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

New Zealand Drug Foundation submission on the Mental Health and Addiction Inquiry

Submitted to the Government Inquiry into Mental Health and Addiction on **Thursday, 7
June 2018**

Tēnā koe

In this submission we propose urgent changes to the way New Zealand responds to addiction issues.

Our biggest frustration is that many sensible solutions have been posed to remedy our ailing addiction sector over the years. Time, effort and money have been invested to design strategies which are then not properly funded or implemented. It is time government and agencies are held to account to make these changes.

Two major barriers for seeking help are New Zealand's outdated drug laws and the stigma attached to drug use. We have outlined solutions to dismantle these barriers.

We also provide a detailed overview of the changes needed to address addictions from a health perspective. We need effective and comprehensive funding for a range of interventions, covering education, prevention, harm reduction and treatment. We also need to remove a host of small (and not so small) barriers to ensure the most vulnerable are able to access help.

Our submission has four parts:

- **PART ONE** New Zealand knows the solutions. Build in accountability to implement them
- **PART TWO** Reform our laws to treat drug use as a health issue not a criminal one
- **PART THREE** Destigmatise drug use to reduce barriers to getting help
- **PART FOUR** Invest more effectively in alcohol and other drug education, prevention, harm reduction and treatment.

Thank you for considering our submission. Please be in touch if you would like to discuss anything.

Ngā mihi,



Ross Bell

Executive Director

The Drug Foundation is a charitable trust. We have been at the forefront of major alcohol and other drug debates for 28 years, promoting healthy approaches to alcohol and other drugs for all New Zealanders.

PART ONE – NEW ZEALAND KNOWS THE SOLUTIONS. BUILD IN ACCOUNTABILITY TO IMPLEMENT THEM

The government knows what needs to happen

1. Various reports¹ and even government strategies over recent years have set out how the mental health and addictions sector needs to improve. They've concluded for example, that we need to:
 - **Eliminate waiting lists.** No one should wait months to get help that is needed immediately
 - **Widen our focus from just those three per cent** experiencing severe mental health and addiction issues. This means providing options for people across the spectrum of drug use, all the way from those who use occasionally, through to those with mild or severe dependence
 - **Properly fund a full range of health interventions,** from prevention and education programmes through to early intervention, harm reduction, and low-threshold help in both primary and secondary care settings
 - **Reduce barriers to accessing services.** This means providing 'low-threshold' services including walk-in centres, peer support services and services that do not require a person to commit to a full 'programme' to access help. 'Low threshold' services offer help without the need to spend weeks getting agency sign-off for funding
 - **Implement a model of care that is consumer-centred,** which means giving people the type of information, help and treatment they need, when they need it and where they need it
 - **Provide services that do not require a person to abstain** from illicit drug taking before becoming eligible for help, including residential care
 - **Integrate services with the work of other agencies.** In particular, ensure people have access to housing and employment opportunities. Services should wrap around and care for people where they are, and wherever in the recovery process they find themselves
 - **Reduce disparity for Māori and other higher risk population groups** by making services more accessible, for example by funding more community- and iwi-based services. Make agencies accountable for supporting vulnerable clients even if they don't show up for appointments.

¹ For example, Costs of Harmful Alcohol and Other Drug Use 2009 (Berl Economics), Rising to the challenge (Ministry of Health, 2012); Blueprint II: How things need to be (Mental Health Commission), Towards the next wave of mental health and addiction services capability (Mental Health and Addiction Service Workforce Review Working Group, 2011); Mental Health Commissioner's Monitoring and Advocacy Report 2018

2. The Government needs to address the operational issues which lead to policies and strategies not being translated into on-the-ground changes. As the Mental Health Commissioner put it on the release of his 2018 monitoring and advocacy report²:

Rising to the Challenge has now expired. With 100 actions and a lack of relative priorities, clear accountabilities, an implementation plan, and clear milestones or measures of success, it has been difficult to measure progress at the completion of the plan.

