matters of substance

AT THE HEART OF THE MATTER, NZ DRUG FOUNDATION.
Te Tūāpapa Tarukino o Aotearoa

August 2008

What to do with 'high' school students

How to deal with drinking and drug taking kids is an issue many boards and principals now face. Some schools boast a zero tolerance policy while others give that approach zero out of ten.

www.drugfoundation.org.nz

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The NZ Drug Foundation has been at the heart of major alcohol and other drug policy debates for over 18 years. During that time, we have demonstrated a strong commitment to advocating policies and practices based on the best evidence available.

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Features

Regulars

News

In our May issue, editing of Martina Melis's article *Human rights and drug control* meant some key points were amended incorrectly. The complete and correct article can be viewed on our website.

The Director's Cut

WELCOME to our August issue, and welcome, Prime Minister, to the alcohol debate.

I have to confess some cynicism at the prime minister now speaking up about liquor licensing and the impact of alcohol in our communities.

Most observers are well aware of the high level of anxiety over alcohol in recent years, and it's not as though alcohol hasn't featured on Parliament's agenda. Over the past nine years, there have been various member's bills about purchase age, licensing and marketing. Then there's the annual data from Statistics NZ showing a constant increase in alcohol consumption (a proven proxy for alcohol harm), driven largely by alcopops. More importantly, we've seen communities taking a stand against the proliferation of alcohol – the hikoi in Clendon and Queenstown's licensing controls the most recent examples.

So why has the prime minister only now found a voice? Some suggest her recent comments about the number of liquor outlets are a cynical political move, exploiting a very sad incident in South Auckland. Others are more pragmatic, saying, regardless of the motivation, the PM is providing a rare opportunity for positive change.

The prime minister showing leadership on alcohol is valuable nonetheless. When prime ministers speak, people tend to listen. But we, and others, have been raising these issues for a long time, only to see action halted. Why have the 2006 alcohol reviews (on supply to minors, and marketing) been stalled for so long? Why has the National Alcohol Strategy been expired for five years?

Fingers crossed, real action will be taken now – the government has recently proposed a new bill giving communities a greater say in liquor licensing, tightening advertising rules and supply of alcohol to minors. Councils, communities, health advocates, even the hospitality industry, are urging change.

But there is one significant hurdle.

Practically, there isn't enough time on this Parliament's calendar to see through a law change. The best we can ask is that this bill will make its way past a first reading to the Health Select Committee for public submissions. After that, we hope the new Parliament will keep the bill on its agenda and, finally, that all parties will vote as one for laws that will help make real change to our drinking culture.

Happy reading, Ross Bell. ■

Feedback

This editorial is published on our website – **www.drugfoundation.org.nz/matters-of-substance** – where you can post responses to this and previous Director's Cuts.

Key Events and Dates

Insights and Solutions
1–3 September, Melbourne, Australia
A chance to consider innovative approaches and improved practice in the field of acquired brain injury.
www.bia.net.au

Life and Death – Cutting Edge
4–6 September, Christchurch
The annual New Zealand addiction treatment sector conference.
This year's keynote speakers include Khun Piyabutr (Thailand) and Alex Wodak (Australia), as well as locals Sally Casswell, Charles Henderson, Paraire Huata and David Fergusson.
www.cuttingedge2008.org.nz

LIFE AND DEATH

1st Global Conference on Methamphetamine: Science, Strategy and Response
15–16 September, Prague, Czech Republic
The 1st Global Conference on Methamphetamine recognises that many countries have been forced to rush towards solutions in response to this new trend; however, many facets of the problem remain to be discovered.
www.globalmethconference.com

Safe Communities
20–23 October, Christchurch
The 17th International Safe Communities Conference aims to celebrate and strengthen community safety as an integral part of national and international injury and violence prevention policy, research and practice.
www.safecom2008.org.nz

National Conference on Injecting Drug Use
26–28 October, Hammersmith, London
This is the world's biggest conference of its kind, bringing together clinicians, researchers and injecting drug users to explore policy and develop skills for harm reduction practices.
www.exchangesupplies.org

Adolescent Health 2008
5–7 November, Melbourne, Australia
The Centre for Adolescent Health presents the 7th Annual Australia and New Zealand Adolescent Health Conference. This conference will examine new knowledge and understandings around young people and explore the future of adolescent health.
www.adolescenthealth08.com

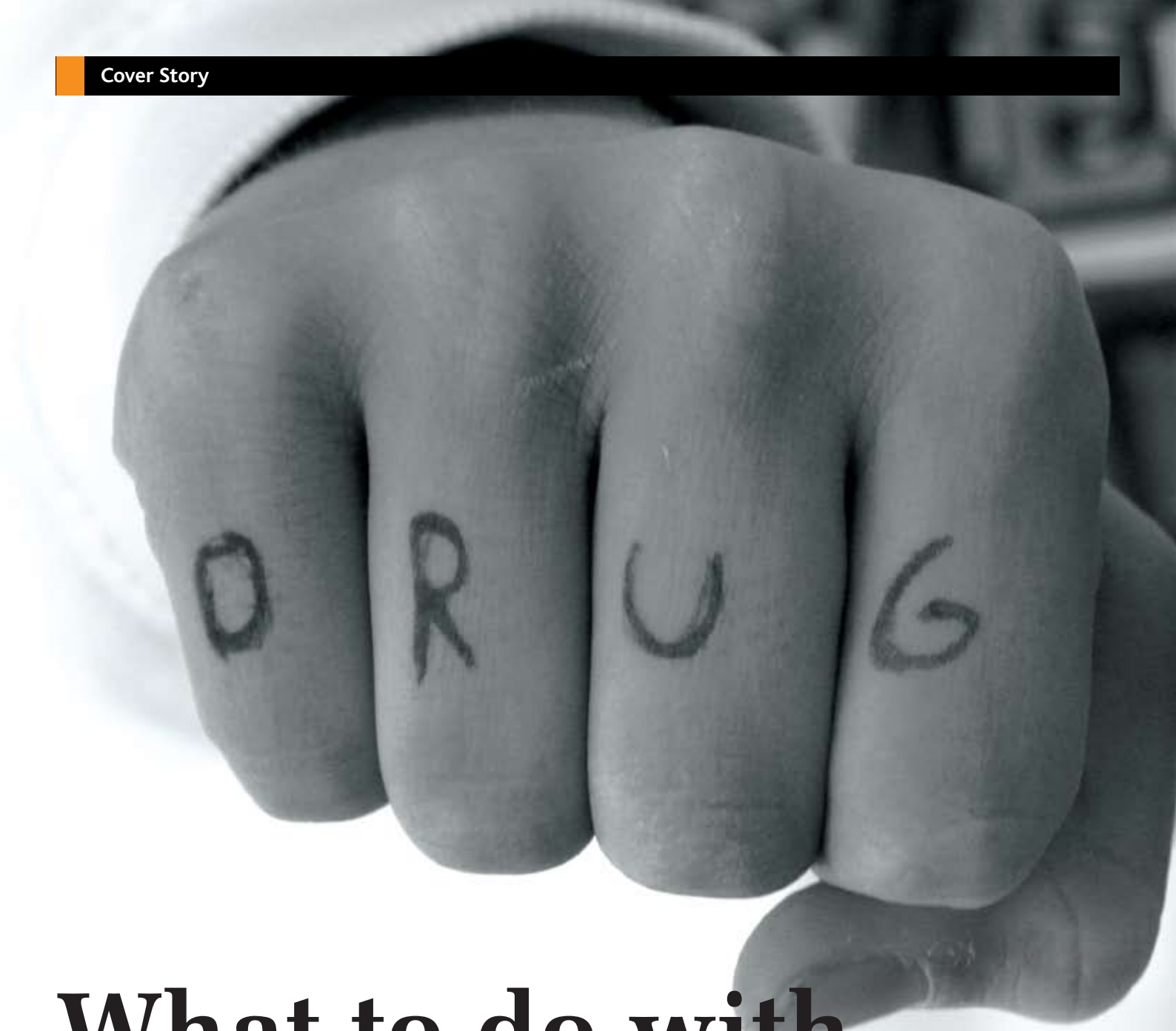
Addiction Treatment Leadership Day
6 November, Wellington
This day is an opportunity for managers, funders, planners and senior clinicians to debate and discuss important issues facing the addiction treatment sector.
www.matuaraki.org.nz

NZ Drug Foundation Annual General Meeting
17 November, Wellington
www.drugfoundation.org.nz

APSAD 2008 Evidence, Policy and Practice
23–26 November, Sydney, Australia
The Australian Professional Society on Alcohol and Other Drugs Conference promotes the use of best practice approaches in the prevention, early intervention and treatment of alcohol and other drug problems.
www.apsad2008.com

3rd International Conference on Fetal Alcohol Spectrum Disorder 2009
11–14 March, Victoria, BC, Canada
The conference aims to act as a catalyst for change around the globe by integrating research and policy into practice to assist governments, parents, services and caregivers who strive to prevent FASD and ultimately provide supports for people and their families living with FASD.
www.interprofessional.ubc.ca

International Harm Reduction Association Conference 2009
19–23 April, Bangkok, Thailand
This event will mark the International Harm Reduction Association's 20th international conference.
The conference theme is Harm Reduction and Human Rights.
Asia has been consciously chosen to host the conference based on many countries in the region failing to provide vital health and harm reduction services to which drugs users are entitled.
www.ihra.net



What to do with 'high' school students

A high-profile Auckland school, trumpeting the battle cry of zero tolerance, kicked out 12 students for drug-related offences earlier this year and, in the process, won kudos from its community.

Other schools are critical and say excluding students does nothing more than pass on the buck along with the problem student. Health, drug and alcohol experts say principals and boards need to involve parents and the community in finding better ways of dealing with school drug problems. **Gael Woods**.

WESTLAKE Boys High, a decile 10 state school in the affluent Auckland suburb of North Shore, boasts having "facilities to make your education experience enjoyable". And presumably, with its policy of zero tolerance, drug-free.

Unlike, Westlake Boys, Napier's William Colenso College does not operate a zero tolerance policy. On the contrary, its position on drug infringements could be described as very tolerant.

The principal, Mark Cleary, is well aware that drugs are a regular feature of some students' lives. "For all that, we make it clear that drug taking is not sanctioned, and we will take drastic action if students have drugs at school," he says.

"But zero tolerance implies exclusion from school, and New Zealand society cannot afford to have a significant group of young people not at school because of drug use."

Cleary has little patience with schools adopting a zero tolerance approach. "They are abdicating responsibility for young people in their school. They're just passing the problem students on to other schools."

A member of the board of trustees at William Colenso, Trish Gledhill, says the school does tend to accept students who've been thrown out of other schools. "While that might not help our reputation, you have to reframe it. We don't want to be seen as a school that takes bad kids, but one that's particularly responsive.

"We do have support services here and a range of prevention and intervention programmes that benefit all kids, not just those with significant problems.

"But it's not always easy. The ministry obviously wants to reduce suspension and exclusion rates, but doesn't always give you a lot of help."

YouthLaw, a community law centre for young people, sometimes becomes involved in cases of drug-related school disciplinary action. A senior solicitor at YouthLaw, John Hancock, says that, legally, schools cannot operate a zero tolerance policy.

"The courts have said you can't take a blanket approach or have a pre-ordained outcome for any one situation. There is a need for proportionate decision making, which takes into account the circumstances and the individual student.

"Zero tolerance clashes with that because it says, if you're caught with drugs, you will be chucked out. Some schools think that sort of policy is a deterrent, but it's probably not enforceable."

Hancock says zero tolerance is a bit of a 'buzz word'. "It sounds like you're saying, 'We're not tolerating this sort of thing', as if other sorts of ways of dealing with it are permissive of the activity, but this isn't."

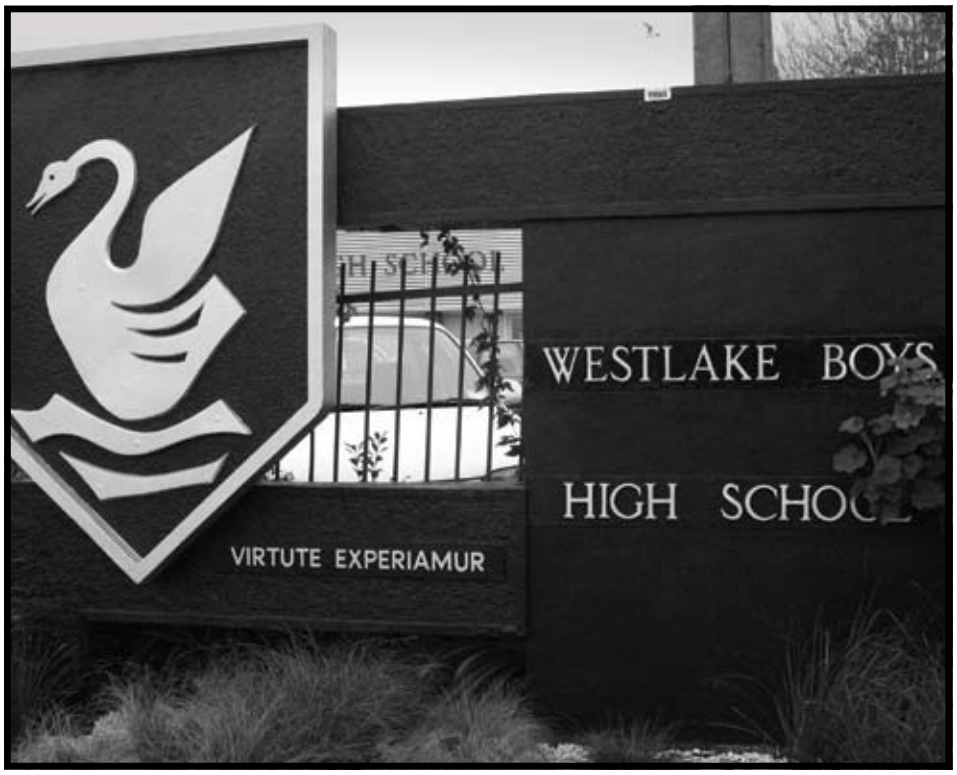


Photo courtesy of NZPA/Mike Millett.

