

Chapter 15

Achieving balance in drug policy

SUMMARY

This chapter examines problem limitation and demand reduction strategies. It also considers options for providing better support for these pillars of drug policy.

INTRODUCTION 15.1 The international drug conventions impose a responsibility on national governments to make treatment available for drug dependent users. Under article 38 of the Single Convention on Narcotic Drugs 1961 and article 20 of the Convention on Psychotropic Substances 1971, parties are required to:¹¹⁷⁶

...take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved...

Over recent years the United Nations Office on Drugs and Crime (UNODC), which historically has concerned itself primarily with strategies aimed at suppressing the supply of drugs, has also begun to stress the importance in drug policy of achieving a balance between strategies and measures aimed at eliminating the supply of drugs and those aimed at reducing demand through prevention and treatment.¹¹⁷⁷ In a similar vein the United Nations agreed in 1998 that:¹¹⁷⁸

The most effective approach towards the drug problem consists of a comprehensive, balanced and coordinated approach, encompassing supply control and demand reduction reinforcing each other, together with the appropriate application of the principle of shared responsibility. There is now a need to intensify our efforts in demand reduction and to provide adequate resources towards that end.

1176 Article 38 and Article 20 contain the same wording.

1177 See, for example, Antonio Maria Costa “Health: The First Principle of Drug Policy” (18 March 2008) Costas Corner www.unodc.org (accessed 15 December 2009).

1178 The United Nations in this context uses the term “demand reduction” to include policies that aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse. See The Declaration on the Guiding Principles of Drug Demand Reduction – UNGA Resolution 20/3 (8 September 1998) A/RES/S-20/3, paras 4 and 8.

- 15.2 As we discussed in chapter 3, New Zealand's National Drug Policy takes a similar approach. Our drug policy emphasises the need for a balance of strategies and measures that support demand reduction and problem limitation as well as the more traditional supply controls centred on prohibition.
- 15.3 In this chapter we consider demand reduction strategies aimed at delaying or preventing the uptake of drug use, and problem limitation measures, such as treatment interventions and harm reduction initiatives, aimed at reducing the harm arising from existing drug use. There is a substantial body of evidence demonstrating the effectiveness of drug treatment and other problem limitation measures aimed at reducing drug-related harm.¹¹⁷⁹ Demand reduction and problem limitation strategies are recognised as essential components of a broad and effective response to drug-related harm. Despite this, we are concerned that these aspects of drug policy do not receive the level of support and attention that they require.

DRUG TREATMENT

- 15.4 For the purposes of our discussion we use the term "treatment" broadly to mean the application of any intervention that aims to have a beneficial impact upon the behaviour and welfare of a problem drug user. Treatment encompasses interventions that operate at the medical, psycho-social and spiritual level and includes interventions that focus on different objectives, such as safer drug use, stabilisation of behaviour, and abstinence.¹¹⁸⁰

Drug use amenable to treatment

- 15.5 Problem drug use takes a number of forms. In the alcohol and drug treatment sector alcohol and drug use is often seen as occurring on a continuum that extends from no use or abstinence at one end through to addiction or severe dependence at the other end. Conceptually a continuum of use also provides a useful approach for considering different levels of treatment to respond to the nature and severity of alcohol or drug use.¹¹⁸¹ The diagram below illustrates this continuum and the level of treatment response proposed by the National Committee for Addiction Treatment.¹¹⁸² Under this continuum, hazardous use, harmful use and any pattern of dependency all constitute problem drug use that might benefit from some form of drug treatment.¹¹⁸³

1179 See, for example, the review of the research and evidence base for drug treatment undertaken by UNODC. United Nations Office on Drug and Crime *Contemporary Drug Abuse Treatment: A Review of the Evidence Base* (United Nations, New York, 2002).

1180 Alex Stevens, Christopher Hallam and Mike Trace *Treatment for Dependent Drug Use: A Guide for Policymakers* (R 10, The Beckley Foundation Drug Policy Programme, Beckley (UK), 2006) 2.

1181 National Addiction Centre *Orientation to the Addiction Treatment Field Aotearoa New Zealand* (National Addiction Centre, Christchurch, 2008) 3.

1182 National Committee for Addiction Treatment (NCAT) *Investing in Addiction Treatment – A Resource for Funders, Planners, Purchasers and Policy Makers* (NCAT, Christchurch, 2008) 7.

1183 National Addiction Centre, above n 1181, 3.

TABLE 5:

The abstinence to addiction continuum	
No use	No treatment required.
Low risk use	Public or population health initiatives apply.
Hazardous use	Likely to benefit from less intensive treatment options, need treatment but do not necessarily need specialist treatment.
Harmful use	
Mild dependency	
Dependency	Need intensive, specialist treatment options.

- 15.6 While more intensive forms of specialist treatment are probably required where a person has become dependent on drugs,¹¹⁸⁴ less intensive treatment options can be utilised where drug use is hazardous or harmful or drug dependency is mild. Drug treatment strategies therefore need to include a range of services and options. Low level and brief interventions, which may be provided in a generalist setting (for example, primary care) rather than by addiction treatment specialists, are needed at an early stage where drug use is first identified as hazardous or harmful, while withdrawal management and specialist community-based and intensive residential treatment options are more applicable where dependency has become severe.
- 15.7 The New Zealand Mental Health Survey 2006 has estimated the prevalence of different groups of mental health disorders including substance abuse disorders (abuse of or dependence on alcohol or drugs). For the survey, substance abuse is defined as a “maladaptive pattern of substance use that involves recurrent and significant adverse consequences”.¹¹⁸⁵ In terms of the continuum discussed above, substance abuse would cover both harmful use and hazardous use. For the survey, dependence is characterised by symptoms including an increased tolerance to a drug, withdrawal symptoms, more prolonged and intense use of a drug and unsuccessful attempts to control use.¹¹⁸⁶
- 15.8 Results from the survey estimate that in the preceding 12 months, 2.6 % of the population experienced alcohol abuse, 1.3 % alcohol dependence, 1.2 % other drug abuse and 0.7 % other drug dependence.¹¹⁸⁷ Alcohol abuse was 2.3 times more prevalent than other drug abuse and alcohol dependence was 1.8 times more common than drug dependence.¹¹⁸⁸ The rates of substance use disorder were markedly higher for young people and also for Māori. Of young people in the 16 to 24 year age group, 7.1 % experienced alcohol abuse, 3.0 % alcohol dependence, 3.8 % other drug abuse and 2.1 % drug dependence.¹¹⁸⁹ For Māori, 7.4 % experienced

1184 NCAT, above n 1182, 7.

1185 J E Wells, J Baxter and D Schaaf (eds) *Substance Use Disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey Final Report* (Alcohol Advisory Council of New Zealand, Wellington, 2006) 12.

1186 *Ibid*, 12.

1187 *Ibid*, 19.

1188 *Ibid*, 23.

1189 *Ibid*, 25.

an alcohol disorder (that is, abuse or dependence) and 4.0 % experienced other drug disorders.¹¹⁹⁰ In crude terms, these figures represent the proportion of the population that potentially might benefit from alcohol and drug treatment.¹¹⁹¹

Alcohol and drug treatment in New Zealand

- 15.9 The alcohol and drug treatment sector in New Zealand encompasses a broad range of treatment types and services. It is beyond the scope of this project to assess the various models or approaches to treatment or their relative effectiveness. However, because we are proposing a rebalancing of the pillars of drug policy with greater emphasis on treatment within drug policy, we believe it is important to understand the nature of drug treatment and its effectiveness at addressing drug-related harm.
- 15.10 In this section we give a brief overview of the treatment sector and the range of treatment services and models of treatment currently available within New Zealand.

Non-specialist health services – “screening” and “brief interventions”

- 15.11 “Screening”, as the name suggests, involves administering a range of screening tools that have been developed to determine the likelihood that a person has a drug-related problem. Screening may also identify the presence of related or co-existing problems and whether there is any immediate risk for the person or others. Screening services provide an essential filter for access to specialist treatment. Where screening indicates that there is a more severe problem like dependence, people can be referred through to specialist services.
- 15.12 Attempts to have primary care services screen for alcohol and drug problems have not been particularly successful to date. Currently screening is undertaken by a few general practitioners and others working in primary care, but not routinely. Some screening is done at emergency services when people present with emergencies and injuries related to alcohol or other drugs, but again it is not undertaken as a matter of course. Probation officers also administer some screening tools as part of the pre-sentence report process and on that basis refer people on to specialist services.
- 15.13 The term “brief intervention” is used to identify other low level interventions that can form part of a preliminary layer of services. Brief interventions include one-off therapeutic consultations, the provision of tailored information and advice about the consequences of current patterns of drug use and possibly some support services to address related social or family issues.¹¹⁹²

1190 Note that these unadjusted prevalence rates describe the actual burden of substance use disorder experienced by Māori. When comparisons are being made with other ethnic groups, adjustments reflecting differences in age and other socioeconomic correlates need to be made. See *ibid*, 32.

