

┌ **National Drug Policy 2015 to 2020**

**Minimise alcohol and other drug-related harm
and promote and protect health and wellbeing**

Citation: Inter-Agency Committee on Drugs. 2015.
National Drug Policy 2015 to 2020. Wellington: Ministry of Health.

Published in August 2015 by the Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

ISBN: 978-0-478-44856-6 (print)

ISBN: 978-0-478-44857-3 (online)

HP 6239

This document is available at health.govt.nz

Foreword

The Government's approach to minimising harm from alcohol and other drug misuse needs to be compassionate, innovative and proportionate. This recognises that alcohol and other drug problems are first and foremost health issues.

Compassion is crucial. Help needs to be available for those who need it, interventions need to happen early, and the stigma that acts as a barrier to help seeking and recovery needs to be reduced. This National Drug Policy emphasises the need for a people-centred intervention system that is responsive to people's circumstances, environment and life stages.

We also have to be prepared to challenge traditional approaches and ways of thinking about these issues. Innovation is essential in a world where new drugs are detected every week and the black market has gone digital. The international landscape has also shifted, with a growing recognition that the harms we are trying to prevent can come from our approach to drugs as much as from their use.

Different drugs have different risk profiles and our responses to them need to reflect this. In some cases, such as with methamphetamine, we want to eradicate all supply and use. For alcohol, we want those who choose to drink to do so moderately and those who are pregnant or planning pregnancy not to drink at all. When legislating to try and reduce harmful behaviour we need to ensure the rules and penalties we

implement are both proportionate to the potential for harm and evidence-based.

In relation to alcohol, the Government has already responded by tightening the rules on the sale of alcohol and putting more control in the hands of local communities through the Sale and Supply of Alcohol Act 2012, reducing the blood-alcohol limit for driving and increasing alcohol screening and brief interventions in primary care.

Actions are also included in this National Drug Policy as the Government's response to the Law Commission's recommendations on the Misuse of Drugs Act 1975. These relate to ensuring the Expert Advisory Committee on Drugs has appropriate decision-making guidance, ensuring appropriate access to controlled drugs for medical purposes (while minimising the risk of diversion), and assessing options for possession and utensils offences to incorporate an enhanced health response.

New Zealand continues to make strong progress in minimising alcohol and other drug harm. Hazardous consumption of alcohol has decreased over the last six years from 18 percent in 2006/07 to 16 percent in 2013/14. The Prime Minister's Methamphetamine Action Plan has helped to more than halve the reported rates of amphetamine use. The combined focus on restricting the supply of methamphetamine and its precursors, with treatment and community-based initiatives has contributed to this reduction.

There is still, however, a lot to do. The Government has set a range of Better Public Services targets and other social sector initiatives to make New Zealand a better place to live for all New Zealanders. These targets and initiatives include reducing long-term welfare dependence, supporting vulnerable children, boosting skills and employment, and reducing crime. When we dig beneath the surface of many of the issues we need to address to achieve these outcomes, we find that misuse of alcohol and drugs is a contributing factor.

There is no quick fix. Progress will take time, and will require coordinated action across the social sector and other agencies to understand where to target resources and provide wrap-around support. Partnership with non-governmental organisations, businesses, communities and families will also be vital in minimising alcohol and other drug related harm. As Minister responsible for this Government's policy on alcohol and other drugs, I will work with my ministerial colleagues to ensure not only that agencies have a coordinated approach to this issue, but that we work with those who deliver services and interventions to make New Zealand a better place.

Hon Peter Dunne

Associate Minister of Health

Contents

Foreword	iii
Introduction	1
New Zealand has high rates of alcohol and other drug use	1
Misuse of AOD harms individuals, communities and society	1
Taking action to minimise harm means looking at the whole picture	2
An investment-based approach ensures support goes where it will make the biggest difference	2
A collaborative response to AOD harm is needed	3
The Government is committed to getting results	3
Our approach for the next five years	4
A shared goal provides a foundation for collaboration	4
Clear objectives focus us on results	6
Evidence-based strategies ensure we are doing the right things	6
Our priorities enable us to achieve results	7
Our objectives	8
Delaying the uptake of AOD by young people	8
Reducing illness and injury from AOD	10
Reducing hazardous drinking of alcohol	12
Shifting our attitudes towards AOD	14
Our strategies	16
Our priorities for Government action	18
Priority area 1: creating a people-centred intervention system	18
Priority area 2: shifting thinking and behaviour	20
Priority area 3: getting the legal balance right	21
Priority area 4: disrupting organised crime	22
Priority area 5: improving information flow	24
Summary of Government actions	25
References	27
Further resources	30

Introduction

The National Drug Policy sets out our response as a society to alcohol and other drug¹ (AOD) issues. The Government will use the Policy to prioritise its resources and assess the effectiveness of the actions taken by government agencies and frontline services.

The Policy aims to guide, influence and support decision-making by local services, communities and non-governmental organisations, and in doing so, improve collaboration and maximise the effectiveness of the system as a whole.

New Zealand has high rates of alcohol and other drug use

Over a lifetime 44 percent of New Zealanders will have tried an illegal drug and 93 percent will have drunk alcohol (Ministry of Health 2015b). A number of adults aged 15+ use illegal drugs:

- 1 in 13 smoke cannabis at least once a month (Ministry of Health 2015b)²
- 1 in 37 have used ecstasy in the last year (Ministry of Health 2015b)
- 1 in 100 have used amphetamine in the last year (Ministry of Health 2014c).

Some people are psychologically or physiologically dependent on these substances. This means they have become so used to having AOD in their system they need to keep using them in order to function normally. It is estimated that 12 percent of the population will experience a substance use disorder at some stage in their lives (Wells et al 2007). Additionally, a recent study found that approximately 11 percent of New Zealand secondary school students use substances at a level that are likely to cause them significant current harm and may cause long-term problems (The University of Auckland 2014).

Misuse of AOD harms individuals, communities and society

While not every instance of AOD use is harmful, the effects of these substances can be significant. Immediate harms related to AOD use include falls, road accidents and the clogging up of hospital accident and emergency departments. Harms can also arise over the long term, such as AOD-related health conditions, relationship issues and difficulty obtaining and maintaining employment.

1. Other drugs include: substances classified under the Medicines Act 1981 or Misuse of Drugs Act 1975 and not used within the controls set out in legislation or for their intended purpose; substances captured by the Psychoactive Substances Act 2013; and other substances such as solvents and aerosols.
2. Data for cannabis and ecstasy use in the last 12 months (as at 2012/13) are provisional and potentially subject to revision or change until they have been through the full quality assurance process and received final approval for release.

For example, approximately 4500 people receiving a health-related benefit have a primary diagnosis of alcohol or substance abuse and a quarter of these people have received a benefit for at least 10 years.

AOD-related harm does not occur in a vacuum. The harm experienced depends on a complicated web of factors, including the substance(s) involved, the extent of use, the method of use, the vulnerabilities of the person using AOD, and the environment in which AOD is used.

Harmful impacts of AOD are not restricted to the individual using the substance. Examples of AOD-related harm to others include violence, foetal AOD exposure, family break-up and child neglect, property crime and public health issues such as the spread of hepatitis.

Problematic AOD use is often multi-generational and can be normalised within family and whānau groups. Such patterns of behaviour may also normalise actions that will bring people, particularly young people, into contact with the criminal justice system, such as cannabis offences or drink driving.

Particular populations often experience a disproportionate amount of harm. For this Policy to be successful, harm needs to be minimised for all populations.

Taking action to minimise harm means looking at the whole picture

AOD policy cannot be viewed in isolation from social factors (such as income, employment, housing and education) that may make people more at risk of being affected, directly or indirectly, by harm from AOD. Effective government intervention requires a cross-agency response. Health care, education and social services, alongside the justice system, communities, families and whānau play critical roles in minimising harm from AOD.

The complexity of these issues means that our responses need to be flexible, targeting the needs of different populations, family and whānau situations and environments, and responding to emerging issues early. Approaches need to be evaluated, tested and refined using domestic and international evidence and best practice.

