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November 2008

Not what the doctor ordered

Recent research suggests doctor shoppers are flooding the illicit market with prescribed pills. Just how serious is New Zealand's prescription drug misuse problem, and are we equipped to deal with it?

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matters of **substance** invites feedback and contributions. If you're interested in contributing a guest editorial or article, please first contact us:
editor@drugfoundation.org.nz
p +64 4 801 6303

Brand development/graphic design
Origin Design +64 4 801 6644
info@origindesign.co.nz
www.origindesign.co.nz

NZ Drug Foundation
3rd Floor, 111 Dixon Street
PO Box 3082, Wellington, New Zealand
p +64 4 801 6303

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Te Tūāpapa Tarukino o Aotearoa

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Quotes of Substance

Our usual collection of drug pronouncements from around the world ranging from the wise to the woeful.



POLITICAL CHANGE has come. The US has their first African-American President, while Labour's nine-year tenure has ended in New Zealand. Both elections will impact on drug policies.

Barack Obama has spoken of removing the Federal funding ban on needle exchanges, and of expanding treatment, including offering treatment as an alternative to prison. He has criticised the War on Drugs saying, "It's expensive, it's counterproductive, and it doesn't make sense." On the world stage, we may see the US promoting progressive, balanced and health-focused drug policy.

What might we expect from the new National-led Government?

National have made the very welcome announcement to double the number of beds in prison Drug Treatment Units. The successful implementation of this policy will require resourcing for the treatment workforce and better management within Corrections to ensure that the new beds are fully utilised.

In a letter to the Drug Foundation, the National Party stated their intention to work for better access to mental health and addiction treatment services. They would also improve primary care, provide early intervention and promote Integrated Family Health Centres that bring together a wider range of health services and professionals into a one stop shop. On alcohol, they support ALAC's Culture Change Programme and want to see retailers obey the law

regarding retail sales.

It remains to be seen how their coalition parties will influence drug policy.

While ACT campaigned on law and order, they are known for their criticism of the current drug law and for their support for prevention and education.

United Future has previously opposed tobacco and alcohol control policy and quashed debate on cannabis policy. It would be a shame if a similar barrier stymies the Misuse of Drugs Act review.

The Māori Party is concerned about the health inequalities created by alcohol and drug harm in Māori communities. They have pedigree on drug policy: Pita Sharples is known for his methamphetamine work at Hoani Waititi Marae; Tariana Turia is a previous associate health minister; and Hone Harawira pulls no punches in his attack on the hypocrisy between legal and illegal drugs.

There is important work to do. Current financial priorities shouldn't stop drug policy progress: the Law Commission's alcohol and drug reviews deserve continued political attention, as does the Supply of Liquor and Liquor Enforcement Bill inherited from the previous government.

Interventions to tackle poverty and social exclusion must include efforts to reduce alcohol and drug harm. The significant cost benefit of addressing drug harm as a health issue makes economic sense (as well as being socially just and humane).

I look forward to working with the new Government. Happy reading, Ross Bell. ■

Dangerous Consumptions Colloquium 2008: Manufacturing Consumptions

4–5 December, Auckland

This two-day international colloquium will explore industrial relationships across the areas of gambling, alcohol, tobacco, pharmaceuticals, body enhancements, fast foods, illegal drug use and other areas where consumption of pleasurable commodities creates harm.

<http://130.216.128.177/health/dcVI/index.html>

17th World Conference of Therapeutic Communities

6–10 February, Lima, Peru

At this conference, experts from all over the world will explore and share experiences of the range of therapeutic community programmes. Discussions will cover the therapeutic community model and the latest scientific discoveries in the treatment of addictions.

www.mundolibre.org.pe

Drug Policy Symposium – Healthy Drug Law

18–20 February, Wellington

A high-level forum for senior and international drug policy officials, politicians, alcohol and other drug sector leaders and academics to discuss the Misuse of Drugs Act review in the context of rethinking international drug control.

For more information, contact ross.bell@drugfoundation.org.nz.

3rd International Conference of the International Society for the Study of Drug Policy

2–3 March, Vienna, Austria

The third annual conference is being hosted by the United Nations Office on Drugs and Crime and should be of interest to a wide array of disciplines including anthropology, economics, epidemiology, political science, public health and sociology.

www.issdp.org

School of Addiction 2009

4–6 March, Auckland

The biennial school, jointly hosted by DAPAANZ and the Pacific Centre for Motivation and Change, is offered to experienced clinicians and practitioners in the field of addiction treatment.

www.matuaraki.org.nz

3rd International Conference on Fetal Alcohol Spectrum Disorder 2009

11–14 March, Victoria, BC, Canada

The conference will be 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.

www.interprofessional.ubc.ca

1st Conference of the Connections Project

25–27 March, Krakow, Poland

Joining the Dots: Criminal Justice, Treatment and Harm Reduction will aim to facilitate the development of knowledge and an evidence base for how different harm reduction and drug free interventions can be incorporated across criminal justice processes.

www.connectionsproject.eu

International Harm Reduction Association Conference 2009

19–23 April, Bangkok, Thailand

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 drug users are entitled.

www.ihra.net



Making it Happen 2009

12–13 May, Fremantle, Western Australia

Making it Happen is a unique, collaborative event between government and non-government organisations across the AOD sector. The conference will focus on the discussion of best practice initiatives to respond to clients affected by drug and alcohol issues.

www.makingithappen2009.com

Publish your own event online at

www.drugfoundation.org.nz/events

Not what the doctor ordered

Recent studies show that misuse of prescription drugs is as much a problem in New Zealand as anywhere else in the world – possibly more so because opioids like heroin aren't plentiful here. But a full understanding of the problem's seriousness is still emerging, which means we may not have the structures in place to deal with it.

Rob Zorn



ACCORDING to an International Narcotics Control Board (INCB) report released in 2007, prescription drug misuse is now a worldwide problem that is increasing rapidly. In fact, in some regions, prescribed medicines are being abused “in quantities similar to or greater than the quantities of illicitly manufactured heroin, cocaine, amphetamine and opioids”.

The Board’s conclusion is borne out by research and reports from various western countries. In the United States, for example, statistics suggest levels of prescription drug misuse are second only to misuse of cannabis. The National Center on Addiction and Substance Abuse (CASA) says 6 percent of Americans (15.1 million people) reported abusing controlled drugs in 2003 – higher than the number of those abusing cocaine (5.9 million),

hallucinogens (4 million), inhalants (2.1 million) and heroin (328,000) combined.

Data from the UK are more patchy, though a 2000 report appearing in the journal *Addiction* described the size of the market for diverted prescription drugs as “substantial”.

In Australia, an increasing number of prescription medicines are being abused. Data from the 2004 National Drug Strategy Household Survey revealed that 7.6 percent of Australians had used pharmaceuticals for non-medical purposes at least once and that the most used substances in the 12 months preceding the survey were painkillers and tranquillisers. In 2006, morphine was the most commonly reported pharmaceutical used by injecting users according to Australia’s Illicit Drug Reporting System (IDRS).

“ In 1990, New Zealand had 600 people on the methadone programme. Now we have around 4,000! ”

Dr Geoff Robinson.



NZPA/Ross Setford

Of particular relevance to us is the Tasmanian component of the IDRS, given that state's geographical similarity to New Zealand. Heroin has not generally been widely available in Tasmania, and this is one accepted reason why the 2006 IDRS reported it had higher rates of benzodiazepine injection than other Australian states.

New Zealand's National Drug Policy also acknowledges that our geographical isolation makes it difficult to import bulk quantities of heroin or raw opium into the country, and therefore, like Tasmania, we are more likely to abuse other opioids such as prescription medicines.

Geoff Robinson, Chief Medical Officer at the Capital and Coast District Health Board, has no doubt that New Zealand's problem with prescription drug misuse ranks up there with other western countries and that a local scarcity of heroin is one main reason why.

"In 1990, New Zealand had 600 people on the methadone programme. Now we have around 4,000! That's a level similar to that of New South Wales. The difference is that heroin is not available here like it has been there, so these people aren't on the programme because of heroin dependence, but as a result of prescription opioid problems."

While such a massive increase in the number of people presenting at clinics makes it clear that prescription drugs misuse is a serious problem, it's not easy to put an accurate finger on the full extent of that seriousness. There are no published data that would provide an overview, and even what we do know is subject to interpretation.

While the amount of opioids prescribed in New Zealand has more than doubled in the last 15 years, it is very difficult to tell just how much of that prescribed medicine is being used legitimately and how much is being diverted and used illicitly. After all, the same patient may be doing both in many cases.

A recent New Zealand study indicated that 14 percent of people in drug and alcohol treatment were diagnosed with sedative dependence. The 2006 Illicit Drug Monitoring System (IDMS) indicated that opiates were

easy/very easy to get, and 50 percent of the injecting drug users taking part in the study said opiates were the drugs most responsible for their drug-related problems.

In April this year, Auckland University's School of Pharmacy released its report *Prescription drug misuse: issues for primary care*. Researchers interviewed 51 general practitioners, community pharmacists and other key experts about their experiences with prescription drug misuse. The GPs and pharmacists indicated that, while it is not generally a major disruption to their practices, they are highly aware of it as an issue.

This qualitative study, led by Professor Janie Sheridan, provides an excellent overview, from the coalface, as it were, of what drugs are typically being misused, how they are being obtained, and what is being done – individually and collectively – to deal with the resulting problems.

The sorts of drugs commonly sought fall into three main categories – opioids, benzodiazepines and stimulants – though interviewees differed on which were mainly targeted in their practices or pharmacies.

“ Drug seekers tend to come from all walks of life so it is hard to generalise about their characteristics. ”

Opioids are synthetic chemical substances mainly used for pain relief. Those sought include codeine, dihydrocodeine tartrate, morphine (including morphine sulphate) and methadone.

Benzodiazepines are a class of psychoactive drug with varying hypnotic, sedative, anxiolytic and muscle-relaxant qualities. They were reported as widely sought by all interviewees and include diazepam (Valium®) clonazepam (Rivotril®) and temazepam (Normison®, Somapam®, Euhypnos®).

Stimulants cause increased alertness, insomnia and raised heart rate and blood pressure. Those sought include pseudoephedrine-containing products and methylphenidate (Ritalin®).

'Drug seekers', as they are known to health professionals, tend to come from all walks of life so it is hard to generalise about their characteristics. While interviewees agreed they were predominantly New Zealand European, some said they tended most to be aged in their 20s and 30s while others indicated they were most often over 50. Only two interviewees were concerned about teenagers abusing their prescription medication.

Males and females seemed to be equally represented, though there were some general differences in approaches. Respondents reported that males were more likely to use standover tactics while females were more successful at fabricating stories as to why they need the medicine. Men were more likely to claim they had physical injuries such as car accidents or that they had been assaulted. Women were more likely to claim emotional anguish, migraines or 'women's problems' in the hopes male doctors wouldn't ask too many questions.

The researchers also pointed out that one emerging theme was a distinction between two types of drug seekers. 'Abusers' are those who seek drugs to use or sell for recreational purposes or to knowingly feed an addiction. 'Over users' are drug seekers who originally began using the drug for legitimate purposes such as for chronic pain or anxiety. However, misuse has developed over time and escalated to the point of addiction. 'Over users' tended to be considered less of a problem by respondents. They were not perceived to be as 'underhand' and didn't fit the 'drug addict' stereotype. They were also thought less likely to sell their medications on the illicit market.

The two main methods of acquiring prescription medications, other than 'raiding grandma's medicine cabinet', are known as 'doctor shopping' and 'pharmacy hopping'.

'Doctor shoppers' will visit a number of different doctors in their own area or in neighbouring districts seeking multiple prescriptions that they will then present at a number of different pharmacies. Sometimes, fraudulent IDs are used, but because it is easy in New Zealand to see a doctor on a one-off basis, these are often not needed.

Using different pharmacies, or 'pharmacy hopping' helps the user hide the extent of his or her prescription drug use, but 'pharmacy hopping' also includes the practice of presenting a prescription at another pharmacy when it is refused the first time due to a pharmacist's concerns.

The respondents said another way drug seekers attempt to obtain medication is by presenting for repeat prescriptions before they are due. Generally, a reason is provided as to why the medication is needed early. It has been 'lost' or 'stolen', or the patient says they are going on holiday and needing additional supplies to take away.

While there are regulations around early prescriptions, pharmacists have discretion to fill them early. For example, a 30-day repeat prescription may be collected after 20 days if the dispensing pharmacist believes there is sufficient reason.

Often, fabricated medical conditions are used to fool GPs and hospital clinics, such as invented pain symptoms or fake psychological states (e.g. grief) – the 'patient' relying on the fact that most doctors would prefer to err on the side of caution and not deny medication, even if they suspect the symptoms are phoney.

Prescription forging is also reasonably common. This can involve altering an authentic prescription by adding drug names to it or by changing the amount of the medication prescribed – for example, by inserting an additional digit to the correct dose. Computer-generated fake prescriptions have also been used, sometimes even verified with stamps stolen from hospitals or surgeries.

The respondents also discussed specific diversion methods relating to obtaining methadone. Most diversion occurs when takeaway doses are given

to patients on the programme.

The methadone is sold or given to someone else. One respondent said that, typically, the methadone diverter would return after half an hour claiming their takeaway dose was lost or spilled in the hopes of receiving another.

But diversions are attempted even with supervised doses, with the user sneaking the dose into a hidden container while pretending to drink it. Another method is to hold the methadone in the mouth and spit it into a container upon leaving the clinic.

Most doctors and pharmacists in New Zealand aren't silly and have become reasonably astute at spotting prescription drug abusers. There are behaviours to watch for including specific requests for a particular drug, a refusal to consider alternatives and agitated behaviour. Drug seekers are most likely to visit surgeries at busy periods such as at the end of the day when doctors are behind schedule and more likely to give the benefit of the doubt to get through their day's workload. It is also common for drug seekers to target new practices, pharmacies or doctors, including locums.

Under their codes of conduct, both doctors and pharmacists are bound to act within the law and withhold medicines from those who would abuse them. The guidelines may well be very clear, but respondents indicated the reality is often much less straightforward.

Even when they are suspicious, there is an understandable reluctance to act. Where doctors don't know a patient, it can be difficult to be certain they are faking it without direct evidence, and most would prefer to prescribe a small amount of medication than make a mistake and leave someone suffering.

Pharmacists say they can find themselves in a similar situation. They are entitled to refuse a prescription if they are in doubt, and it is common for them to call the prescribing doctor to check that a prescription is legitimate. Even where the pharmacist disagrees with the doctor, there is an understandable reluctance to question that doctor's professional integrity or



Prescription drug misuse harms

Harms resulting from prescription medicine abuse are similar to those associated with substance abuse in general.

- Physical harms are mainly from injecting such as venous thromboses, vascular and tissue damage, ulcers and gangrene.
- General harms include having unsafe sex, driving while under the influence of drugs and the risk of blood-borne diseases from sharing injecting equipment.
- There is always the risk of overdose, which increases when differing substances are taken together.
- Social harms include isolation and a lack of connectedness, loss of employment, family and relationship breakdowns and engagement in criminal activity to fund addiction.
- Financial costs to society can also be substantial in terms of lost productivity, a drain on medical and pharmacy practice resources, and time spent by treatment professionals.

Recognising signs of drug seeking and misuse

*from *Best Practice Journal*, September 2008

Many GPs believe they can easily identify drug seekers, but they will not all fit the expected stereotype.

Drug seekers may be known patients or casual attendees to the practice. They may be dependent on the drug themselves or sourcing it for illicit sale. Anyone, regardless of gender, income, ethnicity, health or employment status, can be a drug seeker.

And not all drug seekers are faking symptoms. They may have a legitimate complaint and, over time, have become dependent or tolerant and require larger doses to function in their daily life. Patients with chronic pain, anxiety disorders and attention-deficit disorder are at increased risk of addiction co-morbidity.

Some indicators of drug seeking behaviour are:

- presenting near closing time without an appointment
- reporting a recent move into the area, making validation with a previous practitioner difficult
- requesting a specific drug and refusing all other suggestions – the patient may claim other medications don't work, they have an allergy to them or a high tolerance to drugs or report losing prescriptions
- inconsistent symptoms that do not match objective evidence or physical examination
- manipulating behaviour, which may include comparing one doctor's treatment opinions against another's, offering bribes or making threats
- use of multiple doctors
- assertive personality, often demanding immediate action
- unusual knowledge of medications and symptoms, or evasive and vague answers to history questions
- reluctance to provide personal information such as address or name of regular doctor.

Many drug seekers will target doctors who are new to a practice or doctors who are sympathetic and dislike confrontation. A usual patient/doctor relationship is based on mutual respect; however, a drug seeker has a stronger relationship with the prescription than with the doctor. Some doctors who are pressured for time would rather 'write than fight'.

competence, especially when the pharmacist does not have access to the patient's history or reasons for diagnosis.

Ministry of Health figures suggest that, while reckless or criminal prescribing does occur, it is not widespread. Medicines Control, the Ministry's drug abuse containment arm, actively monitors prescription rates and investigates where a doctor is prescribing unusual amounts of addictive medicines, either in general or to the same persons. Around three or four doctors are approached each month nationwide, but of these, only a few would be referred each year to the Police or Medical Council.

Medical Officers of Health in conjunction with Medicines Control make these decisions on a case-by-case basis, unless there is direct Police intervention.

According to Geoff Robinson, the threshold for what is considered aberrant prescribing may be too low.

"While there can be legitimate reasons why some doctors prescribe more addictive substances than others, the fact is that an incredible amount is diverted to illicit use, and we need tighter controls on what is given out and to whom."

He says that, while there are some doctors willing to supplement their incomes by selling unnecessary prescriptions, the majority who over prescribe would be motivated by a "foolish altruism" where they somehow believe they are helping their patient, or that the patient's situation would be worse if their addiction was not fed.

As with most professional communities, doctors and pharmacists have their own unofficial support networks and liaise with their peers on issues around prescription drug misuse. This can involve consulting nearby colleagues about suspected drug seekers and the sharing of advice between more and less experienced or knowledgeable doctors and pharmacists. Some have even set up fax trees to quickly disseminate information about drug seeking activity in their area.

There are also professional bodies

that can be turned to for help or guidance such as drug treatment agencies that may have specific knowledge about individuals or the general drug scene in the locality. Methadone providers are particularly valuable in this regard.

GPs and pharmacists are able to check a register of known drug seekers published in print form by Medicines Control, but this is only useful when the drug seeker is using his or her real name. Looking up the booklet during a consultation with a suspected drug seeker is also considered impractical by many doctors and pharmacists.

“ If it seems that our institutional response mechanisms to prescription drugs misuse are underdeveloped, that is probably a reflection of the fact that our understanding of the scale and complexity of the problem is still emerging. ”

Medicines Control can be contacted directly for advice on what to do about a drug seeking patient or if there is concern about the prescribing habits of a doctor. Suggested additions to the register of known drug seekers can also be made.

If it seems that our institutional response mechanisms to prescription drugs misuse are underdeveloped, that is probably a reflection of the fact that our understanding of the scale and complexity of the problem is still emerging.

Respondents to the University of Auckland prescription drug misuse study identified three broad areas in which developments could be made to better manage prescription drug misuse in the future.

The first was training and education so that all GPs and pharmacists had a minimum level of understanding around prescription drug misuse issues, not just those with knowledgeable colleagues in

their support networks. The training would include which medications were most targeted and innovations in drug seeking behaviour (such as forgery techniques), how to identify and manage drug seekers and who to contact when issues arise.

The second area was access to electronic information such as an up-to-date national database of known drug seekers/restricted persons, and community databases across pharmacies and practices that would identify a person sourcing potential medicines of abuse from more than one location. Such a system would have immense ethical, privacy and misuse of data implications, however.

The third concern was for improved support systems such as national or regional standard protocols to guide the management of prescription drug misuse. A targeted specialist support body was also suggested, made up of key prescription drug misuse stakeholders such as the Police, AOD treatment representatives and knowledgeable GPs and pharmacists. Lastly, improved support for prescription drug misusers was seen as necessary. Once a prescription has been denied, what then? This is especially relevant to 'over users' with legitimate prescribing indications who do not necessarily fit

the drug addict mould most AOD services are geared towards.

Interestingly, the Medical Council of New Zealand's report *Strategies for Action on the Misuse of Addictive Prescription Drugs* made many of the same recommendations back in 1991. As Sheridan et al. point out, this indicates that "whilst action may have occurred in the intervening period, the problems remain broadly similar and unresolved".

So what action has occurred in the intervening period, particularly on the part of the Ministry of Health?

One thing that has been done is the introduction of electronic monitoring of controlled drug prescribing, which has made surveillance much easier. Plans are afoot to bring in e-prescribing based on a Swedish model, which will mean prescriptions are no longer given out to patients. Instead, they will reside in an online database where they can be accessed by pharmacists according to the patient's unique identifier. It is uncertain when this will be a reality.

Regulations have also been altered so that drugs with a high level of addictive potential, such as morphine and Ritalin®, can only be given out in 10-day amounts.

"But actually, there's not been a lot of change or progress at all," says Geoff Robinson.

"The National Drug Policy contains exactly nine lines on diverted pharmaceuticals and contains no discernable plan for reducing what has become an epidemic."

Robinson would like to see the Ministry of Health conduct a formal review of the issue in conjunction with relevant parties such as The Royal New Zealand College of General Practitioners, the treatment sector and the Police.

He concedes, however, that getting the balance right between optimal pain control and over prescribing is always going to be difficult and suggests doctors need more training and better guidelines to increase their awareness and help them get it right more often.

"You can put all the prescribing controls in place that you like, but it's pretty hard to regulate what happens to the drugs once they're in the hands of the user.

"It's essential, therefore, that prescribing doctors make good decisions based on a sound understanding of the nature and extent of the problem, and we're only going to get that across all sectors if all parties work together." ■

Rob Zorn is a Wellington-based writer.



The price on the street

These were Police estimates of tablet prices in 2007.

Prescription drug	Quantity	Street value
Morphine sulphate	(30mg)	\$40–\$60 per tablet
Morphine sulphate	(60mg)	\$80–\$100 per tablet
Morphine sulphate	(100mg)	\$120 per tablet
Halcion	(0.25mg)	\$5–\$6 each
Ritalin		\$10–\$15 each
Diazepam	(10mg)	\$5 each
Valium	(10mg)	\$6 each
Rivital	(2mg)	\$5 each
Temgesics	(0.2mg)	\$20–\$40 each
Duromine	(30mg)	\$5–\$20 each
Doloxene	(100mg)	\$5–\$10 each
Codeine phosphate	(15mg)	\$10 each
Codeine phosphate	(30mg)	\$15 each
Codeine phosphate	(60mg)	\$30 each

Following the paper trail – drug control in Thailand

In the May 2008 *Matters of Substance*, Martina Melis provided readers with an overview of the situation of Thailand’s drug users during the 2003 war on drugs. “Same same, but different” highlighted worrying signs that the Thai government’s launch of a new drug control strategy in 2008 was, in fact, a second round of drug suppression in the Land of Smiles. In this article, **Pascal Tanguay** presents an overview of recent developments and opportunities in harm reduction in Thailand.



Piyabutr Nakapiew is the manager of O-zone, a Bangkok drop-in centre for injecting drug users.