1191 It is important to note that the population surveyed were people aged 16 and over living in permanent private dwellings throughout New Zealand, so this excludes the prison population and people living in other circumstances.

1192 A Ritter and N Lintzeris “Specialist Interventions in Treating Clients with Alcohol and Drug Problems” in M Hamilton, T King and A Ritter (eds) *Drugs in Australia – Preventing Harm* (2nd ed, Oxford University Press, Melbourne, 2004) 225.

- 15.14 As was discussed in the Commission's issues paper *Alcohol in Our Lives*,¹¹⁹³ there is good evidence that brief interventions can be highly cost-effective for treating less severe alcohol-use problems.¹¹⁹⁴ They can change patterns of alcohol consumption and reduce alcohol-related problems, but are under-utilised in New Zealand.¹¹⁹⁵ There is less evidence about the effectiveness of these types of brief interventions in respect of other drug use. However, it is important not to artificially separate alcohol from other drug use because many people with drug problems also have alcohol problems and require similar interventions for both. For that reason there is a combined telephone Alcohol and Drug Helpline that provides support, advice and information.
- 15.15 Brief interventions are not widely provided within primary care services, although primary care is regarded as best placed to address alcohol and drug screening, problem recognition, early intervention and general management.¹¹⁹⁶
- 15.16 While we recognise that there are obviously some barriers and practical difficulties that need to be overcome,¹¹⁹⁷ increased use should be made of the opportunities for screening and brief interventions within primary care.

Specialist treatment services

- 15.17 Specialist alcohol and drug services are provided by approximately 150 specialist teams spread across the 21 District Health Boards and 16 large non-government organisations. There are also a few alcohol and drug treatment practitioners in Māori health and in services catering for young people. It is estimated that approximately 22,500 people or 0.5 % of the population receive some assistance from specialist alcohol and drug treatment services annually.¹¹⁹⁸ Only a very small portion of people attend residential or intensive day programmes. These are relatively expensive and are only available on a publicly funded basis for those with severe alcohol or drug dependence. The majority of people access specialist alcohol and drug services through outpatient or community-based treatment programmes.

1193 New Zealand Law Commission *Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws* (NZLC IP15, Wellington, 2009) 206.

1194 T Babor and others *Alcohol: No Ordinary Commodity* (Oxford University Press, New York, 2003).

1195 See, for example: J Sheridan and others "Screening and Brief Interventions for Alcohol: Attitudes, Knowledge and Experience of Community Pharmacists in Auckland, New Zealand" (2008) 27 *Drug and Alcohol Review* 380; J Hosking and others "Screening and Intervention for Alcohol Problems among Patients Admitted Following Unintentional Injury: a Missed Opportunity?" (2007) 120 *New Zealand Medical Journal* 2417; J Pulford and others "Alcohol Assessment: the Practice, Knowledge and Attitudes of Staff Working in the General Medical Wards of a Large Metropolitan Hospital" (2007) 120 *New Zealand Medical Journal* 2608; J P McMenamin "Detecting Young Adults with Alcohol Use Disorder in General Practice" (1997) 110 *New Zealand Medical Journal* 127.

1196 Helen Moriarty, Maria Stubbe and Sarah Bradford *Opportunities for Alcohol and Other Drug Advice in the GP Consultation* (University of Otago, Wellington, 2009) 4.

1197 These include time pressures in general practice, the acuteness of other complaints as well as individual practitioners' confidence and experience; see *ibid*.

1198 Between May 2007 and April 2008, 22,696 people accessed specialist alcohol and drug treatment services.

15.18 In the 2007/08 year \$103.5 million of Vote Health was spent on alcohol and drug treatment, comprising:¹¹⁹⁹

- \$69.50 million on community alcohol and drug treatment;
- \$14 million on residential treatment;
- \$13 million on methadone substitution programmes;
- \$7 million in total on detoxification (this includes \$1.5 million spent as a component of community alcohol and drug treatment and \$0.6 million as a component of residential treatment).

Some of the non-government organisations providing alcohol and drug treatment also receive funding from other sources including government departments.

15.19 The specialist treatment sector and most specialist alcohol and drug treatment programmes available in New Zealand provide a range of different interventions.

Comprehensive assessment

15.20 A comprehensive assessment is needed after a person has been identified through screening as requiring specialist alcohol and drug treatment. These assessments are normally undertaken by specialists involved in outpatient or community addiction treatment services or as a first step of a residential or therapeutic community placement. The objective is to properly and adequately determine the nature of the drug problem, and other relevant co-existing problems.¹²⁰⁰ A full risk assessment is also undertaken. Many people accessing alcohol and drug treatment have a range of other issues and needs as well. These include mental and other health problems and social, legal, and family issues. The National Committee for Addiction Treatment reports that in one study, 74% of a representative sample of people seeking alcohol and drug treatment from Community Alcohol and Drug Services had a co-existing psychiatric disorder.¹²⁰¹ Treatment for this group is unlikely to be effective unless it also addresses these types of broader underlying issues. Ideally a treatment plan that addresses a person's particular needs is developed in this way.

Detoxification or withdrawal management

15.21 Where a person has developed a dependence on a drug, he or she is likely to experience withdrawal symptoms when the use of the drug is stopped. Withdrawal from some drugs such as alcohol, benzodiazepines and barbiturates may cause symptoms that are life threatening,¹²⁰² while withdrawal from others, such as opiates, can be extremely unpleasant and involve severe pain, fever, chills and diarrhoea as well as intense drug craving and emotional distress.¹²⁰³ All such symptoms can be minimised, as far as possible, by detoxification treatment and withdrawal management, so that the person can withdraw from drug use as comfortably and safely as possible.¹²⁰⁴ The aim is to reduce physiological

1199 Figures provided by the Ministry of Health.

1200 National Addiction Centre, above n 1181, 17.

1201 NCAT, above n 1182, 27.

1202 Stevens, Hallam and Trace, above n 1180, 4.

1203 Ibid, 4.

1204 Ritter and Lintzeris, above n 1192, 227.

and emotional instability so as to avoid medical or psychiatric complications.¹²⁰⁵ Detoxification will therefore normally involve medical care and the use of other drugs to manage withdrawal symptoms.

- 15.22 Detoxification is not a stand-alone treatment option, as it is now well recognised that by itself detoxification is unlikely to produce a long term withdrawal from drug use.¹²⁰⁶ Detoxification is normally approached as a preliminary step in an ongoing rehabilitation programme and should lead to further treatment aimed at supporting the person's lifestyle changes and avoiding relapse. Withdrawal from heroin, for example, may increase the risk of subsequent death by overdose by reducing tolerance to heroin, so it is particularly important that ongoing treatment and support is available.
- 15.23 In New Zealand, detoxification or withdrawal management is undertaken on an in-patient basis within either a dedicated in-patient detoxification facility in a hospital or a general hospital setting. Detoxification is also undertaken in the community while the person remains in his or her own home with the necessary medical support being provided by visiting nursing and medical staff. Home-based detoxification will only be an option where adequate medical support can be provided by visiting nursing and medical staff, which will not always be the case. In addition the City Mission in Auckland and Christchurch provides some residential detoxification in circumstances where medical oversight is not required.¹²⁰⁷ The Government has recently announced an intention to increase the number of beds available in detoxification facilities of this kind.¹²⁰⁸
- 15.24 There is little evidence available on the comparative efficacy of in-patient and community-based detoxification processes, although inpatient programmes are significantly more expensive.
- 15.25 A large portion of people who enter withdrawal management are seeking a temporary break from the adverse physical, psychological, or social harms arising from their drug use. However, they may not be prepared or be in a position to make the fundamental behavioural changes that are required to maintain longer term abstinence. For these people it is suggested there is still some benefit in completing withdrawal.¹²⁰⁹

Pharmacological therapies – opioid substitution treatment

- 15.26 Drug users who are drug dependent can benefit from ongoing pharmacological treatment and therapies. Pharmacological treatment can take two forms: (a) substitution treatment where a safer legal drug, like methadone, is substituted for illegal street opiates; or (b) prescription of antagonist medications, like naltrexone, that block the effects of other drugs and reinforce a person's