“Drug taking is an issue that doesn’t belong entirely in schools. It’s a New Zealand-wide issue, and if schools are aware of that and treating it that way, they’ll have more chance of succeeding with these kids.”

Jim Greening

Westlake Boys principal, Craig Monaghan, says that, for him, zero tolerance means anyone with drugs will be sent to the school board, which, he acknowledges, cannot take a zero tolerance approach.

“The board will look at every case. It showed that in the most recent case by being willing to take back four boys.”

Monaghan rejects the charge that the school is abdicating its responsibility and simply handing on the problem to another school.

“All schools will, at some stage, exclude students. We have to make the right decision for our students, and at Westlake, we feel that the drugs message needs to be black and white.

“But we don’t just leave the boys [who have been excluded] hung out to dry. I and my PA have been on the phone for many hours finding other places for them.”

Zero tolerance as a school policy is frowned on by the Ministry of Education.

The senior manager of implementation and planning for schools and students, Jim Greening, says the ministry’s preference is for schools to treat drugs as a health issue and deal with students on a case-by-case basis.

“If you put up a brick wall and say, ‘Let’s not think about it, you’re gone,’ you’ll be kidding yourself,” says Greening. “Drug taking is an issue that doesn’t belong entirely in schools; it’s in the community. It’s a New Zealand-wide issue, and if schools are aware of that and treating it that way, they’ll have more chance of succeeding with these kids.”

Greening points to figures for suspensions and stand-downs released last month, which are at their lowest in ten years, as a sign that schools are increasingly dealing with drugs as a health matter. He says the 39 percent fall in drug suspensions since 2000 is the main reason why overall suspensions have fallen.

Moreover, for the first time in eight years, drug suspensions no longer represent the main type of suspensions. The number of exclusion cases for drugs has also dropped (by 45 percent since 2000). The ministry says the “slight” increase in stand-downs is further evidence that schools are not resorting to suspensions as quickly as in the past.

While the ministry might be

perturbed about schools that would rather get rid of offenders than keep them in the school, YouthLaw believes it's a practice that boards have been able to get away with.

John Hancock feels schools are relatively unchecked when it comes to decision making concerning students, particularly with regard to drug searches and drug testing. He says this leaves schools open to possible legal liability if things are done wrongly.

"There are fundamental rights laid down by the Bill of Rights, as well as a number of civil liberties, such as the right to be free from unreasonable search and seizure. There are issues over whether searches and testing are a reasonable or effective response to an alleged situation involving drugs, and whether teachers and other school staff can carry out searches. Some schools bring in sniffer dogs. These are complex issues."

Hancock says the response to action against a student depends on the follow-up from the family, with parents often taking a pragmatic view. "Their child's in trouble. Something untoward in terms of process may have occurred, but their main concern is keeping the child in school."

That is probably why there's little New Zealand case law on drug testing and searches. Whether a board can enforce either measure has never been determined by a court, and someone would need to be willing to take those steps.

"It's a big thing to take legal action against a school, and that's why it seldom happens," says Hancock. "It might not necessarily be in the child's best interests, it takes a long time, it's expensive with no guarantee of success, and even with name suppression, it can still feel like quite a public process." (See sidebar.)

At Kapiti College in Raumati, principal Tony Kane says almost every case of drug testing is done with "grateful" support from parents. He says making a return to school conditional on testing also helps students.

"We say, 'We know you've got a problem and that it's hard to say no, but you'll be compulsorily tested and you can tell your friends outside school that you can't smoke drugs because you're being drug tested'. We've had a few kids who've been quite grateful for that assistance in dealing with their lives outside school."

Legal minefield

Schools are anxiously awaiting a reserved decision from the Court of Appeal over a ground breaking ruling that principals say makes it more difficult to deal with seriously misbehaving students.

Last year, a High Court judge ordered Lynfield College in Auckland to take back an expelled student. Justice Patrick Keane ruled that the school board had overlooked certain legal requirements when twice suspending and ultimately excluding a 16-year-old after alleged incidents of truancy, drug use and misbehaviour.

Principals complained the ruling would make it much harder to suspend disruptive students. The Principals' Council said students were being sent the message that they should always deny they've done anything wrong, because admissions of guilt could be sought only under certain conditions.

The ruling also prompted the Ministry of Education to send advice to schools warning them to bear in mind the court's decision when dealing with disciplinary issues.

Then, earlier this year, Lynfield College went to the Court of Appeal, arguing it had followed proper processes when excluding the student. The school also said it had to balance the interest of the individual with those of the wider school and that the High Court judgement had swung too far in favour of the student.

A senior manager at the Ministry of Education, Jim Greening, says that, at the moment, there is no New Zealand case law on drugs in schools.

"A lot sits up in the air," he says, "and it's only when they're tested at that very high level that we actually get a precedent schools are all well aware of. That's why the Lynfield case is very important. It's the first really big test of the guidelines we've had in place for some time."

Greening says those guidelines for schools on stand-downs, suspensions, exclusions and expulsions will need to change if the Court of Appeal upholds the judgement.

"Our advice at the moment means when a school's senior management is carrying out an investigation, they need to be really aware that students get a fair hearing and that parents are involved as early as possible. Schools are saying that's going to take an awful lot of time. But that's what the judge has said."

Kane says the school talks about taking a zero tolerance approach, but would never kick a student out for drug use.

Bringing drugs on to school property is different. "If we have someone with drugs at schools, I tell the other students who it is and what the consequences are."

Some of his students remember well the day four of their peers caught with drugs had to stand up in assembly and make a speech saying drugs were bad.

"I thought it was funny," says Nick. "It was shameful."

His classmate, Alex, says she thought the matter had been dealt with in a good way. "There were all these rumours, and now everybody knows they got snapped at school. No-one wants to stand in front of assembly and say they've been stupid."

Another student, Kewa, says there was definitely nothing "cool" about it for the students involved – "not when there are 250 students saying you're a loser."

The students approve of their school's overall approach and believe that, while the expression 'zero tolerance' is used, it's not really implemented.

"I like it because people make mistakes," says Alex. "They need to be given a fair chance. Some will think they've got it sussed and drugs will make it all all right. But you can't give up on them.

"Just expelling them and sending them on is saying the school can't be bothered. I'm not saying there shouldn't be punishment, but schools should put in the effort and take them under their wing."

The guidance counsellor at Kapiti College, Fiona Wallace, regularly sees the results of drug use, specifically cannabis, which she describes as the major drug affecting youth. She favours the promotion of zero tolerance, saying there has to be a strong line against drug use.

"The thing I perceive mostly and sadly is the acceptance that, as an adolescent, you're likely to try drugs and alcohol, which wasn't the perception when I was growing up. And they have a perception that's it's all right to have a session every now and then. They don't realise or understand the impact cannabis has on their systems."

While she regards cannabis as the greater evil, alcohol is a real concern, with it featuring in many students' lives.

Drug education research

The latest New Zealand review of drug and alcohol education programmes in schools concludes classroom-based programmes, which are used widely and attract considerable funding, are not effective in reducing drug-related harm.

The Centre for Social and Health Outcomes Research and Evaluation at Massey University, which conducted the review, says its research has created a lot of concern among providers and funders of the programmes.

The centre's director, Sally Casswell, says the review shows that it was very well accepted in all the research that drug and alcohol education did provide knowledge, which resulted in some short-term and minimal changes in behaviour, but the likelihood of that translating into a really significant reduction of drug and alcohol harm down the track was very low.

She says the results were difficult because there were lots of organisations working in the area, which were extremely motivated to do good. "So to have evaluations that show that's not the best way to be spending their time, that's very difficult.

"What they've been doing is very good in terms of teaching. They've got clear objectives, the material is presented really well, and they work interactively with students. That's why young people are learning. But to go beyond that to meet health objectives and achieve a reduction of harm is a big jump."

She says the problem is that a quite small intervention in the classroom is really trying to change behaviour that is deeply embedded in society.

But Professor Casswell says a new process of working through the research with organisations has been very useful.

In an unusual move, the researchers struck up what was called a 'rich dialogue process', which fed information back to the stakeholders and included follow-up sessions. She said the research was received differently by different providers.

Some had already drawn conclusions from the literature over many years and moved on to ways to improve the situation. However, she says, for some groups committed to classroom-based activities, it hasn't been easy to accept the findings.

She supports the Ministry of Education's policy of having drugs and alcohol education as part of the health curriculum in schools. "But we shouldn't do any more than we expect the school to do around other health issues, and we shouldn't assume they work.

"If I was on a school board, I wouldn't support having programmes taught by external providers. Drug and alcohol education needs to be part of a much wider community intervention."

Professor Casswell says that, already, particularly with youth and alcohol, she sees the beginning of a shift in direction, such as increasing community concern about young people's easy access to alcohol and binge drinking.

She says what's needed is a strong-willed government to drastically reduce the marketing of alcohol.

"That would have an impact on parents. What we've got are consistent messages that alcohol is associated with fun and having a good time, but nothing about the negatives. It encourages a feeling that it would be difficult or inappropriate to restrain your teenager's use of alcohol.

"If we got marketing off billboards and the airwaves, it would be an extremely valuable public education message. Parents would get the sense that the government recognises something needs to be done and they would, in turn, feel strengthened in their own ability. That would have a much greater impact than any drug education."

Drug testing in schools

What does not work?

On 28 May this year, members of Parliament's Law and Order Select Committee were briefed by a former drug squad detective on how to solve the methamphetamine crisis in New Zealand.

One of his most troubling recommendations was to implement student random drug testing programmes based on models from the United States.

Most evidence demonstrates that random drug testing in schools is not effective. The Australian National Council on Drugs (ANCD) – an advisory body to the Australian prime minister – spent a year looking at evidence from around the world on drug testing in schools and, in March this year, published a comprehensive report of its findings called *Drug testing in schools: Evidence, impacts and alternatives*. The principal author, Professor Ann Roche, said there was no sound research evidence to support the use of drug testing as a deterrent or that drug testing programmes reduce harms associated with drug use.

Several major problems were found to be associated with random drug testing – a huge cost to the taxpayer being one. The researchers calculated that drug testing each Australian child once a year could cost around $355 million. Annual testing of a random 10 percent of the school population three times yearly could cost up to $110 million.

Another paramount issue is the accuracy of tests. They do not determine the quantity, frequency or context of drug use, so fail to distinguish experimental, occasional or one-off drug users from those with problematic drug use. Neither do the tests distinguish between similar metabolites found in legal or prescribed drugs and illicit drugs.

Finally, there are serious ethical and legal implications such as children's right to privacy. No studies have directly evaluated the safety of random drug testing of school children or any potential adverse outcomes.

Professor Roche warned that introduction of testing into Australian schools would create mistrust, leading directly to students becoming disengaged from the education system.

"One qualitative study showed that, whilst the majority of students were undisturbed by the drug testing experience, more than a quarter were either distressed or angered," she said.

What does work? Alternatives to drug testing

If drug testing in schools doesn't work, then what does?

The ANCD report says evidence supports three very different but complementary strategies:

- Supporting and developing connectedness between children and their school.
- Providing targeted early and brief interventions for high risk students.
- Offering family strengthening interventions.

Schools have made a marked shift to becoming safer, more nurturing social institutions in recent years. Their aim has been to enhance students' sense of connectedness to the school, not only by producing students who are literate and committed to lifelong learning but through programmes that teach social and emotional learning (SEL).

Key to SEL programmes are the quality of student relationships with teachers and peers, and ways that students identify with the school as a social institution.

Studies have shown that such programmes develop attitudes in children that are inconsistent with harmful behaviours, including substance use, and those programmes with a highly interactive approach are more effective than more didactic models.

One recent Australian example is Victoria's Gatehouse Project, which sought to build a sense of security and trust, increase skills and opportunities for effective communication and show students they were valued through participation in aspects of school life.

Evaluations show adolescents' sense of connectedness with their schools was associated with lower levels of emotional distress, suicidal thoughts, violence, use of alcohol, tobacco and cannabis, and a delay in the start of sexual activity. Students who felt more connected to their schools performed better academically and required fewer school nurse visits.