ON 2 April 2008, the Royal Thai Government announced a new six-month drug control strategy effective until 30 September 2008. The strategy focused on reducing the number of traffickers, drug users and vulnerable people, as well as on increasing and intensifying drug control efforts. It also sought to increase the role of civil society in response to drugs. The strategy was to be supported by an action plan that was never produced.

In the six months during which the strategy was implemented, local organisations in Thailand working with drug users reported human rights violations on a much smaller scale than during the 2003 war on drugs. In that sense, the second chapter of the much feared war on drugs has yet to start.

Piyabutr Nakapiew, manager of the O-zone drop-in centre in Bangkok says, “There was [a war on drugs] but perhaps less aggressively implemented than the previous one. I think lessons were learned from 2003 when 2,500 people who used drugs were killed.”

Significantly, the strategy is silent on HIV/AIDS. Although it acknowledges

drug dependence as a health issue, it is heavily influenced by the Rehabilitation Act of 2003 and focuses on short-term rehabilitation through compulsory treatment and incarceration. It encourages blacklisting through ‘community support’, and definitions of target groups are fluid and ill-defined. Further approaches presented point to increased law enforcement responses and the intensification of their efforts through capacity building and increasing manpower.

It is important to note that the strategy includes provisions that could open the door to harm reduction implementation and policy support. In addition, collaboration with civil society is highlighted in several areas outside blacklisting – although the proposed role of civil society seems to be

“I think lessons were learned from 2003 when 2,500 people who used drugs were killed.”
Piyabutr Nakapiew.



to endorse law enforcement responses. When promoting rehabilitation, the strategy stresses reduction of stigma and discrimination, and social reintegration, especially for recovered drug users.

Over the course of the past six months, efforts have been made by many stakeholders to work alongside the Office of the Narcotics Control Board (ONCB) and other government agencies to lobby for a balanced action plan to support the drug control strategy. The UNAIDS Programme Coordinating Board (PCB) meeting set the stage with a demonstration organised by the Thai Network of People Living with HIV/AIDS (TNP+) and the Thai Treatment Action Group (TTAG). Demonstrators from several civil society groups had banners highlighting key advocacy issues discussed in previous consultation meetings supported by AHRN.

Recently, the Thai government included methadone in the universal healthcare scheme, a decision influenced by months of advocacy work by several leading local NGOs. This also led to the formation of a working group on harm

reduction, the 12D, with representatives from a number of civil society groups including the Foundation for AIDS Rights, the Thai Drug Users' Network and the Asian Harm Reduction Network.

In mid-October, the Global Fund announced that Thailand's Round 8 proposal had been accepted, with a strong harm reduction component. In addition, an independent proposal was approved in August supporting local NGOs to deliver harm reduction services.

Meanwhile, AHRN has been lending support to the ONCB by building technical capacity and generating greater awareness about harm reduction among drug control officials and by providing exposure to effective models and key stakeholders in the region. In parallel, the Asian Consortium on Drug Use, HIV/AIDS and Poverty has invited the ONCB and other Thai parliamentarians to play important roles in regional platforms around drug use and HIV/AIDS.

While the latest drug control strategy has significant shortcomings, it does provide an interesting backdrop for considering the future of harm reduction

Recommendations from Thai civil society groups at the UNAIDS Programme Coordinating Board

Thai civil society groups consider the use of punitive measures, especially violence, in drug control efforts to be ineffective and counterproductive to HIV/AIDS prevention, treatment, care and support.

They encourage the Thai government to consider implementation of a national harm reduction policy and to review carefully the drug control strategy issued on 2 April, including revising laws and policies that create barriers to treatment.

Thai civil society groups also recommend that a comprehensive health scheme delivered in a friendly environment, focusing on prevention, treatment, care and support, be accessible to vulnerable communities (including intravenous drug users, migrants, sexual minorities, prisoners, sex workers and so on) in order to achieve Universal Access before 2010.

Civil society groups, particularly people who are using or recovering from drug dependence, recommend they be involved in development and implementation of policies and interventions that affect their lives and livelihoods, especially in the areas of drug, health, social care and sustainable financing to ensure support for building their capacity.

Civil society group representatives consider that their rights – sexual and reproductive health rights and rights to treatment, shelter and work – should be respected regardless of gender, citizenship, lifestyle and so on.

Civil society group representatives recommend that relevant government agencies work to change popular attitudes in order to reduce stigma and discrimination.



“This approach systematically ignores the fact that, to achieve sustainable abstinence, drug users must want to quit drugs and that forcing treatment upon people will not achieve expected outcomes.”

Piyabutr Nakapiew.



UNAIDS officials meet Thai health advocates



Thai Police

in Thailand and analysing salient developments. Indeed, some recent events and the level of engagement of all key stakeholders – including the Thai government – are pointing to growing interest in harm reduction and in addressing drug use through evidence-based approaches. Yet, to reduce trafficking and drug use, the latest policy document proposes approaches and mechanisms that are not supported by evidence.

“The Thai government still believes that forcing people who use drugs into rehabilitation programmes will lead to abstinence,” says Mr Nakapiew. “This approach systematically ignores the fact that, to achieve sustainable abstinence, drug users must want to quit drugs and that forcing treatment upon people will not achieve expected outcomes.”

Although a greater number of decision and policy makers are increasingly exposed to harm reduction approaches, without strong commitment from the highest levels of political leadership, the integration of HIV/AIDS alongside drug demand and supply reduction in Thailand’s drug control efforts will remain elusive, and outreach workers will remain without legal protection for delivering HIV/AIDS prevention services to people who use drugs. Meanwhile, Thai civil society groups are preparing for the April 2009 International Harm Reduction Conference in Bangkok to ensure further discussion on harm reduction and drug control strategies in Thailand.

In the context of the current political changes and tensions in Thailand, it is difficult to assess when the next drug control strategy will be released or to predict what approaches will be proposed by the Thai government. The recommendations formulated by Thai civil society groups at the outset of the 2003 war on drugs and those formulated at the PCB are indeed more important than ever in guiding policy changes in drug control in Thailand. ■

Pascal Tanguay is Communications Manager at the Asian Harm Reduction Network (AHRN) in Thailand, www.ahrn.net.

Expecting grains – the Australian heroin drought debate



Australians have lamented low rainfall for most of this century. But the Lucky Country's population of heroin users has experienced a different kind of drought; that of their drug of choice. The Big H has been thin on the ground since 2001, and many commentators say this is Australia's most severe and long-lasting heroin drought, but also the best documented ever in the world. The causes behind this phenomenon have sparked a lot of interest, research and opinion pieces. Media reports and policy makers generally accepted that the heroin drought resulted mostly from law enforcement efforts, but as **Martina Melis** describes, there were multiple factors involved.

IN August 2008, the *International Journal of Drug Policy* devoted a special issue to an interesting discussion of the possible causes and consequences of Australia's 2001 heroin drought.

A number of articles analysed four possible collections of causes and rated them quite differently in terms of likelihood:

1. Successful drug seizures, the progressive switch from heroin to ATS production and the increased consumption of heroin en route to Australia.
2. Law enforcement's disruption of large trafficking syndicates.
3. A crackdown on opium producers in source countries.
4. Adverse climatic conditions causing a prolonged reduction in opium availability.

The most sensible conclusion a critical reader will come to is that there is clearly insufficient evidence supporting any single factor as the critical one behind the drought. As is often the case in drug matters, multiple factors must be considered for a useful and sensible explanation to be found and so lessons can be learned.

Let's step back to the beginning.

In the 1990s, Australia's heroin market grew rapidly. Data from the Australian National Household Surveys of that time show heroin use in the 1990s was doubling every two or three years. Figures on heroin purity, price and opioid overdoses – the latter rising four-fold between 1990 and 1999 – supported the idea that Australia was experiencing a heroin 'glut'.



Martina Melis

In 2001, the scene changed dramatically. Reports from Sydney first, and from other parts of Australia soon after, indicated a drastic reduction in heroin availability and purity, and an increase in price for all major heroin markets. The number of deaths caused by overdoses dropped from 1,116 in 1999 to 357 in 2003 – a change largely and credibly attributed to the heroin shortage.

Law enforcement and ‘tough on drugs’ champions were quick to claim credit for these changes, asserting that increased intensity of law enforcement operations was the fundamental cause of reduced heroin availability. Comparative statistical data on seizures and estimates of the heroin market pre- and post-seizure sizes were used to prove the drought was caused primarily by the interception of drug supplies at destination (Australia).

Two comments can be easily made in response to such claims. Firstly, the very nature of this illicit business means data and figures related to how accurately seized quantities represent a particular percentage of the overall drug market or the overall number of drug users are only ever ‘best guesses’ and hard to prove as facts.

De Beck and Wood point out in their contribution that “the effort to promote

government accountability has increased pressures on policy makers to justify policy investments and provide scientific-based evidence in support of policy decisions. In the case of funding for supply reduction efforts, this has been difficult to achieve.”

One wonders whether the bold attempts to attribute the shortage to improved law enforcement were somehow influenced by the need to justify increased law enforcement funding in 1998 as a result of the National Illicit Drug Strategy.

Secondly, the claim ignores the essential climatic changes that were happening in the countries of origin. Australia’s almost exclusive heroin supplier is Myanmar. In 1999, severe droughts in Myanmar’s poppy growing areas caused a significant decline in production and cultivation for the third year in a row. Wodak writes, “It seems entirely plausible that a reduction in heroin production in a source country may result in a reduction with different timing and severity in different destination countries.”

And although some reject the climate argument because reduction in heroin supply only affected Australia, it appears that availability in Canada – where there had not been any change in law enforcement funding – also

declined at about the same time.

Another common argument used in support of law enforcement relates to actions aimed at disrupting drug trafficking structures and operations. It refers particularly to the arrest of key players in the heroin supply chain and the possible impacts this has on the amount of heroin imported into Australia.

This may well have had some effects. However, we’ve learned from Colombia, Panama and even Myanmar (the retirement of drug lord Khun Sa) that, where large cartels are disrupted, reduction in supply tends to last only as long as it takes for drug trafficking to reorganise and new players to enter the game. In addition, and to add some more complexity, it should also be noted that the drought happened at a time when the production of amphetamines was sharply increasing in Asia. The possibility of heroin traffickers switching to the amphetamines business therefore cannot be ruled out.

The discussion goes on, and many other issues are raised by different authors. However, it is also time to note that, while there is an abundance of theses and antitheses on the causes of the heroin drought, comparatively little research and analysis has been undertaken to investigate its effects.

Quotes of Substance



Some studies on effects have been done, and they do offer important insights and possible lessons for the future. For example, although heroin prices increased significantly, a large proportion of injectors did not stop injecting drugs. They simply switched to the injection of more readily available cocaine and methamphetamines. Correspondingly, service providers found themselves having to quickly perform treatment switching. Used to providing services to heroin users, they were suddenly asked to deal with stimulant users, their increased violent behaviour and an overall steep rise in amphetamine-related psychosis. Very often, they were not prepared for this.

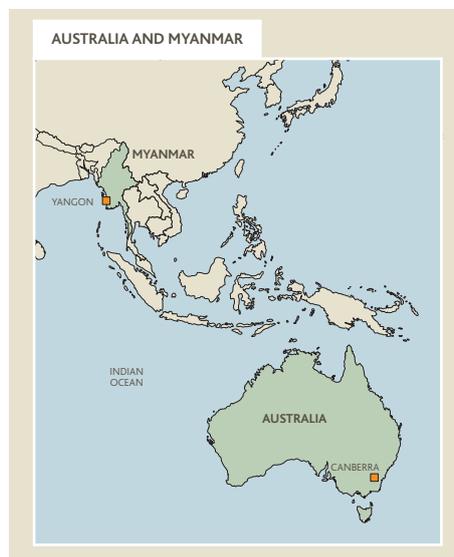
If the heroin drought impacted positively on heroin use and heroin-related deaths, it is reasonable to wonder if positive impacts did indeed stretch across the whole drugs scene. One might also question the narrow focus of rejoicing at the suppression of one substance when another one – with its characteristics, dangers, associated harms and differing response strategies – waits just around the corner to take or share the central stage.

In conclusion, it is clear that the heroin shortage was caused by a number of interrelated factors and that attempting to attribute it solely or largely

to one single factor is of little use. Instead, it is clear that far too little space has been allocated to investigating the consequences of the heroin drought, how a change in supply affects drug users' behaviours and whether supply reduction is an effective strategy to reduce drug use.

Ultimately, the understanding and learning from *the effects* of the drought might have been the lesson for policy and practice that should have been debated. ■

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



“ Today in France, the sight of a bottle of wine has become as offensive as a picture of war or pornography. ”

Daniel Lorson, from an industry body of champagne producers, after a French court ruled the internet should be included in strict laws regarding alcohol advertising.

“ We’re not trying to encourage drinking, but the cathedral has to find ways of meeting people on their territory. Cathedral wine bars should be seen as a potential commercial operation with profits going into the upkeep of the building and paying for evangelistic work. ”

Mark Hope-Urwin, Director of Hospitality and Welcome at Birmingham Cathedral on plans to raise the cathedral's profile with a chain of wine bars.

“ Under the thin veneer of sophistication that 20 years of liberalised licensing laws gave us, we’re a state steeped in wowserism. ”

Michael Hardin on a 2am lockout imposed on Melbourne bars and clubs, which began in October.

“ This is another one of those pretty shonky industry surveys. I mean, shock horror that the spirits industry asks bottle shop owners what they think of an alcohol tax, and they say they don’t like it – well, there are no surprises there. ”

Australian Health Minister **Nicola Roxon** dismisses research by the Distilled Spirits Industry Council of Australia showing, 88 percent of liquor retailers believed tax increases had not reduced alcohol consumption.

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“The drivers to our drug taking are essentially psychological, which suggests we need health-based strategies to drive down demand.”

CAYAD worker **Denis O’Reilly** has spent a lot of time around either alcohol or drugs in one way or another. In this short life story, he muses on the confused nature of our attitudes towards legal and illicit drugs.

MY DAD, Dinny O’Reilly, was a kind and hardworking man who raised his six kids to be good and contributing citizens. We had a family business in Timaru, a service station that was open seven days a week. It was not only the focus of our family’s life, it also served as the fulcrum for an Irish Catholic community of neighbours and friends.

The link of the ‘Faith’ was one thing, but there were others too – a love of horseracing and a genetic predisposition towards alcohol in all its forms, but preferably good whisky. The tyre room, where dad repaired punctures and vulcanised tyres, was a de facto bar. The big tank where we tested tubes for leaks served as a useful beer chiller, and Dad’s friends and relatives would pop in

and chat to him whilst he worked, and generally a beer or two would be consumed.

We'd always be well stocked with crates, and in the days of six o'clock closing, it would not be unknown for one of his mates to come down to the garage and grab a crate or two for replacement the next day. Dad would have bridled at the accusation of being a 'sly grogger', but I'm pretty sure that a licensing inspector may have come to that conclusion.

Timaru is a port town, and many 'wharfies' were amongst his customers and friends. Every now and then, there'd be conspiratorial discussion in the tyre room with one of the wharfies. The lube bay doors would be opened, a hulking Chevy would be driven in, and boxes of whisky would be unloaded.

“ It didn't take a degree in sociology to observe that some people were a lot nicer to deal with when they had been toking as opposed to drinking. ”

Once, I can remember Dad, having consumed some of the 'holy wather' as he called it, putting bottles of whisky in a wheelbarrow and delivering orders to neighbours up and down the street. It was all done with a twinkle in the eye and the celebration of rebelliousness that is a mark of our race.

If you had accused him of being a 'drug smuggler', he would have roared with outrage. He hated drugs and all that they seemed to represent. When I was 18, I managed to score a little bit of hash. He found out, and the furore that followed made the current concern around the collapse of Wall St pale in comparison. I could have said Hail Marys forever and crawled around the Stones of Knock for the rest of my life and it would not have assuaged my guilt. If only it had been whisky!

Later in life, and living in Wellington, I moonlighted as a bouncer for some Greek nightclub owners. I had two

children and a wife to care for, and my earnings were not enough to adequately care for their increasing needs.

Ten o'clock closing had just been introduced, and Jake the Muss stalked the streets. Large-scale drunken brawls were standard fare. Marijuana was starting to be used socially, and it didn't take a degree in sociology to observe that some people were a lot nicer to deal with when they had been toking as opposed to drinking. In fact, when there was no dope around, we knew we were going to have a very heavy and violent night on the door.

Fast forward from the 1970s to the new millennium and the widespread use of methamphetamine. For the past five years, driven by the death of friends, I've worked really hard to build community resilience against this particular substance. In some quarters, there are now 'P free' zones where groups won't tolerate the presence of methamphetamine.

A couple of weeks ago, there was a party amongst such a group. Because booze is legal, readily available, cheap, strong and so easily drinkable in the form of RTDs, it has again become the primary drug of choice.

The partygoers over imbibed, and a nasty fight broke out. People were injured, and property was damaged. Moreover, family turned against family, and it has taken a lot of kōrero to calm things down. In reviewing what had gone down, one of the peacemakers – a non-drinker – said to me, "Bro, this is getting like the 1970s again. I'm committed to our (no P) kaupapa but don't you think we should just go back to smoking dope and lay off the booze?"

The received wisdom is that we take drugs for a variety of reasons: to cope, to self medicate, to forget our troubles and woes, to find structure, to give some theme and purpose to our lives, and for status – to be part of the scene.

At a societal level, we try to control drugs because of intoxication, addiction, impaired decision making, the potential to harm others and the need to look after ourselves.

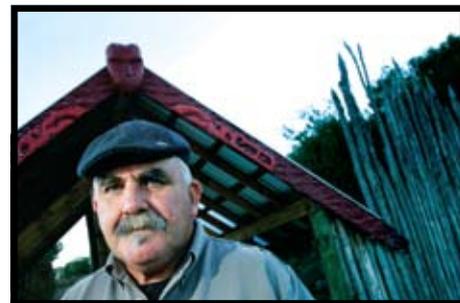
The drivers to our drug taking are essentially psychological, which suggests we need health-based strategies to drive down demand. I don't think there is much debate about that. But when it comes to controlling drugs – that is, reducing supply – we lose consensus.

There are powerful lobbies around the continued sale of legal drugs such as alcohol and tobacco. That's because some people make lots of money out of them. Few people would argue about the harm done by consumption of alcohol and cigarettes but both are currently sold at corner dairies.

Despite the fact that 4,700 New Zealanders are said to die annually from smoking, a major political party has recently rejected the move to keep cigarettes out of sight on the basis that this would be an interference by 'Nanny State'.

Yet, when it comes to those substances we deem illicit, regardless of any balanced scorecard assessing their respective harm impacts against alcohol and tobacco, we simply turn to prohibition, despite its proven ineffectiveness. The accelerating prison population reflects that fact.

Do illicit drugs cause harm? Absolutely. Do they cause worse harm than legal drugs? On balance, I'm not too sure. I don't have any easy answers to the conundrum of legalisation or decriminalisation of particular substances. But I am my father's son, and for some reason, my particular poison is legal and comes in a bottle. ■



Denis O'Reilly is a social activist, coach, businessman and a Community Action Youth and Drugs worker with Consultancy Advocacy and Research Trust and Mokai Whānau Ora.



A matter of trust

No caring parent wants their child to end up an addict, so to be horrified at the thought of your kids smoking dope is pretty normal – about as normal as it is for teenagers to experiment with drugs. Wanting to take a firm hand and insisting on random drug tests is an understandable reaction, but in the end, it may do more harm than good. Take James for instance. **Kim Thomas.**

WHEN he was 17, James used to smoke a bit of cannabis on the weekend with his friends. When his father forced a drug test on him, he started smoking it daily, and began experimenting with LSD.

Now 19, James says his parents' decision to get him drug tested shattered their relationship.

"I was pretty much carted down to the doctor and told to pee in a cup.

It was like my parents didn't trust or believe me any more. We'd always been pretty sweet, but after that, I hardly talked to them at all. I felt totally ripped off and thought 'I'm going to take more drugs just to f*ck you off'."

James' first test was negative, but after a year of smoking daily, a second test was positive.

James says he probably would have confessed to using drugs if his parents had asked him straight out. Instead, he rebelled and cut contact with them.

He's now trying to give drugs up after moving in with his girlfriend and a few of his friends were arrested for possession and supply. Contact with his parents remains infrequent.

Cases like James' do not seem common in New Zealand. While thousands of parents worry about their child's drug use, few take the dramatic and often counterproductive step of putting them to the test.

Rod Dale from the New Zealand Drug Detection Agency, one of the biggest companies of its kind, says they only do about a dozen such tests a year, mainly on Auckland teenagers.

Dale says his company, which focuses on testing people in the workplace, does not recommend parents drug test their teens.

"If a parent cannot communicate with their child in a supportive and open way about drugs, they won't be able to deal constructively with the fall-out from a positive test."

Christchurch youth health expert Sue Bagshaw agrees.

"Parents are on really thin ice if they think drug testing their child will stamp out drug use," she says.

"Whether they realise it or not, the test is going to give them an answer. How they deal with the answer is far more important than what the answer is. Talking to their child and being supportive is far better than pushing them into a test, which is likely to alienate them and make them less likely to communicate."

Bagshaw says most teenagers she knows whose parents contemplated a

drug test were recreational or light users of cannabis.

"Young people experiment because everybody is doing it, and they want to see what they are missing out on, but that doesn't mean they are going to become heavy users. Everybody uses some sort of drug, even if it is only caffeine. It's about recognising this and helping the young person deal with it sensibly themselves."

She suggests parents who think their child is taking drugs sit down with them and say, "Okay, so you've used drugs, what was it like? What was good about it and what was bad?"



“If a parent cannot communicate with their child in a supportive and open way about drugs, they won't be able to deal constructively with the fall-out from a positive test.”

"Tell your teenager you don't want to control them or force them to stop taking drugs, but spell out clearly that you do not believe the ways drugs will affect them will be good for them.

"Focus on short-term negative consequences, such as a failing memory or having trouble concentrating at school. Teenagers will not respond to things too far in the future."

But she says the most important thing is to try to foster trust because it's the only way parents will be able to connect with their child and have any hope of helping them make good choices.

Deb Fraser of Dunedin's Mirror Youth Counselling Services says it is understandable for parents to feel overwhelmed if they suspect their child is taking drugs.

"A lot of parents are out of their depth trying to understand why their child would be doing this to themselves – even those who have experimented with drugs themselves. They often feel completely powerless."

Parents often become concerned about drug use if they don't know where their teenager is spending a lot of time or if the young person is chewing through a lot of money and has rapidly changing moods.

Fraser says in recent years she has seen a small increase in the number of parents asking about drug testing, probably because more companies are providing school and workplace tests, which is increasing awareness. There are also drugs tests available on the internet, but these are not always reliable.

Fraser says drug testing does not always provide an accurate indication of a teenager's level of drug use anyway.

"Some heavier drugs, such as methamphetamine, leave the system quickly, while cannabis can be detected for far longer."

Like Bagshaw, Fraser suggests parents talk to their child and, if they feel out of their depth, get help from an expert, such as the family doctor or a counsellor.

Both women say drug testing can work as a way to monitor a young person's success but only if they have chosen to give up drugs.

Youth Law's John Hancock says the law relating to drug testing of teenagers is not straightforward.

"Tests usually involve taking a urine sample so are viewed as a medical procedure. This means anyone over 16 years must consent before it can be done. Parents and caregivers do have a say if the child is under 16."

The biggest test would be when a teenager challenged being tested in the courts, but so far, there has been no such case in New Zealand. ■

Kim Thomas is a Christchurch-based writer.

Where angels fear to tread

The New Zealand Drug Harm Index, published in June, was developed by Business and Economic Research Limited as a tool for the Police to assess and quantify social harms resulting from illicit drug use. **Alison Ritter** offers a review of the index and suggests it remains useful despite some significant flaws.



NZPA/Wayne Drought

EVALUATING the effectiveness of illicit drug policy is enormously difficult. This is partly because the impacts of drug use span multiple domains: health, crime, social amenity and so on. Measuring the diverse aspects of drug policy involves combining various consequences (such as health and crime outcomes) with prevalence and consumption.

A single index is often a nice solution to the problem of combining different types of consequences across domains, and dollars is a common unit of measurement that can summarise data across them.

Comparisons within a country or region over time, between regions or countries and across domains of policy initiative (such as law enforcement, treatment, harm reduction and prevention) are all difficult without a composite index. It is for these reasons

that the development of an index reported in cost terms is useful.

However, the work is fraught (hence this article's title). It is methodologically complicated, conceptually challenging and the data are limited even when they exist. Furthermore there will always be criticism. The ecological footprint (a single index that measures impact on the environment) has any number of criticisms ranging from conceptual to methodological. Despite this, the ecological footprint as an index has proven useful in environmental policy. My hope is that a drug harm index can also be useful.

The drugs field has been engaged in work across the globe on composite drug indexes. For example, there is the UK Drug Harm Index, the UNODC Illicit Drug Index, the Australian Drug Policy Index (DPMP) and the Australian



“ Because the police seize substantially more cannabis than opioids, the total index largely reflects cannabis social costs savings. This, in itself, may be misleading from a policy perspective. ”

Federal Police (AFP) Drug Harm Index. Each index is constructed differently and for different purposes.

The recently published New Zealand Drug Harm Index adds to this list. The report identifies three components of the work: firstly, to estimate the social costs of illicit drugs to New Zealand; secondly, to calculate a ‘harm-per-kilogram-consumed’ measure; thirdly, the translation of those figures into a single index that can be used for performance monitoring purposes.

The first exercise is useful in demonstrating the extent of financial burden of illicit drugs borne by the community. The results indicate that, in 2005/06, the total social cost burden of illicit drugs in New Zealand was \$1.3 billion dollars.

The social costs include direct consequences associated with illicit drug

use, such as criminal activity, healthcare and road accidents, and indirect costs such as productivity lost. It is very easy to be highly critical of the method and arithmetic used in the calculations – data are often unavailable so proxy information is used to derive estimates. For example, many of the estimates used information from Australia.

The decision about what data to include is also fraught. Where good data exist such as hospital inpatient services or road accidents, it is used extensively. Where limited data exist such as public amenity, the domain is not included.

Aside from estimating the consequences (such as health and crime), there are substantial data uncertainties regarding the population itself.

The most obvious of these are prevalence of drug use, consumption rates, distinctions between occasional

and frequent users and polydrug use. The total social cost estimate cannot be converted to a ‘harm-per-kilogram-consumed’ unit without the population data. All the usual difficulties with population prevalence of illegal behaviours as assessed through random telephone surveys apply here. Likewise, there are significant challenges in estimating consumption levels.

Having established the total social cost of illicit drug use, and the prevalence and consumption levels, these two sets of data can then be combined to estimate a per user social cost and a per kilogram social cost. As should now be apparent, as we work through each aspect of the index (total social cost, unit cost per kilogram and the final index), the degree of confidence in the measure becomes more and more weak.

Quotes of Substance

“If the ACC is right, then Australia would have the most profitable market for illicit drugs on the planet.”

Criminologist **John Walker** on Australian Crime Commission estimates that up to \$12 billion in illicit drug money flows out of Australia annually.

“Why do people want to get pissed?... Surely these teenagers don't suddenly wake up one morning and decide it's time they took up binge drinking.”

The blog *Constant Ramblings* suggests we need to look at reasons why drinking is so entrenched in our culture.

“I loved coke... But what ended it for me was when they caught Klaus Barbie, the Butcher of Lyon, in the early 80s. He was living off the proceeds of being a cocaine baron and I saw how my little sniff of cocaine at a party had an absolute direct route to this f*cking horrible man in South America.”

Actress **Helen Mirren** explains why she stopped using cocaine.

“If there was not a conscience vote, it would certainly assist in securing a coherent, consistent and rational framework for dealing with a substance that imposes significant social costs on New Zealand.”

Law Commission President **Sir Geoffrey Palmer** calls for political parties to abolish the dated practice of conscience voting on alcohol issues.

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Once we arrive at the actual index – which compares the social costs of seizures across the years 2000 to 2006, we are on quite shaky ground. The index multiplies the social cost per kilogram of drug by the kilograms seized by law enforcement. A total annual estimate is then derived.

Interestingly, the index shows that the largest seizure social costs were from cannabis. But this is an artefact of the index – the per kilogram social cost of cannabis is \$11,790 as compared to the per kilogram social cost of opioids at \$1,074,130. But because the police seize substantially more cannabis than opioids, the total index largely reflects cannabis social costs savings. This, in itself, may be misleading from a policy perspective.

More important, however, is the basic assumption underpinning the index that seized drugs are not replaced. Therefore, the social costs associated with the quantity seized are realised savings. The report notes, “The harm per kilogram estimates indicate the gross economic benefit of drug seizures.” This is false, or at least it is only true if those seized quantities are not replaced. In the absence of evidence about changing or reduced consumption, the assumption about seized quantities is unsupported. The authors do point this out and use the term “potential harm

avoided” in the last section of the report, but this important point requires constant clarification.

Despite this fundamental flaw in the usage of the index, the work is important for a number of reasons. It provides further indications of what we do not know and can inform data collection activities. The overall social cost estimate for New Zealand is a useful figure, at least for political and funding purposes.

Methodological advances have been made that can inform international efforts at index development. The New Zealand work has made some methodological advances in the area of productivity losses and in handling the problem of polydrug use.

Finally, the development of indexes that can be used either to monitor the effectiveness of government actions over time (like the UK DHI) or that can be used to compare policy investment options (like the DPMP Policy outcome tool) have a role to play in improving the evidence base and making our field accountable. ■

Professor Alison Ritter is Director of the Drug Policy Modelling Program, an Australian-based multi-disciplinary initiative to provide big picture analyses of policies relating to illicit drugs, www.dpmp.unsw.edu.au.



NZPA/Lynda Forrest

Alcohol is a drug too

The misuse of alcohol is one of the most significant public health issues facing Australia. At \$A15.3 billion per annum, the financial toll on the community is certainly high, but so are the social costs. An increasing number of deaths, mental health issues and diseases are being linked to alcohol. Most frightening of all, says **David Templeman**, is the blasé attitude people have towards excessive drinking.

‘**DRINKING** yourself legless’ or ‘going on a blinder’ is considered a rite of passage for young people in Australia, many of whom do not out-grow this phase. Instead, they adopt it as a weekly practice in their adult lives.

The Alcohol and other Drugs Council of Australia (ADCA) is tackling this issue head on, adopting the theme *Alcohol is a Drug – Too!* highlighting the serious nature of what is a national problem.

This theme hits at the heart of the problem; that many Australians don’t take seriously the harm caused by alcohol.

There was a strong community and industry reaction to the recently released *Australian Alcohol Draft Guidelines for Low Risk Drinking 2008*. The new standards proposed by the National Health and Medical Research Council set the limit of two standard drinks or less in any one day for men and women as being low-risk in terms of immediate or long-term harm. The same guidelines recommend children under 15 do not drink at all, and that women who are pregnant, planning a pregnancy or breastfeeding also refrain from any alcohol.

These recommendations are based on the most recent scientific research available, giving Australians the evidence they need to make informed choices about drinking and providing information on the risks of alcohol-related accidents, injury, illnesses and disease.

The recommendations have startled many, who feel the guidelines might be too strict and not a true reflection of safe drinking levels.

But until we start to be shocked about the effect alcohol is having on our communities, we will not make the changes needed to reverse those negative impacts. Each of us has a responsibility to examine our drinking habits. How long is it since you questioned whether you drink too much? We all justify our habits, but here’s a way of putting yourself to the test. Log on and complete the Odyssey House Alcohol Insights survey (www.odysseyhouse.com.au/site/more/alcohol_insights) and let the results speak for themselves. You might be surprised.

“Until we start to be shocked about the effect alcohol is having on our communities, we will not make the changes needed.”

If your personal drinking levels are safe, then consider these startling statistics for Australia:

- Nearly 80 percent of all presentations in hospital emergency departments on Friday and Saturday nights involve alcohol as a contributing factor – whether it be assault, domestic violence, road trauma or an accident.
- Annually, some 7.5 million working days are lost due to alcohol – impacting the economy with a \$A15.3 billion loss.

- Every year, there are around 3,000 alcohol-related deaths, and 10,000 people require major ongoing treatment for alcohol-related harm.

Earlier this year, ADCA coordinated a week of community activities across Australia to focus on the need for change. In June, Drug Action Week involved some 630 events in every state and territory aimed at changing attitudes towards the consumption of alcohol at a grassroots level.

The community response was strong, and this has been attributed to an awakening to the need to change our national pastime of binge drinking.

The Australian government has also responded to the challenge. This year, it announced a \$A53 million dollar National Binge Drinking Strategy and conducted several inquiries into the sale, branding and marketing of alcohol.

ADCA looks forward to a continued strong response from Government and other community groups in order to achieve real long-term change across the generations in Australia. ■

David Templeman is Chief Executive of the Alcohol and other Drugs Council of Australia, www.adca.org.au.

Feedback

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

Not all beer and skittles. What does a health protection advisor do?

Ross Henderson, Drug Foundation Director in the early 1990s, now works as a Health Protection Advisor with the Population Health Service of the Waikato District Health Board. Ross enacts the Medical Officer of Health role under the Sale of Liquor Act to investigate and report to licensing agencies and the Liquor Licensing Authority on granting or renewing licences for the sale of alcohol. We caught up with Ross and asked him about his work.



Ross Henderson

WHEN there's a reported problem with a liquor licence holder or a licence application in the Waikato region, Ross Henderson is bound to be involved. It's his job to check on matters such as whether standards of host responsibility are being met, whether a duty manager is always on site or whether drunks are being served.

Because it's difficult to get the real story on how a bar is operating at high-risk times, it has to be assessed without staff knowing. The work can be a little 'cloak and dagger' as Ross slips in unnoticed until he gains a feel for what's going on.

This is not always easy as he is well known to most of the 900 or so premises on his books.

There are times, he says, when he's at an outlet and will notice customers confused at being asked for identification.

"Obviously, they've been served there lots of times before and don't realise the only reason they're now being asked for ID is because the manager knows I'm there."

And then there are the controlled purchase operations (CPOs), which are run with the Police and used to catch retailers or publicans who sell alcohol to minors. The aim is to ensure there are at least two CPOs in each of his 10 local authority areas every year.

"We know that a direct sale is the tip of the iceberg of supply to minors, but we have to start somewhere."

In your typical CPO, care is taken that the volunteer minor sent in to purchase alcohol doesn't look particularly old for his or her age, but Ross would have no problem, in principle, with sending in a 17-year-old who looked over 18.

“Many perceive a public liquor ban as stealing their freedom, but really it's about reclaiming our public places from idiots abusing alcohol and making nuisances of themselves.”

"In real life, it's the older-looking kid who is chosen by his mates to buy the alcohol. Staff should be automatically checking anyone who looks under 25, just for that reason. If they only checked people who look under 18, they'd be continually getting it wrong because at least half the 17-year-olds out there look older."

Ross says the issue of kids looking older is often particularly relevant with Māori and Pacific Island kids.

“The fact is these young people are often bigger and look older than their pākehā counterparts. If particular young people can purchase alcohol more easily, it has a direct impact on specific communities adding to existing problems.”

Under the current Sale of Liquor Act, it is a defence if the seller had reasonable grounds to believe a person was over 18, and sellers will sometimes use the young person’s appearance as ‘reasonable grounds’. Ross says that defence has got to go.

“Just because someone looks over 18, it doesn’t mean they are. The only defence should be when a good-quality fraudulent ID has been produced. Checking IDs has to be an automatic part of the alcohol transaction.”

Supermarkets are among the most frequent offenders because often management hasn’t given the underage issue enough attention. Ross says it’s something they must start taking more seriously.

In one supermarket, a young checkout operator said she couldn’t sell the volunteer alcohol and called on her supervisor. The supervisor promptly put the purchase through and warned the volunteer to bring ID next time because, “They’re running stings at the moment, you know.”

Ross says he really feels for the young ones when he and the police march in after the sting. But there is an upside.

“Sometimes young workers have been intimidated into selling alcohol by kids older and bigger than they are, or their inexperience and lack of training left them unable to deal with the situation. They’re scared because they’ve been caught, but eventually their boss sees the problem and puts proper procedures in place to protect them in the future.”

Ross says that his own experience in the hospitality and entertainment industries is a real asset, especially when it comes to training bar managers and staff. He says this can be one of the most rewarding aspects of the job.

“It’s about reframing the way bar owners look at the whole responsible host thing. Good host responsibility is

good risk management – and risks are multiplied whenever alcohol is present – so it’s simply good business.”

Changing the way people see things is also important when working with local authorities.

“Many perceive a public liquor ban as stealing their freedom, for example, but really it’s about reclaiming our public places from idiots abusing alcohol and making nuisances of themselves.”

One of the things he enjoys most about the work is the way in which it can touch every area of life, particularly in a small community.

“We fix up a pub that’s performing badly in a small town and it impacts on everyone. An isolated rural club can act as the social focal point for a whole community, so helping it get back on track can really contribute to people’s feelings of connectedness.

“We get a liquor ban in place and people can have tears of gratitude because they feel like they’ve got their town back.”

He warns, though, that the alcohol problem is dynamic, multi-faceted and never fixed.

“Things have moved so quickly that alcohol policy has lagged behind,” says Ross. “For example, we’re doing nothing to address RTDs pumped up to 12 percent alcohol and targeting kids. We ignore the fact that cheap, loss leader, alcohol promotions from supermarkets are changing the whole social landscape, and at the end of the day, licences are still easy to get and bloody hard to take away.

“And every time there’s success in managing an alcohol problem, people are tempted to think it’s fixed, especially when resources are tight. For example, we get drink driving down and we say, ‘Great, we don’t have to worry about that any more.’ We pull the resources and then wonder why the problem returns.

“The reality is that, if we don’t keep working on an alcohol problem, it will come back again or manifest in a different way.”

And that means there will always be a role for people like Ross. ■

Quotes of Substance

“Like it or not, our livelihood depends on selling people the products they want – and people still want cigarettes.”

Wellington dairy owner **Rustin Nahulandran**, whose four-year-old son tells him he shouldn’t be selling fags, explains why he does, and why moves to outlaw displays of tobacco products would hurt his business.

“I honestly felt dead, cold sober. I was honestly f*cking sure I was sweet to drive.”

Criminal sociologist and high-profile commentator on criminal affairs **Greg Newbold** outside the Christchurch District Court after his second drink-driving charge in three years.

“People who attend church should give more so that this doesn’t have to happen. The idea of the church getting involved with selling alcohol will worry people.”

Rev David Phillips on Birmingham Cathedral’s plans to open wine bars to attract new worshippers.

“People were positively disposed to finding [a beneficial] effect, whether there’s actually an effect or not.”

Professor Roche, Director of the National Centre for Education and Training on Addiction at Flinders University, on people’s tendency to use alcohol’s health benefits to justify or increase their drinking.

“In the shop, we found 120 pieces of magic mushroom chocolate and countless cannabis lollipops.”

German Police after closing down a sweet shop in east Berlin.

continued on page 28 ▶

It's just not cricket

In defending its hold on sport sponsorship, the liquor industry argues there's no link between alcohol advertising and sales, and that it's really only about brand loyalty. It's quite a startling claim, but there are plenty out there ready to believe it. **Richard Boock.**

A COUPLE of years ago, while addressing the Australia and New Zealand Sports Law Association, Lion Nathan Managing Director Peter Kean insisted that a ban on alcohol advertising and sponsorship wouldn't make any difference to youth binge drinking. He also said the purpose of alcohol promotion was "to build adoration for brands", rather than encouraging consumers to drink more. Who knows? He might even have believed himself.

In 2006, Sport and Recreation New Zealand (SPARC) certainly swallowed his suggestion – hook, line and ice cube. In addressing the review of liquor advertising on radio and television, the government sports-funding agency accepted the alcohol lobby's claim and argued to retain the status-quo of self-regulation.

Talk about a sell-out.

Never mind that, only a few years earlier, the tobacco industry made the same claim during its own attempts to avoid advertising bans.

The claim was roundly discredited by a host of international studies and laughed out of Europe, the United States, Canada, Australia

and New Zealand. Among the most definitive of findings were:

- advertising was directly related to the number of cigarettes smoked – increased advertising meant more cigarettes smoked, and less advertising meant fewer smoked
- consumption fell annually by 1.6 percent on average in countries that banned tobacco advertising
- the percentage of young people who smoked decreased more rapidly in countries where advertising was banned
- in countries that banned tobacco advertising, the ban had been followed by a fall in smoking on a scale that could not reasonably be attributed to other factors.

“ The world of sport is saturated by liquor advertising. Clubhouses and grounds are awash with invitations to drink. ”

And never mind the New Zealand study showing that, just 10 years after alcohol advertising was relaxed in 1992, consumption had doubled among our 14–17-year-olds, and a third of our teenagers were drinking to get drunk.

Look at the anecdotal evidence in sport: 22 alcohol-related scandals in the NRL this season alone. A phalanx of New Zealand rugby players has been involved in booze-related controversies: Jimmy Cowan, Doug Howlett, Jerome Kaino, Lucky Mulipola.



Canterbury's
Richie McCaw

NZPA/Tim Hales



NZPA/Wayne Drought

All Black Dan Carter

The world of sport is saturated by liquor advertising. Clubhouses and grounds are awash with invitations to drink. Competitions are named after grog. Players' uniforms are emblazoned with the logos of booze companies, and every NRL, AFL, Super 14 and NPC side is visibly aligned to one. Sport has become a Trojan horse for the alcohol industry; what it can't get away with in terms of direct advertising, it can easily do through sponsorship.

And it's not doing it in moderation. The All Blacks are backed by Steinlager, the Wallabies by Bundaberg Rum, the Welsh by Brains, Scotland by Famous Grouse and the England cricket team by Marstons. The London Wasps, who won the Guinness Premiership last season, are sponsored by Magners Irish Cider. The European Rugby Championship is sponsored by Heineken. Yet we're told the messages aren't aimed at children or youth.

Liverpool and Everton FC are aligned to Carlsberg, the football League Cup to Carling, and the Champions League to Heineken. Liquor companies are beaming their way into households via all sorts of sporting competitions at any time of the night or day. A young soccer

fan wanting to watch a live telecast of Chelsea playing Roma at 6am New Zealand time must negotiate Heineken beer commercials before, during and after the match. So much for the evening threshold.

If anything, the hypocrisy is worse in Australia, where cricket organisers last year announced a crackdown on drunken hoons, despite the fact that some of their biggest and most visible sponsors at the time were Johnny Walker Whisky and VB Bitter. The latter was promoted on the back of an advertising campaign featuring national selector and former test batsman David Boon in mid-swill. League, rugby and AFL officials writhe in apparent anguish over the drunken antics of their players, but continue to accept the advances of just about every booze label in the land.

It wasn't long ago that tobacco companies were using a similar ruse to flog their poison. They would issue card collections featuring pen portraits of our most famous sportspeople in order to glamorise and normalise a practice that would kill millions of us. They carefully hijacked sporting attributes such as mateship, loyalty and generosity in their advertising campaigns, and when we finally started to awaken to their duplicity, they screamed blue murder about the right to choose.

Now the alcohol industry is up to the same old tricks, positively reinforcing liquor in the minds of young fans, many of whom want nothing more than to simply emulate their local heroes. Former World Health Organization Director-General Gro Harlem-Brundtland hit the nail on the head when she

warned, "Aggressive marketing of alcoholic products to youth is an important part of the problem. Not only are children growing up in an environment where they're bombarded with positive images of alcohol, but our youth are a key target of the marketing practices of the alcohol industry."

It's something we need to be more aware of. Even if it is true that liquor advertising and sponsorship in sport isn't specifically aimed at young people, it's not really the point, is it? The main question is whether young people are being exposed to alcohol advertising in sport, and the answer is an unequivocal yes: at the ground, on television, on the radio, in the newspaper and on the internet. They're being beckoned by an industry that's as parasitical as the common greenfly.

With that in mind, it's about time we viewed the liquor barons as the main perpetrators of the problem, rather than part of the solution. It took us a while to understand why the smoking industry wanted such a strong advertising alliance with sport, but there is no such excuse on this occasion with alcohol. The motives are crystal clear. ■

Richard Boock is an Auckland-based sports writer.

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.

Is that really how we're drinking?

Most people reading this will remember the heavily intoxicated woman getting dragged into the dark alley, the child being forcefully thrown against the wall or the young girl watching her father collapsed on a filthy bathroom floor. And most of us got the message. It's not the drinking, it's how we are drinking. As **Ed Ptilidi** explains, the ads by the Alcohol Advisory Council and advertising agency Clemenger BBDO have certainly caused some controversy.



Ed Ptilidi

RESEARCH shows 94 percent of adult New Zealanders can recall seeing at least one of ALAC's three advertisements featuring either Lisa, Danny or Uncle Mark.

And now the controversial campaign has won an award for effective advertising – The Gold Effie for Social Marketing/ Public Service.

The Effie Awards are run by the Communication Agencies Association of New Zealand (CAANZ) in conjunction with the Association of New Zealand Advertisers (ANZA) and Television New Zealand.

According to the judges, the ads were “short, sharp and meaningful” and “did a good job in a cluttered social marketing environment”. We are not sure the hospitality industry would be happy about the ads' success. Earlier this year, an Auckland bar manager lodged an

official complaint saying they portrayed bar staff in a negative way because, in real life, the drunks would not have been served.

Hospitality Association (HANZ) Chief Executive Bruce Robertson agrees, saying the ads reinforced the idea that it is okay to get so drunk.

“If a manager allowed someone to get to that stage, their licence could be suspended,” he says.

While supporting the aim of the campaign, he points out that two of the three ads are set in a licensed premises environment.

“Seventy percent of alcohol is consumed away from licensed premises, so why do two of the three ads focus on them? They are showing an activity that is illegal.

“The next series of ads should



feature the same people with bar staff looking after them and saying, 'You've had enough'."

ALAC Chair Peter Glensor says the advertisements attracted a large number of complaints due to their hard hitting content, but he makes no apologies.

“If we released ads that show the way the French or Spanish drink, we would be criticised for being soft.”

"The ads show graphic examples of excessive drinking leading to harm, with three realistic characters eventually making poor and dangerous choices. These commercials are unpleasant, but so are the consequences of binge drinking.

"They mirror what is happening, unfortunately, every week around this country. It is time to be brutally honest about some of the worst effects of intoxication."

ALAC CEO Gerard Vaughan says the idea was to design a communication that was real and would touch people.

"In New Zealand, people go to bars and drink to get drunk."

He says the ad where the woman gets dragged away targets women under 35 because, in that age group, many people do drink in bars.

ALAC's Advertising Manager, Shelley Crestani from Clemenger BBDO, says they did a lot of qualitative research to identify the main reasons people drink.

One focused on a woman named Lisa, a 'confidence drinker' who drinks quickly to get in the mood for socialising

but soon crosses a line.

"Many women rate sexual vulnerability while drunk as one of the things that scare them the most. We are trying to tell a story that is believable," Crestani says.

"The ad was not designed to expose badly behaved publicans."

Vaughan says when ALAC communicates with the public, the message needs to be one that accurately reflects life in New Zealand, and this is the way that many Kiwis behave when they drink.

"If we released ads that show the way the French or Spanish drink, we would be criticised for being soft." ■

Ed Ptilidi is media officer at the New Zealand Drug Foundation.

Quotes of Substance

“Historically, there have only been two deaths worldwide attributed to cannabis, whereas alcohol and tobacco together are responsible for an estimated 150,000 deaths per annum in the UK alone.”

The Beckley Foundation Global Cannabis Commission calls for a “serious rethink” of drugs policy.

“About 5,000 people die in New Zealand each year as a result of smoking, and that means tobacco companies have to find 5,000 new customers each year just to hold their ground.”

Cancer Society Chief Executive Dalton Kelly, whose petition in support of a tobacco display ban received 20,000 signatures.

“Drugs are dumb.”

Former Labour Leader and Prime Minister Helen Clark on the campaign trail speaks to primary students about drugs – and folks, that’s about as sophisticated as the election campaign got on drug issues.

“It’s difficult to have a rational debate. But I think we need to have a continuing and rational debate about what the best form of the law is and look at what is happening in other western countries where there’s a wider range of approaches.”

Helen Clark on the stump, again speaking on cannabis policy to students eligible to vote. It was a pity Ms Clark previously signed a coalition agreement preventing her from having any rational debate. ■



Are New Zealanders driving high to avoid being caught driving drunk? Do people think some drugs affect driving worse than others? Would roadside drug testing make a difference to attitudes or behaviour? The New Zealand Drug Foundation wants answers to these and other questions to get a sense of just how much we know about what drugs can do to us when we’re behind the wheel.

EARLIER this month, the Drug Foundation launched its Drugs and Driving research project, with funding from the National Drug Policy Discretionary Grant Fund.

The Drugs and Driving survey is online at www.drugdrivingsurvey.org.nz, where we plan to collect responses from thousands of New Zealanders. We want to hear from anyone and everyone – drivers, non-drivers, people who use drugs and those who don’t – whether or not they think drug driving is a problem in New Zealand.

The survey asks about a variety of legal, illegal and prescription drugs. We are interested in which drugs people have and have not driven under the influence of, and which drugs are perceived to be more dangerous or safe when driving.

A wide range of responses is expected from people in every corner

of the country and from a broad cross-section of society. The information gathered will, for the first time, present a picture of the drug driving situation across New Zealand.

Not only will this help us see which drugs people are using when driving, it will also reveal what New Zealanders think about it. This information will help develop any education and information messages for the public.

So get online and complete the survey at www.drugdrivingsurvey.org.nz, and when you’re done, email the link to all your friends, family, neighbours, colleagues, in-laws and acquaintances around New Zealand. And if you’re someone who wouldn’t drive after eating a brandy-snap, we want to hear from you too!

The more responses we get, the better we will understand New Zealand’s drug driving situation. ■

Watch out for more than the scenery

YOU'RE almost twice as likely to be assaulted in Queenstown according to new Police statistics.

The central business district is where most assaults occur, though there's a 17 percent chance it will happen on licensed premises. The likelihood is just 3 percent elsewhere in New Zealand. In 97 percent of cases, attackers are affected by alcohol.

A New Zealander or visitor had a one-in-139 chance of being the victim of a violent crime in Queenstown compared with a one-in-202 chance in the rest of New Zealand.

Constable Sean Drader of Queenstown Police said it was up to the community in general, and bar owners in particular, to own the problem and take steps alongside Police and the Council to resolve it.

Addiction harm statistics dire indeed

A PAPER released by the National Committee for Addiction Treatment (NCAT) reveals what one member called "horrifying" statistics on the devastation wrought by addicts.

Approximately 89 percent of serious offences are committed under the influence of alcohol and drugs; 75-90 percent of weekend crime is alcohol-related; half the men who physically abuse their partners have substance abuse problems; alcohol plays a role in 30 percent of fatal car crashes and 70 percent of emergency department admissions.

But only 22,000

New Zealanders access addiction treatment services in any given year, leaving an estimated 138,000 unaided, says NCAT co-chair Christine Kalin, "And staff in the sector are sick of turning away people who need help."

Treatment costs range from \$80 for a low level intervention to more than \$8,000 for months of residential treatment, but National Addiction Centre Director Doug Sellman said \$8 could be saved for every dollar spent on treating drug addicts.



The cost of your lung cancer



SMOKERS can work out how much their addiction is costing them quickly and easily. Enter the type and number of smokes you have per day into the calculator at The Quit Group website along with the cost of a packet. The calculator will tell you just what you're paying. It's enough to give you a heart attack! See www.quit.org.nz/page/quittingSmoking/quitCalculator.php.

Reading, writing and forgery

STUDENTS at six Waikato schools have been using school computers to make fake drivers' licences to help them buy cigarettes or alcohol or to get into bars, Police say.

Constable Murray MacDonald of the Hamilton Police Liquor Licensing Team said the kids were playing for high stakes, as the maximum penalty for such offending is 10 years' imprisonment.

A Hamilton teenager told the *New Zealand Herald* that making fake licences is "pretty simple" and costs around \$1.50 in materials. "It can be hard to get them to fly past some bar staff though."

Alan Menzies, who manages a popular student bar, said some of the licences were quite convincing. "Then again, we've seen some shockers, like some people who have completely different skin complexions."

He said his staff document each incident and retain the fake identification before sending the offenders to police.

Doctors lured with free beer



EXPAT health professionals are being offered a free beer and a flight home by southern health boards.

The free pint was offered to the first 100 expat Kiwi health professionals who attended a Return to your Southern Roots gathering at the Speight's Southerner bar in London.

Southland board member Fiona McArthur questioned the promotion and asked whether it was appropriate for the health board to align itself with Speights, given the

government's announcements regarding healthy lifestyles. She qualified the statement by saying it was not a criticism and that she was a consumer of the product.

Chief Medical Officer Pim Allen said the offer was not in conflict with the government's position on alcohol consumption. "The offer is for one free beer, and I think the government advertising is about responsible drinking, not no drinking."

It's still cheap to drink

DESPITE rising petrol prices, food costs and an international credit crisis, New Zealanders can still afford to drink. A Nielsen survey revealed 47 percent of New Zealanders were not influenced by the current state of the economy when buying alcohol.

Alcohol Advisory Council of New Zealand Chief Executive Gerard Vaughan said steady alcohol consumption could be pinned to its cheap cost.

"Alcohol is so cheap these days. We have seen huge increases in basic household products such as milk and cheese but not with alcohol."

Hospitality Association of New Zealand Chief Executive Bruce Robertson said he had not noticed any trends in consumer spending.

"A lot of New Zealanders are still in a good [financial] position in terms of being employed, so why shouldn't they spend their money on a few drinks, as long as it is in moderation?"

The survey also revealed 45 to 55 percent off all age groups were going out less often for their drinks.

Recall for party pills

THE Ministry of Health has instructed health boards to recall party drugs that contain the powdered form of DMAA. Labels on party pills commonly refer to DMAA as ‘geranium oil’. The recall follows concern that pill makers have simply swapped banned BZP for DMAA.

DMAA stands for 1,3 dimethylamylamine, which health officials say put four users in Waikato Hospital recently. Party pill brands, such as Sunrise, are marketed as containing 99.9 percent DMAA.

Though the Ministry did not consider DMAA a “significant public health risk”, it was concerned after the Waikato cases, a spokeswoman said.

Addicts face long wait for treatment



A NATIONAL Addiction Centre report says drug addicts are lapsing back into crime and prostitution while waiting to access “poorly resourced and overburdened” treatment programmes.

Crime by opiate addicts awaiting treatment is estimated to cost \$286m a year, while a 12-month course of methadone treatment costs about \$5,000.

About 4,600 addicts are receiving methadone through opioid substitution treatment (OST) programmes, but demand far outweighs the resources available.

Addicts wait an average of

90.3 days between their first presentation and their first dose of methadone at New Zealand’s 18 treatment centres. Ministry of Health guidelines recommend a four-week wait.

Addiction experts have slammed the delays. Needle Exchange Programme National Co-ordinator Charles Henderson said, “If those people are open to treatment, that’s when we need to get them on to methadone, not six months later or even three weeks later. The horse could have bolted by then.”

Opiate addicts, whose addictions could cost about \$1,000 a week to maintain, were often engaged in crime, prostitution and drug abuse, experts said. They were also 13 times more likely to die prematurely than their peers, and have health problems such as AIDS and hepatitis B and C.

The report, commissioned by the Ministry of Health, recommends the OST programme be renewed.

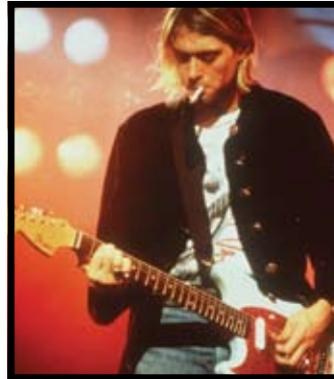
What a me(th)ss!

HOUSING New Zealand is suing a drug ring after one of its homes in Napier had to be demolished because of contamination from chemicals used to make methamphetamine. The total site clean-up bill came to \$185,000.

Housing New Zealand says it will not tolerate unlawful activities in state homes, and it is determined to recover the costs of damage from those responsible.

Ten people have been convicted of charges relating to the manufacture of methamphetamine at the house. ■

Will it smell like Kurt’s spirit?



AP Images

AN Australian artist wants to smoke the stolen ashes of Kurt Cobain as part of an exhibition she claims will set the late Nirvana singer free.

Natascha Stellmach claimed she would smoke the ashes in a joint to end her Set Me Free exhibition at Berlin’s Wagner + Partner museum and that this would symbolically set Cobain “free” from the media circus.

“(It’s) kind of magic,” she said.

Stellmach wouldn’t elaborate on how she had acquired the ashes, which went missing during a burglary at Courtney Love’s home earlier this year.

Round ban “unAustralian”

ROUNDS of drinks, jugs of beer and shots could be banned after 1am as police and Liquor Licensing Victoria trials new measures aimed at curbing late-night ‘shouts’ and enabling bar staff to better monitor individual alcohol consumption.

Police Licensing Inspector Chris Duthie said the trial could be extended to all late-night venues if successful. “Unless these premises do more in terms of responsible service of alcohol, then something will be thrust

upon them,” he said.

Escobar owner Jonathan Sherrin said the initiative would help improve the industry’s image. “This will hopefully show we are doing something positive and trying to improve industry standards,” Mr Sherrin said.

The proposal comes as figures from the Australian Institute of Health and Welfare show that 51 percent of men aged 18 to 24 (up from 49 percent last year) and 37 percent of women (up 1 percent) of the same age are drinking at risky levels.

Melbourne drinker Grant King supported a late-night ban on the sale of jugs and shots, but branded any move to stop shouts or rounds of drinks as “unAustralian”.

Wine online “non bon”



FRENCH winemakers and other players in the drinks industry are fighting to avert a ban on advertising, sales and even vineyard websites that has been looming ever since a court ruled that the internet should be included in strict laws regarding alcohol advertising.

The ruling has forced Heineken to block French access to its corporate site, and some of the biggest drinks brands have shut out French

visitors for fear of prosecution.

The industry says it is being demonised and that an internet ban would penalise one of the glories of French national heritage.

Even the alcohol-fuelled world of sport has not been left unscathed. When Liverpool played Marseilles in the Champions League match, the logo of Carlsberg, the team's main sponsor, was absent from their shirts, while rugby union's Heineken Cup is simply called the European Rugby Trophy in France.

"We are not inciting people to crime. We are sensitive to the risks of alcohol," said Frédéric Delesque, the Marketing Director of Camus Cognac, which has also bowed to the law and blocks French visitors. "There are three countries in the world that ban the discussion of alcohol: Iran, Afghanistan and France. It is a pity for the image of our products," he said.

Winemakers and merchants, many of whom depend on the internet for promotion and sales, are urging the government not to be swayed by demands from the health lobby to enforce the "Heineken ruling" with a new law, currently under preparation.

The new law would be an extension of the Evin law, passed in 1991, which limits the advertising of alcoholic drinks but only to the press, the radio and on posters. Since the world wide web did not exist then, it is not approved for drink advertising. The court upheld that argument in the Heineken case, but added that it should be clarified.

Drugs' costs outweigh gold, platinum, and human blood



THE Evil Mad Scientist Laboratories website has produced a guide to the value per pound of various commodities, from flour through to kobe beef, marijuana, human blood, gold, cocaine and antimatter.

Cocaine, at \$22,680 per pound is worth way more than gold (\$12,000), platinum (\$20,679) or sending stuff into space by rocket (\$10,000). LSD will set you back a cool \$55 million dollars per pound, and is second in cost only to antimatter. At \$26 quadrillion, a pound of antimatter will cost you more than all your pocket money (even if you save up for absolutely ages).

Cannabis, it turns out, costs more than uranium, human blood and saffron, and is ten times as expensive as silver.

It should, of course, be pointed out that the ridiculously inflated prices of illegal drugs are specifically due to the fact that they are illegal rather than reflecting intrinsic value or production costs.

Unlike saffron, for example, marijuana is laughably easy to produce in large quantities for almost no cost. Similarly, cocaine would probably cost no more than aspirin to produce, were it a more conventional legally regulated product.

Let's just hope no-one finds a way of smoking antimatter.

Item	Price per pound (US\$)
All purpose flour	0.52
Bottled water	1.00
Copper	3.50
Turkey feathers	26
Kobe beef filet mignon	112
Human blood	181
Silver	197
Peacock feathers	410
Saffron	1,000
Marijuana	2,000
Industrial diamonds	2,300
Gold	12,000
Platinum	20,679
Cocaine	22,680
Good quality one-carat diamonds	11.4 M
LSD	55 M
Antimatter	26 quadrillion

Alcopop tax okay says poll

MOST Australians want the hefty alcopops tax to stay and would support increased tobacco tax if proceeds went to disease prevention, a Newspoll shows.

A survey commissioned by health and anti-smoking groups has found the 70 percent tax hike on pre-mixed alcoholic drinks is supported by 57 percent of adults irrespective of how the money is used, but support rose to 84 percent if most of the revenue funded programmes to help prevent heart disease and cancer.

However, a survey of 480 liquor retailers released by the industry earlier this month found 88 percent believed the tax increase had not reduced alcohol consumption. Four out of five said most alcopops consumers had switched to other, often more alcoholic options.

Federal Health Minister Nicola Roxon dismissed those findings as "shonky".

Drinking is healthy for lazy smokers



IN possibly the most unfair medical finding ever, Britain's leading researcher on the link between health and behaviour found that smokers with the worst diets and poorest exercise habits could consume as many as 14 standard drinks a week – the threshold of what is considered harmful under proposed Australian guidelines – and still lower their risk of having a heart attack, stroke or other form of cardiovascular disease.

Greater quantities were less beneficial, though still better than being teetotal.

Professor Marmot, from the Department of Epidemiology and Public Health at University College, London, said health advice – which supports moderate drinking from middle age onwards – should now be modified to reflect how people may be differently affected.

"Most people drink for reasons other than alcohol's health benefits, but the widely publicised [heart protection] benefits may be used to justify or increase their habit," he wrote in the *Journal Of*

Epidemiology And Community Health. “The most [protective] effects from moderate drinking were found among those with the worst behaviour profile.”

People should still clean up their lifestyle, rather than turning to drink, Professor Marmot said. “Stopping smoking, eating more fruit and vegetables and taking more exercise will also reduce coronary heart disease risk and have fewer side-effects.”

A proposed revision of Australian drinking guidelines suggests men and women should limit their alcohol consumption to 14 standard drinks a week at most. The guidelines are expected to be formalised by the National Health and Medical Research Council later this year.

Millions in Police drugs missing

THE Victorian Ombudsman is investigating claims that seized drugs worth millions of dollars are missing from the Police forensic science laboratory. Drugs listed as destroyed years ago may have been kept, and chemicals that should have been stored are missing.

Senior police have admitted privately they are unable to say whether the missing drugs have been destroyed, are lost or were stolen. A full audit would require checking thousands of computer page entries against lists of drugs and chemicals meant to have been destroyed.

“The truth is we will never know. Many cases go back years, and it is impossible to find out what

really happened in each case,” one senior policeman said.

The now disbanded Ceja corruption taskforce investigated claims that seized drugs were recycled by the former drug squad and either sold or given to informers as a reward for information. One former Ceja investigator said there were suspicions at the time that some seized drugs were not destroyed as required by law.

UK drug advisors review class A for ecstasy



ECSTASY remains the third most popular illicit drug in Britain, with 5 percent of young adults aged 16 to 24 saying they have used it in the last year.

The decision by the Advisory Council on the Misuse of Drugs (ACMD) to review the legal status of ecstasy follows a report by the Commons Science and Technology Committee, which recommended urgent action two years ago.

A landmark Police Foundation inquiry in 2000 found the best estimates of the toxicity of ecstasy suggested it was several thousand times less dangerous than heroin and was probably involved in fewer than 10 deaths a year.

MPs heard evidence from Professor Colin Blakemore, then Chief Executive of the Medical Research Council, that ecstasy was “at the bottom of the scale of harm” and “on the basis of present evidence... should not be a class A drug”.

This view was confirmed by Professor David Nutt, the incoming chairman of the ACMD, in evidence to the MPs and in a *Lancet* paper last year in which he argued that alcohol and tobacco were more dangerous than cannabis, LSD and ecstasy.

Nutt said last year that young people already knew ecstasy was relatively safe, so making it a class A drug made a mockery of the entire ABC classification system. “The whole harm reduction message disappears because people say, ‘They are lying’,” he said. “Let’s treat people as adults, tell them the truth and hopefully work with them to minimise its use.”

Drugs Minister Vernon Coaker has made clear the government believes it should remain in class A but said he would consider any ACMD recommendation.

Possession of ecstasy, as a class A drug, carries a maximum seven-year jail term, while dealing can result in a life sentence.

Government to unify laws on alcohol to minors



THE Australian federal government plans to unify

laws across all states and territories to control the supply of alcohol to minors, but has ruled out banning people aged 18 to 21 from buying from bottle shops.

The government’s taskforce on binge drinking, the Ministerial Council on Drug Strategy, wants to wipe out inconsistencies across Australian jurisdictions affecting minors and alcohol.

In Victoria, for example, it is okay to serve alcohol to minors in private homes if they are supervised by adults, who do not have to be parents. Restrictions on supplying alcohol to minors relate only to licensed premises or public venues. State penalties vary from \$550 to \$20,000.

A spokeswoman for Minister for Gaming and Racing Graham West said, in NSW, adults can give an under-18 alcohol as long as the minor’s parent has given permission.

Health Minister Nicola Roxon has dismissed calls to raise the legal drinking age despite extensive American research showing that increasing it to 21 reduced road crashes and violence and cut the amount drunk by young people.

Paul Dillon, Director of Drug and Alcohol Research and Training Australia, said cheap alcohol means teenagers can easily get dangerously intoxicated.

“I go out to private schools, and the girls tell me they will drink a whole bottle of \$30 vodka between three of them, which is just \$10 each, while in the poorer areas, kids can get two litres of cask wine for \$12,” he said. ■

Drinking during hard times – where’s the proof?

“People are drinking more, because people tend to drink more during tough times.” **A US ‘beverage analyst’, 2008**

“It is an article of folk wisdom that heavy drinking increases during economic downturns: when people lose their jobs, they turn to alcohol.” **Business Week, 2007**

WITH the US economy leading the rest of the world into recession, Mythbusters thought it timely to check out the facts behind the widespread belief that hard times mean hard drinking.

At first glance, it seems to make sense, and research does suggest that some individuals ‘self-medicate’ with alcohol in reaction to such stresses.

But does this always apply across the whole population, as *Business Week* implies?

There is no shortage of long-term data on the issue. In fact, economists are so interested in debating whether alcohol use is ‘pro-cyclical’ (increasing in economic upturns, decreasing in downturns), they even hold regular ‘Beeronomics’ conferences.

The data are clear that alcohol sales increase in economic upturns, as do drink-driving rates, alcohol-related illnesses and perhaps even alcohol-related deaths.

When it comes to recessions, however, things get more complicated.

Long-term research from the US and Europe shows overall alcohol consumption doesn’t rise much during recessions and can even decline. In the US, for example, a 1 percent increase in state unemployment corresponded to a 3 percent reduction in alcohol consumption. The decrease was even larger when unemployment went up nationally.

But just because overall consumption dips doesn’t mean everyone cuts back on alcohol. Researchers using the same US

dataset found a 5 percent increase in the unemployment rate corresponded to an 8 percent increase in binge drinking.

So who’s most likely to cut back on alcohol, and who’s most likely to binge?

Interestingly, the increase in binge drinking was concentrated among employed people rather than the unemployed. Researchers point out that, when the economy tanks, the wealthy can afford to keep drinking, while poorer consumers (despite often being stereotyped as the ones with drinking problems) are the first to cut back. It may be that, during hard times, it’s the people that still have jobs that are the most stressed.

Some researchers have found that, in recessions, heavier drinkers reduce their alcohol consumption more than social or light drinkers, but there’s still debate about this.

Recessions don’t make people stop drinking alcohol altogether. Instead, they change how much and what kinds of alcohol they drink. In tougher times, people are less likely to eat and drink out and are more likely to stay at home – a pattern already showing up in the US economy. And there’s a shift from expensive to cheaper types of alcohol – from imported to local beers, for instance, and possibly from spirits towards beers.

The last word goes to the Chief Economist for the US’s Distilled Spirits Council, who went out of his way to dispel the “widely held myth” that alcohol is “recession-proof”.

“We have the same ups and downs

as anyone else,” he said. “While liquor sales aren’t nearly as cyclical as autos, homes or other big ticket items, typically in a recession, we see liquor sales go down.” ■

Back in the real world

So what’s happening with drinking right now?

It’s easy to find news stories supporting the belief that ‘sin stocks’ like alcohol are recession-resistant, as if they were just consumer staples alongside toothpaste.

A closer look suggests the picture is more mixed. In August, worldwide beer shipments by the world’s largest brewer, SABMiller, fell around 1 percent in contrast to the 13 percent growth at the same time last year. Diageo, the world’s biggest maker of alcoholic drinks, also saw pre-tax profits decline – although with a profit of over £2 billion, the company probably isn’t too worried yet.

Beer consumption seems to have taken a big hit, with Britain’s Beer and Pub Association complaining that “a credit crunch, contracting economy and jittery consumers” were causing their sector “one of its biggest ever headaches.” Even in the Czech Republic, easily the world’s largest beer drinking nation, beer consumption has decreased by 10 percent.

US consumer data in the last few months show a move from more upmarket to cheaper brands of beer, and falling restaurant sales suggest Americans are staying home to drink.

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