1205 Stevens, Hallam and Trace, above n 1180, 4.

1206 Ritter and Lintzeris, above n 1192, 229.

1207 This usually involves a short stay of between one to seven nights in a supportive setting for safe withdrawal.

1208 Department of Prime Minister and Cabinet *Tackling Methamphetamine: An Action Plan* (DPMC, Wellington, 2009) 41.

1209 Ritter and Lintzeris, above n 1192, 229.

decision not to use those other drugs. In New Zealand, relatively little use is made of the second type of pharmacological treatment, so the rest of the discussion concerns drug substitution.¹²¹⁰

- 15.27 Many studies have shown that opioid substitution is effective and it is a well established form of drug treatment. Currently almost all opioid substitution treatment in New Zealand is undertaken with methadone. A more recently developed drug buprenorphine is registered for use as a medicine in New Zealand, but it is not funded by PHARMAC, and is not readily available for use. Internationally buprenorphine is increasingly being used in opioid substitution. It has been used widely in France in treatment since the 1990s and is now established in many countries. Studies have compared it to methadone and found it to have some advantages. It is less likely to lead to overdose, needs to be administered less frequently and provokes milder withdrawal symptoms when use is ceased. However, it costs significantly more than methadone. In some countries, like the United Kingdom, diamorphine (heroin) is also used, although only as a drug of last resort and largely as a harm reduction measure. We consider the issue of prescription heroin later in the chapter as a specific problem limitation measure. Methadone is still by far the most widely used substitution medication.
- 15.28 We should note here that, although there may be cost and approval barriers that limit the use that is currently made of naltrexone, buprenorphine and other newer pharmacological treatments, there are not legal barriers. Such drugs can be supplied under provisions in the Misuse of Drugs Act 1975 in the same way as methadone. The Ministry of Health guidelines on opioid substitution treatment now also cover buprenorphine.¹²¹¹
- 15.29 Methadone substitution treatment is delivered either by specialist addiction services or by authorised general practitioners supported by specialist addiction services. Methadone is generally administered or dispensed at community pharmacies. Approximately 4500 people currently receive methadone treatment in New Zealand and, as noted above, \$13 million was spent on methadone substitution programmes in 2005/06.¹²¹²
- 15.30 Participants in opioid substitution programmes report significant quality of life improvements, and studies show that it is helpful in reducing the use of street opiates, the risks associated with intravenous drug use, and drug-related property crimes. A portion of people in opioid substitution programmes are seeking a temporary break from the adverse physical, psychological, or social harms arising from intravenous drug use.
- 15.31 Many studies of pharmacological treatments for drug dependence stress that substitution treatment should also involve psycho-social assistance. Guidelines governing opioid substitution in New Zealand stress the importance of methadone

1210 For a discussion on other pharmacological treatments see *ibid*, 242.

1211 Ministry of Health *Practice Guidelines for Opioid Substitution Treatment in New Zealand* (Ministry of Health, Wellington, 2008).

1212 Figures provided by the Ministry of Health.

substitution being approached as only a component of treatment and the need for specialist alcohol and drug treatment services to accompany the substitution with a range of psycho-social therapies.¹²¹³

Psycho-social therapies

15.32 Psycho-social therapies are an important part of drug treatment. Included within this broad category are all forms of individual or group counselling, motivational interviewing, cognitive-behavioural therapies, community reinforcement approaches, coping and social skills training, and relapse prevention therapies. Psycho-social therapies form a core component of most drug treatment approaches and residential and non-residential treatment programmes.

15.33 The National Committee for Addiction Treatment says that a wide range of psycho-social therapies have been shown to be effective.¹²¹⁴ Similarly the UNODC in its report *Contemporary Drug Abuse Treatment: A Review of the Evidence Base*¹²¹⁵ identifies four categories of psycho-social therapies that have been associated with a lower risk of relapse:¹²¹⁶

- **General outpatient drug-free counselling** – in individual or group sessions with a counsellor or facilitator. According to the UNODC, studies evaluating the effectiveness of this in the United States suggest that it is associated with reductions in drug use and crime together with improvements in health and well being.
- **Specific cognitive psychotherapies** – most notably “motivational interviewing”, in which the counsellor focuses on the client’s experiences and directs him or her towards resolving ambivalence and making a commitment towards change.
- **Cognitive-behavioural approaches** – these are based on the assumption that dependent drug users can learn new skills and strategies for avoiding drug use and relapse.
- **Community reinforcement** – this approach focuses on changing external social factors like unemployment, homelessness and social networks that play an important part in reinforcing drug dependence. Alternative reinforcements, such as employment, social contact with non-drug users and improved family relationships, are developed and encouraged.

15.34 There seems to be evidence of the effectiveness of all these different forms of psycho-social therapies in reducing problematic drug use, although for some the evidence suggests that the approach is more often effective when used in combination with a range of other measures.¹²¹⁷ Participation in peer-support networks and self-help groups of individuals who meet for the purpose

1213 Ministry of Health, above n 1211.

1214 NCAT, above n 1182, 22. A similar view is also expressed by the NHS National Treatment Agency for Substance Misuse in the United Kingdom; see the review of studies and evidence on the effectiveness of counselling in the NHS National Treatment Agency for Substance Misuse *Models of Care for the Treatment of Drug Misusers* (Department of Health, London, 2002) 64.

1215 United Nations Office on Drug and Crime, above n 1179.

1216 Ibid, 11–13.

1217 Stevens, Hallam and Trace, above n 1180, 6; see also the review of studies and evidence on the effectiveness of counselling in the NHS National Treatment Agency for Substance Misuse, above n 1214, 64.

of supporting each other's efforts to maintain sobriety, such as Alcoholics Anonymous or Narcotics Anonymous, is also generally recognised as a valuable support to other treatment, although little formal evaluation has been done.¹²¹⁸

Post-treatment care

- 15.35 The treatment sector has identified the provision of continuing or post-treatment support as an important component of recovery.¹²¹⁹ Drug users face a high risk of relapse in the period after treatment ends. Post-treatment care, which may include relapse prevention therapy, recovery support groups, or ongoing individual support, can assist those trying to maintain a drug-free lifestyle. Twelve step fellowships like Alcoholics Anonymous or Narcotics Anonymous and other peer-support networks may also form part of this post-treatment care approach.
- 15.36 Access to a broad range of community services and support is also an important part of post-treatment care, particularly where people have other needs arising from mental health issues or social dislocation.¹²²⁰ Access to broader advisory services, accommodation, education or training, and employment support might also be included as part of a strategy of post-treatment care and relapse prevention. There is a need to ensure that there are links between drug treatment and other health and social services to provide ongoing community support for changes made through treatment.

Treatment goals – abstinence or harm reduction

- 15.37 There are two distinct philosophies underpinning the work of the alcohol and other drug treatment sector, representing different sides of one of the most longstanding debates in the treatment field. One promotes abstinence as the only valid goal of treatment; the other identifies a reduction in specific harms arising from drug use and related behaviour as the goal, with abstinence, if it can be achieved, as only one among a number of ways of doing this. In drug treatment there are genuine tensions between abstinence and harm reduction approaches. Some people might argue that providing services that reduce the harm and hardship associated with drug use simply supports drug use and delays a user's decision to become abstinent, while others argue that requiring abstinence for participation in treatment sets too high a threshold because it means that those who continue to use drugs are excluded. This latter group suggests that there are benefits in encouraging those who continue to use drugs to contact alcohol and drug services. For example, problems like the risks of overdose and intravenous infection may be reduced, trust can be developed, and a basis for behavioural change established.¹²²¹
- 15.38 At a policy level the approach in New Zealand is to recognise that where eliminating drug use is not possible, the personal and social cost associated with such behaviour should still be minimised.¹²²² In the treatment context this has translated into

1218 United Nations Office on Drug and Crime, above n 1179, 13.

1219 Stevens, Hallam and Trace, above n 1180, 8.

1220 NCAT, above n 1182, 16.

1221 Stevens, Hallam and Trace, above n 1180, 4.

1222 Ministerial Committee on Drug Policy *National Drug Policy 2007–2012* (Ministry of Health, Wellington, 2007) 5.

support for a wide range of approaches, including abstinence-oriented strategies, but also publicly funded treatment interventions for people who continue to use drugs. Most treatment services seem to provide a blend of both approaches.¹²²³ The National Committee for Addiction Treatment suggests that abstinence-based approaches are normally targeted at people with moderate to severe dependence, while treatment informed by harm reduction tends to be most appropriate for people with a mild level of dependence or for people who are severely dependent but unable to achieve a drug-free lifestyle.¹²²⁴