Such approaches to improve school bonding have also been effective at primary school level, helping children maintain a positive developmental course through high school.

Schools can also play a key role in identifying high risk students and targeting interventions specifically for them.

Motivational enhancement interventions, for example, use client-centred interviewing principles that are known to be effective. Focusing on risk factors rather than problem behaviours provides an opportunity to intervene before problem behaviours such as drug use develop.

Finally, some of the strongest supporting evidence for effective drug prevention programmes comes from those involving families. This is not surprising, given the important role families play in both the prevention (and development) of drug problems. However, a major problem with such programmes is how to engage 'hard-to-reach' parents (including the unemployed, or socially isolated) who are more likely to have children with problem behaviours.

One of the most effective school-based family drug prevention programmes is the Strengthening Families Programme (SFP). It involves training in parent skills, children skills and family life skills. SFP has been shown to have promise as an effective long-term universal intervention.

It's also worth mentioning that the effectiveness of individual school-based drug prevention programmes should not be considered in isolation. The question should be, 'Which combinations or sequences of strategies work best?'

Find out more

Read the ANCD report here: **www.ancd.org.au/publications/pdf/rp16_drug_testing_in_schools.pdf**.

Watch this video of interviews with experts on school drug testing attending Beyond 2008: **www.drogriporter.hu/en/node/1042**.

"Sadly, I've seen students who have adopted a lifestyle around alcohol, including one who, by 14, was quite dependent on it. I am alarmed at the amount they drink over a week, let alone in one session, and it's mainly pre-mixed drinks and spirits."

Tony Kane says it is extraordinarily difficult to do anything about alcohol when it's so easy for young people to get.

"At the time, I thought lowering the drinking age to 18 was probably just acknowledging reality. But it was a bad idea because it simply dropped the entire set of ages. There is no problem whatsoever for them to get alcohol. Older brothers and sisters will get it, and I know very well that some places have no compunction about selling it to them. Kids can get it whenever they like."

Several Kapiti College students make the point that, while drugs affect a small number of students, most people at senior school level drink.

"Every Monday morning, it's always laughs about what people got up to at the weekend; who was so drunk, so out of it," says Alex.

"It used to be movie nights," says Kewa, "but now it's drinks, and that's most weekends."

Fiona Wallace is unimpressed with student 'drinks'. But, she says, cannabis is far worse than alcohol. "Alcohol is removed from the system quickly. Cannabis has much more damaging effects and remains in the body for a month or more, and how it affects the developing brain is just devastating. The kids don't realise how severe it is on them and how they function."

For all that, a leading researcher on drugs and alcohol says that, without doubt, alcohol is the major drug problem for New Zealand.

The director of the Centre for Social and Health Outcomes Research and Evaluation at Massey University, Sally Casswell, says that the wide availability and increasingly sophisticated marketing of alcohol, combined with greater consumption by young people, make it much more difficult for messages against alcohol to be effective.

In a research paper to be published shortly (see sidebar on page 6), Professor Casswell says the problem for school-based drug and alcohol education programmes is that they try to go beyond what schools normally do, by attempting to change behaviours that are deeply embedded in our culture.

"Nobody expects the teaching of geography or history to change behaviours in the way we expect a few classroom lessons to change how students think about behaviour around drugs and alcohol, particularly when it is constantly reinforced by peers, family, marketing and availability.

"With marijuana, which is the most widely used illicit drug, there is control of supply, and we don't have the level of availability because society treats it differently. With alcohol, there is some control, but it's pretty feeble in terms of access, and consequently, there's widespread use."

Professor Casswell says, while the evidence suggests that classroom-based universal drug and alcohol education programmes have minimal effect, there is research that shows changing the whole school environment might be more helpful and that schools should be seen as just one side of a community-wide intervention.

At William Colenso College, Trish Gledhill agrees the problem is a community one, and drug education that works well usually involves the family. Her work with families and addiction has also convinced her that schools work well when they are linked to the community, which is why she believes that it would be wrong to impose an over-arching central approach on schools.

It would be hard to find a school that has never had to deal with a drug or alcohol issue, but, while it's often complex and never easy, schools have had to become practised at dealing with it over the past 20 years.

"Even if it's just knowing when not to panic." ■

"Nobody expects the teaching of geography or history to change behaviours in the way we expect a few classroom lessons to change how students think about behaviour around drugs and alcohol..."

Sally Casswell

Gael Woods is Radio New Zealand's education correspondent.

Stand-downs, suspensions, exclusions and expulsions

In July 1999, suspension rules under the Education Act 1989 were amended to help schools manage student misbehaviour. The goal was to keep students engaged in education rather than have them removed from school, and a new stand-down option was introduced.

The Stand-down and Suspension Database (SDS) was also established to collate national data from state schools and identify trends. Baseline data revealed low decile secondary schools, and Māori students in particular, were over-represented in stand-downs and suspensions.

In 2001, the Ministry of Education responded by introducing the Suspension Reduction Initiative (SRI), which emphasised preventative strategies and encouraged schools to make greater use of stand-downs or restorative practices.

There was definite improvement under SRI, but high rates of suspensions, early leaving and truancy remained a problem. In 2003, the Student Engagement Initiative (SEI) was born, aiming to help schools identify best practice and opportunities to improve policies and procedures.

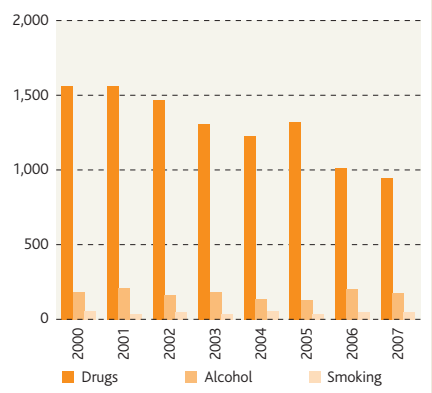
The latest data shows both initiatives are working, with participating schools having fewer suspensions – including a 25 percent reduction in rates for Māori. However, Māori students are still over-represented in both stand-downs and suspensions.

So what does this have to do with drugs?

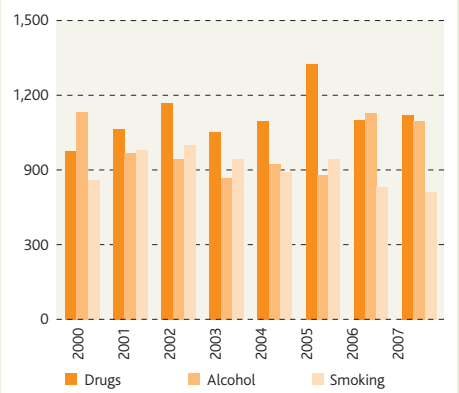
The 2000 SDS data recorded drug use (not including alcohol or smoking) as the most common behaviour resulting in suspension (31 percent).

Data from 2007 shows that figure is now just 20 percent. However, drug misuse is still the second most common cause for suspension. The rate of drug-related stand-downs has risen slightly.

Number of suspensions at state schools by behaviour



Number of stand-downs at state schools by behaviour



Suspension is the formal removal of a student from a school until the board of trustees decides the outcome at a suspension meeting.

Stand-down is the formal removal of a student from a school for a specified period totalling no more than five school days in any term, or ten days in a school year.

Source: www.educationcounts.govt.nz

The global state of harm reduction

Published in May, the *Global State of Harm Reduction 2008* report provides a region-by-region assessment on drug-related HIV and hepatitis C epidemics, as well as the extent of policy and programmatic responses from multilateral agencies, government and civil society. **Catherine Cook**.

THE evidence base for interventions that aim to reduce harms associated with drug use is extensive and unequivocal. United Nations agencies have long endorsed harm reduction and international best practice guidelines to promote access to harm reduction services as both a human right and a public health imperative.

At a national level, government policy and strategy increasingly includes harm reduction, which, in many countries, now forms an integral part of the response to drug use. Leadership and innovation in the harm reduction field has traditionally hailed from civil society. Non-governmental and community-based organisations, including peer-led initiatives, continue to provide essential services, with or without government support and often in difficult circumstances.

Despite this, HIV, hepatitis C and numerous other health, social and economic harms affect people who use drugs – particularly those who inject – to staggering extents in much of the world. Globally, the vast majority of people who inject drugs have no access to life-saving harm reduction services. The recently released United Nations Secretary General's report revealed that only 34 percent of countries with an HIV epidemic concentrated among key populations have programmes in place to reduce the risk of HIV transmission among people who inject drugs.

Throughout 2007, the International Harm Reduction Association (IHRA) worked with harm reduction networks, researchers and organisations of people who use drugs around the world to piece together a global snapshot of the harm reduction response. This ambitious project involved gathering the most reliable data to reflect the situation in over 200 countries and territories worldwide.

In New Zealand, where both harm reduction and research in this area is

long established, IHRA collaborated with the New Zealand Drug Foundation. In some countries, research on this issue was plentiful, whereas in others, for example, the Pacific Island countries and territories, there was a severe drought of information. The *Global State of Harm Reduction 2008* has, for the first time, enabled us to view the harm reduction picture worldwide and examine how far harm reduction has developed, but also to identify the gaps and to determine how much more work there is to be done.

Injecting drug use, HIV and hepatitis C

Injecting drug use is now a global phenomenon reported in 158 countries and territories across all regions of the world. IHRA cautiously estimates the number of people injecting drugs worldwide is 11.6 million, with the vast majority living in developing and transitional countries. The most commonly injected drugs are heroin, cocaine and amphetamine-type stimulants. People who inject drugs are predominantly male, ranging from approximately 70 to 75 percent in Europe and North America to over 90 percent in many Asian countries.

The regions with the highest numbers of people who inject drugs are Asia and Eastern Europe, with the largest numbers residing in Russia, China and India. In New Zealand, it is estimated that 31,000 people inject drugs. Opioids are the most commonly injected substances here and, to a lesser extent, amphetamine-type substances, including methamphetamine.

Many health, economic and social issues are faced by injecting drug users, who continue to be among the most marginalised in societies across the globe. The *Global State of Harm Reduction* research focused on the often overlapping epidemics of HIV and hepatitis C affecting increasing numbers of people who inject drugs in all continents around the world.

It is estimated that up to 10 percent of all HIV infections occur through injecting drug use. Therefore, using the United Nations Joint Programme on HIV/AIDS (UNAIDS) latest estimates, there may be up to 3.3 million people who inject drugs and live with HIV. In much of Western Europe as well as Australia and New Zealand, where harm reduction initiatives are long established, HIV prevalence among people who inject drugs remains below 5 percent.

At the other extreme, in countries such as China, Estonia, India, Kenya, Myanmar, Nepal, Thailand and Vietnam, HIV prevalence has reached 50 percent or higher among people who inject. While these figures illustrate the national prevalence rates among people who inject drugs, where it is available, data on populations such as prisoners often reveal even higher prevalence rates.

Hepatitis C (HCV) is the most common infectious disease among people who inject drugs. Most HCV infections around the world occur through unsafe injecting drug use. Due to the lack of symptoms, many people remain unaware they have the virus and, therefore, are less likely to seek treatment. This outcome is even more pronounced among populations who have poor access to general healthcare services.

In some areas, HCV prevalence rates among people who inject drugs are as high as 95 percent. Worldwide, it is reported to be over 50 percent in 49 countries or territories. The vast majority of people who inject drugs in countries as far ranging as Indonesia, Thailand, Pakistan, Mauritius, Estonia, Lithuania, Russia, Ukraine, Luxembourg and Switzerland are living with HCV. In New Zealand, this figure remains very high at 70 percent, despite very low HCV prevalence within the national population.

The global harm reduction response

Established in response to growing epidemics of HIV and other blood-borne infections, harm reduction has grown in acceptance, popularity, scientific support, advocacy methods and evidence base since the late 1980s. The harm reduction approach is currently endorsed by the majority of EU countries, Australia, New Zealand and a growing number of more recent converts including Indonesia, Malaysia, Taiwan,

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“‘Universal access’ to HIV prevention, treatment and care, including harm reduction services, is far from a reality for the majority of the people who inject drugs.”

China, Iran and Morocco. Harm reduction programmes currently operate in a wide variety of cultural, religious and political contexts. They have been adapted to suit most settings, resource restrictions and populations. Harm reduction is a mainstay of United Nations policies and is supported by UNAIDS, UNICEF, UNESCO, UNODC and the WHO.

Presently, at least 77 countries and territories have some form of syringe distribution programme, and approximately 63 have some type of methadone or buprenorphine substitution treatment. Seventy-one countries or territories explicitly support harm reduction in their national HIV and/or drug-related national policies.

While these numbers have been steadily increasing since the late 1980s when the first harm reduction projects began in the Netherlands and the UK, many countries have small pilot projects, or very limited services in place, which do not reach all who could benefit. In New Zealand, needle and syringe exchange, opioid substitution therapy and wider HIV and HCV prevention, treatment and care services are available for people who inject drugs, but to a much lesser extent for those in prisons.

“Presently, at least 77 countries and territories have some form of syringe distribution programme, and approximately 63 have some type of methadone or buprenorphine substitution treatment.”