3. We wholeheartedly support the Mental Health Commissioner's conclusion that to see real progress we need collaborative leadership supported by robust structures and accountabilities.
4. To give a similar example from our own experience, in 2015 the Ministry of Health commissioned us to scope a drug use destigmatisation campaign. There was clear evidence to support the need for a campaign, and tax-payer funded money and time was invested to scope up a proposal. However, no campaign was funded.
5. In New Zealand we are good at thinking, writing and planning, but much less impressive at implementation. This must change.

We need to create structures that hold agencies, particularly DHBs, to account to provide the services that are needed

6. There are several issues with funding and procurement for addiction services:
 - The first and most obvious is that the addictions treatment sector is not allocated enough money to deliver quality services that meet the needs of their community
 - Secondly, of the total investment in mental health and addictions, not enough is directed at addictions. In 2014/15, only 11% of total mental health and addictions funding went to addiction services³
 - In theory, 30% of District Health Board (DHB) funding is ring-fenced to commission mental health and addiction services⁴. Views differ on whether that amount is spent on what it is intended for. It is also difficult to establish how

² Health and Disability Commissioner. (2018). *New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*. Retrieved from <https://www.hdc.org.nz/media/4680/mental-health-commissioners-monitoring-and-advocacy-report-2018.pdf>

³ National Committee for Addiction Treatment. (2017). *Shaping the sector*. Retrieved from <http://ncat.org.nz/wp-content/uploads/NCAT-shaping-the-sector-single-pages-full.pdf>

⁴ Health and Disability Commissioner. (2018). *New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*. Retrieved from <https://www.hdc.org.nz/media/4680/mental-health-commissioners-monitoring-and-advocacy-report-2018.pdf>

much of the allocated funding goes towards addictions, which is seen as the ‘poor cousin’ of mental health

- Addiction services are not provided in a consistent way across DHBs. There are discrepancies about what services are offered, and where
 - DHBs tend to fund their own services at a higher rate than non-government organisations (NGOs) doing the same work
 - Each year NGO overheads increase, but there is little to no funding increase. Each year services are being asked to do more with less
 - DHBs are required to provide services only to the 3% of the population with the most serious concerns. It is illogical and inefficient to wait until a person’s condition becomes acute before taking action.
7. We would like to see systems and structures put in place to remedy these issues and build in accountability. We are agnostic about how this would look, but three possible suggestions are:
- Create an independent body to commission services according to pre-determined guidelines. This body could be directly accountable to the Health Minister.
 - Create legislation or regulations to ensure DHBs are accountable for the way they commission addiction services. They should commission a full range of evidence-based approaches. For example, they could be required to put a specified percentage of all funding received into community-based and low threshold support.
 - Encourage DHBs, Ministry of Health, NGO service providers and consumers of addiction services to co-design people-centred responses at a national level, which can then be replicated regionally.
8. We welcome the government’s proposal to re-establish the Mental Health Commission. The Commission would act as a much-needed independent watchdog over the Ministry of Health, services and DHBs.

PART TWO - REFORM OUR LAWS TO TREAT DRUG USE AS A HEALTH ISSUE NOT A CRIMINAL ONE

10. Overhauling New Zealand's outdated drug laws is crucial if we want to see meaningful changes to the addictions sector. This is because the current law:

- Stops people seeking help
- Creates stigma which impacts the care that people receive
- Leaves people with convictions that impact their lives negatively, meaning they find it even harder to find a job and beat their addiction
- Diverts funding from healthcare into enforcement.

People can overcome an addiction but not a conviction

11. The Misuse of Drugs Act (MoDA) 1975 criminalises people who struggle with addiction, instead of supporting them.

12. Thousands of people are convicted of drug offences each year under MoDA, and the majority of them are for low-level drug offences^{5,6}. In 2016 alone:

- 3,511 people were convicted for low-level drug offences (possession, use and/or use of a drug utensil)
- 799 were imprisoned for low-level drug offences⁷.