New Zealand is not alone in facing the challenge of reducing harm caused by AOD. We can learn from international practice, policy and structures. This includes international agreements, such as the United Nations Drug Conventions, trade agreements and human rights instruments. The Government will monitor innovative approaches as they are tested internationally, including experimental regimes that make cannabis available for medicinal use.

An investment-based approach ensures support goes where it will make the biggest difference

Harmful use of AOD has been estimated to cost our country around \$6.5 billion each year (Business and Economic Research Limited 2009). This includes the cost to healthcare of responding to AOD related accidents, illnesses and injuries, the cost of welfare payments for people who have become incapacitated through substance dependence and the costs to the criminal justice system of enforcing AOD-related legislation.

By focussing on prevention and early intervention at the population level, through to targeted, people-centred responses for those individuals who need greater support, we can reduce these harms and their flow on effects to families, whānau, communities and the wider public. The Policy's first Priority Area for action is targeted specifically at ensuring a people-centred intervention system.

A collaborative response to AOD harm is needed

There are many people and organisations – including district health boards, service providers, iwi and hapū groups, schools, churches and community organisations – making a difference by minimising AOD-related harm and working to promote and protect health and wellbeing. Indeed, everyone can have a role in minimising AOD harm.

- Individuals can take action to reduce harmful use.
- Family, whānau and friends can support someone to make changes in their use.
- Community members and leaders can advocate for positive AOD policies in community settings such as a local sports club, and also model responsible AOD use.
- Educational institutions can introduce policies to support students struggling with AOD issues to stay engaged in education.

- Employers can offer a chance to people who are in the process of recovering from substance dependence.
- Frontline services can provide appropriate interventions, plans and treatment for those who need help.

Government agencies have a role by collaborating, supporting and partnering with others to achieve common goals. In particular, the principles of partnership, participation and protection will continue to underpin the relationship between government and Māori to achieve pae ora³ and health equity by supporting the health and wellbeing aspirations of Māori.

The Government is committed to getting results

The Government has instructed the Inter-Agency Committee on Drugs (IACD) to oversee the implementation of actions and monitor progress made against the objectives set out in this Policy. The Inter-Agency Committee on Drugs brings together chief executives of

the Ministries of Health, Justice, Social Development, and Education, the New Zealand Police, the Department of Corrections, and the New Zealand Customs Service. The Accident Compensation Corporation, National Drug Intelligence Bureau, Health Promotion Agency and Te Puni Kōkiri also participate at the working group level. This collection of agencies will ensure integration between the delivery of this Policy and broader Social Sector objectives.

The IACD will report to the Government annually. Their advice will cover progress on implementing actions, whether objectives are being achieved, and any changes to actions and timelines that may be required as evidence emerges. The IACD will also provide advice on whether achieving the objectives of this Policy is helping to drive progress on the government's broader social sector goals, including the Better Public Services Result Areas.

3. Pae ora is a holistic concept including three interconnected elements of mauri ora (healthy individuals), whānau ora (healthy families) and wai ora (healthy environments). Pae ora is also the Government's vision for Māori health and can be accessed through <http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures>.

Our approach for the next five years

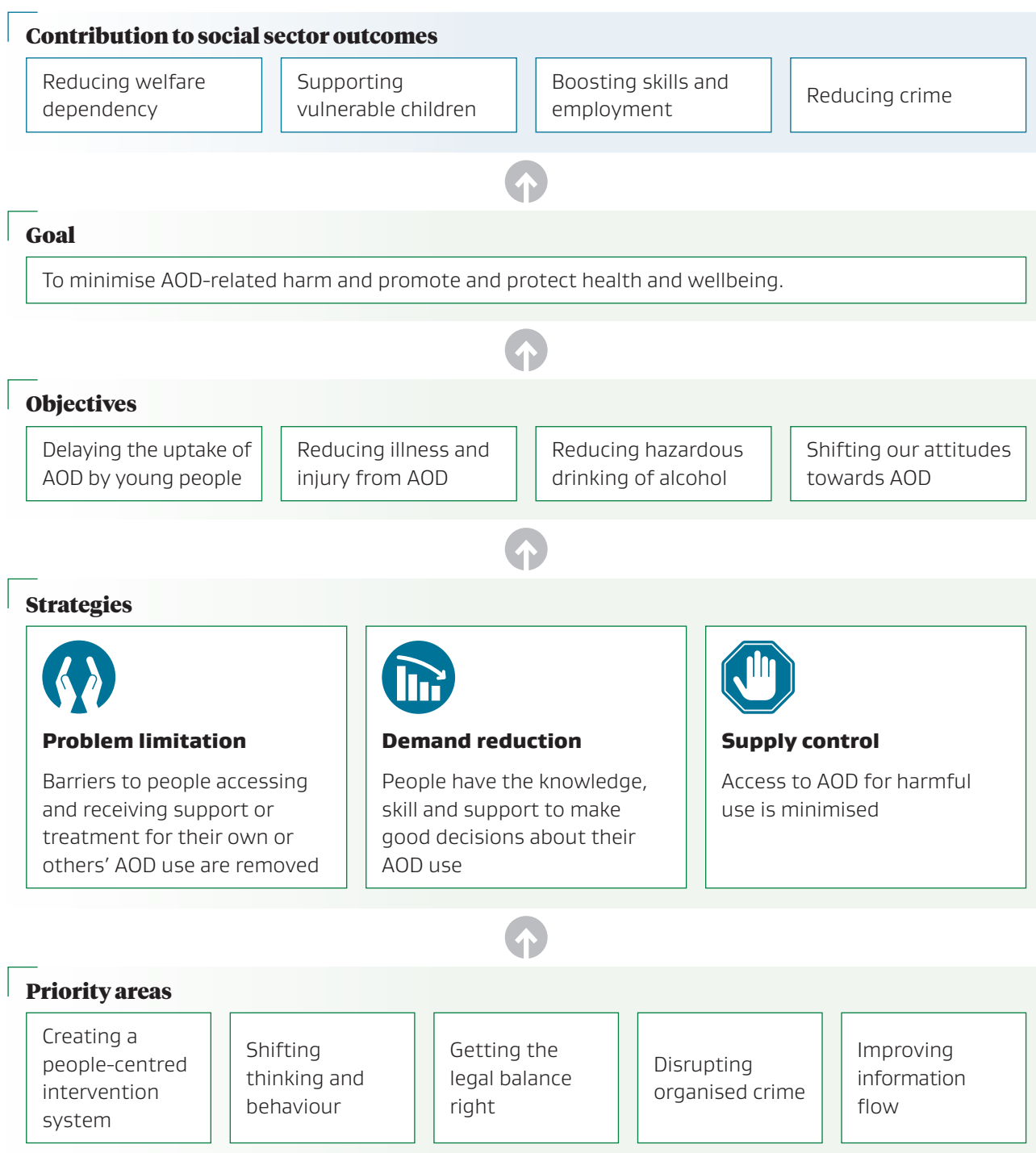
The Government's approach over the next five years includes a shared goal, objectives, strategies and priorities for action. This approach, and its contribution to wider social sector outcomes, is summarised in Figure 1 and discussed in detail in the rest of the chapter.

A shared goal provides a foundation for collaboration

The goal of this Policy is to minimise AOD-related harm and promote and protect health and wellbeing for all New Zealanders. The idea of harm minimisation encompasses the prevention and reduction of health, social and economic harms experienced by individuals, their families and friends, communities and society from AOD use. The promotion and protection of wellbeing integrates physical, mental and social needs to strengthen protective factors for individuals, families and communities.

Making progress towards this goal will impact on wider social objectives, and in particular four of the Better Public Services Result Areas in relation to reducing welfare dependency, supporting vulnerable children, boosting skills and employment and reducing crime.

Figure 1: The framework for the National Drug Policy 2015–2020



Clear objectives focus us on results

As well as having a shared goal, we need clear objectives to provide a focus over the entire life of the Policy. These objectives are:

- delayed uptake of AOD by young people
- reduced AOD-related illness and injury
- reduced hazardous drinking of alcohol
- a shift in attitudes towards AOD.

Progress on these objectives will mean progress on reducing overall harm from AOD. To know whether progress is being made, high-level indicators and measures have been developed. These will be based on the latest available data and will enable high-level trends to be assessed.