The choice of treatment

- 15.39 Different levels of treatment and different types of approach are appropriate for different people depending on their degree of drug use or dependence and other surrounding circumstances. For severe dependence, specialist treatment via an intensive community-based or residential programme may be necessary over several months, followed by ongoing community support and after-care. A less severe problem with drug use may be resolved by access to advisory or information services or some counselling. Drug users often need to engage with different treatment services in an episodic manner over a number of years.¹²²⁵ Treatment consequently should be seen as a process, which provides a mix of different interventions and services, rather than one single event.¹²²⁶
- 15.40 The length of time in treatment has been found to be one of the most consistent predictors of favourable post-treatment outcomes among drug users.¹²²⁷ For this reason the National Committee for Addiction Treatment advocates that intensive intervention provided by residential programmes should be of at least three months duration.¹²²⁸ As with all treatment it needs to be of sufficient quality and duration to facilitate change. The relatively high cost of longer intensive programmes acts as something of a barrier to this.
- 15.41 Some programmes, both residential and community-based, cater for specific needs – for example, those of youth, Māori or Pacific people. The National Committee for Addiction Treatment says that kaupapa Māori addiction treatment options have been steadily developing based on evidence that treatment programmes and interventions that are firmly based on Māori beliefs, values and experiences can increase access to and retention in treatment.¹²²⁹ In a recent stock-take of services undertaken for the Ministry of Health, out of a representative sample of 100 service providers, 20 provided kaupapa Māori community treatment, two provided kaupapa Māori residential services for adults and two took a kaupapa Māori approach in residential services for youth.¹²³⁰

1223 NCAT, above n 1182, 13.

1224 Ibid, 7.

1225 Ibid, 2.

1226 Ibid.

1227 Micheal Gossop “Developments in the Treatment of Drug Problems” in Philip Bean and Teresa Nemitz *Drug Treatment: What Works?* (Routledge, United Kingdom, 2004) 65, 70.

1228 NCAT, above n 1182, 12.

1229 Ibid, 23.

1230 Allen & Clarke *Stocktake of Services and Resources to Minimise the Harm from Drugs* (Allen & Clarke, Wellington, 2009).

Cost-effectiveness of drug treatment

- 15.42 It is not always possible or particularly helpful to try and determine the effectiveness of different components of treatment in isolation. Many working in the alcohol and drug treatment field would argue that treatment needs to be seen as a process that provides an ongoing mix of different interventions and services, rather than a single point of engagement with one form of treatment or one programme. Typically a person suffering from dependence has to engage with a range of different treatment services over a number of years. For this reason easy access to well linked services is likely to offer the best potential for positive treatment outcomes.
- 15.43 Notwithstanding this, there is clear evidence that specialist alcohol and drug treatment can be cost-effective.¹²³¹ The National Committee for Addiction Treatment states that most reviews consistently find that addiction treatment yields net economic benefits to society.¹²³² It cites studies that estimate that for every \$1 spent on addiction treatment there is a \$4 to \$7 reduction in the cost associated with drug-related crimes and that for some non-residential programmes total savings can exceed costs by a ratio of 12:1.¹²³³ There is also evidence that drug and alcohol treatment for people convicted of a crime can be as effective when people are coerced as when they choose to go into treatment voluntarily.¹²³⁴ Similarly, reports prepared by both the Beckley Foundation and the UNODC reviewing the research evidence on drug treatment have concluded that there is evidence that drug treatment can be cost-effective.¹²³⁵

Access to treatment and gaps in current services

- 15.44 Currently treatment services do not appear to be adequate to deal with existing demands for treatment. The capacity problems seem to be more pronounced in some regions and for some types of services than others. In a recent stock-take of treatment services completed for the Ministry of Health¹²³⁶ gaps in services were identified in many areas. These included:
- services in rural areas;
 - specialist services catering for youth, particularly residential facilities;
 - adult residential services in some regions;
 - treatment services specifically catering for woman, particularly those with young children;
 - specialist services for specific population groups, including Māori, Pacific people, and Asian people in some regions;
 - detoxification beds and services and better support for community-based detoxification; and
 - services for prisoners, including those being released from prison following completion of treatment.

1231 Babor, above n 1194; Ritter and Lintzeris, above n 1192, 225.

1232 NCAT, above n 1182, 2.

1233 These figures, cited by the NCAT, seem to be based on information the National Institute on Drug Abuse on evaluations in the United States rather than in New Zealand. See NCAT, above n 1182, 2.

1234 NCAT, above n 1182.

1235 See Stevens, Hallam and Trace, above n 1180; UNODC, above n 1179.

1236 Allen & Clarke, above n 1230.

- 15.45 The overall impression we have gained from the stock-take is that there is generally insufficient capacity across the full spectrum of treatment services, with more acute capacity problems in some geographical areas and for some service types, such as residential. Some population groups, particularly youth, are also not adequately provided for in some parts of the country. This is consistent with other feedback we have received in both this project and our project reviewing the Sale of Liquor Act.¹²³⁷
- 15.46 The National Committee for Addiction Treatment estimated in 2008 that the capacity of addiction treatment services needed to double over three years in order to have the capacity to treat 1 % of the population and broadly meet treatment targets that have been set by government.¹²³⁸
- 15.47 A major barrier to increasing treatment provision, however, is a shortage of skilled practitioners, both specialist addiction treatment practitioners and non-specialist professionals with the capability to provide lower level treatment services.¹²³⁹ There is a limited alcohol and drug treatment workforce of approximately 1300. Workforce development for the addiction treatment sector has been identified as an area of need, and is being addressed through existing strategies.¹²⁴⁰ There will be a time lag between training new people for this workforce and their availability to contribute to it.
- 15.48 It is important also to consider the alcohol and drug treatment workforce outside the health sector – for example, in Corrections, Police, and social and youth services. Additional workforce development will require further government investment. Non-specialist workforce limitations could be mitigated in part by increasing the use of electronic or web-based brief interventions, which are known to be well-received and effective in some settings.¹²⁴¹ This is a new area of research that would benefit from further investigation because it has the potential to be highly cost-effective.
- 15.49 The types of treatment services that should be publicly funded and the optimal mix and configuration of those services are matters that fall outside the scope of this project and the Commission’s expertise. However, we draw attention to the existing capacity issues because, although these are not legal matters, the alcohol and drug treatment sector would need an increased capacity before a number of the reform proposals discussed in chapter 11 of this paper could be effectively implemented.

1237 See New Zealand Law Commission, above n 1193.

1238 NCAT, above n 1182, 2.

1239 Ibid.

1240 Minister of Health *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Ministry of Health, Wellington, 2006).

1241 K Kypri and others “Randomized Controlled Trial of Web-based Alcohol Screening and Brief Intervention in Primary Care” (2008) 168 *Archives of Internal Medicine* 530.

THE CRIMINAL
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- 15.50 A significant portion of defendants that appear before the criminal courts have alcohol or other drug dependence or abuse issues. The drug involved is usually alcohol.¹²⁴² Many jurisdictions, including in New Zealand, have put processes in place to ensure that offenders in the criminal justice system with issues such as these are identified and referred to appropriate treatment if required.
- 15.51 Where substance abuse or dependence is identified as a contributing factor in offending, the judge may obtain an alcohol and drug assessment during the remand and sentencing process.¹²⁴³ The judge may then take into account an offender's treatment needs when deciding on the appropriate sentence.¹²⁴⁴
- 15.52 Offenders sentenced to non-custodial sentences may be required to attend community-based alcohol and drug treatment programmes funded by District Health Boards, residential programmes, or intensive day programmes provided by community organisations.¹²⁴⁵
- 15.53 Drug treatment is also available for offenders sentenced to imprisonment. Drug treatment units have been established in six New Zealand prisons, with units in a further three prisons planned.¹²⁴⁶ These units have had some demonstrated success in reducing reoffending amongst participants.¹²⁴⁷
- 15.54 Where a defendant is an identified substance abuser and appropriate treatment is available, a judge may decide to defer sentencing and remand the defendant on bail to provide him or her with an opportunity to undergo treatment on a voluntary basis. The defendant's progress with treatment may then be taken into account in the sentencing process.
- 15.55 Publicly funded programmes are expected to accept offenders referred through the court system. However, due to capacity issues, the treatment sector may not be able to respond immediately to referrals from the courts. Delays in accessing treatment can prevent its delivery as a condition of a sentence.
- 15.56 Some District Court judges have expressed concern to us about the absence of adequate assessment and treatment facilities and programmes in some regions to which they can refer people during the remand and sentencing process.

1242 Judges in the District Courts reported to the Law Commission that they estimate that at least 80% of defendants appearing in the District Courts have alcohol or other drug dependence or abuse issues. They believed that in at least 80% of these cases alcohol was the drug involved. See the letter prepared on behalf of the Chief District Court Judge by Judge John Walker included as appendix 1 in New Zealand Law Commission, above n 1193.

1243 As we have already noted in chapter 2 the link between drug use and crime is contested. See Alex Stevens, Mike Trace, and Dave Bewley-Taylor *Reducing Drug-Related Crime: An Overview of the Global Evidence* (R5, Beckley Foundation Drug Policy Programme, Beckley (UK), 2005).