13. Māori are disproportionately represented in conviction and imprisonment rates.

- Māori make up 15% of our population but 42% of low-level drug convictions⁸.
- Amongst cannabis users, nearly twice as many Māori report legal problems as non-Māori⁹.

14. Māori already face many barriers to getting help. The law should not be one of them.

15. There is widespread agreement that our current drug control efforts are themselves causing harm. New Zealand has a regime that burdens people, particularly young

⁵ Low level offences consist of drug possession, use and/or 'other' (mostly possession of a drug utensil).

⁶ Ministry of Justice. (2017). Response to an Official Information Request from New Zealand Drug Foundation. Retrieved from <https://www.drugfoundation.org.nz/policy-and-advocacy/drug-use-and-criminal-justice/>

⁷ Someone will not likely go to prison for low-level drug convictions alone and will likely have other charges (e.g. burglary etc). But the low-level drug convictions will make a difference to the length of sentence etc.

⁸ Ministry of Justice. (2017). Response to an Official Information Request from New Zealand Drug Foundation. Retrieved from <https://www.drugfoundation.org.nz/policy-and-advocacy/drug-use-and-criminal-justice/>

⁹ Ministry of Health. (2015). *Cannabis use 2012/13: New Zealand Health Survey*. Wellington: Ministry of Health. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/cannabis-use-2012-13-nzhs-may15-v2.pdf>

people¹⁰, with drug convictions that can stay with them for a lifetime. This makes it difficult – if not impossible – for them to obtain jobs and fully participate in society.

16. The punitive approach has not worked, here or abroad. New Zealand still has high rates of drug use. It is clear this approach does not stop people using drugs. People who struggle with drug use need support, compassion and access to treatment - not a criminal conviction.

We need to reform drug law to minimise harm from addictions

17. New Zealand is spending money on the wrong things. In 2014/15 \$273.1 million was spent on drug enforcement (Police, Courts and Corrections), while only \$78.3 million was spent on drug health interventions¹¹. We are spending 3.5 times more on punishing people than helping them. This is the wrong way around – it is more cost-effective and humane to focus on health.
18. The current drug laws put barriers in place for people seeking help. The 2006/07 NZ Health Survey reported 50,000 people each year want help for their alcohol or drug use but do not receive it. The 2007/08 Health Survey showed 16.5 percent of these people say they don't get help because they fear the law or police¹². That is a lot of people that may never get support from the addictions sector.
19. In July 2017, the Drug Foundation launched *Whakawātea te Huarahi*¹³, a model drug law to 2020 and beyond. The approach is based on recommendations from the 2011 Law Commission Review¹⁴ and best-available international evidence.
20. We want to replace the Misuse of Drugs Act 1975 with a law that treats drug use and possession as a health issue, not a crime. This would minimise the harms caused by drug addiction, and by our current law. We propose:
 - Removing criminal penalties for the possession, use and social supply of all drugs
 - Developing a strictly regulated cannabis market
 - Putting more resources into prevention, education and treatment.
21. Under our proposed model, people found with small amounts of illicit drugs would be diverted into a health intervention, instead of a criminal one. This means they would

¹⁰ Ministry of Justice. (2017). Response to an Official Information Request from New Zealand Drug Foundation. Retrieved from <https://www.drugfoundation.org.nz/policy-and-advocacy/drug-use-and-criminal-justice/>

¹¹ McFadden Consultancy. (2016). *The New Zealand Drug Harm Index 2016* (2nd edn). Wellington: Ministry of Health. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/nz-drug-harm-index-2016-2nd-ed-jul16.pdf>

¹² Ministry of Health. (2010). *Drug Use in New Zealand: Key Results of the 2007/08 New Zealand Alcohol and Drug Use Survey*. Wellington: Ministry of Health. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/drug-use-in-nz-v2-jan2010.pdf>

¹³ <https://www.drugfoundation.org.nz/assets/uploads/2017-uploads/Model-drug-law//Whakawatea-te-Huarahi-July2017.pdf>

¹⁴ New Zealand Law Commission. (2011). *Controlling and Regulating Drugs: A review of the Misuse of Drugs Act 1975*. Wellington: Law Commission. Retrieved from <http://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20R122.pdf>

have earlier access to help. Commercial supply and trafficking of drugs would still carry criminal sanctions.