‘Universal access’ to HIV prevention, treatment and care, including harm reduction services, is far from a reality for the majority of the people who inject drugs. Barriers to accessing harm reduction services are very similar from region to region, but, in general, are experienced much more severely in transitional and developing countries. These include poor coverage and quality of services, costs associated with service access, police harassment or arrest, stigma and discrimination. Scale-up of quality harm reduction services is often impeded by repressive legislation (for example, criminalising needle and syringe services or prohibiting prescription of opiate substitution therapies), lack of funding and/or support from government and limited capacity for service delivery.

Civil society, including groups of people who use drugs, has a key role to play in advocating to governments, donors and multi- and bi-lateral organisations for the rights of people who use drugs to access life-saving harm reduction services. The *Global State of Harm Reduction 2008* is intended to serve as a useful reference and advocacy tool for all key stakeholders. It is also proving useful in informing strategic planning for harm reduction advocacy campaigns and project implementation, using a process of identifying priority countries according to the data gathered. ■

To read the report and to find out more about the International Harm Reduction Association, please visit www.ihra.net. Later this year, the IHRA website will host a web-based *Global State of Harm Reduction* resource, which will be updated periodically.

Catherine Cook is the research analyst for HR², the International Harm Reduction Association’s Harm Reduction and Human Rights Monitoring and Policy Analysis Programme.

ihra
INTERNATIONAL HARM REDUCTION ASSOCIATION

Feedback

This guest editorial, with full references, is published on our website – **www.drugfoundation.org.nz/matters-of-substance** – where you can post responses to this and previous guest editorials.

Quotes of Substance

“Now cannabis is Class B and we all know how bad it is for you again, there’s no point wasting money on education, treatment and prevention any more. That cash would be far better given to the police so they can alienate us with some futile heavy-handed enforcement.”

A UK smoker is less than impressed with Prime Minister **Gordon Brown’s** decision to increase the classification of cannabis against expert advice.

“In some industries, it’s more prevalent because there is a perception that it helps people do their work – for example, in the transport industry.”

Dr Ken Pidd talks about methamphetamine use among Australian workers and its implications for prevention.

“Is he aware of any side effects that may occur from consuming drinks containing absinthe?”

A parliamentary question from **Dr Paul Hutchison** to Associate Minister of Health Damien O’Connor.

“With absinthe containing such high levels of alcohol by volume (60 to 90 percent), I believe that intoxication (and other side effects typically related to alcohol over-consumption) would constitute a side effect.”

The Minister responds.

“It’s annoying when you hear the heads of these companies saying, ‘Oh no, we don’t target kids’. I mean, they taste like cordial.”

Sofia Jasek, 17, says the price hike on alcopops in Australia won’t stop young people drinking – but it’s still a good idea, as the money could go towards things like education.

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Treating drug addiction from the inside

The Drug Treatment Unit of Arohata Women's Prison in Tawa, near Wellington, is using a cognitive behaviour therapy model to help make a difference in the lives of prisoners wanting to change. The process can be a painful one, but no one is more pleased with the results than the graduating participants. **Hilda Tait**.

"We are here because there is no refuge finally from ourselves."

The Arohata DTU Creed

IT could be a graduation ceremony like any other. The three women who will receive their certificates today sit in their chairs at the front of the sun-filled hall; proud family and friends have arrived to support them.

There is a real and palpable sense of expectation as each woman stands to give a speech about what it means to her to be in this position. They have had to complete a six-month programme of intense work to be here. Voices crack with emotion, tears are held back. This is a special, important day for everyone in the room.

The only difference is that this graduation is not being held in a university or school but in the Drug Treatment Unit (DTU) of Arohata Women's Prison. The graduates have had to battle their dependence on drugs – for some, the main reason they are in prison – to get to this point.

Storm* is one of them. She's in Arohata for burglary and conspiracy to supply the Class B drug Ritalin. It's her sixth time in prison. Now in her late 30s, she first took drugs at the age of 21, precipitated by a breakup with her husband. Heroin users shared the house they lived in and gave her a free supply. She was hooked instantly.

Storm has overdosed three times on morphine over the years, ending up in hospital. She's taken speed and Ritalin too. She's supported her habit through the generosity of 'sugar daddies', occasional work as a prostitute, as well as through burglaries and fraud.

Storm comes from a background in care – her mother was an alcoholic, her father also spent time in prison. Her adopted mother physically and emotionally abused her. She has known violence from a young age, as have just about all the women in the DTU.

"There was no stability in my life. I was not taught family values," she says. She used drugs to bolster low self-esteem and give her a sense of belonging.

When she's released later this year, Storm plans to work as a chef. She's already completed National Certificates 1 and 2 in cooking whilst in prison. After that, the plan is for the youngest of her three children to be returned to her from care.

She says the treatment programme has given her an "understanding of my old behaviours, the reasons for my addictions and the effects." She now has the tools to focus on her recovery and knows what to do if she thinks she might

be relapsing. It finally seems like she's turned the corner.

At 20 years of age, Shanelle is the youngest woman in the DTU. If she continues on this journey, she should graduate in two months' time. Everyone knows it's really hard, and for a woman like Shanelle who candidly admits "the drugs were fantastic", it's been a struggle to find the necessary commitment to change.

Halfway through the programme, she almost quit. However, the memory of two personal tragedies that were "wake up calls" have motivated her to keep going and break her addiction to methamphetamine. She says the programme has helped her "get to know herself, to release the demons".

She has less than a year left of a sentence for violent offending and car theft and now realises she used drugs to self-medicate against the violence she suffered at the hands of family members and then foster parents. Some of her family are gang members who were generous with free drugs. As well as methamphetamine, she's taken benzopdiazepines, cannabis, and LSD. Since the age of 13, she's been using intravenously.

Shanelle says she's good with numbers and hopes to be an accountant one day, though she thinks her prison record means no one will want to employ her.

Arohata's DTU is the only one of its kind for female prisoners in the whole country. Corrections staff can make referrals to the 20-bed unit from anywhere in New Zealand but the women must have served the majority of their sentence and they must want to take part.

The programme was started 11 years ago and is the brainchild of Tim Harding, chief executive of Care NZ, a national drug and alcohol intervention and treatment organisation.

Nadine Winter is Care NZ's clinical coordinator at Arohata. Her leadership has been instrumental and inspiring for the graduates. Their speeches reflect that, and she clearly thrives on her job.

She says the programme uses a version of what's called the Therapeutic Community Treatment Method where the main objective is to reduce re-offending.

The journey is one of self-discovery, making each participant focus inwardly on themselves to be able to work to change past behaviours. Using specialists like counsellors and music therapists, group therapy is held three times a week, supplemented by educational groups covering topics like anger management, managing stress, recreation and physical fitness, healthy communication, healthy relationships and addiction models and cycles. Each phase is more difficult and challenging than the one before.

The programme has four daily rituals, kicking off with reciting The Creed, a reminder which begins, "We are here because there is no refuge finally from ourselves." It's widely accepted that rituals create and sustain a positive recovery culture.

There are values and rules to follow: respect and open-mindedness feature heavily. Confidentiality is key; sexist, racist or derogatory remarks are not permitted, nor is gang culture or offensive language. There is immediate discharge or stand-down from the programme for violence or intimidation, alcohol and/or other drug use, sexually acting out or stealing. Peer support is crucial to success, and those in the DTU are isolated from the other inmates at Arohata for the duration of the programme.

Once they leave prison, each woman has a plan to help them stay out and in recovery. They will also be assisted by counsellors, psychologists and supportive family and friends in the community.

Corrections says 60 percent of offenders have drug or alcohol issues at the time of their conviction. Research has shown that reconviction rates for those who have been through a DTU are 13 percent lower over a two-year period than for untreated offenders.

The ceremony draws to a close. People hug, the room is full of acceptance and peace. Everyone understands that the end of the programme is really just the beginning. The graduates can't believe how far they have come. They are different people, hungry to protect the changes they have made in themselves. And you really want them to succeed. ■

* Names have been changed to protect identities.

Hilda Tait is a Wellington-based writer.

Way to go

Drug policy is often controversial. Opinions and beliefs about goals, priorities, responses and outcomes differ across geographical, political and professional contexts. Finding agreement on a common drug policy framework at an international level is therefore an extremely challenging exercise. Yet this was exactly what was achieved at the 'Beyond 2008' Forum held 5–7 July 2008 in Vienna. **Martina Melis**.

THE OBJECTIVE of the International NGO Forum 'Beyond 2008' was to agree on a Declaration and three accompanying Resolutions embodying shared priorities and recommendations for future international drug policy approaches and responses. The documents will represent the contributions of the international community of NGOs to the 2009 meeting of the Commission on Narcotics Drugs (CND), where future international drug policy directions will be shaped.

Delegates came to the Forum with differing moods and expectations. Some had limited optimism about reaching consensus and about the importance the Declaration and Resolutions would eventually be accorded by UN member states at the 2009 CND.

Others saw the Forum as an unprecedented opportunity to better understand the politics and processes of international drug policy setting and the chance to engage in a modified dress rehearsal of the 'real thing'.

There were those who came with clear agendas – the most vocal being to defend and preserve the status quo – and those who hoped agreement could be found to bring realism and innovation into the current but aged international framework.

With broadly different starting points, some form of compromise was inevitable to a successful outcome. However, a common willingness to focus on commonalities rather than dissent and to work towards consensus soon took over the Forum, and a very good compromise – probably the best that could have been hoped for – was achieved.

Though, at times, extensive negotiations were held around predictable sensitivities (such as the use of particular terminology, for example, drug abuse/drug use/drug misuse/harmful use), the Forum was ultimately able to reach agreement through discussion without having to resort to either majority voting or recorded dissent. The endorsement of the entire Forum means the Declaration and Resolutions carry a substantive strength and legitimacy.

The Declaration and Resolutions contain key principles and clear recommendations on the priorities and approaches that should inform and guide future international drug policy. These include: a call to address drug use as a public health issue; human rights and fundamental freedoms as the underlying basis upon which drug policies must be formulated and evaluated; the importance of collective action and global partnerships to achieve progress in reducing illicit/harmful drug

use; and the need for a common standard to measure the efficacy and outcomes of demand, harm and supply reduction activities, including an analysis of the unintended consequences of the drug control system.

Though an important result, the Declaration and Resolutions represent just one element in the wider process that will culminate in the meeting of the CND in March 2009. While the NGO community will continue to prepare for the March sessions – in some cases, as part of government delegations, in others, as advisors, experts and advocates at home – the bulk of responsibility for the outcomes of the CND 2009 lies with governments.

In his opening remarks to the Forum, UNODC Executive Director Antonio Costa said, "In the same way you expect all UN Member States to agree at the CND, I urge you all to agree on a declaration to be submitted to governments." The NGO community has exceeded these expectations. Its inclusive and content-focused consultative process, has achieved far beyond what the CND has been able to do to date, setting a big challenge for next year.

Government representatives have some important tasks and responsibilities ahead. Clearly, they need to work with their national NGOs to ensure outcomes from the meeting in 2009 truly reflect the views and recommendations of their populations. They also need to consider seriously the recommendations of the international community of NGOs as clear indications for the way ahead. Lastly, they must be prepared to contribute meaningfully to the design of more humane, just and effective future international drug policy. We are confident this is what the New Zealand delegation to the 2009 CND is already gearing up to achieve. ■

Martina Melis is a senior policy analyst at the New Zealand Drug Foundation.

Finding out more

- For a copy of the Beyond 2008 Declaration and Resolutions, visit the Vienna NGO Committee website – **www.vngoc.org.**
- To keep an eye on CND preparations, visit the UN Office of Drugs and Crime website – **www.unodc.org.**
- To watch the Beyond 2008 documentary produced by the NZ delegates, visit the Drug Foundation's international section – **www.drugfoundation.org.nz/UNGASS-beyond-2008.**

If you take away the fear, it's cool to be queer!

Diana Rands

Do you work to provide alcohol and other drug services in New Zealand? If so, how conscious are you of the special needs of your gay, lesbian, bisexual, transgender, transexual and intersex clients? **Diana Rands** outlines how you can increase your understanding of what are often invisible individuals and communities.

ONE OF the first people to identify that sexuality is best viewed as a continuum was Alfred Kinsey. In a study of 20,000 post-war Americans, Kinsey and his colleagues found similar numbers – approximately 10 percent – reported being exclusively homosexual, as exclusively heterosexual. Most participants – 80 percent – sat somewhere along a continuum from exclusively homosexual to exclusively heterosexual.

The prevalence of heterosexism and homophobia, however, has made identifying as heterosexual the norm. Homosexual fantasies and behaviour are kept secret and often seen as a source of shame.

For those of you still reading – well done, it suggests you have the desire or interest in working inclusively.

So… let's do a little reality check.

When was the last time you thought about or discussed your own or someone else's sexual orientation?

- In the last week.
- In the last 6 months.
- I don't talk about sexual orientation.

If your answer is in the last week – congratulations, you are one of few people who do.

When was the last time you thought about gender? Do you have any clients who are transgender or who are struggling with their gender identity? Are there any transgender people in your family or social circle? Gender is another matter not often talked about, and it is even less understood.

What about the most invisible population – people who are born intersex (with genetic and physical variations placing them in between male and female). What do you know about them?

One of the biggest hurdles to providing a queer-friendly service is invisibility caused by homophobia and heterosexism. Homophobia is the fear and loathing of gay and lesbian people. Heterosexism is similar to racism, as it presumes a 'less than' quality for people who are not heterosexual. Transgender and intersex people face the same, if not greater, discrimination and fear.

So what does it take to be queer-friendly?

Start with yourself! What are your values and attitudes towards queer people? How comfortable are you with your own homosexual tendencies? How would you feel if your son or daughter were gay, transgender or intersex?

A baseline for anyone working with

Queer drug use

There has been minimal research into the prevalence of alcohol and other drug use within New Zealand's queer communities.

One of the few pieces of research was conducted by the New Zealand Aids Foundation as part of its Gay Auckland Periodic Sex Survey in 2006. It surveyed 1,228 men who have sex with men. One of the questions asked was about illicit drug use.

When compared with the general population:

- 40 percent had used amyl, compared to 4 percent of the general population
- 38 percent had used cannabis, compared to 14 percent
- 21 percent had used ecstasy, compared to 3 percent
- 20 percent had used amphetamines/ methamphetamines, compared to 4 percent.

Frank Pega and Nicole Coupe analysed data from the 1.5 percent who identified as lesbian, gay or bisexual in their health behaviours research on alcohol and drug use. They found that gay, lesbian and bisexual people are significantly higher users of alcohol, tobacco and illicit drugs than the heterosexual population.

In 1999, Miriam Saphira and Marewa Glover conducted a National Lesbian Health Survey. In this, they found higher rates of tobacco and cannabis use when compared to a representative sample of the general population.

This research indicates that lesbian, gay, bisexual, transgender, takataapui and fa'afafine people are an 'at risk' group when it comes to alcohol and other drug use. It is therefore essential that alcohol and drug treatment, prevention and health promotion recognise them as priority populations.

queer clients is that their client's sexual orientation and gender identity is affirmed and celebrated in exactly the same way as for their non-queer clients. It is absolutely not about sympathy, i.e. "What a shame that you have these feelings" – it is about empathy, i.e. "It must be disappointing that your family does not support you to be true to yourself."

I believe the more something is talked about, the less threatening it becomes. At present, many people who access alcohol and other drug (AOD) services are not given opportunity to talk about their sexual orientation. Although their sexual orientation may not be significant in their addiction, it is always significant in their lives!

Increase your knowledge. There are lots of ways to increase your knowledge. It is important not to think about your queer clients as your main source of information. Sure, there may be some things that need to be clarified, but it is not their role to educate you on best practice!

Many excellent resources are available online at the click of a button (for example, www.samhsa.gov, www.ianz.org.nz). Movies can be helpful as they often provide a human angle. I recommend *Kinsey, Brokeback Mountain* and *Transamerica*. There are also many superb books available. A great New Zealand resource is Terry Stewart's book for parents of lesbian and gay children *Invisible Families*. There are many more.

Tea room conversations can be an ideal place to start. There may be people you work with everyday who have in-depth knowledge and insight into the specific challenges facing queer people. We need to start talking about sexual and gender orientation and diversity. Only in this way can we break free from those invisible threads that keep our mouths shut and our minds closed.

Familiarise yourself with community resources. You may be surprised to know that most places in New Zealand have some type of queer community support group. To find out the details of the one in your area, just go to www.gaynz.com.

Usually, people who run these groups are volunteers who would welcome contact with their alcohol and drug treatment centre. It may be appropriate for you to attend a meeting. You could find out more about what they do, and they could receive quality alcohol and other drug information from you. This process could also be an insightful journey into some of the everyday challenges facing queer people.

The journey towards providing queer friendly service can be one that is enriching, worthwhile, liberating and fun! It is not about reaching a destination – it is all about the process and enjoying the scenery along the way! ■

Diana Rands is a Gay Communities Project Worker with Auckland Community Alcohol and Drug Services (CADS).

Rainbow Recognition Checklist

In order for an individual to provide queer-friendly service, they have to be supported by the organisation they work for! The Rainbow Recognition Checklist was developed to give organisations guidance in this area.

It can be used as an audit tool, as it links to relevant AOD and mental health sector standards as well as AOD practitioner competencies.

For a copy, contact diana.rands@waitematadhb.govt.nz

Who are we?

Gender identity – Gender identity is an aspect of identity that can be understood as the psychological sex. It is an individual's internal sense of being male or female or something other or in between. It may or may not correspond to a person's physical sex. A person's sexual orientation cannot be assumed on the basis of their gender identity.

Sexual orientation – Sexual orientation denotes the direction of a person's sexuality relative to their own sex. It is usually classified according to the sex or gender of the people an individual finds sexually attractive. Some people always identify with one sexual orientation, whereas others may change their primary orientation and the meaning they give it throughout their life course.

Transgender – The term transgender is used by different groups in different ways. It is often used as an umbrella term for a variety of people who feel the sex they were assigned at birth is a false or incomplete description of themselves. The term can include a number of subcategories, including, among others, transsexuals, cross-dressers, transvestites, genderqueer and consciously androgynous people.

Takataapui – The traditional meaning of takataapui is 'intimate companion of the same sex'. Many Māori have adopted this term to describe themselves, instead of or in addition to terms such as lesbian, gay, bisexual, queer or trans. It refers to cultural and sexual/gender identity.

Fa'afafine – Fa'afafine is a Samoan term that literally means 'like a woman'. Fa'afafine is often used to refer to people born male who express feminine gender identities in a range of ways, but is sometimes used more broadly to refer to all Pacific people who do not identify with or live according to common understandings of their birth gender. Sometimes the term 'third sex' is used.

Intersex – Intersex people are born with any of a number of physical variations meaning they do not fit expectations of either male or female physical sex (for example, they have genitals that are atypical, XXY chromosomes, etc).

Note: For the purposes of this article, I have used 'queer' to refer to people who identify as gay, lesbian, bisexual, transgender, takataapui, fa'afafine and intersex.

High in the saddle: cannabis-affected driving

New Zealand's response to an apparent increase in drivers under the influence of cannabis seems likely to be more legislation and new penalties. But is this good policy, based on solid evidence? It might be, but **Geoff Noller** argues that the issues and evidence are complex and require much more discussion before we act.

IN October 2007, Otago University published research suggesting driving under the influence of cannabis (DUIC) may be more common and riskier than driving drunk. The release of this research coincided with the introduction of the Land Transport Amendment Bill (No. 4), which creates a new offence of driving while impaired by illegal drugs. Intuitively, we might consider this an example of evidence-informed policy. It seems reasonable that cannabis use impairs driving, and there is evidence of DUIC in New Zealand, hence legislation.

As with so much about cannabis, however, the actual situation is complicated, giving rise to a number of questions.

What does the evidence say about how cannabis affects driving? To what extent is it a problem in New Zealand? If it is a problem, what response would be most effective?

Attempting to answer the first question immediately reveals the issue's complexity. There is vast literature on the negative consequences of drunk driving, but there is much less on driving under the influence of drugs in general (DUID). What exists is contested, particularly where cannabis is concerned.

DUID may be examined through epidemiological analyses or by laboratory and experimental means where impairment is assessed by assigning people to either drug taking or placebo/non-drug groups and having them perform certain tasks. With driving, these include cognitive tests (i.e. divided attention), coordination and testing reaction time.

One criticism of this type of study is that laboratory tests do not necessarily reflect actual driving conditions or drivers' experience. While cannabis studies do find deficits in concentration, reaction time, spatial and temporal judgement and attention to peripheral stimuli, these effects are less marked in non-experimental settings, and more experienced cannabis users appear even less affected. Other studies suggest that, while cannabis does impair driving, users are more aware of their impairment and respond by driving slower and less aggressively. This isn't usually the case with alcohol.

> **"Given New Zealand's high prevalence of cannabis use, as well as research suggesting a high rate of intoxication while driving, it seems likely that DUIC is a significant issue."**

Some researchers claim that more accurate data may be gathered via epidemiological studies such as the one by Otago University, which focus on DUID prevalence amongst subpopulations. These studies aim to describe the magnitude of the problem or analyse it in terms of which drugs are over-represented in accidents.

Two ways of doing this are through 'case-control' studies, where injured and non-injured drivers are matched and compared for their drug use, and through 'culpability' studies, where injured or killed drivers are assigned blame, relative to their use or otherwise of different substances.

But these studies also leave the cannabis case unresolved. One review article indicated a range across studies suggesting 2.7–13.9 percent of drivers had used cannabis. However, the authors noted it is difficult to determine causality, as the relationship between injury or death and drug use is one of association.

Also, the psychoactive metabolite of cannabis degrades relatively rapidly, potentially before it can be identified,

which might lead to underestimated impairment. Alternatively, the inactive parent molecule remains longer, potentially providing a false positive for impairment.

Adding to these difficulties is some curious data suggesting cannabis-affected drivers are either at no greater risk or in fact are at less risk of an injury or fatal accident. This was the case in a large Australian study of 2,279 non-fatally injured drivers, which found cannabis-only subjects to be marginally less culpable than drug-free drivers.

In summarising the mixed data on cannabis-affected driving, a Canadian review noted that, while cannabis is the most commonly used illicit drug and there is evidence of it moderately impairing driver performance, epidemiological data fails to show it is a major contributor to traffic crashes.

Given New Zealand's high prevalence of cannabis use, as well as research suggesting a high rate of intoxication while driving, it seems likely that DUIC is a significant issue.

Data from Massey University's National Drug Survey 2001 noted an increasing trend to DUIC, particularly by youth. From 1998 to 2001, reported rates for those aged 15–17 years increased from 18 percent to 39 percent. This data supports the notion that, in some New Zealand subpopulations, DUIC is an accepted aspect of culture, but also that injury and possibly death may result, particularly where drivers are inexperienced or prone to risk taking.

How best to address these issues? An obvious response is legislation such as that currently before Parliament. Nonetheless, questions remain about its specifics. With cannabis, is impairment, or simply evidence of past use, to be acted on? How accurate are tests, and will particular populations, such as Māori, be targeted?

Internationally, legislative responses to such questions have varied. In Sweden, there is zero tolerance for anyone identified as DUID, while Germany has instigated an upper limit for cannabis, similar to the commonly operating blood alcohol content (BAC). Supporters of zero tolerance claim any level is too high, given some evidence of impairment, and that, regardless, cannabis is illegal. However, the issue's complexity implies that simplistic solutions may not provide the best outcomes.

In 2005, an international panel, having examined 140 studies, noted the advantages of having a BAC equivalent for cannabis, i.e. a BCC. With the evidence indicating that low levels of cannabis do not significantly elevate risk of accident and that drivers might test positive while not being impaired, zero tolerance and the potential consequence of criminalisation were described as counterproductive.

An interesting US study further supports arguments favouring a BCC. Researchers found that, where alcohol was more expensive and harder to obtain, and cannabis less interdicted (i.e. decriminalised for medical purposes), those aged between 18–24 would substitute cannabis for alcohol and that, in these circumstances, driver injury and death would reduce. In the reverse situation, with cannabis use more heavily penalised and alcohol seen as more attractive, driver injuries and fatalities increased. They concluded that, despite a potential increase of cannabis use resulting from decreased penalties, a net harm reduction would result.

This article has aimed to extend the conversation on cannabis into an area of recognised concern and one requiring practical response. The complexity of issues surrounding DUIC requires consideration based on evidence but also discussion. Though one legislative response might suggest zero tolerance for DUIC, other measures such as a maximum BCC combined with education may ultimately produce better long-term outcomes.

There are, however, barriers to implementing alternative policies. For example, education around the safe use of cannabis in a prohibition environment may be too difficult a nettle to grasp. Nonetheless, if we are unable to discuss these issues, we are likely to develop policies that, at best, have little impact on the problem or even make it worse.

A harm minimisation approach would suggest those with whom this conversation must occur are those most able to reduce the negative consequences of cannabis-affected driving – cannabis users themselves. ■

Geoff Noller is a Dunedin-based researcher. He recently completed a PhD with Otago University's Department of Psychological Medicine entitled *Cannabis use in New Zealand: perceptions of use, users and policy*.

A global alcohol strategy at last

New Zealand has been a world leader on alcohol control issues in recent years. Our mana and influence made us able to broker consensus at the 2008 World Health Assembly, starting a process that could lead to alcohol's equivalent of the Framework Convention on Tobacco Control.

Rob Zorn writes about what happened this year in Geneva and what a WHO global alcohol strategy might look like.

Ashley Bloomfield

AT THE meeting of the World Health Assembly (WHA) in May 2008, all 193 World Health Organization (WHO) member delegates voted in favour of a resolution to draft a global strategy to address the harmful use of alcohol.

The collective sigh of relief was probably audible across town. A similar resolution in 2007 had not found sufficient agreement, and the risk was high it would founder again, leaving WHO without a mandate to develop a strategy on a significant global health issue.

That the resolution did pass this time is largely due to the efforts of New Zealand's WHA delegates, whose leadership and delicate corridor negotiations helped create and preserve a fragile consensus.

In fact, New Zealand can take credit for the matter being on WHO's agenda at all. It was then Health Minister Annette King who repeatedly pushed the issue of alcohol-related harm at Western Pacific Region (WPRO) meetings in the early 2000s.

Her efforts helped pave the way for a 2005 WHA resolution that called on WHO to examine public health problems caused by the harmful use of alcohol and provided a mandate for developing regional approaches. A Draft WPRO Regional Strategy to Reduce Alcohol-Related Harm was agreed at a meeting in Auckland in September 2006.

At the 2007 WHA, New Zealand delegate Ashley Bloomfield chaired the drafting group that attempted to agree on a resolution calling for a global alcohol strategy.

When that resolution failed, New Zealand continued to work with WHO and other interested countries to draft the successful 2008 resolution.

The reason consensus has been so elusive is not because WHO member countries don't agree that alcohol misuse is an important problem. The main bugbear has been whether the alcohol industry should help form a strategy to control it.

A number of countries rely heavily on exporting alcohol and fear industry exclusion could impact on their economies. It was largely Cuba's opposition that scuttled the 2007 resolution.

Therefore, the draft 2008 resolution stated that WHO should collaborate and consult with member states and other stakeholders including "economic operators" (i.e. the alcohol industry) on ways to reduce alcohol harms.

However, the idea of industry collaboration proved to be an equally serious stumbling block. Thai delegate Dr Thaksaphon Thamarangsi, for example, said it would be like Manchester United inviting the Chelsea coach to help them with team strategy.

Thailand refused to agree to the wording and compared the behaviour of the alcohol industry to that of big tobacco.

From rhetoric to reality – the Rudd government and alcohol change

John Rogerson, head of the Australian Drug Foundation, did not mind being woken up at 7am, even if the ringing phone interrupted a long weekend sleep in. On the other end of the line, an Australian senator gave him news that brightened his day and lent hope to the fight against one of the 'lucky' country's biggest curses – binge drinking.

The senator said the government proposed increasing the excise on 'alcopops' from $39 a litre of pure alcohol to $67.

In the government's sights are drinks like the cask of Cowboy brand 'lolly water' Rogerson has in his office to remind him of the battle against alcohol-fuelled lawlessness and harm.

The two-litre cask boasts a hefty 15 percent alcohol content, is sweetened for teenage taste buds and costs just $20.

"Maybe young people will switch to other drinks. We'll have to wait and see,'' Rogerson says. "Increasing the excise isn't a silver bullet but it does seem to be the start of something big.''

New Prime Minister Kevin Rudd recently announced that addressing the country's binge drinking culture was one of his main priorities, and the proposed tax on alcopops is just one of a number of initiatives being discussed.

His government has allocated more than $53 million over four years to programmes relating to the prevention of binge drinking. Under consideration are tightening laws around alcohol advertising, health warnings on packaging and reducing the alcohol content in products aimed at young people.

In one Australian state, it is illegal to supply alcohol to those under 18 without a parent's consent. Similar legislation is planned in other states.

Soon to be released National Health and Medical Research Council Guidelines say two standard drinks per day is unsafe drinking and four standard drinks constitutes a 'binge'.

"The alcohol issue is really pumping in Australia at the moment,'' says Rogerson. "It's partly because the central government has decided to buy into the issue big time. But everyday people have also had enough. This issue has been bubbling along for some time but suddenly people are working together to try and fix it."

Rogerson said his first reaction to the proposal to increase the excise on pre-mixed drinks was "Wow!''

"We know from evidence worldwide that adjusting taxation on alcoholic beverages according to the amount of alcohol in the drink has a significant impact on harm. It's exciting because volumetric taxation hasn't happened in Australia before.''

The regulation must first go before the Senate but Rogerson is quietly confident the law will pass.

Change is also afoot in New Zealand, though arguably to a lesser extent than in Australia. There has been recent debate in the media and community about the social carnage caused by binge drinking, particularly in sparking violent crime.

Manurewa MP George Hawkins introduced a private member's bill that would allow local bodies to consider the density of liquor outlets in an area and their social impact before granting a licence.

Prime Minister Helen Clark recently pledged to take action to stop the proliferation of liquor outlets. There were 6,295 in 1989 when the Sale of Liquor Act came into force. Now there are 14,970.

Clark is asking the Law Commission to review the Sale of Liquor Act 1989 and its amendments – including the 1999 change allowing supermarkets to sell beer.

Associate Justice Minister Lianne Dalziel announced in late June that she was drafting a bill that would make supply to minors illegal and give police greater powers to caution people for drunkenness.

Back in Australia, Rogerson is gearing up for a big year of action. The Foundation is drafting its latest strategic plan for the way ahead.

While he acknowledges drugs such as methamphetamine are a big and very real problem, alcohol will be his top priority. It remains the drug of choice causing the most damage to Australians.

Rogerson says while he is pleased with what the Rudd government and leaders at a state level are proposing, there is still much more to be done. He wants to see further action on volumetric taxation and says all such revenues should be put back into the community for preventative work.

Rogerson also wants government to exempt alcohol from anti-competition laws, so residents can have a say in whether more liquor stores are allowed into their suburbs.

"There hasn't been alcohol on the agenda at such a high level in government for a long period of time. We're trying to support that and be part of the action. We're watching, but if significant things don't happen, we'll step in and start agitating. We want to see the rhetoric backed up by action.''

Kim Thomas is a Christchurch-based writer.

Quotes of Substance

“My old life rotated around drugs: find or steal money to buy drugs, find money for tomorrow and so on and so forth. Buprenorphine set me free from this ceaseless merry-go-round.”

Oleg Voynarenko, a 29-year-old substitution maintenance therapy client from Ukraine.

“I always used to think if I had two or three days where I did not drink at all, it cancelled out the badness.”

Londoner **Caroline Eardley**, 27, classes herself as a social drinker. She was shocked to see her week’s total of 37 units consumed compared to the recommended low-risk level of 14 units.

“When we get one person to stop using drugs, others around them are also more likely to stop, meaning that every dollar spent on treatment goes much further than we ever thought.”

Harvard Professor of Sociology **Nicholas Christakis** in his paper “What networks can teach us about drug use. Ideas and habits related to the use of legal and illegal drugs can spread from person to person to person”, (*BMJ* 2008;336;420).

“It’s expensive, it’s counterproductive, and it doesn’t make sense.”

US Presidential candidate **Barack Obama**, in a *Rolling Stone* interview on the US$500 billion ‘war on drugs’. Obama says he would shift drug policy towards a public-health approach, investing more money into education, treatment, prevention and demand reduction.

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“They attempt to weaken and tone down policy, publish research that counters scientific knowledge and deviates momentum into what is ineffective. They want to be part of the process but their approaches lead to just one end; to protect and sustain their business at the cost of the health of the population.”

Several countries backed Thailand, resulting in another standoff. With a number of last minute amendments further threatening to derail the resolution and time running out, the New Zealand delegates worked furiously to find common ground.

“We felt that, while the resolution was not perfect, it was good enough to start the strategy process, and we were keen to do everything we could to get it through,” says Ashley Bloomfield.

“We were crossing the floor back and forth and negotiating behind the scenes, trying to find some sort of consensus lest the issue be ‘kicked for touch’ yet again.”

At the last minute, New Zealand made an important move, proposing an amendment that the resolution read: “to collaborate and consult with member states, *as well as consult* with [other stakeholders] and economic operators on ways they could contribute to reducing harmful use of alcohol.”

“The morning of the vote was an incredibly tense one for us. We just didn’t know whether we had achieved support from all parties,” says Ashley Bloomfield.

“We were nervously waiting for Barbados, which was working hard to get agreement within its region, but when the question was finally put, everyone agreed and the resolution passed.”

The first draft of the global alcohol strategy will be presented to the WHO Executive Board in January 2010. New Zealand will continue to provide input and advice, and has been asked to host this region’s Member State Consultation in early 2009, a request the Ministry is considering.

It is unlikely the first draft will be anything like a finished product. Tobacco was on WHO’s agenda for many years before the Framework Convention on Tobacco Control eventuated. By comparison, the alcohol issue is relatively new.

According to Sally Casswell, Director of the Centre for Social and Health Outcome Research and Evaluation at Massey University, the 2006 WPRO Draft Regional Strategy would be a logical starting point as it already embodies the current mood of world health leaders on what needs to happen globally to control harm from alcohol misuse.

“The WPRO draft is very much evidence-based around physical availability, price/taxation and marketing. While the global strategy will have to be adaptable to each country and culture, these are the common key areas it must also deal with.

“Reducing access to and the affordability of alcohol is going to be really important, so the strategy must also address how governments can get informal and illegal alcohol production under control. It’s difficult to use tax and non-availability as disincentives if unlicensed alcohol is readily available.

“Marketing control will also require enormous international cooperation as satellites and the web make national laws and borders insignificant.”

The strategy will have implications for New Zealand though they probably won’t be dramatic in the short term. Most of what’s likely to be in it is already happening here. Our drink drive laws are well established, we have an excise on alcohol, and there are voluntary industry restrictions over advertising in place.

However, the basis for our government’s action on alcohol has only been a moral one so far. A collective WHA global alcohol strategy would see that basis move to one of agreed international norms, which could lead to increased marketing control and regulation here at home.

Should a framework convention on alcohol control eventuate, those increases would become more certain as the government’s basis for action moves to one of internationally binding law. ■

Rob Zorn is a Wellington-based writer.

Supermarkets stretching the spirit of the law

Supermarkets are increasingly stretching the letter and spirit of the law when it comes to selling alcohol, at times, even blatantly breaking agreements they made with Parliament before the passing of the Sale of Liquor Act 1989. **Bruce Roberston**.

PROGRESSIVE ENTERPRISES, one of the New Zealand's major supermarket chains, has recently applied for full liquor licences to sell beer, wine and spirits from premises in Christchurch, Lower Hutt and Porirua.

This contradicts the submissions and commitment supermarkets gave to Parliament prior to receiving permission to sell beer and wine – that beer and wine, as accompaniments to food, should also be available from supermarkets.

Progressive is now pushing to begin also selling spirits in what would constitute a store within a store. In effect, this means achieving a full off-licence – something contrary to the spirit and policy of the Sale of Liquor Act.

The application will be considered by the Liquor Licensing Authority, which will decide just what constitutes a separate retail operation and whether a store within a store meets Parliament's wishes.

At the time the Act was passed in 1989, Parliament explicitly disallowed supermarkets from selling spirits.

Another way supermarkets are flouting their original promises to Parliament is by using alcohol as a loss leader, that is, selling it at a loss to entice customers into their stores. This is something they said they would not do.

Now, both main supermarket chains, Progressive Enterprises and Foodstuffs, are using price as a key weapon to enhance market share. Each week, flyers in letterboxes announce the latest price discounts on beer and wine, blatantly breaking the rules under which they said they'd operate.

Perhaps it's time for Parliament to look again at the way supermarkets operate and their pricing strategies.

And more broadly, by changing the rules of the game so thoroughly, supermarkets have invited politicians to revisit the law to ensure its original intent is being upheld – that supermarkets may sell beer and wine in a responsible way as an adjunct to food products. ■

Bruce Robertson is the Chief Executive of the Hospitality Association of New Zealand.

Feedback

This opinion piece is published on our website – **www.drugfoundation.org.nz/matters-of-substance** – where you can post responses to this and previous opinions.

Quotes of Substance

“The general principle is that it’s not advisable that we continue to give criminals and corrupt police a monopoly to sell a drug that is soon going to be consumed by more people than tobacco.”

St Vincent’s Hospital Director of Alcohol and Drug Service **Alex Wodak** proposes to sell cannabis in Australia’s post offices.

“The dog couldn’t find it, and the officer forgot which bag he put it in. If by some chance passengers find it in their suitcase, we’re asking them to return it.”

A Customs officer at Tokyo’s Narita International Airport explains how 142 grams of cannabis was lost after a bungled exercise using sniffer dogs.

“They were traumatised but we wanted them to be traumatised. That’s how they get the message.”

The guidance counsellor of a San Diego high school talks about their novel anti-drink driving shock tactics. Students are informed their classmates have been killed in a drink drive accident – but it turns out to be only a simulation. Several students cried and became hysterical, and a few upset parents called the school.

“Pilots and cabin crew reporting drunk for duty is common – mainly around Christmas and New Year. Intoxication can prove to be dangerous, especially during landing.”

India’s senior aviation officials reveal the intoxication problem among crew members. Around 50 pilots and cabin crew are caught each year.

“If you can buy an ecstasy pill for $20, why would you buy alcohol?”

Australian Hotels Association director **Bill Healey** is concerned clamping down on alcopops will drive people to illicit drugs.

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The mountains, the rivers and Richard

The Helensville/Te Awaroa district lies just a stone’s throw from West Auckland. Its young population has swelled as Auckland workers seek cheaper housing outside the main centre. But industry dried up years ago, and there are few local jobs.

Cannabis and alcohol use is high among youth, and each year, it seems, there are more methamphetamine lab busts. In 2003, the area was chosen as part of the expanded CAYAD programme.