Evidence-based strategies ensure we are doing the right things

This Policy provides a structure for the wide range of activity already being undertaken by the Government and others to minimise harm and to promote and protect wellbeing. The activities can be categorised under three broad strategies, or 'pillars': problem limitation, demand reduction and supply control. These pillars are underpinned with high quality data to ensure the right balance and targeting of activity. These strategies also act as a guide for new initiatives.

The approach is similar to that used in other countries, including the United Kingdom, Australia and many nations in the European Union.



Problem limitation aims to reduce harm that is already occurring to those who use AOD or those affected by someone else's AOD use. It includes activities that provide safer equipment and environments for AOD use, ensure access to quality AOD treatment services through New Zealand's health system, and support people in recovery. It also includes activities that support others who are affected, such as the children of people with dependence problems.



Demand reduction aims to reduce the desire to use AOD. It includes activities that delay or prevent uptake. This means reducing use through education, health promotion, advertising and marketing restrictions, and influencing the conditions that make people turn to AOD through community action, such as keeping children in school.



Supply control aims to prevent or reduce the availability of AOD. It includes controlling New Zealand's borders to prevent illegal drugs being imported, and shutting down domestic growing, manufacturing and supply. It also aims to control and manage the supply of legal drugs through things like prescribing guidelines, age restrictions, licensing conditions and permitted trading hours.

Our priorities enable us to achieve results

This Policy identifies five areas that will require additional focus over the next five years if the Government is to make meaningful progress against the objectives:

- Priority area 1: creating a people-centred intervention system
- Priority area 2: shifting thinking and behaviour
- Priority area 3: getting the legal balance right
- Priority area 4: disrupting organised crime
- Priority area 5: improving information flow.

Each priority area has an initial set of actions to be undertaken by 2017/18. These actions are drawn from across the three strategies and build on, rather than replace, the significant contributions government, communities and individuals already make to the goal and objectives of this Policy.

Many of the initial actions are designed to enhance collaboration and links across government, service providers and communities in order to achieve better outcomes collectively than can be achieved alone. This collaborative approach recognises that everyone has a role in minimising AOD-related harm, but that the Government has a responsibility to lead.

The initial actions are also designed to build a foundation to better enable individuals, families and communities to contribute to the Policy's goals and objectives, and to support prevention and intervention activity, particularly for young people.

Our objectives

Delaying the uptake of AOD by young people

Around 75 percent of people who develop a substance use disorder (eg. substance abuse or dependence) will do so by the age of 25 (Wells et al 2007).

By age 15 one in four people have drunk alcohol and one in six have used an illegal drug (Ministry of Health 2015a and 2015b).

By the age of 21 approximately 80 percent of young New Zealanders will have used cannabis, with 10 percent developing a pattern of heavy, dependent use (Office of the Prime Minister's Science Advisory Committee and Gluckman 2011).

Early uptake of AOD is a predictor for ongoing problems, including substance use and dependence.

Early use of AOD raises very serious issues for our children and society. The brain does not fully mature until the third decade of life, and the evidence suggests that exposure to AOD during adolescence and young adulthood may interrupt important neurological processes and natural brain maturation. This can have consequences for social and neurobiological functioning in adulthood (Squeglia et al 2009; Office of the Prime Minister's Science Committee and Gluckman 2011). This is more likely when people start using AOD earlier (early onset) and do so regularly or heavily.

Early onset of alcohol consumption tends to increase the likelihood of regular and heavy use and has been associated with increased rates of violence and injury, unprotected sex, mental health problems, suicide, poorer educational outcomes and problem drinking later in life (Dawson et al 2008; Fergusson et al 1994; Hingston et al 2006, 2009; Komro et al 2010; Office of the Prime Minister's Science Advisory Committee, 2011; Swahn et al 2010). Of adults aged 15 years and over who reported drinking hazardously in the past 12 months 48 percent had first used alcohol before age 15 (Ministry of Health 2015b).



The evidence highlights that early onset of cannabis use also tends to increase the likelihood of misuse, as well as mental health issues, other illicit drug use, school drop-out and educational underachievement, neurocognitive deficits and injury (Meier et al. 2012; Office of the Prime Minister's Science Advisory Committee 2011; Silins et al 2014).

Early use and misuse of AOD is linked to a range of social and environmental factors, including exposure to traumatic life experiences such as child abuse and neglect, family violence and household dysfunction (Office of the Prime Minister's Science Committee and Gluckman 2011). The way young people socialise

can also influence use. We know people are more likely to use drugs such as cannabis when their peers are doing so (Kuntsche and Delgrande 2006) and that social and parental modelling influences youth AOD use. There is also a strong genetic component to AOD issues (Office of the Prime Minister's Science Advisory Committee 2011).

The way that we respond to young people's use of AOD can have life-long consequences. Accordingly, the Prime Minister's Chief Science Advisor warns against responding punitively to behaviours that reflect incomplete maturation (Office of the Prime Minister's Chief Science Advisor 2011). Drugs (excluding alcohol)

were the second most prevalent reason cited by school boards for exclusions⁴ in 2013, accounting for 17 percent, and the main reason for expulsions⁵, at 34 percent (Ministry of Education 2013). Not being able to participate fully in school life can limit a young person's ability to gain employment, sustain relationships and make life choices. Similarly, consequences from interaction with the criminal justice system from low-level AOD-related offending can be far reaching. During 2013/14 (ie, fiscal year ending 30 June 2014) 2410 police proceedings⁶ for illicit drug possession or use against youth (aged 5–24) were recorded, with approximately a quarter resulting in court action.⁷

Table 1: Indicator for delaying the uptake of AOD by young people

Indicator of success	Delayed uptake of alcohol and other drugs by young people
Measure	Initiation of first use as reported by adults aged 15+ years
Data source	New Zealand Health Survey (5 yearly)
	(Alcohol) Baseline 2012/13 Under 15: 27%; 15-19: 60%; 20-24: 10%
	(Other drugs) Baseline: 2012/13 ⁸ 14 and under: 16%; 15-17: 33%; 18-20: 29%

4. Exclusion means the formal removal of a student aged under 16 from the school and the requirement that the student enrol elsewhere.
 5. Expulsion means the formal removal of a student aged 16 or over from the school. If the student wishes to continue schooling, he or she may enrol elsewhere.
 6. Proceedings include court action, formal and informal warnings, non-court referred conferences and other non-court action.
 7. These figures have been produced from a statistical dataset that is still under development, and which will, in the future be used to produce Recorded Crime Offender Statistics. Those Tier 1 statistics should be available from 1 July 2015.
 8. Data for other drug use in the last 12 months (as at 2012/13) are provisional and potentially subject to revision or change until they have been through the full quality assurance process and received final approval for release.

Reducing illness and injury from AOD

Approximately 12 percent of New Zealanders will experience a substance use disorder at some stage in their lives (Oakley et al 2006).

AOD use accounts for about 5 percent of all health loss⁹ experienced by New Zealanders and 23 percent of mental illness, mainly through substance use disorders. Alcohol comprises the majority of this loss (3.9% and 18% respectively) (Ministry of Health 2013b).

Sharing needles and other drug utensils remains the key route for hepatitis C virus transmission in New Zealand. Eighty-three percent of people with hepatitis C virus infection report a history of intravenous drug use (Gane et al 2014).

AOD misuse has serious consequences for the health of New Zealanders.

AOD taken recreationally produces physiological changes to the body. These effects are generally intended to be pleasurable, but they also have the potential to cause considerable harm to the people that use them and to others. Each year about 150,000 New Zealanders aged 16 and older experience substance use problems that could benefit from an intervention (Mental Health Commission 2011). Different drugs also carry different risk profiles and the impact on individuals will vary depending on their vulnerabilities, environmental and social circumstances and patterns of use.

Around 800 deaths per year are attributable to alcohol. Injuries are the dominant cause of alcohol-attributable deaths for people under 45, with alcohol-induced cancers becoming increasingly dominant from the age of 45 (Connor et al 2013). Alcohol-attributable injuries are estimated to account for 11 percent of all ACC claims, at a cost of \$350 million per year (Accident Compensation Corporation 2012).

Regular and heavy cannabis smokers are at increased risk of contracting chronic bronchitis, respiratory infections and pneumonia when compared to

9. Health loss is a measure of how much healthy life is lost due to early death, illness or disability.



non-smokers and may suffer cancers of the lung (Room et al 2008).

Large doses of methamphetamine can cause potentially life-threatening conditions, such as hypothermia, renal and liver failure, cardiac arrhythmias, heart attacks, strokes and seizures (Krasnova & Cadet, 2009; Drake et al 2008). The long-term health impacts of frequent methamphetamine use can include respiratory problems, stroke, irregular heartbeat, anorexia, and neurotoxicity as well as affecting cardiovascular health, and cognitive functioning (Drake et al 2008).

Rates of accidental poisonings (including overdose) are higher for opioids such as heroin, methadone and codeine than for any other illegal drug in New Zealand. These substances are also the most likely to be injected, which can cause vein damage and increase exposure to

communicable diseases. Availability of clean equipment will reduce harm: the introduction of the 1-for-1 needle exchange has reduced the rate of hepatitis C infection among people who currently inject drugs by around 25 percent (Noller and Henderson, 2014; Henderson et al 2011).

Additionally, stopping use of alcohol or other drugs after daily or frequent use over a couple of months can trigger withdrawal symptoms. Most people will experience mild to moderate symptoms, but for some, the effects will be more serious (for example, alcohol and benzodiazepine withdrawal can be fatal (Bayard et al 2004; Lann and Molina 2009)).

Relapse is common, and people who have stopped using even for a short period of time are at risk of over-dosing should they resume use. Relapse prevention plans and

transition plans between services – for example from specialist care to primary care – are important tools to assist people with recovery.

Reducing illness and injury from AOD includes having a focus on other people who are affected by an individual's use, particularly children. For example:

- AOD misuse is a factor in 25 percent of families with children in Child, Youth and Family care (Office of the Chief Social Worker 2014)
- alcohol was a contributing factor in 34 percent of all family violence incidents in 2007/08 (Ministry of Justice 2010).
- for every 100 alcohol or drug-impaired drivers or riders who died in road crashes, 47 of their passengers and 17 sober road users died with them (Ministry of Transport 2014).

Table 2: Indicator for reducing illness and injury from AOD

Indicator of success	Reduced AOD-related illness and injury
Measure	Alcohol-related emergency department presentations
Data source	Ministry of Health National Collections data (annual) Baseline to be established in 2015/16
Measure	Accidental poisoning by exposure to opioids
Data source	Mortality collection, Ministry of Health 2011 baseline: 39
Measure	People receiving a health-related benefit where primary diagnosis is listed as alcohol or substance abuse
Data source	Ministry of Social Development March 2015 baseline: 4,435

Reducing hazardous drinking of alcohol

Men (22 percent) are twice as likely as women (11 percent) to drink hazardously.

One in three 18–24-year-olds drink at levels that are hazardous to their health (Ministry of Health 2014b).

Alcohol contributes to around 30 percent of New Zealand's fatal road crashes (Ministry of Transport 2014).

Approximately 10 percent of women drink heavily during pregnancy (Ministry of Health 2015a).

One in six New Zealand adults have hazardous drinking patterns.¹⁰

It is encouraging that both total and hazardous consumption of alcohol by New Zealanders aged 15+ has reduced over the last six years (Ministry of Health, 2014b).

- The proportion of the adult population who drink has decreased from 84 percent in 2006/07 to 80 percent in 2013/14.
- The proportion who drink hazardously has decreased from 18 percent in 2006/07 to 16 percent in 2013/14.

Despite these positive trends, the rates of hazardous drinking continue to be high. Approximately 575,000 New Zealanders report drinking in a way that carries a risk of harm to themselves and others around them. Additionally, while total and hazardous consumption of alcohol by young people aged 18-24 also decreased between 2006/07 and 2013/14 (from 89 to 84 percent and 43 to 33 percent respectively) this group remains most likely to drink hazardously (Ministry of Health, 2014b).

Hazardous drinking can contribute to a number of social harms – not just to individuals, but also to those around them. The most common harmful effects reported

10. Ministry of Health, 2014b. The Alcohol Use Disorders Identification Test (AUDIT) developed by the World Health Organization is used to identify hazardous drinking patterns. The AUDIT is a 10-item questionnaire covering alcohol consumption, alcohol-related problems, and abnormal drinking behaviour. Each question is scored from 0 to 4, so the questionnaire has a maximum score of 40. An AUDIT score of 8 or more is defined as hazardous drinking.



by adults due to someone else's drinking are damage to friendships and social life, and damage to home life and financial position (Ministry of Health 2010). Alcohol consumption is also a factor in offending behaviour. Police estimate that at least one-third of recorded violent offences and 15 percent of sexual offences occur after the offender has consumed alcohol (New Zealand Police 2009).

Babies exposed to alcohol before birth can develop lifelong problems, including behavioural problems, intellectual disability and heart defects. This can lead to poor life outcomes and increased risk of involvement with the criminal justice and welfare systems. There is no cure for Fetal Alcohol Spectrum Disorders

(FASD), but they are preventable. For women who are pregnant or planning a pregnancy, the safest option is to avoid drinking alcohol.

New Zealand has relatively high rates of alcohol consumption during pregnancy, with up to a third of New Zealand women consuming some alcohol while pregnant, and around 10 percent drinking heavily (Morton et al, 2010; Mallard et al, 2013; Ministry of Health 2015a). The Health Select Committee's *Inquiry into Improving Child Health Outcomes and Preventing Child Abuse, with a Focus from Pre-conception until Three years of Age* identified estimates of the number of babies born each year in New Zealand with FASD ranging from 173 to 3000.

There is also evidence that parental alcohol use can harm children. Children with parents or caregivers who drink heavily are likely to suffer from a greater number of hospital admissions for physical injuries (Families Commission 2006). Children raised by caregivers who are alcohol dependent can have higher levels of anxiety, behavioural problems and other mental health issues than children who do not have alcohol-dependent parents (Maynard 1997). Research also suggests that children of alcohol-dependent parents are more likely to become alcohol dependent themselves, creating generational impacts (Jennison and Johnson 1998).

Table 2: Indicator for reducing hazardous drinking of alcohol

Indicator of success New Zealand past-year drinkers who report hazardous drinking patterns	
Measure	Hazardous drinking score (AUDIT) in past-year drinkers aged 15 years and over
Data source	New Zealand Health Survey (annual) 2011/12 Baseline: 19%
Measure	Women who had been pregnant in the last 12 months and drank during most recent pregnancy
Data source	New Zealand Health Survey (5 yearly) 2012/13 Baseline: 19%

Shifting our attitudes towards AOD

Social attitudes towards AOD can promote misuse and act as barriers to help-seeking and recovery.

Six percent of all adult past-year drinkers planned to get drunk on their most recent drinking occasion, and 12 percent reported having 'got drunk or had too much to drink' on their most recent drinking occasion (Research New Zealand 2014).

Twenty-five percent of high school age students thought it was okay for people their age to drink alcohol, and 10 percent thought it was okay to use cannabis (almost the same number as for cigarettes) (Adolescent Health Research Group 2013).

Around 50,000 people wanted help to reduce their AOD use in the past 12 months but had, for a variety of reasons, not received it (Mental Health Commission 2011).

Our attitudes are a key predictor of our behaviour. They are shaped by our individual values and beliefs, the values and beliefs of our peers and people of influence, and by our surroundings, such as the messages we are exposed to and the rules set by the Government.

People use AOD for many reasons, including enjoyment of the effects, relaxation, alleviation of stress or a depressed mood, to enhance an activity, to better bond with peers, and to keep awake at night to socialise (Boys et al 2001; Duff 2008; Jay 1999). Young people have also reported that they have used drugs to 'fit in' with peers, to cope with problems, to relieve boredom, and to rebel (Ministry of Health 2009b).

Environmental factors contribute to AOD use and can be a barrier to help-seeking and recovery. These factors include ease of access to substances, the presence of violence in the home, peer pressure, unemployment, and/or mental health issues. Such factors can in turn be exacerbated by AOD use.



In most cases AOD use is not problematic. For example, many people enjoy moderate consumption of alcohol in social settings with few ill effects. However, harm can result when people misuse AOD, particularly when social patterns of misuse and intoxication become entrenched.

There are many reasons why people who feel they need help for their AOD use might not seek assistance to do so. These include not being ready to stop use, not knowing where to go for help or encountering long waiting lists, and being concerned about the potential negative effects on employment, or that receiving help might cause others to have a negative opinion of them (Ministry

of Health 2009b). For example, a dedicated methamphetamine telephone helpline service found that many callers were deeply concerned about confidentiality because of such fears. Information that allowed them to self-manage their issues was often considered more important than seeing a counsellor. Offering people a variety of choices for treatment is more likely to change behaviour than limiting support to only a few options. Several studies have found that substance use disorders are more highly stigmatised than other health conditions (Livingston et al 2012).

Stigma can also impact people’s recovery journey. For many people, recovery means assuming some

control over their lives. This means being able to be better parents, to be employed, and to live as others do. This can be difficult if they encounter discrimination for their past actions. As well as their AOD use, their offending histories can severely limit future possibilities, for example, cannabis convictions can limit someone’s ability to travel overseas, or to get a job.

Over the medium to long term, achieving our objectives will require shifting the attitudes of individuals and communities to AOD use and misuse, and to seeking help. But, as we have seen with tobacco and drink-driving, it is possible to shift attitudes over time.

Table 4: Indicator for shifting our attitudes towards AOD

Indicator of success	Shifting our attitudes towards AOD
Measure	Adults aged 15+ who sought or have been given advice, information or help on how to cut back their drinking in the last 12 months¹¹
Data source	HPA Alcohol Behaviours and Attitudes Survey (annual) Baseline 2013: 5%
Measure	AOD outcome measure for AOD treatment services
Data source	AOD treatment services reporting requirements to the Ministry of Health Baseline to be established in 2015/16

¹¹. Note that this question is only asked of people who had consumed two or more drinks on their last drinking occasion (within the last three months).

Our strategies

In order to achieve these objectives and move towards the goal of minimising AOD harm and promoting and protecting health and wellbeing, we need clear strategies for action. This Policy carries over from previous policies the three strategies for action of **problem limitation, demand reduction** and **supply control**.

Current activities by government, communities, families and individuals can be categorised under one or more of these strategies, and these strategies act as a guide for the development of new initiatives. The three strategies, and examples of activities, are described in Table 5.

Table 5: National Drug Policy strategies and example activities



Problem limitation

Barriers are removed to people accessing and receiving support or treatment for their own or others' AOD use

New Zealand is working in this area to:

- provide effective, high-quality, compassionate, timely, accessible, and age- and culture-appropriate support and treatment services
- address the factors that have an impact on people's ability to access treatment and support, including destigmatising help-seeking
- provide AOD services that are responsive to people with co-existing problems
- ensure all frontline services (justice, health, education, etc.) provide an entry point to AOD support, referral and treatment (including for the child affected by a parent's addiction)
- support and strengthen harm reduction approaches such as the needle exchange programme
- ensure continuity of care for people transitioning from one service or environment to another, including from youth to adult services, and between justice facilities and the community.



Demand reduction

People have the knowledge, skill and support to make good decisions about their AOD use

New Zealand is working in this area to:

- ensure messages about AOD harm, harm reduction and help-seeking (including information about less harmful consumption and means of administration) are consistent, evidence-based, accessible and relevant
- tailor messages, resources and services appropriately to respond to different cultures, populations and communities
- encourage women to abstain from AOD use (or use less harmful substitutions, such as methadone, where appropriate) during pregnancy and while breast feeding
- bring about a societal shift in attitudes about harmful AOD use.



Supply control

Access to AOD for harmful use is minimised

New Zealand is working in this area to achieve:

- legislation and enforcement that can respond to changing environments and new technologies
- enforcement action that seeks prevention and has broad coverage (eg. border control), while also targeting substances, environments and organisations (such as gangs) that cause the most harm
- effective detection of substances and enforcement of the law relating to the importation, manufacture and distribution of drugs for illegal use
- effective regulation and monitoring of the supply chain for prescription drugs.

All three strategies are needed

Often they work well together, but sometimes they come into conflict and require a balancing act. For example, fear of the legal consequences of using an illegal drug can act as a barrier to some people seeking the help they need. In these instances, assessment of the best available evidence is needed to determine which mix of approaches is required to best address social, economic and health harms. This is harm minimisation in action.

Our priorities for Government action

Five areas have been identified to focus on if we are to make meaningful progress towards achieving our objectives. These have been labelled:

- Priority area 1: creating a people-centred intervention system
- Priority area 2: shifting thinking and behaviour
- Priority area 3: getting the legal balance right
- Priority area 4: disrupting organised crime
- Priority area 5: improving information flow.

This Policy makes a commitment to an initial set of actions, and these will be reviewed and updated by the end of 2017. The actions are drawn from across the three strategies and will build on, rather than replace, the significant contributions that government, communities and individuals already make to the goal and objectives of this Policy.

The AOD landscape continues to evolve, and new evidence will continue to emerge about the issues that need to be addressed and the effectiveness of the interventions aimed at addressing them. The IACD will review the progress made and emerging evidence, and will provide advice on a revised set of actions in 2017. This will ensure initiatives are added, cancelled and amended as appropriate, to reflect changes in AOD issues and evidence on the effectiveness of interventions.

Priority area 1: creating a people-centred intervention system

This priority area involves creating an AOD intervention system that responds to people at their place of need, as early, efficiently and effectively as possible. For people living with AOD addiction or dependence this may mean accessible, high-quality addiction treatment services, access to housing or counselling services. But we also don't want to wait for people to be in crisis, or for young people to adopt habits that will become problematic in later life.

The Prime Minister’s Youth Mental Health Project introduced national waiting time targets for 12–19 year olds to be seen within three weeks of contacting a youth alcohol and drug service and with eight weeks of referral from a service. Initial results show that youth are being provided with better access to timely and appropriate treatment and follow-up (Ministry of Health 2014). However, we need to continue to monitor this to avoid access slipping.

All many people may need is reliable, internet-based information, or their family doctor or school nurse asking about their drinking and drug-taking

habits and providing advice. For children of parents with addiction issues, it could be that a specific plan is required to ensure their needs are looked after.













In order to make the most of opportunities to build resilience (eg. through peer support, positive role-modelling and confidence-building programmes) and intervene (eg. through the provision of information and by connecting people to AOD treatment) we will need to:

- be clear about the roles, responsibilities and opportunities for individuals, families and community

organisations to prevent and reduce AOD-related harm

- identify and connect referral pathways so that ‘any door is the right door’
- know what works, including opportunities to intervene earlier, and tailoring activities to different populations and needs across life stages
- identify the settings that are needed to better support individuals, community organisations and services to carry out their roles and responsibilities for the greatest impact.

By 2017/18 the Government will:

Action	Date	Strategies
Develop a system map of potential resilience and intervention points across a person’s life stages	2016/17	 
Develop and implement a strategic framework for adult and youth AOD services	2017/18	 
Regularly disseminate case studies of good and innovative practice	Annual	  
Develop common tools and/or forums to share practice and celebrate success to foster system learning and improvement	2017/18	  
Develop initiatives and an implementation plan to improve outcomes for the children of parents with mental illness and addiction	2017/18	 

These actions will integrate closely with the Government’s Rising to the Challenge plan for mental health and addiction services, and the new ways of working to target

government services and provide wrap-around responses through the Government’s Better Public Services Result Areas.

Priority area 2: shifting thinking and behaviour











This priority area involves encouraging a positive shift in thinking and behaviour in New Zealand in relation to:

- the culture of drinking and intoxication, including during pregnancy
- help seeking
- the way in which the system intervenes to help.

If we are going to achieve real change, then, just like smoking, AOD misuse needs to become less desirable and help-seeking encouraged with the right support available at the right time. Social sector agencies also need to work together to identify people who need additional support and tailor responses and services to their needs. This includes young people whose schooling is impacted by AOD use, people not in education or employment, and people affected by a fetal alcohol spectrum disorder.

Making progress in this area will require sustained effort over a considerable period. Change will be gradual, but efforts in this area will be vital in the long term. Communities play an integral role in mobilising and sustaining change, so we will also develop a set of actions that builds the capacity and capability of communities, particularly those most affected by AOD use and related harm.

By 2017/18 the Government will:

Action	Date	Strategies
Build on existing AOD-related public education campaigns to shift AOD culture, promote help-seeking and address stigma	Ongoing	  
Publish a Fetal Alcohol Spectrum Disorders Action Plan	2015/16	  
Provide guidance to support schools dealing with AOD issues and helping students who need it, with a focus on keeping students engaged, where possible	2015/16	 
Develop guidance for improving AOD intervention for services engaging with young people not in education or employment	2016/17	 

Priority area 3: getting the legal balance right

This priority area involves ensuring we monitor and evaluate how well legislation – and its implementation – is working for individuals, communities and society so that we can provide the right support and make changes where they are needed.












Legislation and law enforcement acts to prevent and deter people from accessing and using AOD harmfully. Laws set the boundaries of what can be legally sold and under what circumstances and whether penalties enable health-oriented responses where an offence has been committed.

For example:










- recent changes to the regulation of alcohol and psychoactive substances have set national requirements, while giving communities a greater say about where and when these products will be sold
- the pilot for the Alcohol and Other Drug Treatment Court offers offenders the opportunity to enter an intensive treatment programme for their AOD dependency with frequent, random drug testing, and, if their participation is successful, for this to be taken into account when they are sentenced.

The enforcement of the Misuse of Drugs Act 1975 also provides scope to offer low-level offenders alternatives to the criminal justice system. For example, a study into cannabis use offences in New Zealand between 1991 and 2008 found a substantial decline in arrests, prosecutions and convictions for cannabis use over that period. This was despite any changes to the statutory penalties for cannabis use since the enactment of the Misuse of Drugs Act in 1975 (Wilkins et al 2012).

By 2017/18 the Government will:

Action	Date	Strategies
Work with the Expert Advisory Committee on Drugs (EACD) to ensure harm minimisation is a central feature of drug classification assessments	2015/16	  
Review the regulation of controlled drugs for legitimate purposes (such as medicines) alongside reviews of the Medicines Act 1981 and other therapeutics legislation	2017/18	 
Develop options for further minimising harm in relation to the offence and penalty regime for personal possession within the Misuse of Drugs Act 1975	2017/18	 
Release a discussion document seeking feedback on appropriate regulation of drug utensils	2015/16	 
Introduce the Substance Addiction (Compulsory Assessment and Treatment) Bill to Parliament	2015/16	 

By 2017/18 the Government will:

Action	Date	Strategies
Develop a New Zealand position for the United Nations General Assembly Special Session on Drugs 2016	2015/16	  
Review the effectiveness of new police powers to deal with breaches of local alcohol bans introduced through the Local Government (Alcohol Reform) Amendment Act 2012	2015/16	
Evaluate the Alcohol and other Drug Treatment Court Pilot	2017/18	 
Commence a review of the policy and operation of the Psychoactive Substances Act 2013	2017/18	  

Priority area 4: disrupting organised crime

This priority area involves taking a multi-agency approach to disrupt the ability of sophisticated domestic and trans-national organised crime groups to operate illicit drug networks in New Zealand. It recognises that these groups drive the importation, manufacture and regular supply of chemicals and illicit drugs that both sustain and expand the domestic illicit drug market. Given the illegal nature of these activities, these groups are also often associated with a range of other offending, including violence, crimes against property and money laundering.

As well as contributing to broader societal harms, certain families and communities are disproportionately affected by these activities (for example, children living in clandestine laboratories).








Disrupting activity as far up the supply chain as possible is a continuing focus for New Zealand enforcement agencies. For example, 'Taskforce GHOST' – an operation in December 2013 conducted by New Zealand Police, the Organised and Financial Crime Agency of New Zealand and the New Zealand Customs Service – prevented 578kg of pseudoephedrine and 16kg of ephedrine entering the country and being used in the domestic methamphetamine manufacturing process.

To successfully disrupt organised crime enforcement efforts must be supported by initiatives aimed at reducing social harm. These initiatives need to address the social, economic and cultural factors that facilitate the recruitment of individuals by organised crime groups. We need to place emphasis both on building resilience in communities with a large organised crime presence and supporting individuals and families to turn away from the organised crime environment.

We need to maintain our focus on:

- making it easier for communities to report illegal activities such as the presence of tinny houses and clandestine labs and taking prompt action to remove these
- reducing social harm through a range of prevention and law enforcement actions that are supported by improved multi-agency information-sharing, analysis and intelligence
- reinforcing law enforcement efforts to break supply chains and sophisticated distribution networks
- strengthening border protection efforts to target drug trafficking networks
- reducing the availability of chemicals and other specialist equipment used by domestic drug manufacturers
- targeting the proceeds from illicit drug networks to remove the profit motive and prevent the financing of further crime.

By 2017/18 the Government will:

Action	Date	Strategies
Conduct the National Cannabis and Crime Operation to disrupt the activities of organised crime groups involved in the cultivation of cannabis	Annual	
Implement the Whole of Government Action Plan on Tackling Gangs	2017/18	  
Work with authorities in drug source and transit countries to break precursor chemical and drug supply chains into New Zealand	Ongoing	
Continue multi-agency investigations and targeting operations focussed on identified vulnerabilities of key organised crime groups and the drug supply chain	Ongoing	
Implement the Organised Crime and Anti-corruption Legislation Bill provisions (once enacted) which include initiatives that will assist disruption of illicit drug supply, using: → a more effective money laundering offence → improved detection of drug supply networks through reporting of international and large cash transactions to Police	2017/18	

Priority area 5: improving information flow
















The aim of this priority area is to improve the use and sharing of information we collect so that we, communities and individuals, can better:

- understand and respond to the causes of harmful AOD use
- target the right resources and initiatives to people in need at the right time
- collaborate to provide wrap-around services
- assess the effectiveness of policy and service responses, and make improvements
- track overall progress towards the objectives and goal of this Policy and its contribution to the government's wider social objectives.

Collection, use and sharing of information is vital if we are to anticipate and respond to AOD issues early and effectively, and

target policy, interventions, services and resources where they will have the greatest impact. Making information accessible is also crucial in order for communities to decide the AOD issues that are important to them and that shape their environment, and for individuals to be able to make informed choices about their own AOD use.

By 2017/18 the Government will:

Action	Date	Strategies
develop Tier 1 statistics for alcohol and other drug harm	2015/16	  
develop a multi-agency Early Warning System for the purposes of monitoring emerging trends and informing both enforcement and harm reduction strategies	2016/17	  
update the New Zealand Drug Harm Index	2016/17	  
publish a literature review of population-level AOD impacts and unmet needs	2015/16	  
develop and implement an AOD information plan	2016/17	  

Summary of Government actions

Action	Year
Priority Area 1 – Creating a people-centred intervention system	
→ develop a system map of potential resilience and intervention points across a person's life stages	2016/17
→ develop and implement a strategic framework for adult and youth AOD services	2017/18
→ regularly disseminate case studies of good and innovative practice	Annual
→ develop common tools and/or forums to share practice and celebrate success to foster system learning and improvement	2017/18
→ develop initiatives and an implementation plan to improve outcomes for children of parents with mental illness and addiction	2017/18
Priority Area 2 – Shifting thinking and behaviour	
→ build on existing AOD-related public education campaigns to change culture, promote help seeking and address stigma	Ongoing
→ publish a Fetal Alcohol Spectrum Disorders Action Plan	2015/16
→ provide guidance to support schools dealing with AOD issues and helping students who need it, with a focus on keeping students engaged where possible	2016/17
→ develop guidance for improving AOD intervention for services engaging with young people not in education or employment	2016/17
Priority Area 3 – Getting the legal balance right	
→ work with the Expert Advisory Committee on Drugs to ensure that harm minimisation is a central feature of drug classification assessments	2015/16
→ review the regulation of controlled drugs for legitimate purposes (such as medicines) alongside reviews of the Medicines Act and other therapeutics legislation	2017/18
→ develop options for further minimising harm in relation to the offence and penalty regime for personal possession within the Misuse of Drugs Act 1975.	2017/18
→ release a discussion document seeking feedback on appropriate regulation of drug utensils	2015/16
→ introduce the Substance Addiction (Compulsory Assessment and Treatment) Bill to Parliament	2015/16

Action	Year
→ develop a New Zealand position for United Nations General Assembly Special Session on Drugs 2016	2015/16
→ review the effectiveness of new police powers to deal with breaches of local alcohol bans introduced through the Local Government (Alcohol Reform) Amendment Act 2012	2015/16
→ evaluate the Alcohol and other Drug Treatment Court Pilot	2017/18
→ commence a review of the policy and operation of the Psychoactive Substances Act 2013	2017/18
Priority Area 4 – Disrupting organised crime	
→ conduct the National Cannabis and Crime Operation to disrupt the activities of organised crime groups involved in the cultivation of cannabis	Annual
→ implement the Whole of Government Action Plan on Tackling Gangs	2017/18
→ work with authorities in drug source and transit countries to break precursor chemical and drug supply chains into New Zealand	Ongoing
→ continue multi-agency investigations and targeting operations focussed on identified vulnerabilities of key organised crime groups and the supply chain	Ongoing
→ implement the Organised Crime and Anti-corruption Legislation Bill provisions	2017/18
Priority Area 5 – Improving information flow	
→ develop Tier 1 statistics for alcohol and other drug harm	2015/16
→ develop a multi-agency Early Warning System to monitor emerging trends and inform enforcement and harm reduction strategies	2016/17
→ update the New Zealand Drug Harm Index	2016/17
→ publish a literature review of population level AOD impacts and unmet needs	2015/16
→ develop and implement an AOD information plan	2016/17

References

- Accident Compensation Corporation. 2012. *Public Injury Prevention Programme: Logic to reduce alcohol as a contributing factor to injury*. Unpublished.
- Adolescent Health Research Group. 2013. *The Health and Wellbeing of New Zealand Secondary School Students in 2012: Youth'12 prevalence tables*. Auckland: University of Auckland. URL: <https://cdn.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/2012prevalence-tables-report.pdf>Boys A, Marden J, Strang J. 2001. Understanding reasons for drug use amongst young people: a functional perspective. *Health Education Research* 16: 457–69.
- Bayard M, McIntyre J, Hill K, Woodside J, Quillen J. Alcohol Withdrawal Syndrome. *Am Fam Physician* 2004 Mar 15;69(6):1443-1450.
- Business and Economic Research Limited (BERL). 2009. *Costs of Harmful Alcohol and Other Drug Use*. Wellington: BERL Economics.
- Connor J, Kydd R, Shield K, et al. 2013. *Alcohol-attributable Burden of Disease and Injury in New Zealand: 2004 and 2007*. Wellington: Health Promotion Agency.
- Dawson DA, Goldstein RB, Chou SP, Ruan WJ, Grant BF. 2008. Age at first drink and the first incidence of adult-onset DSM-IV alcohol use disorders. *Alcoholism: Clinical and Experimental Research* 32(12):2149-60.
- Doll R, Peto R, Boreham J, Sutherland I. 2004. Mortality in relation to smoking: 50 years' observations on male British doctors. *BMJ (Clinical research ed.)*. 328(7455):1519.
- Duff C. 2008. Research paper: The pleasure in context. *International Journal of Drug Policy* 19: 384-392
- Families Commission. 2006. *Families and Heavy Drinking: Impacts on children's wellbeing: Systematic review*. URL: <http://www.superu.govt.nz/sites/default/files/downloads/BS-families-and-heavy-drinking.pdf>
- Fergusson DM, Lynskey MT, Horwood LJ. Alcohol consumption and associated problems in a birth cohort of 15 year olds. *New Zealand Medical Journal* 1994(107): 167-170.
- Fergusson DM, Lynskey MT, Horwood LJ. 1996. Alcohol misuse and juvenile offending in adolescence. *Addiction* 91(4): 483-94.
- Gane E, Stedman C, Brunton C, Radke S, Henderson C, Estes C, Razavi H. 2014. Impact of improved treatment on disease burden of chronic hepatitis C in New Zealand. *New Zealand Medical Journal* 127(1407): 61-47.
- Gray, R., Gordon, C. and Newcombe, R. (2014). *Experiences with alcohol consumption culture and environments. [In Fact]*. Wellington: Health Promotion Agency Research and Evaluation Unit.
- Henderson C, Brunton C, Lauzon C. 2011. *Final Report of the National Needle Exchange Blood-borne Virus Seroprevalence Survey [BBVNEX2009] to the New Zealand Ministry of Health*. Unpublished report to the Ministry of Health.
- Hingston RW, Edwards EM, Heeran T, Rosenbloom D. 2009. Age of Drinking Onset and Injuries, Motor Vehicle Crashes, and Physical Fights after drinking and not drinking. *Alcoholism: Clinical and Experimental Research* 33(5): 783-790.
- Hingston RW, Heeren T, Winter MR. 2006. Age at drinking onset and alcohol dependence: age at onset, duration, and severity. *Archives of Pediatrics & Adolescent Medicine* 160(7):739-46.
- Jay M. 1999. Why do people take drugs? *International Journal of Drug Policy* 10(2): 5-7.
- Jennison KM, Johnson KA. 1998. Alcohol dependence in adult children of alcoholics: longitudinal evidence of early risk. *Journal of Drug Education* 28(1): 19-37.
- Komro KA, Tobler AL, Maldonado-Molina MM, Perry CL. 2010. Effects of alcohol use initiation patterns on high-risk behaviors among urban, low-income, young adolescents. *Prevention Science*.11:14-23.
- Kuntsche E, Delgrande JM. 2006. Adolescent alcohol and cannabis use in relation to peer and school factors: results of multilevel analyses. *Drug and Alcohol Dependence* 84(2): 167-174.
- Lann MA, Molina DK. 2009. A fatal case of benzodiazepine withdrawal. *American Journal of Forensic Medicine & Pathology* 30(2): 177-179.
- Livingston JD, Milne T, Fang ML, Amari E. 2012. The effectiveness of interventions for reducing stigma related to substance use disorders. *Addiction* 107(1): 39-50.

- Mallard SR, Connor JL and Houghton LA. 2013. Maternal factors associated with heavy periconceptional alcohol intake and drinking following pregnancy recognition: A post-partum survey of New Zealand women. *Drug and Alcohol Review* 32(4): 389-397
- Maynard S. 1997. Growing up in an alcoholic family system: the effect on anxiety and differentiation of self. *Journal of Substance Abuse* 9: 161-170.
- Meier MH, Caspi A, Ambler A et al. 2012. Persistent cannabis users show neuropsychological decline from childhood to midlife. *Proceedings of the National Academy of Sciences of the United States of America* 109(40): 2657-2664
- Mental Health Commission. 2011. *National Indicators 2011: Measuring mental health and addiction in New Zealand*. URL: <http://www.hdc.org.nz/media/199059/national%20indicators%202011%20measuring%20mental%20health%20and%20addiction%20in%20new%20zealand.pdf>
- Ministry of Education. 2013. Stand-downs, suspensions, exclusions and expulsions from school. *Education Counts*. URL: www.educationcounts.govt.nz/indicators/main/student-engagement-participation/Stand-downs-suspensions-exclusions-expulsions.
- Ministry of Health. 2009a. *Alcohol Use in New Zealand: Key results of the 2007/08 New Zealand Alcohol and Drug Use Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2009b. *Research into Knowledge and Attitudes to Illegal Drugs*. Wellington: Acumen Ltd & UMR Ltd.
- 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.
- Ministry of Health. 2013a. *Hazardous Drinking in 2011/2012: Findings from the New Zealand Health Survey*. URL: www.health.govt.nz/system/files/documents/publications/12-findings-from-the-new-zealand-health-survey.pdf
- Ministry of Health. 2013b. *Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006-2016*. Wellington: Ministry of Health.
- Ministry of Health. 2014a. *Tobacco Use 2012/13: New Zealand Health Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2014b. *New Zealand Health Survey — Annual update of key findings 2013/2014: Adult data tables — Health status, health behaviours and risk factors*. Wellington: Ministry of Health.
- Ministry of Health. 2014c. *Amphetamine Use 2013/14: New Zealand Health Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2014d. *Unpublished data from National Collections PRIMHD datamart*. Accessed September 2014.
- Ministry of Health. 2015a. *Alcohol Use 2012/13: New Zealand Health Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2015b. *Unpublished data from Drug Use 2012/13: New Zealand Health Survey*.
- Ministry of Justice. 2010. *The New Zealand Crime and Safety Survey: 2009*. Wellington: Ministry of Justice.
- Ministry of Transport. 2014. *Alcohol and drugs 2014*. URL: <http://www.transport.govt.nz/assets/Uploads/Research/Documents/Alcohol-drugs-2014.pdf>.
- Morton SMB, Atatoa Carr PE, Bandara DK et al. 2010. *Growing Up in New Zealand: A longitudinal study of New Zealand children and their families. Report 1: Before we are born*. Auckland: Growing Up in New Zealand.
- New Zealand Police. 2009. *National Alcohol Assessment*. Wellington: NZ Police.
- Noller G, Henderson C. 2014. *Report of the National Needle Exchange Blood-borne Virus Seroprevalence Survey [BBVNEX2013] to the New Zealand Ministry of Health*. Unpublished report to the Ministry of Health.
- Office of the Chief Coroner. 2012. *Recommendations Recap: a summary of coronial recommendations and comments made between 1 January-31 March 2012*. Issue 2. New Zealand: Officer of the Chief Coroner.
- Office of the Chief Social Worker. 2014. *Workload and Casework Review: Qualitative review of social worker caseload, casework and workload management*. URL: www.msd.govt.nz/documents/about-msd-and-our-work/newsroom/media-releases/2014/workload-and-casework-review.pdf
- Office of the Prime Minister's Science Advisory Committee, Gluckman PD. 2011. *Improving the Transition: Reducing social and psychological morbidity during adolescence*. Wellington: Office of the Prime Minister's Science Advisory Committee.

- Peto, Lopez et. al. *Mortality from Smoking in Developing Countries 1950–2010 (revised March 2012)*. URL: www.ctsu.ox.ac.uk/research/mega-studies/mortality-from-smoking-in-developed-countries-1950-2010.
- Research New Zealand. 2014. *HPA Attitudes and Behaviour Towards Alcohol Survey 2010–2012: Report 1.2 – Planning, actions and consequences of the last drinking occasion (adults, 18 years and over)*. Wellington: Health Promotion Agency.
- Robin Room et.al. 2008. *The Global Cannabis Commission Report – Cannabis Policy: Moving Beyond Stalemate*. URL <http://www.undrugcontrol.info/en/issues/cannabis/item/2406-cannabis-policy-moving-beyond-stalemate>.
- Silins E, Horwood LJ, Patton GC et al. 2014. Young adult sequelae of adolescent cannabis use: an integrative analysis. *Lancet Psychiatry* 1: 286 – 93.
- Squeglia LM, Jacobus J, Tapert SF. 2009. The influence of substance use on adolescent brain development. *Clinical EEG and Neuroscience* 40(1): 31–38.
- Swahn MH, Bossarte RM, Ashby JS, Meyers J. 2010. Pre-teen alcohol use initiation and suicide attempts among middle and high school students: findings from the 2006 Georgia Student Health Survey. *Addictive Behaviours*. 2010 May; 35(5):452-8.
- The University of Auckland. 2014. *Problem substance use among New Zealand secondary school students: Findings from the Youth'12 National Youth Health and Wellbeing Survey*. Auckland: The University of Auckland – Faculty of Medical and Health Sciences.
- Wells JE, 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.
- Wilkins C, Sweetsur, P. 2012. Criminal justice outcomes for cannabis use offences in New Zealand, 1991–2008. *International Journal of Drug Policy* 23(6): 505–511

Further resources

- Alcohol Advisory Council of New Zealand. 2012. *The Impacts of Liquor Outlets in Manukau City: Report No. 4: A spatial econometric analysis of selected impacts of liquor outlet density in Manukau City*. Wellington: Alcohol Advisory Council of New Zealand.
- Barker CA. 2011. Children in New Zealand methamphetamine laboratories. PhD thesis, ResearchSpace@Auckland, University of Auckland.
- Business and Economic Research Limited (BERL). 2008. *New Zealand Drug Harm Index*. Wellington: BERL Economics.
- Casas-Gill MJ, Navarro-Guzman JI. 2002. School characteristics among children of alcoholic parents. *Psychological Reports* 90: 341–8.
- 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.
- Darke S, Kaye S, McKetin R, et al. 2008. Major physical and psychological harms of methamphetamine use. *Drug and Alcohol Review* 27: 253.
- Expert Advisory Committee on Drugs. 2004. *Advice to the Minister on ,4-methylendioxyamphetamine (MDMA)*. URL: www.health.govt.nz/system/files/documents/pages/eacdm dma.pdf
- Families Commission. 2009. *Family Violence: Statistics report*. URL: <http://www.superu.govt.nz/sites/default/files/downloads/family-violence-statistics-report.pdf>
- Fisk J, Murphy P, Montgomery C, et al. 2011. Modelling the adverse effects associated with ecstasy use. *Addiction* 106: 798–805.
- Hoaken P, Stewart S. 2003. Drug of abuse and the elicitation of human aggressive behaviour. *Addictive Behaviour* 28(9): 1533–54.
- Hyphantis T, Koutras V, Liakos A, et al. 1991. Alcohol and drug use, family situation and school performance in adolescent children of alcoholics. *International Journal of Social Psychiatry* 37(1): 35–42.
- Krasnova IN, Cadet JL. 2009. Methamphetamine toxicity and messengers of death. *Brain Research Reviews* 60(2): 379, 380.
- Lynskey MT, Fergusson DM. 1994. The effect of parental alcohol problems on rates of adolescent psychiatric disorders. *Addiction* 89(10): 1277–86.
- McKetin R, McLaren J, Riddell S, et al. 2006. The relationship between methamphetamine use and violent behaviour. *BOSCAR NSW Crime and Justice Bulletin* 97.
- Ministry of Health. 2013. *New Zealand Health Survey: Annual update of key findings 2012/2013*. Wellington: Ministry of Health.
- National Drug Intelligence Bureau. 2013. *Illicit Drug Assessment*. Wellington: National Drug Intelligence Bureau.
- New Zealand Drug Foundation. *About a Drug: MDMA*. URL: www.drugfoundation.org.nz/content/about-drug-mdma
- New Zealand Law Commission. 2010. *Controlling and Regulating Drugs: A review of the Misuse of Drugs Act 1975*. Issues Paper 16. Wellington: New Zealand Law Commission.
- Obot IS, Anthony JC. 2004. Mental health problems in adolescent children of alcohol dependent parents: epidemiologic research with a nationally representative sample. *Journal of Child and Adolescent Substance Abuse* 13(4): 88–96.
- Room R, Fischer B, Lenton S, et al. 2008. *The Global Cannabis Commission Report – Cannabis policy: Moving beyond stalemate*. Oxford: The Beckley Foundation.
- Rush R, Gliksman L, Brook R. 1986. Alcohol availability, alcohol consumption and alcohol-related damage: the distribution of consumption model. *Journal of Studies on Alcohol and Drugs* 47(1): 1–10.
- Todd FC. 2010. *Te Ariari o te Oranga: The Assessment and Management of People with Co-existing Mental Health and Substance Use Problems*. Wellington: Ministry of Health.
- White J. 2013. *Use of Alcohol Among Year 10 students. [In Fact]*. Wellington: Health Promotion Agency Research and Evaluation Unit.
- Wilkins C, Sweetsur P, Moewaka Barnes H, et al. 2012. *New Zealand Drug Use Monitoring (NZ-ADUM) 2011 Report*. Auckland: SHORE and Whariki Research Centre, Massey University.
- Wilkins C, Sweetsur P, Smart B, et al. 2012. *Recent Trends in Illegal Drug Use in New Zealand: Findings from the 2006, 2007, 2008, 2009, 2010 and 2011 Illicit Drug Monitoring System (IDMS)*. Auckland: SHORE and Whariki Research Centre, Massey University.