22. Portugal decriminalised the use of all drugs in 2001¹⁵. The country saw dramatic reductions in drug-related harm and more people seeking treatment. And despite fears at the time, researchers have concluded there was little, if any, change to drug use prevalence rates as a result of decriminalisation¹⁶.
23. Drug law reform is vital to make sure everyone that needs addiction support can get it. Our current drug law stops people getting help, wastes money on enforcement that could be spent on treatment, creates stigma and leaves thousands of people with convictions that can further impact their addiction. Changing our drug laws is crucial to ensure people with addictions get help.

¹⁵ Eastwood, N., Fox., E. & Rosmarin, A. (2016). *A quiet revolution: Drug decriminalisation across the globe* (2 edn.). London, UK: Release. Retrieved from <https://www.release.org.uk/sites/default/files/pdf/publications/A%20Quiet%20Revolution%20-%20Decriminalisation%20Across%20the%20Globe.pdf>

¹⁶ Ibid.

PART THREE - DESTIGMATISE DRUG USE TO REDUCE BARRIERS TO GETTING HELP

Drug use is highly stigmatised in New Zealand

24. Stigma towards people who use alcohol and drugs exists at all levels of society. People with addictions can feel a lot of shame and face high levels of social and legal discrimination because of stigma¹⁷.
25. Drug use is the most stigmatised health condition of all¹⁸. The media and the general public often portray drug use and drug taking as a psychological and moral flaw. Terms like “junkie”, “addict”, “meth baby” – intended or otherwise – act to dehumanise and set people apart from society as inferior and flawed¹⁹.
26. The New Zealand media uses negative and stigmatising language, both blatant and implied:
 - “Tragically, she has the spectral visage of a meth head.”²⁰
 - “P babies prove problem kids who cause chaos at school”²¹
 - “Death of transient drug addict could have been prevented”²²
27. These negative attitudes and beliefs are often shared by the public, family and friends. This stigma can result in people being socially excluded and isolated from their communities²³.

Stigma stops people seeking help, and influences the quality of the help they receive

28. Stigma can be common with people who struggle with addictions. Stigma can become yet another barrier for people seeking help and can stop their families providing support²⁴.

¹⁷ New Zealand Drug Foundation. (2015). *Scoping of a destigmatisation programme on drug use and drug dependence*. A report for the Ministry of Health by the New Zealand Drug Foundation.

¹⁸ Global Commission on Drug Policy. (2017). *The world drug perception problem: Countering prejudice about people who use drugs*. Retrieved from http://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf

¹⁹ Ibid.

²⁰ <https://www.stuff.co.nz/the-press/opinion/78762077/giving-money-to-beggars-a-big-waste>

²¹ <http://www.stuff.co.nz/sunday-news/latest-edition/583890/P-babies-prove-problem-kids-who-cause-chaos-at-school>

²² https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11933407

²³ New Zealand Drug Foundation. (2015). *Scoping of a destigmatisation programme on drug use and drug dependence*. A report for the Ministry of Health by the New Zealand Drug Foundation.

²⁴ Ibid.

29. Stigma can influence the quality and types of addictions treatment people can access²⁵. This reduces the likelihood of these groups receiving quality non-judgemental services or having access to the same treatment and opportunities that non-stigmatised groups receive.
30. Stigma causes people with addictions to be treated badly within public institutions, such as criminal justice and healthcare²⁶. The Global Commission on Drug Policy published a major report in 2017 about stigma and misperceptions of drug use. They highlighted how these misconceptions contributed to bad policies, laws and treatment²⁷.
31. In one example from America, researchers conducted a randomized study²⁸ in which mental health clinicians were given identical case studies about individuals in court-ordered drug treatment programs. The individual was either referred to as “a substance abuser” or “someone with a substance use disorder.” The professionals who read about an “abuser” were more likely to believe that the individual in question was personally culpable for their situation and that punitive measures should be taken against them.