WHEN the Waitemata District Health Board came looking for a CAYAD coordinator, Richard Nahi’s long history of tribal and community youth work made him the obvious choice.

Of Ngāti Whātua descent, Richard describes himself as an outdoors man and believes that re-acquainting young Māori with the mountains, rivers and forests of their history and culture is a key to their positive development. His work, both before and during the CAYAD role, has focused on increasing the number of outdoor activities that would help young people find out who they are and develop social and leadership skills.

The Tribal Leadership Programme, which is in its eighth consecutive year, is a case in point. It is run in conjunction with the local Ngāti Whātua iwi and involves taking young people into the bush, mountain climbing, canoeing and tramping for up to two weeks.

Richard says that, along the way, he seeks to expose youth not just to the outdoors and the elements, but also to their history and the spiritual aspects of their culture.

“I work with a team of people to make young people feel proud of who they are and where they have come from. We teach the kids about the importance of their connection to the land.

“We talk about how important it is to be alcohol and drug free and about important life skills, like how to set goals, and how to make them real.”

Some of Richard’s programmes target ‘at-risk’ youth aged 14–17, though he says many already have incredible skills in their own way.

“I could survive in the bush, but I doubt I’d last very long on the cold streets the way some youths do. Most just haven’t had the right sort of role models to show them there are better alternatives to alcohol and drugs.”

How successful is he?

He papakupu Māori e pā ana ki ngā taru kino
What's in a name? Māori terms for alcohol and other drugs

Māori had no traditional words for alcohol or other drugs, as Aotearoa New Zealand was one of the few countries with no use of fermented drinks or psychoactive substances.

While some Māori terms for the drugs we use have simply been adapted from English, such as *pia* (beer) or *wāina* (wine), others have come into use over time, or been devised by experts at the Māori Language Commission.

One example is the Drug Foundation's te reo Māori name, *Te Tuāpapa Tarukino o Aotearoa*. *Tuāpapa*, originally meaning a foundation for buildings, has come to be used for organisations such as ours. *Tarukino* or *taru kino* is the most common term for drugs and comes from *taru* (things or herbs) and *kino* (meaning bad or evil).

Similar concepts can be seen in other Māori terms for drugs, such as *whakapōauau*, from *pōauau*, meaning mistaken or confused.

Here are some more:

Cannabis: *whakamāngina* from *māngina*, flowing, fleeting, unreliable.

Heroin: *taimiri* from *miri*, tranquillise.

Cocaine: *kukarou* from *kuka*, dry leaves, and *rou*, intoxicated.

Stimulants: *whakakori*, kori means to move or wriggle.

Thanks to *Te Matatiki: Contemporary Māori Words*, H.M. Ngata's *English-Māori Dictionary* and H.W. Williams' *Dictionary of the Māori Language*.

More information on te reo Māori, including resources for learners, can be found at www.korero.maori.nz. ■

Richard laughs at the question, but says he feels really valued. At a recent birthday bash, several community leaders turned up to speak positively about his contribution.

"I reckon they gave me nine-and-a-half out of ten."

He says the real measure of the impact he's had are young ones who get up in the whare hui on the marae and speak about their changed lives; the ones who have started at the bottom and gone on to tertiary education or who have battled addiction and won.

And how does he cope with the failures?

"One by one," he says, but he quickly adds there are more successes than failures.

"You need to dwell on the successes, but never forget the ones who didn't make it. Maybe it's just not their time yet."

When it is their time, the mountains, rivers and forests will still be there. And, probably, so will Richard. ■

What's a CAYAD when it's at home?

The Community Action on Youth and Drugs (CAYAD) project is a collaborative approach to addressing health issues around young people, alcohol and drugs. Funded by the Ministry of Health, there are several CAYAD organisations in New Zealand run by a diverse range of agencies and community groups.

CAYADs promote community ownership of both problems and solutions and operate according to five main objectives:

- Increasing informed debate on drug issues.
- Promoting safe behaviours on drug use.
- Identifying 'best practice' programmes to address school and student needs.
- Developing alliances between key community organisations and sectors.
- Developing local resources to support youth discussion on reducing drug-related harm.

The first CAYAD projects were carried out in six places during the mid to late 90s. In 2003, funding was increased to allow for 15 sites across 16 New Zealand communities.

CAYAD sites are chosen according to a number of criteria including Police apprehension statistics, information from treatment centres, school drug suspension and stand-down statistics, Ministry of Social Development data on social deprivation and youth unemployment statistics.

Quotes of Substance

“A more sensible approach would be to say to people, ‘We know you are going to drink to get drunk – so make sure you do not do it very often’.”

UK’s **Dr Andrew Bengry-Howell**, expert in young people’s behaviour, says ministers should stop labelling Britain a nation of binge drinkers and accept that people enjoy going out and getting drunk.

“We need to clamp down… smash the gangs… these people are filth… Anyone supplying or manufacturing illicit drugs should be exterminated.”

New Zealand First’s law and order spokesman **Ron Mark** on his solution to New Zealand’s liberal approach to drugs and gangs.

“I asked him about the fact the child was unrestrained and the beer was, and he said he didn’t know anything about it.”

An Aussie constable was shocked when he pulled over a driver with a 30 pack of beer wearing a seatbelt and a 5-year-old unrestrained. The driver was fined $750.

“Mums and dads are anxious when their kids go out on a Friday and Saturday night as to what’s going to happen to them. Street violence, people being taken to Accident and Emergency, in greater and greater numbers.”

Australian Prime Minister **Kevin Rudd** discusses his views on binge drinking.

“I take my hat off to the Australians. They’ve put their head above the ramparts and got a bit of a hammering for it but I hope they can actually stay there.”

Alcohol Healthwatch director **Rebecca Williams** comments on Australia’s alcohol policy. ■

Volatile substances – A guide for retailers

Good for your business, good for your community.

VOLATILE substances, such as aerosols and solvents (spray paints, glues, gases), are readily available at hardware stores, paint merchants, supermarkets, dairies and service stations. They have many legitimate uses, but they can also be a means of intoxication. This doesn’t leave retailers in an easy situation.

Tackling harms from inhalant and solvent use isn’t straightforward. Increased media attention increases the risk of curiosity and experimentation – and curiosity can kill.

So, in June, the New Zealand Drug Foundation launched an online resource for sellers of volatile substances as one practical tool to help mitigate their harms.

The website has simple tools to help retailers, including ways to improve in-store displays and signage, training on handling difficult customers, dealing with emergencies and ways to improve security. It also has video clips of shop owners and health workers talking about the issue.

“This resource is practical and fills the current need for a consistent nationwide guide for sellers of volatile substances. It is something retailers can easily adopt so they can play a role in tackling this difficult issue,” said Drug Foundation Executive Director Ross Bell at the launch.

Associate Health Minister Jim Anderton said, “The misuse of volatile substances led to six tragic deaths between 2003 and 2004, which obviously had a profound effect on the family, friends and communities who knew the deceased. I very much welcome the development of a guide such as this. I believe it will give retailers the tools they need to act in a more informed way when it comes to the sale of volatile substances in their communities. This can only be a good thing.”

The Drug Foundation warmly welcomes the New Zealand Retailers’ Association’s endorsement of the resource. ■

To find out more, visit www.volatilesubstances.co.nz.

Watch

Watch videos of the launch on the Drug Foundation’s YouTube channel: **www.youtube.com/nzdrugfoundation**.

Smokefree at Springhill

It used to be commonly accepted that trying to quit smoking while in treatment just made battling drug addiction harder. Research now suggests giving up cigarettes at the same time may actually be quite helpful. Results at Springfield seem to back this up.

MICHAEL (not his real name) is in his mid-50s and has smoked 50 cigarettes a day for most of his life. Social smoking was just the done thing, and drinking after work each day just accelerated the amount, he says.

Now he hasn't smoked for almost three weeks, and this time, he thinks it's for good. He's at Springhill, an addictions treatment centre in Hawke's Bay, to face his addictions and get the support he needs so he doesn't relapse when a personal or family crisis comes along.

"I've had three years of inactivity due to ill health. My heart's in it to continue [being smokefree] once I leave," he says.

Michael's not the only one. Sandra, who works in the dairy industry, has also given up. Her husband is supporting her by quitting too. Now 40, she's been smoking since she was 10 years old. Her 25 cigarette a day habit has left her with emphysema.

Sandra's been in the programme since Springhill first went smokefree in May this year. Apart from a weekend a few weeks ago "when I smoked my eyes out," she's hasn't smoked in over two months and intends to stay that way. She says she's already noticed a real difference in her health and is now able to jog around the park outside the residence.

Attendance at Springhill is voluntary, and Sandra believes many people will think twice before going, now that smoking is completely banned. But her advice is to come – "It will be good for you," she says.

Springhill's residential treatment/rehabilitation service runs for three months and treats all types of substance addictions. There are 15 places on the programme.

Traditionally, treatment services have tended to ignore nicotine addiction. Research now supports helping people to give up smoking along with their other addictions while in rehab.

The programme uses patches and gum to wean clients off nicotine, works with referrers, provides support groups and runs alternative activities at smoking times. Clients are then supported to continue being smokefree once they return to their communities.

Springhill staff have worked hard to make the programme succeed. In fact, the two staff members who smoked have both quit voluntarily.

Probably most important of all, going smokefree has been aligned to other healthy living strategies such as relaxation and good nutrition.

It hasn't all been plain sailing. Not all clients readily accepted the smokefree transition, and there have been outbreaks of smoking. Five patients have either been discharged or left of their own accord, but four have since returned to the programme.

Fran Lowe, Springhill's clinical coordinator, is buoyed by the results so far. She's noticed clients now seem more focused on their recovery and are enjoying the obvious health benefits. Some have even encouraged family members to give up. ■

You know you've made it when...

SHORTLAND STREET, a popular New Zealand soap opera, tackled the subject of party drugs in episodes in June. Kieran (Adam Rickitt) organised underground dance parties, which resulted in a punter being rushed to hospital with a suspected overdose. And to ensure honest and factual information was provided about drugs, *Shortland Street* turned to the Drug Foundation for advice and resources. You too can get your hands on our famous resources! Order online at www.drugfoundation.org.nz.

High-dose alcopops to go

NEW ZEALAND'S two main liquor companies say they will soon have their highest-volume alcopops off the shelves. Lion Nathan's corporate affairs manager Liz Read says the company is moving towards the two standard drinks limit. They have stopped making any product over that limit, and existing stocks are expected to be sold off by the end of August. Rival Independent Liquor CEO Doug McKay said they are also working on phasing out anything over two standard drinks but could not provide a specific date.

Otago students protest cannabis charge

OTAGO UNIVERSITY students protested against Campus Watch and the Campus Cop on 28 May for overstepping their roles and intimidation. History student Logan Anderson (21) had been arrested for cannabis possession on campus during the previous week. Around 120 protestors met outside the offices of Campus Watch and Proctor Simon Thompson, chanting slogans such as, "I don't pay my fees to pay for quasi-police," and "Hey-ho Campus Watch, don't forget you're not the cops."

Outcry over one-stop P shop

AUTHORITIES reacted quickly after a *One News* investigation revealed how ingredients to make methamphetamine are being sold in dairies in the Northland town of Moerewa. The two stores were selling large quantities of isopropyl, a key ingredient used in making the Class A drug.

After visiting six stores, *One News* had everything necessary to make methamphetamine except the cold remedy medicine containing pseudoephedrine. During undercover filming, one shopkeeper, Mr Patel, offered to do a cheap deal on a bulk purchase of isopropyl, knowing the buyer wanted it to make drugs.

When told it was used to make drugs, Patel is shown on camera saying, "It's got nothing to do with me so I don't mind."

However, when the media crew returned, he said it would not be good to sell isopropyl for use in drug making. "It is killing people and we are not here to kill people," Patel says.
Four Square brand owner Foodstuffs have given Mr Patel one month notice to shut up shop, claiming he has "brought Foodstuffs and their brand into disrepute".

Mr Patel called Foodstuffs' actions "disappointing" as he is a loyal customer despite this recent hiccup.

Unfortunate case of the munchies

WADE CHURCHWARD, a 28-year-old mechanic, had a fair amount of alcohol in his system when he entered a Carterton service station in March. He grabbed a packet of chippies and two packets of M&Ms. The munchies would not wait, so he opened the M&Ms and started eating. With no money on him, he offered the attendant 12 grams of cannabis and a pipe, placing them on the counter. Unfortunately, the man waiting in the queue behind him was a police officer. Bummer.

People at risk of hepatitis urged to get tested

THE Ministry of Health joined other groups to raise public awareness of hepatitis C on World Hepatitis Day (19 May). Associate Professor Gane, who chairs the Hepatitis C Treatment Advisory Group, says most people who contract the virus will go on to become carriers for life. At least 10 percent of people diagnosed with hepatitis C have no idea how they got it. But Associate Professor Gane says anything that can puncture the skin can carry infected blood, including razors and toothbrushes.

It is estimated that 45,000–50,000 people in New Zealand have hepatitis C, with around 25 new infections every week. Unusual tiredness is the most commonly reported symptom.

A helpline has been set up for those needing support and advice. The number is 0800 224372.

Get protected with Spikey, but do you need it?

THREE entrepreneurial Christchurch high school students have become the legal distributors of a stopper to protect bottled drinks from being spiked. They retail at $2.50 for a bag of 10. Branded as Spikey, the stoppers are widely used in Britain, Spain and Australia, the girls say. Christchurch central city area commander Detective Inspector Gary Knowles said Spikey was a great idea and a novel way of stopping drink-spiking. "We support the concept 100 percent."

However, new Australian research suggests drink spiking is largely a myth. The study revealed most claiming to be victims had either knowingly taken drugs or simply drunk too much.

Primate in the hood

CO-PRESIDING Archbishop of New Zealand David Moxon had to borrow a hoodie from his eldest son so he could join marking Youthweek's first ever Hoodie Day on 30 May. The 56-year-old was one of more than 30 community leaders who gathered on the steps of Parliament wearing the popular type of sweatshirt.

Archbishop Moxon said the day was an effective way

to combat the view that only troublemakers wore hoodies. "Through my job, I have met a lot of young people, many of whom wear hoodies, including my two sons. None of them have anything to do with gangs or crime," he said. "They're a comfortable, warm top, which can take a lot of rough and tough wear. I can see why teenagers take to wearing them. By wearing hoodies, we're showing we support our youth."

Other hoodie wearers included Green Party MPs Sue Bradford and Metiria Turei, recently retired MP Nandor Tanczos, Māori Party MP Hone Harawira and the Minister of Youth Affairs Hon Nanaia Mahuta.

National MPs Nicky Wagner and Paula Bennett boycotted Hoodie Day. Ms Bennett said, "There are bigger issues for youth out there, and me fronting up and wearing a hoodie is not what I think will fix any of the biggest issues for young people."

New Zealand First MP Ron Mark criticised Hoodie Day and his fellow MPs supporting the event. "I think it's a little bizarre that a Māori MP would be promoting black American gang culture to try to generate some positive messages about youth." ■

Workers 'breaking the ice' and alcohol

THE party drug ice is infiltrating Australia's workplaces at a disturbing rate and creating potentially deadly situations, researchers have warned. Academics at Flinders University say almost one in 10 hospitality workers, and more than 5 percent of construction and transport industry workers, are using the drug. National statistics released this week show that ice use in the community has decreased from 3.2 percent to 2.3 percent. The 2007 National Drug Strategy Household survey found 4 percent of those aged 14 and over (about 690,000 people) have admitted going to work under the influence of alcohol.

Absinthe's mystique cops a blow

ALBERT MAIGNAN'S painting *Green Muse* (1895) shows a poet succumbing to absinthe's mind-altering effects *(Source: Musée de Picardie, Amiens).*

Absinthe, which inspiration-seeking artists once drank in excess, is not a psychedelic beverage, say international researchers. They say the drink's reputation for expanding consciousness is due to nothing more exotic than its high alcohol content. In the 19th century, many drinkers developed 'absinthe madness' or 'absinthism', a collection of symptoms including hallucinations, facial contractions, numbness and dementia. Absinthe soon gained a reputation as a dangerous psychedelic drink and was banned after growing reports of illness and violence.

Alcopop theft soars

SINCE the Australian government ramped up alcohol tax to curb binge drinking, alcopops are walking off the shelves – illegally. Some bottle shop owners in Sydney's southwest are reporting a surge in theft, not only of the so-called 'ready-to-drink' mixes, which are small and easy to conceal, but also the 700ml bottles of spirits many young people appear to now see as an alternative.

Vodka Cruisers' condom not on

A TOP Australian booze executive has apologised for a campaign that supplied free condoms with alcopops. The promotion for Vodka Cruisers also offered the chance to win a free pole-dancing kit. The Independent Distillers executive chairman told a Senate inquiry he was "extremely embarrassed" by the campaign. "It slipped through the net," he said.

Cook Islands raises cigarette and alcohol tax

THE Cook Islands finance minister has presented a $US80 million budget to Parliament, increasing taxes on soft drinks, cigarettes and alcohol. Although Cook Islands' income from donor agencies has been reduced, the government says the tax increases are primarily designed to reduce consumption by young people in a bid to improve health.

Nightclubs to get drug advice

UK nightclubs are getting guidance from National Health Service specialists on spotting patrons who may have taken drugs and when to summon medical help. The advice was co-written by doctors, police officers and bar owners.

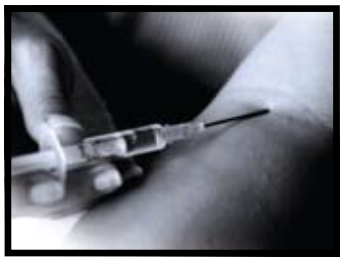
One author said some staff had avoided calling an ambulance for a clubber as they feared losing their licence. Many clubs now have designated medical rooms where people who have fallen ill while on the premises can be assessed and treated. The guidelines are available at www.substanceabusepolicy.com.

Big tobacco funds secret university research

VIRGINIA COMMONWEALTH University signed a contract to do research for Philip Morris USA – but academics are barred from publishing the results or even talking about them without the tobacco company's permission. Last year, they received $1.3 million in research grants that included the restricted contract and a more traditional independent grant.

A professor at the University of California said, "University administrators who are desperate for money will basically do anything." About 15 public health and medical schools no longer accept donations from the tobacco industry.

Record drug seizures hit heroin supplies



THE price of heroin is soaring on Melbourne's streets as authorities seize record amounts of the drug at Australia's borders. The starting price of heroin in Victoria increased from $270 per gram in 2005–06 to $370 in 2006–07. Authorities seized 4,781kg of cannabis, 993kg of amphetamine-type stimulants, 634kg of cocaine and 85kg of heroin.

Drinkers to face 'walk of shame'

BUYING drink at the supermarket could involve a walk of shame to an 'alcohol-only' checkout counter under new plans to help Scotland curb its binge drinking culture. The scheme is designed to deter shoppers from making excessive purchases by placing them under the scrutiny of fellow customers. The idea is part of a package of radical measures, with an estimated cost of more than £2 billion a year.

Beer for man's best friend

DOG BEER, designed by a Sydney pet store owner after noticing her own dogs' keen interest in the beverage, tastes like beef, smells like beer and costs A$5 a bottle.

Code cracks down on Irish ads

NEW restrictions aimed at reducing the exposure of Irish children to alcohol advertising came into effect on 1 July. They impose a limit on alcohol advertising to 25 percent of advertising space in any media at any time. Advertising drink in media where more than 25 percent of the audience is under 18 is completely banned.

Drink companies are also banned from sponsoring sports events where participants are under 18 years. Placing ads on television between 6am and 10am is prohibited, and the amount of advertising per viewing in cinemas has been reduced by 15 percent.

No kids for smokers

SMOKERS are to be banned from adopting or fostering children under the age of five in South Lanarkshire. Would-be parents will have their applications rejected unless they agree to kick the habit.

Eight previously-approved smokers who look after pre-school children will be offered help and support to quit. Several councils in England have imposed similar restrictions following guidance from the British Association for Adoption and Fostering.

Post office pot

CANNABIS would be sold legally in post offices in packets that warn against its effects under a proposal outlined by the head of a Sydney drug and alcohol clinic. St Vincent's Hospital's Alex Wodak said Australia needed to learn from the tobacco industry and the US Prohibition era, as he believes cannabis consumption will soon overtake tobacco. "I don't want to see that [industry] fall into the hands of tobacco companies or rapacious businessmen."

Dr Wodak said he suggested Australia Post as it had branches across the country, which would help regulate distribution.

Colleagues of Dr Wodak cautioned against the suggestion.

"It's really going beyond the evidence to say regulatory control would effectively reduce adverse effects," said a deputy director of the National Drug Research Institute, Simon Lenton. "We don't know what the effects would be."

Iran carries out 'mass execution' of drug offenders

LAST month, the government of Iran hanged 20 people convicted of drug offences. In total, 29 persons were hanged in what the state broadcaster described as the largest mass execution carried out in the country in recent years. The executions took place after the death sentences had been ratified by Iran's Supreme Court.

The hangings bring the total number of persons executed in Iran this year to 155, according to press reports. According to Amnesty International, Iran executed 317 people in 2007, ranking the country second only to China in the number of death sentences carried out that year.

Iranian officials have described those executed as 'traffickers', and Tehran prosecutor Saeed Mortazavi told the state broadcaster, "We believe that executing these thugs reflects the Islamic Republic's will to confront such crimes."

However, Iran's narcotics laws cast a wide net when it comes to those drug offences punishable by death.

A mandatory death sentence is imposed in Iranian legislation for possession of more than 30g of heroin or 5kg of opium. However, under this legislation, this quantity may be calculated cumulatively, and therefore based either upon the weight seized during a single arrest or added together over a number of cases. As a result, a person with several convictions for possession of smaller quantities of drugs may receive a mandatory death sentence if the total amount seized from all convictions exceeds the prescribed threshold. Iranian legislation also prescribes the death penalty for a repeat conviction for 'intentionally caus(ing) another person to be addicted to the drugs'. ■

Substance and substantiation

Coming clean on meth

Mythbusters always enjoy a grain of salt or two while reading media stories about rampant methamphetamine epidemics. However, we do concede the drug is quickly addictive and incredibly difficult for addicts to give up.

IS METHAMPHETAMINE addiction untreatable, as many commonly believe? Mythbusters don't think so. While treatment development is still in early stages, some standard therapies are beginning to provide very real and measurable results.

When methamphetamine use burst onto the scene in the mid 90s, treatment providers hadn't seen anything like it. The psychotic behaviours associated with its use, though similar to those of cocaine, were far more intense, and so was resistance to traditional treatment.

Unlike cocaine, which interferes with the body's ability to recycle dopamine, methamphetamine actually causes its excessive release directly within nerve cells. The euphoria and increased energy from these dopamine spikes are incredibly addictive. But resistance also rapidly develops, increasing dependency.

It's the over-stimulation of dopamine that causes the psychotic episodes, but perhaps the most significant effect is the body compensating by releasing less dopamine naturally. The result is intense anhedonia – the inability to experience pleasure – which can last for months and be much more difficult to endure than the withdrawal effects of other drugs.

In 2001, the Cochrane Review said, "No available [medical] treatment has been demonstrated to be effective [for] amphetamine withdrawal."

However, Fraser Todd, Deputy Director (Teaching) of the National Addiction Centre, says we shouldn't understand these and similar findings to mean no medical treatment works – just that the evidence is inconclusive at this stage.

"We should note this review considered only controlled trials of pharmacological treatments for withdrawal. While no pharmacological treatment worked better than placebos in the studies reviewed, more than 80 percent of subjects still managed to complete detox.

"More importantly, it does not mean psychosocial withdrawal strategies are ineffective, just that the medications studied didn't add to them. In the larger of the two studies reviewed, 36 out of 43 subjects successfully withdrew from amphetamines."

This equates to a success rate of about 83 percent where standard treatments for withdrawal were used.

Cognitive Behavioural Therapy (CBT) is one psychosocial intervention that has had promising results in a number of controlled studies. It aims to help patients recognise and challenge their own beliefs and behaviours that reinforce their unwanted behaviour.

The Matrix Model, used by the Center for Substance Abuse Treatment (CSAT) in California, for example, boasts a 50–60 percent success rate after one year – better results than from behavioural therapy for heroin addiction (without the use of methadone), but not as good as figures for recovery from alcoholism.

The basic element of the Matrix Model is group or individual therapy, where patients are taught about their addiction and trained to manage cravings and avoid activities that could trigger relapse. Family therapy, urine testing and 12-step approaches are also part of the programme.

Fraser Todd says the components of the Matrix Model have been standard practice for some time in New Zealand, though we may have taken them further.

"The Matrix Model was developed in America as a way of moving beyond the incumbent 12-step programmes, which focus on confrontation of denial. But it has become highly systematised and manual-based. We're much freer here to adapt techniques according to individual circumstances."

In New Zealand, methamphetamine addiction is typically treated using a mix of therapies and techniques tailored for individual situations. These may include: detoxification, CBT, family interventions, community reinforcement and contingency management.
In addition, associated problems such as mental and physical health and problems in other life areas – such as accommodation, employment, finances and relationships – would also be taken into account.

So far, there hasn't been significant outcome research on treatments for amphetamine dependence here, but current approaches appear about as successful as they are for other serious drug addictions.

Meanwhile, all eyes are on the Methamphetamine Treatment Evaluation Study (MATES) currently underway in Australia. Managed by the National Drug and Alcohol Research Centre, it is the first large-scale community-based treatment outcomes study for methamphetamine use either in Australia or internationally.

The MATES study will conclude in 2009. With a large participant group and very high follow-up rates, its findings will be able to be extrapolated amongst the population with a high degree of accuracy.

There may never be a definitive treatment for meth addiction because there will never be a definitive addict. But by adapting the methods and ideas we have now with what we'll learn from MATES and other studies, the number of treatment options should increase. We'll also better understand how to apply them, and methamphetamine addiction, which is already very treatable in many cases, will certainly become more treatable. ■

For a full list of references used by Mythbusters, visit www.drugfoundation.org.nz

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