1244 For example, participation in treatment may be a condition of a sentence of supervision, intensive supervision, or home detention, or may be a special condition that applies on release of an offender from a short-term sentence of imprisonment.

1245 Department of Corrections *Drug and Alcohol Treatment Strategy 2009–2014* (Department of Corrections, Wellington, 2009) 8.

1246 Drug treatment units have been established in Waikeria, Christchurch Men's, Hawkes Bay, Rimutaka, Springhill and Arohata Women's prisons. A further three units are now planned for Otago, Wanganui and Northland prisons.

1247 A 2006 evaluation of the 24-week programmes in a prison showed a reduction in the re-conviction rate of about 10–14%. Department of Corrections, above n 1245, 8.

Because the courts cannot direct that treatment be provided, the use of treatment as a disposition option at all stages of the court process is dependent on what programmes and facilities are available in the community at any given time.

- 15.57 Attempts have been made to put in place processes that more effectively identify and address the drug and alcohol treatment needs of offenders through the court process. This includes an Addictions Assessment Services Pilot that was implemented at the Tauranga District Court in 2006. The pilot provided screening and assessment of addiction problems (which included alcohol, drug or gambling addictions and co-existing mental health problems) and referral to a brief intervention and further treatment if required. We understand that this pilot has since been extended to the Whangarei, Kaikohe, Wellington and Porirua District Courts.
- 15.58 Since 2002, a Youth Drug Court has been operating at the Christchurch Youth Court. The Youth Court targets young offenders with moderate to severe alcohol and/or other drug dependence that is linked to their offending.¹²⁴⁸ Young offenders are expected to follow an alcohol and drug treatment plan and are monitored by the same judge throughout the process. Services to young offenders are coordinated via a multidisciplinary team that includes the judge, a social worker, the youth justice coordinator, a police prosecutor, the youth advocate, and health and education workers.¹²⁴⁹
- 15.59 Drug courts and other court-based drug diversion programmes have proliferated in other jurisdictions. For example, over 2000 drug courts are now in place in the United States following their inception in the late 1980s.¹²⁵⁰ Drug courts are also in place in Australia, Canada and the United Kingdom.
- 15.60 The Australian drug courts can operate before sentencing,¹²⁵¹ or post-adjudication and post-sentencing.¹²⁵² The courts all target serious high-end offenders¹²⁵³ with significant drug dependence issues that are linked to their offending. They are presided over by a judicial officer, who provides intensive judicial supervision, and involve an interdisciplinary team of specialists who take a collaborative approach. There is a system of graduated rewards and sanctions, with participants required to undergo frequent random tests for drug use.¹²⁵⁴

1248 Wendy Searle and Philip Spier *Christchurch Youth Drug Court Pilot: One Year Follow-up Study* (Ministry of Justice, Wellington, 2006) 21.

1249 *Ibid.*, 20–21.

1250 *Summary of Drug Court Activity by State and County: Bureau of Justice Assistance Drug Court Clearinghouse Project* (2009) www1.spa.american.edu/justice/documents/2150.pdf (accessed 28 September 2009).

1251 For example, Youth Drug and Alcohol Court (NSW); South Australian Drug Court (which operates pre-sentence but post-plea); Western Australia's Drug Court Regime.

1252 For example, Drug Court Act 1998 (NSW), s 5A; Sentencing Act 1991 (Vic), s 18Z; Drug Court Act 2000 (Qld), s 19.

1253 The programmes only apply to individuals facing a term of imprisonment or who have had a custodial sentence imposed.

1254 Joy Wundersitz *Criminal Justice Responses to Drug and Drug-Related Offending: Are they Working?* (Technical and Background Paper 25, Australian Institute of Criminology, Canberra, 2007) 20–21.

- 15.61 All of the Australian states and territories also have less intensive court-based drug diversion programmes in place. Most programmes are in the lower level courts, and are limited to less serious offences committed by adults (although some jurisdictions have similar programmes for youth).¹²⁵⁵
- 15.62 Evaluations of drug courts and similar programmes tend to indicate that they can reduce drug use by participants and have a positive impact on participants' general health and wellbeing.¹²⁵⁶ Evidence about their impact on rates of reoffending is more mixed.¹²⁵⁷ Depending on the programme design, they can also be heavily resource-intensive.¹²⁵⁸
- 15.63 We think that greater use should be made of the opportunity to provide assessment and treatment within the court system where alcohol or other drug abuse and dependence are identified. In this sense, drug courts and similar programmes, which ensure that appropriate focus is given to the particular needs of drug users in the criminal justice system, are desirable. However, further refinements to programmes like these seem required before they can become an established part of the criminal justice system.
- 15.64 The programmes often have multiple, confusing, and poorly articulated aims. Potential aims of these programmes may include, for example, to divert the offender from the conventional criminal justice process or into alternative programmes or penalties, to provide a greater and more active monitoring role for the judge, to ensure that all relevant agencies are involved in the court process, or to prioritise treatment resources and provide the courts with access to these resources.
- 15.65 In addition, there is a potential for some delay in the court process if offenders who would otherwise be dealt with on their first appearance must instead be remanded to the specialist court or programme. Depending on how the programme itself is implemented, the time required to dispose of a case may also be longer.
- 15.66 Perhaps most fundamentally, the effectiveness of these programmes relies on adequate treatment services being available. As we have noted above, there is concern that current treatment services available to the court system are insufficient to meet demand. There is also a risk that the delivery of assessment and treatment services will become focused on the programme's clients at the expense of services in geographical areas where a programme is not operating, or at the expense of the delivery of services to users who have not offended and are seeking to access services on a voluntary basis.

Q145 Should greater use be made of treatment as a disposition option within the courts for people with alcohol and other drug dependence and abuse problems? If so, how?

¹²⁵⁵ Ibid, 11.

¹²⁵⁶ Ibid, 105 and 107; Searle and Spier, above n 1248, 78.

¹²⁵⁷ Ibid, 107–108 and above n 1248, 12–14.

¹²⁵⁸ See Wundersitz, above n 1254, 11–12.

- 15.67 Problem limitation measures aim at reducing the specific harms that result from existing drug use. In addition to treatment there are a range of other strategies and approaches that have developed internationally. Some are controversial because they implicitly tolerate ongoing drug use. Presently such measures in New Zealand focus on intravenous drug use.
- 15.68 The New Zealand Drug Foundation estimates that in 2008 approximately 31,000 people injected drugs.¹²⁵⁹ Opiates are the most commonly injected substances. To a lesser extent amphetamine-type stimulants like methamphetamine and benzodiazepines are also injected.

Needle exchange programme

- 15.69 Needle and syringe exchange programmes were introduced in 1988 after an amendment was made to the Misuse of Drugs Act authorising the possession of needles and syringes obtained through the needle exchange programme. This was a response to concern over the risk of the HIV virus spreading among intravenous drug users. Under the exchange programme people can buy clean needles and syringes from specified exchange outlets and can also, for free, exchange used injecting equipment for new on a one-for-one basis. Similar approaches are adopted in overseas jurisdictions. Many years before the term “harm reduction” was coined, the risks of HIV/AIDS among injecting drug users prompted the widespread introduction of needle and syringe exchange programmes within a number of countries across Europe, Oceania,¹²⁶⁰ parts of North America and, more latterly, within developing countries.¹²⁶¹
- 15.70 As well as addressing the immediate concern about HIV, a reduction in the reuse or sharing of injecting equipment also reduces the risk of other blood-borne illnesses (for example, hepatitis). Clean needles can also reduce the risk of infections and related complications for intravenous drug users. A review of studies relating to needle and syringe programmes by the World Health Organisation in 2004 concluded that there was compelling evidence that increasing the availability and use of sterile injecting equipment by intravenous drug users reduced HIV infection substantially. It also found that there was no convincing evidence of any major unintended negative consequences.¹²⁶²
- 15.71 A review of the needle and syringe exchange programme in New Zealand was completed in 2002. It found that most of the scientific evidence available clearly demonstrated that needle and syringe programmes worldwide were effective in reducing the prevalence and/or incidence of HIV infection in injecting drug users. It also found that New Zealand had one of the lowest rates of HIV infection

1259 Catherine Cook “The Global State of Harm Reduction” (2008) 18 *Matters of Substance*.

1260 The term is used in United Nations publications to cover Australia, New Zealand, Pacific and Melanesian states.

1261 Neil Hunt, Mike Trace and Dave Bewley-Taylor *Reducing Drug-Related Harms to Health: An Overview of the Global Evidence* (R4, The Beckley Foundation Drug Policy Programme, Beckley (UK), 2004) 1.

1262 Cited by *ibid*, 5.

in intravenous drug users (0.9 %) among more developed nations.¹²⁶³ Provisional figures from Needle Exchange New Zealand indicate that this figure was reduced to 0.3 % in 2009.¹²⁶⁴

- 15.72 However, the rates of infection with the Hepatitis C virus are much higher. Surveys during the 1990s found that the virus is thoroughly entrenched in New Zealand's injecting drug user population, just as in Australia and other Western countries. In a number of studies during the 1990s infection rates among different populations of injecting drug users ranged from 53 % to 84 %.¹²⁶⁵ A study undertaken for Needle Exchange New Zealand estimated that in 2004 nearly three out of four injecting drug users had been exposed to the Hepatitis C virus, although a similar study in 2009 indicated a significant drop to around half.¹²⁶⁶ Needle Exchange New Zealand attributes this reduction to the impact of the exchange programmes.¹²⁶⁷
- 15.73 Needle exchange is now well established across the country, although there are some access difficulties for people living in more remote areas.¹²⁶⁸ To some degree this is unavoidable given New Zealand's geography and population size. The needle exchange programme also provides information on safer injecting practices and information on drugs and the risks of different methods of use. Needle exchanges may also function as a point of early access to referral to drug treatment. This is suggested by research in the United Kingdom which found that as many as 40 % of a sample of visitors to one programme acted on a referral to external help.¹²⁶⁹

Provision of heroin in substitution treatment

- 15.74 We discussed opioid substitution treatment in paragraphs 15.26 to 15.31 earlier in the chapter. In a few European jurisdictions harm reduction initiatives also include limited state provision of heroin to addicts where other opioid substitution treatment is not effective.¹²⁷⁰ Some commentators say that state provision of heroin to chronic addicts offers some health and social gains for long term users where other approaches have been exhausted,¹²⁷¹ although the evidence base is still relatively limited.

1263 Campbell Atkins *New Zealand's Needle and Syringe Exchange Programme Review* (Centre for Harm Reduction, Wellington, 2002) 5.

1264 Figures provided by the Ministry of Health.

1265 A range of surveys from this period are cited in Atkins, above n 1263, 30.

1266 Figures are from Needle Exchange New Zealand "NZ Needle Exchange One of World's Most Successful" (19 November 2009) Press Release.

1267 Ibid.

1268 Another issue relating to access that has been identified by Needle Exchange New Zealand and also by the New Zealand Drug Foundation is the absence of needle exchange programmes within New Zealand prisons. In recent years clean needle and syringe programmes have been developed within prisons in a few European jurisdictions.

1269 Hunt, Trace and Bewley-Taylor, above n 1261, 5.

1270 Heroin has been prescribed to treat addicts in the United Kingdom since the 1920s and limited schemes have been adopted in the Netherlands and Switzerland also.

1271 Hunt, Trace and Bewley-Taylor, above n 1261, 5.

15.75 Given New Zealand's low rates of heroin use there would seem to be a limited benefit in providing it here at present. However, we suggest that the exemptions (which were discussed in chapter 13) authorising the pharmacological treatment of drug dependence needs to remain flexible enough to accommodate the development of new drug-based treatments in the future.

Drug consumption rooms

15.76 A number of overseas jurisdictions have also established what are termed drug consumption rooms or supervised injecting facilities for intravenous drug users.¹²⁷² Drug consumption rooms or supervised injecting facilities are considered to provide a protected place for the hygienic consumption of pre-obtained drugs in a non-judgemental environment and under the supervision of trained staff.¹²⁷³ They reduce harm by providing a relatively safe and clean environment for intravenous drug users. Normally there is access to sterile equipment and a degree of medical supervision. In some countries these types of facilities are combined with the state provision of heroin.¹²⁷⁴ The primary form of harm addressed by supervised injecting facilities, which is not addressed by needle exchange, is the risk of overdose associated with intravenous drug use, particularly hurried covert use. The clean conditions also minimise blood-borne disease. As well as the benefits for users, society obviously benefits from avoiding the social costs associated with those types of problems.

15.77 Internationally these types of facilities have been established in large cities and other locations where large numbers of intravenous drug users are concentrated, and where drug use in the streets causes a degree of public nuisance.¹²⁷⁵ The establishment by states of drug consumption rooms, although it has occurred in a few jurisdictions, is still a controversial harm reduction measure. The International Narcotics Control Board does not believe that drug consumption rooms conform with international drug control obligations under the Single Convention on Narcotic Drugs 1961 and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988. The Board's view is that states violate their international obligations if they authorise the possession and consumption, within these facilities, of drugs that have not been medically prescribed.¹²⁷⁶

15.78 Again, in New Zealand's case, the relatively low rates of intravenous drug use suggest that the provision of these types of facilities may not be warranted anyway. New Zealand also does not at present have the public nuisance issues around drug use in the streets that occur in some international cities.

1272 These are mainly in European countries, although there is a pilot of a medically supervised safer injecting facility in Vancouver in Canada.

1273 Hunt, Trace and Bewley-Taylor, above n 1261, 11.

1274 For example, in Zurich, Switzerland.

1275 For example, in Sydney, Vancouver and Zurich.

1276 International Narcotics Control Board *Report of the International Narcotics Control Board on Follow-up to the Twentieth Special Session of the General Assembly* (United Nations, New York, 2009) 21.

Interventions to reduce overdose and poisoning

15.79 A range of measures have also been developed and adopted to varying degrees in a number of countries as a response to concern over accidental overdose and drug-related poisoning. Illegal drugs are not subject to the types of manufacturing and distribution controls that apply to legally available drugs supplied through a regulated market. Harm can arise from contamination, adulteration, misrepresentation and uncertainty over strength and purity. As well as fatalities through overdose and poisoning, there have been cases of botulism and other infections from contaminated drugs.¹²⁷⁷ In response two types of harm reduction responses have developed: early warning systems; and pill testing.

Early warning systems

15.80 In the United Kingdom and a number of other jurisdictions information campaigns have been undertaken to encourage drug users to call emergency services in the event of an unanticipated drug reaction. Information concerning overdose and its prevention and management has been provided to drug users, recognising that other users are most likely to be present at the time a user overdoses or has a severe reaction. In addition, opioid antagonist medications have been supplied to drug users and those associated with them for use in such an emergency.¹²⁷⁸

15.81 Systems for posting early warnings, such as the European Early Warning System on New Synthetic Drugs, have also developed as another way of getting out messages in response to contamination and adulteration problems. For example, alerts are issued through the Internet when contaminated ecstasy or other synthetic pills surface, so that potential users are made aware of the problem and can, if they wish, avoid the identified batches of drugs.¹²⁷⁹

Pill testing

15.82 Pill testing is one of the newest and probably most controversial harm reduction approaches implemented in some European countries. It aims at reducing fatalities due to the impurity and/or adulteration of substances by providing drug users with access to quality control analysis for drugs. Pill testing normally takes place either on site at dance and rave parties or in clubs where pill use is anticipated, using relatively inexpensive self-test kits, or alternatively it occurs in advance at a government designated facility. Although they provide relatively instant results, there are currently questions over the accuracy and comprehensiveness of tests undertaken with simple pill testing kits. Apparently these are not always effective at identifying different substances and the results are not always clear or easy to understand.¹²⁸⁰ Testing facilities, in contrast, use more accurate laboratory test techniques but are slower and much more costly. Since these do not give on the spot information they tend to be used, as they are in the

1277 Hunt, Trace and Bewley-Taylor, above n 1261, 11.

1278 Ibid.

1279 Ibid.

1280 Adam R Winstock, Kim Wolff and John Ramsey, "Ecstasy Pill Testing: Harm Minimization Gone too Far?" (2001) 96 *Addiction* 1139, 1143.

Netherlands, to feed information into an early warning system. Where pills of a high strength or contaminated or adulterated pills are identified through testing, warnings are posted.¹²⁸¹

- 15.83 State-sanctioned pill testing, although it occurs in a few jurisdictions, is still a particularly controversial approach to harm reduction. The International Narcotics Control Board has, for example, suggested that “the defeatism at the base of this approach and the misleading message it sends to society at large, run contrary to the spirit of the Convention”.¹²⁸² The Board does recognise, however, that this type of initiative can minimise suffering and hospitalisation¹²⁸³ and there is at least an argument that pill testing is done for medical purposes and therefore falls within the scope of the drug conventions.
- 15.84 The Beckley Foundation cites some evidence that these types of measures can be effective at preventing overdose and improving emergency responses, but suggests that the evidence is still relatively limited.¹²⁸⁴ There has been one study undertaken that involved surveying ecstasy users. The responses suggest that pill testing made relatively little difference to the surveyed groups’ use of the drug. In fact some pill users reported that they used more pills where they were identified as being of a high quality.¹²⁸⁵
- 15.85 We suggest a cautious approach should be taken to pill testing in New Zealand. One option would be to allow it to develop, if there is sufficient demand, in relation to the legally available regulated psychoactive substances discussed in chapter 8 and evaluate its role in reducing harm in that context. If it proved effective, consideration could be given to extending the range of substances that might be tested. Of course, pill testing may not be required at all in that context, because the conditions attached to the manufacture and supply of legal psychoactive substances might be sufficient to maintain appropriate quality and potency.

Problem limitation measures in legislation

- 15.86 Many of the measures discussed above can only be implemented by legislation.
- 15.87 We think that it is important that legislation anticipates the development and adoption of new types of harm reduction measures. Although some of the measures discussed are not currently appropriate or necessary, they may become so in the future if there are significant changes in patterns of drug use. The technology for pill testing, for example, is currently developing, and some legislative flexibility that would allow an expansion of a pill testing regime beyond regulated substances would seem to be desirable.
- 15.88 It is also likely that over time other strategies and approaches will develop and prove effective at reducing the risk of harm resulting from drug use.

1281 Ibid.

1282 International Narcotics Control Board “Flexibility of Treaty Provisions as Regards Harm Reduction Approaches” (30 September 2002) E/INCB/2002/W.13/SS.5.

1283 Ibid.

1284 Hunt, Trace and Bewley-Taylor, above n 1261, 11.

1285 Winstock, Wolff and Ramsey, above n 1280, 1145.

- 15.89 For these reasons we suggest that a new legislative framework should allow for additional measures aimed at reducing the harm associated with drug use to be adopted by regulation, where specified statutory criteria are met.

Q146 Do you think that the new legislative framework should allow for additional problem limitation measures to be adopted by regulation?

DEMAND REDUCTION

- 15.90 The demand reduction pillar encompasses drug education, health promotion, social marketing and community action. Each of these components has a different focus and approach. Drug education is the delivery of information to improve knowledge and awareness. Health promotion is the process of enabling people to increase control over and improve their health. Social marketing uses commercial marketing technologies to persuade target audiences to make behaviour changes. Community action is a process under which local resources and knowledge are utilised to address social issues.
- 15.91 In practice many demand reduction initiatives can incorporate a number of these different components, so it is not always useful to put a demand reduction measure in one category or another. Health promotion in particular tends to be integral to all programmes. We do not therefore consider this separately.

Drug education

- 15.92 The target group for drug education has traditionally been youth at school, although there are also a range of other audiences. To be effective and not counterproductive, drug education must be well designed, have clear and realistic objectives,¹²⁸⁶ and be based on evidence of what works and does not work. One-off sessions that only use ex-addicts, scare tactics or “just say no” approaches have, for example, been shown not to work.¹²⁸⁷
- 15.93 Drug education in schools forms part of health education and must comply with the Health and Physical Education in the New Zealand Curriculum. To support the curriculum the Ministry of Education and other agencies provide drug education guidance for teachers, principals, and boards of trustees.¹²⁸⁸ These outline essential elements of drug education and give advice on developing drug education programmes and policies. However, to deliver the curriculum effectively teachers need adequate professional development and sufficient allocation of time to teach it. The New Zealand Drug Foundation found in 2003 that anecdotal evidence suggested only a limited number of schools had teachers trained to properly deliver the Health and Physical Education curriculum, so that the quality of health education was uneven. Implementation of the curriculum and drug education guidelines was hindered by health education and

1286 United Nations Office on Drugs and Crime “Reducing the Adverse Health and Social Consequences of Drug Abuse: A Comprehensive Approach” (22 January 2008) 2.

1287 Ministry of Youth Development *Strengthening Drug Education in School Communities – A Practical Guide for Years 7–13* (Ministry of Youth Development, Wellington, 2004) 7.

1288 For example Ministry of Education *Drug Education: A Guide for Principals and Boards of Trustees* (Learning Media Ltd, Wellington, 2000); Ministry of Youth Development, above n 1287; *Drug Education Matrix of Learning Outcomes for Levels 1–8 within the New Zealand Health and Physical Education Curriculum* www.tki.org.nz (accessed 23 October 2009).

health policies not being given a high priority in some schools.¹²⁸⁹ An updated set of drug education guidelines is in the process of being released to schools at present.

- 15.94 Research undertaken for the Ministry of Youth Development in 2003 found that targeted drug education programmes delivered outside the school system could be effective and were needed for at-risk youth.¹²⁹⁰ There was positive evidence about the effectiveness of family-based drug education as a strategy for reducing drug-related harm, particularly among high-risk populations.¹²⁹¹ Similarly, community-based education could be effective, particularly when it was based on collaborative action by groups and agencies that already had responsibility for reducing drug-related harm.¹²⁹²

Community action programmes

- 15.95 Community action programmes aim to promote inter-sectoral collaboration between existing community resources utilising local knowledge to facilitate positive social change and build social resilience. Social change of this kind takes time, so community action projects have to be sustained over a reasonable period of time before they show results.¹²⁹³

Community Action on Youth and Drugs

- 15.96 The Community Action on Youth and Drugs (CAYAD) programme contains the best example of a community action programme aimed at youth at risk. It focuses on reducing drug-related harm to young people and their families. The current projects are based on earlier projects which began initially in a few locations as a collaborative approach between communities and researchers from Massey University Centre for Social Health Outcomes Research and Evaluation (SHORE) and its Māori partner Te Ropu Whariki (Whariki) with public funding through the health and education budgets.¹²⁹⁴ In 2000/01 the Ministry of Health took over the funding of CAYAD from the Ministry of Education. Over time additional locations or sites have been added to CAYAD.
- 15.97 CAYAD is considered a successful community action initiative because it utilises evidence-based research and formative evaluation alongside a combined community action and kaupapa Māori approach. The overall goal of CAYAD is to reduce alcohol and other drug-related harm experienced by young people. Projects do this by meeting a number of objectives:
- increased informed community discussion and debate about issues relating to illegal drugs;

1289 New Zealand Drug Foundation *New Zealand Drug Foundation Policy Paper on Drugs in Schools* (Wellington, 2003) 6.

1290 Allen & Clarke *Effective Drug Education for Young People: Literature Review and Analysis* (Ministry of Youth Development, Wellington, 2003).

1291 Ibid, 15.

1292 Ibid.

1293 Ibid.

1294 Centre for Social and Health Outcomes Research and Evaluation and Te Ropu Whariki *Community Action on Youth and Drugs Project (CAYAD) Final Impact Evaluation Report Summary* (Massey University, Auckland, 2006).

- effective policies and practices to reduce harm adopted;
 - increased local capacity to support young people in education, employment and recreation; and
 - reduced supply of drugs to young people.
- 15.98 Currently CAYAD projects are located in both rural and urban settings across New Zealand. There are now 25 providers operating in 30 sites.¹²⁹⁵ Funding for CAYAD projects was approximately \$4 million in 2007/08.¹²⁹⁶ An impact evaluation involving four CAYAD projects was undertaken by SHORE and Whariki between 2004 and 2006. The evaluation found evidence of progress in meeting their objectives in most sites over the evaluation period.¹²⁹⁷ It needs to be stressed that the project sites evaluated were still at an early stage and that the timeframe for the evaluation was relatively short for a community action approach.¹²⁹⁸ Against this backdrop the evidence of progress against the objectives can be considered quite promising.

Social marketing and health promotion

- 15.99 Drug education can also be delivered through mass media and other types of interventions like product labelling. The research commissioned by the Ministry of Youth Development concluded that these types of strategies may slowly change the social cultures around tobacco, alcohol and drugs that influence individual behaviour, and reinforce messages provided through school-based education and community action programmes.¹²⁹⁹
- 15.100 Currently there are a number of these types of social marketing and lifestyle campaigns, such as those undertaken by the Alcohol Advisory Council about the way New Zealanders drink and by the Ministry of Health and Health Sponsorship Council promoting smoke-free lifestyles. Social marketing campaigns undertaken at a mass media level have been utilised as a public health tool to convey other messages.¹³⁰⁰ To date they have not been used in New Zealand for campaigns around drugs other than alcohol and tobacco. This is probably because education campaigns with messages about the safer use of illegal drugs are seen as inconsistent with the aims of prohibition.
- 15.101 New Zealand and overseas evidence suggests that providing information about treatment is more effective than general drug education social marketing campaigns.¹³⁰¹ The Ministry of Health is currently funding a demand reduction campaign to improve public awareness, access to, and utilisation of demand reduction resources, services and community initiatives. This will centre on a new web-based resource that will provide reliable and accurate information about drugs

1295 Figures provided by the Ministry of Health.

1296 Figures provided by the Ministry of Health.

1297 Centre for Social and Health Outcomes Research and Evaluation and Te Ropu Whariki, above n 1294.

1298 Ibid.

1299 Allen & Clarke, above n 1290, 16.

1300 As well as the ALAC and smoke free campaigns they are used for promoting exercise SPARC “push play”; Education “20 minutes a day with your kids”; Family violence “it’s not Ok”, for example.

1301 See Ministry of Health *Literature Review on Models and Efficacy of Illegal Drug Social Marketing Campaigns* (Wellington, 2008).

and about where to access help with drug-related problems. The objective of the campaign is to enable people to be aware of the risks of taking drugs and to access reliable information about drugs and sources of advice and help when they are concerned about their own or another's drug use. Approximately \$1 million will be available over the next three years for improving informational resources to support the programme.¹³⁰² The alcohol and drug treatment sector will be involved in developing and managing the web resources.

SUPPORT FOR TREATMENT AND DEMAND REDUCTION

- 15.102 We suggest that a greater balance is needed between the pillars of drug policy and that any new legislative framework resulting from the Commission's review should recognise and support all three pillars. We have suggested that there particularly needs to be much more emphasis on treatment.
- 15.103 With the exception of the statutory exemption to allow pharmacological treatment for drug dependency (considered in chapter 13), the drug treatment strategies discussed in this chapter do not require legislation.¹³⁰³ Similarly, demand reduction strategies aimed at preventing or limiting the uptake of harmful drug use can also be implemented without legislation. However, there could be advantages in providing increased statutory recognition and support for drug treatment and demand reduction measures. We have noted already in chapter 4 that the Blake-Palmer Committee's recommendations in its 1973 report, that treatment options and support for those dependent on drugs be improved and high quality community education about the risks of drug abuse and drug dependence be developed,¹³⁰⁴ have not received the attention they deserved. A possible explanation for this is that, unlike supply control measures, their implementation did not require legislation. As a consequence, insufficient support, attention, and resources may have been devoted to drug treatment, other problem limitation measures and education strategies and programmes. Instead the criminal law, and its enforcement, has been the main focus of drug policy, at least for drugs other than alcohol and tobacco. It has certainly dominated the debate around policy in respect of illegal drugs, perhaps at the expense of other measures that may better reduce harm.
- 15.104 The apparent lack of emphasis on treatment may have been exacerbated by the devolution of decision-making to District Health Boards. Under the New Zealand Public Health and Disability Services Act 2000 each individual District Health Board is responsible for the provision of health services specified in its Crown funding agreement within its regions. District Health Boards (within the limits allowed by the funding arrangements) set their own priorities and approach within their treatment services. This has the advantage of allowing priorities to be set closer to the community, but carries an inherent risk that the result will not produce a coherent national strategy or service. The very recent establishment of the National Health Board, which will sit within the Ministry of Health and oversee how the 21 District Health Boards plan and fund health services,

1302 Figures provided by the Ministry of Health.

1303 It should be noted that specific legislative authority is needed for any form of compulsory treatment. Currently the Alcohol and Drug Addiction Act 1966 authorises the detention for treatment of alcoholics and drug addicts where certain conditions are met. We examine this Act and the options for compulsory treatment separately in the next chapter.

1304 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report* (New Zealand, Board of Health Report Series, No 18, Wellington, 1973) 89.

should help address this issue. The Board is to supervise all spending on health IT, workforce planning and capital investment and will also inject a stronger national perspective into service planning.

Statutory mechanisms

- 15.105 We have considered whether there ought to be some further statutory mechanisms to support and encourage government efforts in the treatment area. The first type of approach would be to impose a statutory responsibility on the Minister of Health for developing and reporting against a national strategy on alcohol and drug treatment. However, this would partly duplicate reporting against the National Drug Policy and the Mental Health Strategy. It would also inevitably occur at a high level of generality. It may therefore add little value to the current planning and reporting arrangements.
- 15.106 Another option would be to establish an advisory committee. It could have a number of functions:
- (a) It could provide an independent voice on policy choices that would not be constrained by the immediate priorities of the Government of the day. However, we are not convinced that a body that is outside of government would be effective in this area. Drug policy (as with much health policy) is ultimately about determining detailed funding and performance arrangements for District Health Boards. It is difficult to see how an independent body that sits outside government could perform this function better than the Ministry of Health and officials from other departments under current arrangements.¹³⁰⁵ It is also difficult to see how this would make the current arrangements work better.
 - (b) It could hold the Government publicly to account for implementing drug policy in a balanced and effective way. There are already a number of mechanisms that are designed to do this both inside and outside government.¹³⁰⁶ Outside government the Alcohol Advisory Council and the Mental Health Commission already have this type of role, although in the case of the Alcohol Advisory Council its role is confined to alcohol. To some degree the New Zealand Drug Foundation also informally has this role. These external bodies have limited capacity to hold government to account because they are removed from the process of budget setting, which in the health context with District Health Boards is complex and detailed. However, to the extent that they can do this, they do already and there would appear to be no value in duplication.
 - (c) It could have a public advocacy role – identifying issues and lobbying for change. Again the three bodies mentioned above already perform this function. There is also the National Committee for Addiction Treatment, which is a “voluntary grouping” of service leaders, educators, representative groups and elected individuals established by the treatment sector to provide

¹³⁰⁵ The Ministry of Health is the Government’s primary source of advice on demand reduction and problem limitation issues and more generally on drug policy. Other government departments and the Police also have advisory functions in various areas of drug policy.

¹³⁰⁶ Within Government there is currently an Inter-Agency Committee on Drugs (IACD) made up of officials drawn from the interested government departments and agencies that monitors the implementation of National Drug Policy to ensure that policies and programmes pursued by agencies are consistent and mutually supportive.

a national voice and advocate best practice within the treatment sector. There would seem little value in duplicating the role of all these bodies and committees. We suggest that between them these bodies already articulate the problems around alcohol and drug use and the benefits and effectiveness of treatment. We believe the problem is not a lack of advocacy or understanding of the benefits of treatment, but rather that priority is not given to it despite the recognition of its benefits.

- 15.107 We are not therefore convinced that the imposition of additional reporting requirements or the establishment of an advisory committee will alter the balance within drug policy in favour of treatment. While there may be some benefits, they would, in our view, be unlikely to outweigh the costs.

Q147 Do you agree that additional reporting requirements or the establishment of an advisory committee with policy, accountability, and advocacy functions for drugs and alcohol would have insufficient benefit to justify the cost? If not, what benefits would there be?

Alternative approach – Mental Health Commission proposal

- 15.108 As an alternative to a statutory mechanism, the Law Commission has identified during its review of the Sale of Liquor Act an approach that the Commission is proposing to support as one of the recommendations of that review.

- 15.109 The proposal is that the Mental Health Commission be supported to develop a blueprint for drug and alcohol and other addiction service delivery for the next five years. The work would be led by the Mental Health Commission and would be undertaken with support from key groups, such as the Alcohol Advisory Council, New Zealand Drug Foundation, and National Committee for Addiction Treatment, along with input from all relevant government agencies and departments. The Mental Health Commission has proposed that the blueprint should be based on best practice principles and address:

- the level and type of service, how much, what type, and where it is based;
- required resourcing and staffing levels, including workforce issues;
- the design of a service system, including models of care pathways, service delivery systems and co-ordination;
- transition and implementation planning; and
- monitoring and oversight.

- 15.110 We believe that developing a blueprint, which includes transition and implementation planning, provides a very practical way to increase the emphasis on treatment. Our tentative view is that the Mental Health Commission would be an appropriate agency to lead such work.

Q148 Do you agree that the development of a blueprint for drug and alcohol and other addiction service delivery could provide a practical way of significantly increasing the emphasis on treatment?

Q149 What else might be done to provide greater support for demand reduction and problem limitation measures?

Administration of the proposed legislative framework

- 15.111 Finally, we suggest that a strong signal would also be given through changing the way drugs legislation is administered. Currently parts of the Misuse of Drugs Act are administered by the Ministry of Justice and other parts by the Ministry of Health.
- 15.112 We propose that in order to further emphasise prevention and treatment and to ensure a coordinated legislative approach to the whole of drug policy, the new legislative framework should be administered solely by the Ministry of Health. This may be seen as partly symbolic, but it will also help ensure that the health dimension of the legislation remains at the fore of future policy debate on drug use. It may also affect the nature of public information and advice within government on the Act and its implementation and enforcement. As a result of this change we anticipate that information and advice on the Act would be principally shaped by a public health rather than a criminal justice perspective. This may further assist in shifting the balance within drug policy.