Fund a destigmatisation campaign to reduce barriers to help-seeking and receiving quality treatment

32. In 2015 the Ministry of Health commissioned the NZ Drug Foundation to scope a campaign to reduce stigma around drug use. The findings and proposals were not implemented.
33. A campaign, similar to ‘Like Mine, Like Minds’²⁹, would help to change attitudes, and reduce the personal, social and structural stigma that faces those who use drugs.
34. The campaign would also work with targeted populations, such as service providers, employers, families and people who use drugs. The aim would be to raise awareness of the issues faced by those using drugs, break down social barriers, and facilitate people accessing support.
35. Combatting stigma needs to be a priority if we want to improve outcomes for those struggling with their drug use.

²⁵ New Zealand Drug Foundation. (2015). *Scoping of a destigmatisation programme on drug use and drug dependence*. A report for the Ministry of Health by the New Zealand Drug Foundation.

²⁶ Global Commission on Drug Policy. (2017). *The world drug perception problem: Countering prejudice about people who use drugs*. Retrieved from http://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf

²⁷ Ibid.

²⁸ Ibid.

²⁹ <https://www.likeminds.org.nz/>

PART FOUR - INVEST MORE EFFECTIVELY IN ALCOHOL AND OTHER DRUG EDUCATION, PREVENTION, HARM REDUCTION AND TREATMENT

And he signed out [committed suicide due to a meth addiction]. Literally. If this is what our young people think the answer is and they can't get a response from adults and services when they are trying to reach out for help, then yeah, we are in big trouble.

- Lizzie McMillan-Makalio, Founder of P Pull, 2018³⁰

Without a shadow of a doubt if you are homeless with multiple disadvantages then you will be furthest from having your addiction or your mental health needs met and that is a disgrace.

- Stephanie McIntyre, DCM Wellington, 2018³¹

36. The current system is costing New Zealand billions. Harmful alcohol use was estimated to cost New Zealand \$4.9 billion over a decade ago (2005/06)³², with other estimates ranging between \$734m and \$16.1b. Harm from illicit drugs was estimated to cost New Zealand \$1.8 billion in 2014/15³³.
37. Despite this cost, New Zealand is not investing wisely in treatment. Services are overburdened. In 2007/08, 50,000 people each year wanted help for their alcohol or drug use but did not receive it³⁴. Investment is not keeping up with demand: The number of people presenting to mental health and addiction services increased by 73% in the last ten years, while funding only increased by 40%³⁵.
38. Right now, people struggling with drug use are met with huge, sometimes insurmountable barriers when trying to get help. Strict criteria, long waiting lists, difficult locations and unsuitable services all prevent people from accessing help.

³⁰ https://www.youtube.com/watch?v=SauH5eE_BhU

³¹ <https://www.youtube.com/watch?v=ieZfkJnIIXE>

³² ACC, NZ Police & HPA. *Alcohol: Quick facts*. Retrieved from https://www.alcohol.org.nz/sites/default/files/documents/Alcohol%20Quickfact%20Facts_0.pdf

³³ McFadden Consultancy. (2016). *The New Zealand Drug Harm Index 2016* (2nd edn). Wellington: Ministry of Health. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/nz-drug-harm-index-2016-2nd-ed-jul16.pdf>

³⁴ Mental Health Commission. (2012). *National indicators 2012: Measuring mental health and addiction in New Zealand*. Wellington, NZ: Mental Health Commission. Retrieved from <https://www.hdc.org.nz/media/2769/national-indicators-2012.pdf>

³⁵ Health and Disability Commissioner. (2018). *New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*. Retrieved from <https://www.hdc.org.nz/media/4680/mental-health-commissioners-monitoring-and-advocacy-report-2018.pdf>

39. Urgent, decisive, evidence-based action is required.

40. We recommend:

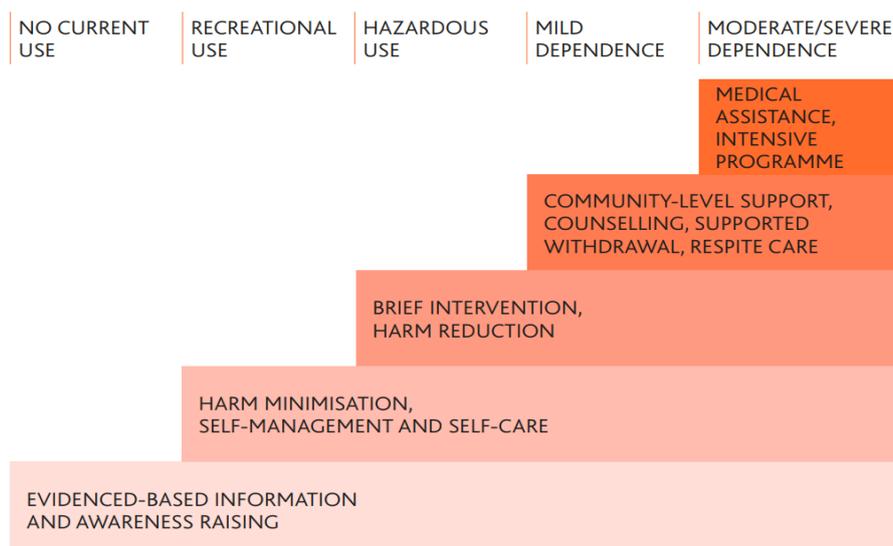
- Doubling the funding for treatment services to eliminate waiting lists
- Increasing investment in evidence-based alcohol and other drug prevention and education
- Funding a full range of treatment options, including community-, iwi-, whānau-based and peer support services
- Build in addictions treatment within other settings. For example, tie it into Housing First programmes
- Ensure services are person-centred and address multiple wellbeing needs
- Remove legal barriers to harm-reduction services such as supervised consumption rooms and drug checking.

We need to change the way we deliver interventions

Effective intervention means offering a wide range of options to suit different needs

41. We need smart investment. To make real impact and reduce harm, all levels of alcohol and other drug use must be targeted.

42. The diagram³⁶ below shows how a range of approaches can target different needs, from those who don't use alcohol and other drugs at all, through to people who are severely dependent. More detail is provided in Appendix 1.



³⁶ National Committee for Addiction Treatment. (2017). *Shaping the sector*. Retrieved from <http://ncat.org.nz/wp-content/uploads/NCAT-shaping-the-sector-single-pages-full.pdf>

43. Government and services must take a completely new approach. Services should be placing the person at the centre, and be inventive, adaptable and flexible. The government must support them to do so, by dramatically changing its purchasing models.

All barriers to accessing services must be removed

44. People, particularly vulnerable people, face multiple barriers to accessing treatment services. These barriers range from the very small through to large structural issues. For example:

- Poverty, including lack of transport, makes it hard for people to visit their GP or specialist
- Being put on a waiting list for an assessment means people can lose hard won motivation to address their issues
- Needing a referral from a GP to access treatment can seem like one difficulty too many for those who don't regularly access these services
- Punitive policies, such as being stood down for missing an appointment, mean people fall through the cracks.

45. Each of these barriers can impact on getting help. Compounding barriers can make seeking treatment impossible for some people, especially those who are socially or economically marginalised.

46. Services need to change their approach. To engage with the most vulnerable, they must travel to where those people are, and work with them on the most pressing problems. Flexible opening hours and outreach teams should be introduced and stand down periods removed.

Services need to be available at the times people need support

47. People experiencing immediate mental distress or addiction issues cannot always wait for traditional opening hours. They often need help immediately. Currently, