, are crucial.

Note that Māori and Pasifika people are disproportionately affected by drug-related harm, including harm from our attempts to respond to drug use via the criminal justice system. If policies, strategies and interventions do not work for Māori and Pasifika then they will never be effective. Māori and Pasifika should lead the development and facilitation of the new National Drug Policy and developing harm minimisation approaches that work for their communities. Reducing inequalities must continue to be a key principle of the National Drug Policy to improve access to care for Māori, Pasifika people and rural communities.

Recognise that we need to create a culture that actively encourages recovery and eliminates stigma. Stigmatisation of people who use, or are dependent on drugs, is one of the most significant barriers to people accessing help. This requires a significant shift in perspective by the public and the health and social service workforce as well as a whole-of-government commitment to pro-recovery policy making.

Recognise that some people may choose abstinence or non-use and this option must be supported as a viable option through our National Drug Policy.

Acknowledge what works for one person may not work for another. Although our response to drug use and related harm needs to be cohesive, it also needs to be flexible enough to meet the particular needs and aspirations of different individuals, families/whānau and communities.

Acknowledge harm reduction is possible within the context of continuing drug use and promoting safer drug use is not the same as encouraging people to use drugs.

Insist that while we all have a responsibility in reducing drug-related harm, government needs to lead change. This leadership needs to focus on increasing investment in health and social drug-related harm-reduction measures as well as effective drug law reform.

Recognise the need for our drug policy and practise to be informed by those who have personal experience with drug-related issues. People who use drugs, those in recovery and

[27] Clark, T.C, Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., Fortune, S., Lucassen, M., Peiris-John, R., Robinson, E., Rossen, F., Sheridan, J., Teevale, T., Utter, J. (2013). *Youth'12 Overviw: The health and wellbeing of New Zealand secondary school students in 2012*. Auckland, New Zealand: The University of Auckland.

their families/whānau need to be included in policy and practice design, implementation, evaluation and the workforce.

Recognise the need to respect the human rights of people who use drugs, and their rights under the Health and Disability Commission's Code of Rights[28]. This includes their rights in respect of appropriate prescribing practice and the use of prescription drugs. This also includes the right of access to essential medicines, and protection from harm caused by medications, especially where compulsory treatment is used. Drug control policies, compulsory treatment, and enforcement practices often entrench and exacerbate discrimination towards people who use drugs. This can drive people with serious health needs away from the help that should be made accessible to them.

Guiding principles resolutions

That good policy and effective actions to reduce drug-related harm are based on robust data, solid evidence and greater monitoring and accountability for outcomes.

That the government prioritise the proactive collection and dissemination of up-to-date research and survey data, information on emerging issues and best practice for prevention, treatment and harm minimisation. This collection also needs to include detailed information on the prevalence and patterns of drug use and the related health, social and economic harms experienced by the population.

That Ministry of Health and other relevant ministries ensure a coordinated and funded programme of research is implemented which addresses information gaps and informs future drug policy development and evaluation.

That the Treasury conduct a study of the cost/benefit of current functions deployed through the national drug policy, which will be peer reviewed and include a health impact assessment.

That the government improve legislative and policy development processes to increase the ability of frontline workers and those most affected by drug policy (including people who use drugs and their families/whānau) to contribute to legislative and policy development and evaluation.

[28] http://www.hdc.org.nz/the-act--code/the-code-of-rights

Prevention, early intervention and education

Note a wealth of international and local evidence clearly identifies that a young person's engagement in education and connection to their school is one of the most important protective factors in their lives. Students who feel connected to their school are less likely to engage in risky behaviours, including drug use. Disconnection from school increases the likelihood that a young person will experience drug-related harm.

We note there is minimal access to programmes in schools, alternative education, tertiary environments and other education providers that address students' alcohol and drug issues.

Note that the onset of substance use disorders[29] occurs mostly in the late teenage years and early 20s with 75 percent of those who develop a substance use disorder doing so by age 24.[30]

Note that in a recent survey of secondary school students, 29.5 percent of those aged 13 or younger, 47.1 percent of those aged 14 and 61.4 percent of those aged 15 had tried alcohol. 18.5 percent of those 13 and younger, 34.8 percent of those aged 14 and 48.8 percent of those aged 15 reported that they were current drinkers. [31]

Note that the same survey of secondary school students found the most common sources of alcohol among current drinkers were parents (60 percent) and friends (44 percent). Thirty percent got someone else to buy alcohol for them and 11 percent of students bought alcohol themselves.

Note that 69 percent of secondary students who bought their own alcohol did so from bottle shops or liquor stores and one in four were not asked to show proof of age. Not being asked

[29] In this document we follow the lead of the DSM-V and use the term "substance use disorder" to encompass the continuum of problematic drug use from substance abuse to substance dependence and addiction. In many instances of its use in this document, it also reflects the language used in the research cited.

[30] Wells, J.E., Baxter, J., & Schaaf, D. (Eds). (2007). *Substance use disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Alcohol Advisory Council of New Zealand pg. 19

[31] Clark, T.C, Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., Fortune, S., Lucassen, M., Peiris-John, R., Robinson, E., Rossen, F., Sheridan, J., Teevale, T., Utter, J. (2013). *Youth'12 Prevalence Tables: The health and wellbeing of New Zealand secondary school students in 2012*. Auckland, New Zealand: The University of Auckland. pg. 103

to show identification was most common for those aged 14, with 68.2 percent of 14-year-olds who bought their own alcohol reporting that they were not asked for proof of age.[32]

Note that 23 percent of secondary students reported using cannabis at least once, with 13 percent reporting they were current smokers. Three percent of students reported using cannabis weekly or more often. Twenty-one percent of all students who had ever used cannabis reported using it before or during school.

Note that use of other drugs among secondary students was not common. Party pills[33] (4 percent) and ecstasy (3 percent) were the most common 'other' [34] drugs ever used by all students. Most students who reported using ecstasy had used it only once. The use of other drugs, such as LSD, heroin, or amphetamine-type stimulants was uncommon. Less than 1 percent of students reported ever using methamphetamine and most of these students reported only having used it once.[35]

Note that at last count rates of drug use among students in alternative education were much higher.[36] Almost all alternative education students had tried alcohol (93 percent) and cannabis (86 percent), with the majority using these drugs at least weekly (59 percent and 55 percent respectively).

Note that opioids and alcohol were the two most common implicated substances in unintentional poisoning deaths in 17-24 year olds in Aotearoa New Zealand.[37] In other countries, changes in opioid prescribing practice have increasingly exposed young people to opioid pharmaceuticals prescribed for someone else.

Note that addiction services report they are seeing signs of earlier uptake, including drug use in those of primary school age. Aside from local reporting from frontline services, we have

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[32] Clark, T.C, Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., Fortune, S., Lucassen, M., Peiris-John, R., Robinson, E., Rossen, F., Sheridan, J., Teevale, T., Utter, J. (2013). *Youth'12 Prevalence Tables: The health and wellbeing of New Zealand secondary school students in 2012*. Auckland, New Zealand: The University of Auckland. pg. 108

[33] This category included smokable products such as synthetic cannabis.

[34] The full list of "other" drugs can be found on page 114 of *Youth'12 Prevalence Tables.*

[35] Clark, T.C, Smith, J.M., Raphael, D., et. al. (2013). *Youth'12 Prevalence Tables: The health and wellbeing of New Zealand secondary school students in 2012*. pg. 114

[36] Clark, T.C., Smith, J.M., Raphael, D., Jackson, C., Fleming, T., Denny, S., Ameratunga, S., & Robinson, E. (2010). Youth'09: *The health and wellbeing of young people in Alternative Education. A report on the needs of Alternative Education students in Auckland and Northland.* Auckland: The University of Auckland.

[37] Child and Youth Mortality Review Committee (2013). Op. cit. pg. 16

no current national data on the rates of drug use among young people below secondary school age.

Note the need for adult addiction treatment services to recognise the extra needs of the children of the people they see, and intervene early to reduce any potential harm, including their own early onset drug use, due to drug use in their families/whānau.

Agree the evidence is clear that significant neurological development takes place during childhood, adolescence and early adulthood and that drug use during these periods can cause significant and sometimes lifelong damage.[38]

Agree that delaying uptake is a key strategy for reducing drug-related (and other) harm.

Acknowledge that early onset of substance use, particularly problematic use, tends to be a signifier of other issues. Drug use, and particularly problematic drug use, at an early age should be seen as a sign of reduced resilience and a need for greater support. Punishing young people for using drugs is counterproductive as it can further compound existing vulnerabilities.

Are concerned about the effectiveness and the variable quality of drug education and prevention programmes being used in schools, and are further concerned that there is a lack of leadership and national coordination in ensuring the delivery of effective, evidence-based drug prevention programmes in schools, tertiary environments and other education and training settings including alternative education.

Are concerned some schools take a punitive, rather than supportive, approach to drug issues. While drugs (including "substance abuse") were not a predominant reason for stand downs and suspensions in 2011, drugs were the main reason for expulsions (27.3 percent) and exclusions (16.9 percent) among male students.[39]

Note that parents/caregivers have an important role to play in protecting their children from drug-related harm, including delaying uptake and building resilience. This requires families/whānau having easy access to resources that support and strengthen their role.

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[38] Prime Minister's Chief Science Advisor (2011). *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence.* Office of the Prime Minister's Science Advisory Committee: Wellington

[39] Education Counts: Stand-downs, suspensions, exclusions and expulsions from school. http://www.educationcounts.govt.nz/indicators/main/student-engagement-participation/80346

Prevention, early intervention and education resolutions

That the Ministry of Education encourages, supports and adequately resources all schools, and the Alternative Education National Body, to develop and implement best practice policies and procedures relating to drug harm minimisation. Drug harm minimisation activities should be restorative rather than punitive. While recognising schools' responsibility for the safety and wellbeing of all students, the priority should be to keep young people in school and provide appropriate interventions, including reintegration, into school and treatment options.

That District Health Boards resource youth health services to provide significantly increased access to a range of specialist interventions for students and/or their families/whānau with drug-related issues, in schools, tertiary environments and other education and training settings including alternative education. Well evaluated and evidence-based programmes should be scaled up nationwide.

That the Ministry of Education and the Ministry of Health collaboratively develop resources to support consistent teaching of a nation-wide school curriculum based on best practice, evidence-based programmes for: a) building young people's resilience; b) age and developmentally appropriate education about harm minimisation.

That community action funding should provide young people, their families/whānau and community with needs-based services and support to initiate their own prevention and harm minimisation projects and lead change within their communities.

That the Ministry of Education, Ministry of Health, Ministry of Justice, Ministry of Social Development and Ministry of Youth Development work collaboratively to provide ongoing professional development to educators and service providers to implement harm minimisation measures.

The Ministries of Health and Education should jointly develop a model of support for school guidance counsellors and other relevant personnel that ensures staff have appropriate skills to identify and work with people who use drugs, receive professional development and have a supportive relationship with mental health and addiction workers.

That the Ministry of Health develop programmes to increase young people's capacity to be agents of health promotion and drug-related harm reduction. This includes training programmes around what to do and when to seek help if they are with someone suffering a negative drug reaction, how to recognise when people are dangerously intoxicated and how to provide first aid.

That the Police, Public Health Units and local government enforcement officers are better resourced to enhance monitoring and enforcement initiatives to prevent retailers from selling alcohol and new psychoactive substances to minors.

That the Ministry of Health provide long-term funding to community action initiatives on volatile substance use prevention.

That the Ministry of Health develop volatile substance focussed resources containing information on products, methods, warning signs and risk factors around use for parents, teachers and community agencies. This includes the development of occupation specific education resources and toolkits for staff in frontline agencies.

That all health promotion resources must be designed following the *Rauemi Atawhai – A guide to developing health education resources in New Zealand*.[40]

That the Ministry of Health should work in partnership with media organisations to develop a resource highlighting good practice with regard to the media coverage of poisoning. Until such time as this resource is developed, guidance from the Australian 1985 Senate Select Committee on Volatile Fumes should be followed. All those who provide information on poisonings to the media (e.g. Police, Coroners and health professionals) should guide the media about the safe use of such information and use the Australian guidance until Aotearoa New Zealand guidance is available.

That the government implement the Law Commission's alcohol reform recommendations relating to the advertising, sponsorship and promotion of alcohol.

That the Health Promotion Agency, in collaboration with other stakeholders, develops prevention and early intervention initiatives that focus on groups at high risk of drinking during pregnancy.

[40] http://www.health.govt.nz/publication/rauemi-atawhai-guide-developing-health-education-resources-new-zealand

That the Health Promotion Agency and the Ministry of Health develop targeted interventions to prevent drug-related harm for high risk groups such as the LGBTI community.

That the Ministry of Health in collaboration with other agencies develop targeted interventions and resources to prevent drug-related harm from new psychoactive substances.

That Primary Health Organisations, District Health Boards, pharmacies and palliative care services work with others to ensure communities have well-advertised systems that encourage the safe disposal of prescription medicine. Information gained about the wastage should be collated and used to guide prescribing and dispensing practices and systems of care at both community and national levels.

That the Ministry of Health leads substantial improvement in monitoring and reporting of prescription drugs and prescribing patterns. The Ministry and the Medical Council must then respond with effective and timely containment of aberrant prescribing.

Harm reduction

Note harm reduction includes a range of interventions that aim to reduce risk associated with a range of health and social harms to the individual, families/whānau and the broader community.

Acknowledge that harm reduction exists throughout the country in many forms. In the context of this document, harm reduction can be specifically aimed at people who continue to use drugs and are unable or unwilling to stop. One strategy of harm reduction is to encourage safer use by those who are already using drugs.

Note that polydrug use is common among people who inject drugs. Research suggests pharmaceutical opioids, locally manufactured heroin analogues (i.e. 'home bake'), and amphetamine-type stimulants are the main drugs injected among needle exchange attendees.[41] Cost/benefit analysis has shown the Needle Exchange Programme to be one of

[41] Brunton, C., Mackay K., Henderson C. (2004). *Report of the National Needle Exchange Blood Borne Virus Seroprevalence Survey.* Prepared for the New Zealand Ministry of Health by the Department of Public Health & General Practice, University of Otago and Needle Exchange New Zealand.

the most successful and cost-effective public health interventions undertaken in Aotearoa New Zealand,[42] currently distributing 3 million injection units annually.

Note that the New Zealand Needle Exchange Programme is widely recognised as a global leader in effective harm reduction, particularly in respect to HIV transmission. It provides peer-based, low-cost, client-centred services situated in a broad range of accessible environments or delivery mechanisms, these include safer sex and injection equipment provision, blood borne virus testing, diagnosis, assessment and referral to treatment where appropriate.

Note that drug use (including injectable drug use) and rates of blood borne viruses are concentrated within the prison population. Eighty-nine percent of prisoners have a lifetime prevalence of substance abuse disorder and rates of Hepatitis C infection among this population sit at around 8 percent for female and 6 percent for male prisoners.[43]

We also note that drug detection programmes in prisons incentivise prisoners to move from drugs such as cannabis, which have longer detection periods, to drugs such as methamphetamine and opioids, which have shorter detection periods and are capable of providing a longer high with a smaller amount of the substance.

Note that harm reduction services are extremely limited in prison, especially for those on remand. Despite being a population with significantly higher health needs than the wider public, prisoners are not able to access the same level of care they would be able to in the community.

Note that while Aotearoa New Zealand does not collect data on post-prison mortality, a significant number of international studies have found that overdose rates for people during their first two weeks of release from prison are significantly higher than in any other population[44].

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[42] Aitken C. (2002) Op. cit.

[43] National Health Committee (2010). Op. cit. pg. 25

[44] White P. and Whiteford H. (2006) "Prisons: mental health institutions of the 21st century?" Medical Journal of Australia 185(6): 302–303; Kariminia A, Law MG, Butler TG, et al. (2007). Suicide risk among recently released prisoners in New South Wales, Australia. Medical Journal of Australia 187(7): 387–390.; Binswanger I.A., Stern M.F., Deyo R.A., et al. (2007). "Release from prison: A high risk of death for former inmates." *New England Journal of Medicine* 356(2): 157–165; Bird S.M., Hutchinson S. J. (2003). "Male drug-related deaths in the fortnight after release from prison: Scotland, 1996–1999." *Addiction* 98(2): 185–190.

Note that waiting times for Opioid Substitution Therapy can be longer than six months, with inconsistent service provision. There is wide variation in the range of involuntary withdrawal across Aotearoa New Zealand.

Note that the World Health Organisation estimates that every dollar invested in opioid dependence treatment programmes yields a return of $4-7 in reduced drug-related crime, criminal justice costs and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12:1.[45]

Note that there are a range of evidence-based opioid substitution therapies as well as other treatment modalities and each comes with its own set of issues and benefits. Some are better suited to some clients than others.

Note that the funding mechanism for access to opioid substitution therapy is based on the provision of opioid substitution therapy without necessarily providing resource for the treatment of underlying causes leading to, and perpetuating, opioid dependence.

Note that there are currently no wet houses[46] in Aotearoa New Zealand.

Note that there is currently limited provision of harm reduction services to people who use non-injecting drugs in Aotearoa New Zealand. All drugs have the potential to cause harm, to both the person using them, and others, particularly through the spread of communicable viruses. Some of these harms can be easily mitigated through the use of different consumption techniques, and harm reduction devices including vapourisers, water pipes and pill testing kits.

Insist that the criminalisation of drugs and public attitudes to people who use drugs are barriers to the provision and extension of effective harm reduction services.

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[45] World Health Organization, United Nations Office on Drugs and Crime,
Joint United Nations Programme on HIV/AIDS (2004). Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention pg. 21

[46] "The key difference between wet and other forms of supported housing is that residents are not required to be sober as a condition of entry or for ongoing entitlement to the accommodation. Wet houses not only welcome residents who are alcohol dependent but, most significantly, allow them to openly consume alcohol on-site." From McIntyre, S (2009). *Wet Housing: an accommodation option for people who have experienced chronic homelessness and long-term alcohol dependence.* Pg. 3

Harm reduction resolutions

That the Ministry of Health explores scaling up Needle Exchange Programme services (including delivery modifications and workforce development) to ensure more complete national coverage (availability of equipment and accessibility of outlets/services) and reach subpopulations of people who inject drugs e.g. Māori, Pasifika, Asian, people who inject psychostimulants or steroids, same sex oriented individuals, young people, new initiates and sex workers.

That the Department of Corrections identifies individuals at high risk of overdose and provide them with effective overdose prevention tools prior to release.

That the Ministry of Health increases the availability of appropriate overdose prevention strategies and relevant services to high risk drug using populations, particularly young people and new initiates.

That the Ministry of Health ensure that those undergoing opioid substitution therapy are entitled to funding streams (e.g. CarePlus or equivalent) in order to incentivise provision of opioid substitution therapy in primary health settings.

That the Ministry of Health investigate introducing harm reduction programmes for non-intravenous drug use, including pill testing and the provision of information around safer consumption techniques.

That the Ministry of Health fund and evaluate a wet house. We note that efforts have already begun to establish a service in Wellington.

That the Ministry of Health investigate barriers to harm reduction services for those under 16 years of age, including the review of any relevant legislation.

Treatment and recovery

Endorse the vision put forward by *Blueprint II*[47] and *Rising to the Challenge*[48.] This includes an acknowledgement that mental health and wellbeing is our collective responsibility and

[47] *Improving mental health and well-being for all New Zealanders*
[48] *The Mental Health and Addiction Service Development Plan 2012 – 2017*

plays a critical role in creating a well-functioning and productive society. In particular, we support earlier identification and intervention in primary care through routine screening and brief intervention and referral to specialist services when required, and better integration between primary and secondary services including stronger collaboration, referrals and the sharing of information.

Acknowledge the Prime Minister's project for improved mental health and well-being for young people. We support this project's focus on prevention and early intervention, its use of universal, targeted and youth-centred initiatives, and the emphasis placed on integration and evaluation.

Acknowledge the Ministry of Health's work on the youth exemplar project for enhanced alcohol and co-existing problems and service development for young people. This project will highlight our best performing projects and the reasons for their success as a way to increase the level of best practice in youth service development and delivery.

Acknowledge Ministry of Health's Children of Parents with Mental Illness or Addiction work aimed at improving outcomes for children impacted by a parent's mental illness and/or addiction. We support addiction services being adequately resourced and trained to identify the children's needs and work proactively.

Acknowledge the Ministry of Health's support and resourcing of addiction workforce development.

Note that an estimated 12.3 percent of New Zealanders will suffer from a substance use disorder at some stage in their lives. Around 3.5 percent will do so per year and around 1.5 percent will do so per month.[49] This means that in any given year around 150,000 people will need treatment, while a larger number of people who use drugs would benefit from the availability of advice or brief intervention.[50]

Note that while polydrug use is common, most people will primarily need treatment for alcohol-related issues, followed by cannabis-related issues.[51]

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[49] Wells, J.E., Baxter, J., and Schaaf D. (Eds). (2007). *Substance use disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Alcohol Advisory Council of New Zealand.) pg. 19

[50] National Committee on Addiction Treatment (2011) pg. 3

[51] Wells, J.E., Baxter, J., and Schaaf D. (Eds). (2007) *Substance use disorders in Te Rau*

Note that substance abuse disorders are more common in certain populations such as those with mental health issues. The more severe the drug-related issue, the more likely there will be a co-existing psychiatric issue. While the twelve month prevalence of substance abuse disorder in the general population is 3.5 percent, in males aged 16-24 it is 12.5 percent and in young Māori males it is 22 percent[52].

Note that harm resulting from drug use within Māori and Pasifika populations can be compounded by socio-economic disadvantage and inequitable allocation of funding for treatment services. Within this there is a particularly hard to reach population that requires a different response. The youthfulness of the Māori and Pasifika community plays a key role in the concentration of drug-related harm within these populations.

Note that most people with lifetime substance use disorders eventually make contact with treatment services if their disorder continues. However, it tends to take people a long time to do so. A 2006 survey showed that the median time between onset and service contact was 16 years for "alcohol abuse", 7 years for "alcohol dependence", 8 years for "other drug abuse", and 3 years for "other drug dependence"[53].

Note that the unmet need for help with "substance dependence" is significant. Around 50,000 people (1.9 percent of the population aged 16–64 years) want help to reduce their alcohol or drug use every year but do not receive it, while a larger number are experiencing issues as a result of their drug use but have yet to decide they want help.[54]

Note that people in the most deprived neighbourhoods were the most likely to report that they wanted help to reduce their drug use but did not receive it. Those in the most deprived neighbourhoods were over five times more likely to report unmet need than those living in the least deprived areas.[55]

Hinengaro: The New Zealand Mental Health Survey. Wellington: Alcohol Advisory Council of New Zealand. pg. 19

[52] Wells, J.E., Baxter, J., and Schaaf D. (Eds). (2007) *Substance use disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Alcohol Advisory Council of New Zealand. pg. 26

[53] Mental Health Commission (2012). *National Indicators Report 2012*, pg. 20

[54] National Committee for Addiction Treatment (2011) pg. 2

[55] Ministry of Health. (2010). *Drug Use in New Zealand: Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey*. Wellington: Ministry of Health

Note that addiction treatment services receive around 10 percent of total mental health funding but treat around 20 percent of all mental health clients.[56]

Note funding for addiction intervention in primary care earmarked for mental health and addiction is almost entirely spent on mental health.

Note that addiction treatment tends to be more effective when family members/whānau are involved.[57] This is more than just keeping family/whānau informed and, in some cases, may require intensive work with a person's support systems — particularly those who have drug issues themselves.

Note that recovery is about building a satisfying and meaningful life as defined by the person themselves. While control over substance use is a key aspect of recovery, positive health and well-being and participation in society are also central. Accordingly, recovery can be helped or hindered by the person's treatment provider, friends, family/whānau and wider community.

Note that recovery is a process, not a single event, and may take time to achieve and effort to maintain.

Note that the process of recovery and the time it takes will vary between individuals. It may be achieved without any formal external help or may, for other people, only be achieved with a number of different types of support and interventions, including medical treatment. No 'one size fits all'.

Recognise that mutual aid support groups provide an essential, independent and free continuing support framework for those seeking recovery from all forms of substance use disorder.

Treatment and recovery resolutions

That the government gives an enduring commitment to *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012 – 2017* and *Blueprint II: Improving mental health and wellbeing for all New Zealanders – How things need to be*.

[56] NCAT (2011). *Addiction treatment is everybody's business, p2*
[57] NCAT (2008). *Investing in Addiction Treatment: A Resource for Funders, Planners, Purchasers and Policy Makers*. NCAT: New Zealand

That a population health-based programme of screening, brief intervention and referral to treatment be implemented in primary care and other appropriate settings, including mental health settings, and that adequate funding and resources be allocated to sustain these services.

That the Ministry of Health and the Health Promotion Agency implement a destigmatisation campaign focussed on reducing negative public assumptions about people who use or are dependent on drugs and those in recovery.

That the Ministry of Health and District Health Boards increase funding to drug treatment interventions for young people, with a specific focus on youth-centred initiatives.

That the Ministry of Health, in conjunction with the Health Promotion Agency, significantly scale up existing social marketing programmes to encourage help-seeking behaviour and inform people with substance use disorders and their families/whānau about how to obtain advice, treatment and support.

That the Ministry of Health and District Health Boards make adequate funding available to meet the need for access to treatment interventions.

That the Ministry of Health continue to provide funding for the workforce development of people who work with those who have addiction related issues, including in primary care and peer support.

That the Ministry of Health and District Health Boards increase support for Children of Parents with Mental Illness or Addiction initiatives.

That the Ministry of Health continue to support workforce development initiatives aimed at supporting adult addiction services to identify and respond to potential risk to children.

That the Ministry of Health continue to support workforce development programmes to grow the Māori and Pasifika workforce.

That the Ministry of Social Development targets resources towards people who have drug-related issues. This includes working with business to promote the hiring of people in recovery, particularly those undergoing opioid substitution therapy, and supporting them in to work when they are ready for it.

That all people who inject drugs accessing any treatment service are proactively supported for diagnosis, assessment, and referral to appropriate treatment as required for Hepatitis C.

That opioid substitution therapy services support those clients wishing to withdraw from substitution therapy and ensure they are fully assisted and supported to do so and the full range of services is offered to them. The National Association of Opioid Treatment Providers needs to lend oversight and support to ensure this happens.

That the Ministry of Health ensure funding is allocated for: a) the assessment and diagnosis of foetal alcohol spectrum disorder; b) training for the relevant workforce to support early intervention; and c) the provision of coordinated care and support.

That the Department of Corrections, Ministry of Health and District Health Boards improve continuity of care for prisoners. This includes enrolling prisoners in primary health care services before release, ensuring opioid substation and other medications are not disrupted as people move between the community and prison, and that those who have undergone drug treatment in prison are linked to support networks, treatment and aftercare services before they leave.

That the Department of Corrections continue to extend and improve the provision of prison treatment services, particularly for prisoners on remand.

That the Ministry of Health and the Ministry of Social Development investigate ways to improve support to family members/whānau who are caring for people with drug issues or the children of people with drug issues. This includes improving outcomes for children, better information provision, financial support and access to respite care for grandparents raising grandchildren and other people taking on carer roles.

That grandparents raising grandchildren, and other family members/whānau taking on childcare roles are given access to early assessment for those children in their care due to parental mental health and/or addiction issues, and education on hereditary aspects of addiction and mental health issues.

That the Ministry of Justice draw on evaluations of alcohol and other drug courts to consider extending this approach to those whose offending is attributed to alcohol and other drugs.

Legislation

Note that the Misuse of Drugs Act is almost 40 years old and that the Law Commission's review of it concluded that this Act "does not adequately support the overarching goal of the National Drug Policy" and "fails to recognise and respond appropriately to the health and addiction issues which frequently underpin the use of illegal drugs, and therefore does little to support demand reduction."[58]

Note that the Law Commission review concluded that the classification of drugs under the Misuse of Drugs Act is based on either no, or out-dated, evidence.

Note that the Alcohol and Drug Addiction Act is almost 50 years old and that the Law Commission review of the Act concluded it is not fit for purpose and does not adequately safeguard individual rights.

Recognise the Law Commission's recommendations around the reform of the Misuse of Drugs Act 1975 and the Alcohol and Drug Addiction Act 1966.

Note that in 2012, there were 20,682 apprehensions for "illicit drug offences". Of these, 8,563 were for possession or use of an "illicit drug" and 4,589 for possessing a drug utensil. These relatively minor drug offences (13,735) accounted for 66.41 percent of all "illicit drug" apprehensions. 4,728 (or 34 percent) of these apprehensions were of a person who was Māori. 10,476 (or 76 percent) of these charges related to cannabis.[59]

Note that between 2007 and 2011, 12,895 people under the age of 25 were convicted of possession and/or use of an illegal drug or drug utensil. That is around 2,500 young people a year.[60]

Note that between 2007 and 2011, there were 3387 prison sentences handed out for relatively minor drug offences. The average sentence was 64 days in prison at an average imprisonment-only cost of around $18,000 per person over the duration of their sentence.[61]

[58] Law Commission (2011). Controlling and regulating drugs: a review of the Misuse of Drugs Act 1975 (Law Commission report; 122) pg. 108
[59] Statistics New Zealand table builder
[60] OIA to the Ministry of Justice
[61] OIA to the Ministry of Justice

Note that where a person is arrested and/or prosecuted for a drug offence, the drug offence is not necessarily the only or the most serious charge that person faces.

Note that we do not have good data on the total cost of drug prohibition. 2005/06 estimates put total illegal drug enforcement costs at around $303 million during that financial year, with 38 percent of this (or $116.2 million) and 333,684 police hours spent on cannabis enforcement, and $145.5 million (48 percent) and 257,140 hours of Police time spent on methamphetamine enforcement. In total, police spent 598,000 hours during that period on illegal drug enforcement.[62]

Note that the justice sector cost associated with alcohol related crime is estimated at more than $716 million annually; that Police estimate that they spend around $200 million on dealing with the misuse of alcohol annually; and that at least one third of all arrests include alcohol as a factor.[63]

Note that there are on average 30,000 drink drive convictions each year and that currently fewer than five percent of these people are referred to alcohol and drug treatment[64].

Note a growing evidence base highlighting the therapeutic properties[65] of cannabis, but that current legislation creates barriers to research on this in Aotearoa New Zealand.

Note the relationship between international trade and investment agreements and the implementation of public health interventions.

Note the application to require an alcohol and pregnancy health advisory statement for alcohol containers was submitted to Food Standards Australia New Zealand in 2006 (A576).

Note the introduction of the Psychoactive Substances Act and the associated regulation and safety requirements.

Legislation resolutions

That the Government draft new drug control legislation based on the recommendations of the Law Commission yet to be implemented, including:

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[62] Law Commission (2010). *Controlling and regulating drugs (Law Commission issues paper; 16)* pp 29 and 35.
[63] New Zealand Police
[64] Ministry of Justice (2011). Drivers of Crime Investment Package. Accessed from http://beehive.govt.nz/sites/all/files/DriversofCrimeInvestmentPackage.pdf on 03/09/2013.
[65] See the Law Commission (2010) for a good summary of the evidence.

a. That the Misuse of Drugs Act 1975 should be repealed and replaced by a new Act administered by the Ministry of Health.

b. That an independent expert advisory committee should commence a systematic, evidence-based review of the current classification of all drugs sitting in the Misuse of Drugs Act (based on their risk of harm) with regular reviews into the future.

c. That a statutory presumption against imprisonment in any case of simple possession, use or social dealing be introduced.

d. That the possession of needle and utensil offences from section 13 of Misuse of Drugs Act be removed.

e. That a mandatory cautioning scheme in lieu of prosecution for first offenders caught in possession of illegal drugs, and second and third offenders caught in possession of the less harmful illegal drugs be introduced.

f. That prosecution for possession of an illegal drug be prohibited, unless the person has either been referred for a health assessment and intervention but has failed to participate, or has had such a referral for an earlier possession offence.

g. That the Police should take a policy of not prosecuting in cases where they are satisfied that cannabis use is directed towards managing the symptoms of chronic or debilitating illness.

h. That the justice sector provides separate treatment funding for offenders.

That the Methamphetamine and Cannabis Utensils (prohibition) Notice 2003 be amended to allow the legal importation and supply of harm reduction devices.

That the Treasury consider the Law Commission's alcohol reform recommendations on alcohol excise tax.

That the Ministry of Health, Ministry of Foreign Affairs and Trade and other appropriate ministries ensure that the public health implications of international trade agreements are considered.

That the Government supports Food Standards Australia New Zealand application A576 becoming mandatory, and complemented by a public awareness programme.

That the Government closely monitor international models of innovative, harm-minimising drug policies (e.g. Portugal) and consider building on the concept of regulating psychoactive substances when reviewing the Misuse of Drugs Act.

That the Government prioritise the introduction of the Compulsory Addiction (Assessment and Treatment) Bill to Parliament.

Aotearoa New Zealand as a global citizen

Acknowledge the importance of contributing to the development and implementation of global policy matters and underscore the breadth of experience and expertise Aotearoa New Zealand Non-government Organisations can bring to the international stage.

Note that the Government has obligations under the United Nations Conventions on Narcotic Drugs.

Recognise that the international drug control conventions are being challenged by law reform measures adopted by two states in the United States of America, Mexico, Columbia, Bolivia, Uruguay, Portugal, the Netherlands and the Czech Republic, among others.

Recommend that the Government support the adoption of an international drug control regime that reflects the policy priorities and regulatory approaches of Aotearoa New Zealand.

Commit ourselves to supporting the work of the Vienna NGO Committee on Drugs through the active involvement of the New Zealand Drug Foundation among others from Aotearoa New Zealand active in the Committee's work.

Agree to actively contribute to and participate in activities leading to the 2014 High Level Segment of the Commission on Narcotic Drugs and for the 2016 United Nations General Assembly Special Session so as to ensure Aotearoa New Zealand priorities figure prominently at those forums.

Agree to contribute to regional activities aimed at improving drug-related programs and activities, and will commit to strong Aotearoa New Zealand participation, leadership and contributions leading up to and at the First Asia Pacific Congress on Drug and Alcohol Issues, hosted in Bangkok in September 2015.

Recommend that the Government expand civil society representation on its international delegations and actively support the work of the Vienna NGO Committee and Aotearoa New Zealand Non-governmental Organisations working in that forum.

Recommend that the Government call upon and bring the expertise of Aotearoa New Zealand Non-governmental Organisations to the World Health Assembly on matters related to the implementation of the Global Alcohol Strategy.

Our commitment over the next five years

Commit ourselves to the principles espoused by this declaration and ensuring that they are reflected in our own policies and practices.

Commit ourselves to continue sharing our experience and expertise to governmental and non-governmental agencies in efforts to find humane, just and effective responses to reduce drug-related harm.

Commit ourselves to draw upon existing networks and the relationships established at this summit to continue to find ways to establish shared goals and work together to make a collective impact on these complex and often contentious issues.

Commit ourselves to actively evaluating the progress made on the resolutions contained in this declaration, including coming together again in 2015 to review our individual and collective achievements.

Call upon all Non-governmental Organisations, community organisations, relevant agencies and individuals to come together in a spirit of shared responsibility and accountability and commit to the principles and resolutions contained within this declaration.

Appendix 1

Principles

Participants came up with a number of principles to underpin New Zealand's national drug policy. They agreed that the overarching goal needs to be the reduction of drug-related harm and the promotion and protection of health and wellbeing. This includes minimising the harm that arises from responding to drug use via the criminal justice system.

Other principles included:

- The effectiveness (including cost effectiveness) of policies and practices for reducing drug-related harm must be evaluated. Where possible, policies should be designed and implemented to allow for later evaluation.
- Drug-related harm needs to be accurately assessed. In order to do so, the costs of drug use need to be separated from the costs of enforcement.
- Drug use needs to be understood and responded to as a health and social issue rather than a criminal justice one.
- Everyone shares accountability and responsibility for reducing drug related harm. However government needs to lead change – particularly through investment in health and social harm reduction measures and effective drug reform.
- Entrenched drug use needs to be understood and addressed within its social, cultural and economic context including inequality and social exclusion.
- Children and young people are particularly vulnerable to harm from their own and other's drug use.
- Reducing inequalities must remain a key principle of the national drug policy. Māori and Pasifika need to lead harm reduction approaches that work for their own communities.
- Develop a culture that actively encourages recovery and eliminates drug-related stigma.
- Abstinence and non-use must be supported within the national drug policy.
- Harm reduction is possible within the context of continuing drug use. Promoting safer drug use is not the same as encouraging people to use drugs.
- Drug policy and practice needs to be informed by those who have personal experience with drug-related issues.
- Respect the human rights of people who use drugs and their rights under the Health and Disability Commission's Code of Rights.

Appendix 2

Participants

Auckland Council
Auckland Council CAYAD
Auckland Drug Information Outreach
Alcohol & Drug Assessment & Counselling
Alcohol Drug Association NZ
Alcohol Healthwatch
Allen & Clark
Alternative Education National Body
Ara Taiohi
Atareira
Capri Hospital
CareNZ
Centre for Addiction Research
Child & Youth Mortality Review Committee
Community Alcohol & Drug Service Wellington
Drug & Alcohol Practitioners' Association
Drugs Project
Environmental Science & Research
Fetal Alcohol Network
Grandparents Raising Grandchildren
Hawkes Bay CAYAD
Health Action Trust
Health and Disability Commission
Health Promotion Agency
Hoani Waititi Marae
Hutt Valley DHB
JustSpeak
Kim Barnett
Le Va
Matauranga Whanui CAYAD
Matua Raki
Mirror Trust
Ministry of Health
National Addiction Centre
Nat. Assn. of Opioid Treatment Providers
National Council on Addiction Treatment
National Drug Intelligence Bureau
NORML
Needle Exchange NZ
NZ College of Public Health Medicine
New Zealand Drug Foundation
NZ Police Association
NZ Society on Alcohol & Drug Dependence
Pacific Advisory Group HPA
PPTA
Principal's Federation
Public Health Association
Regional Public Health
Rubicon
Salvation Army
STAR Trust
Substance Use & Policy Analysis
Supporting Families
Te Puni Kōkiri
University of Canterbury
University of Otago
Vienna NGO Committee on Drugs
Waipuna Trust CAYAD
Warren Young
Wellington CAYAD
WELTEC
Welltrust
Wesley Community Action
Young Labour
Young National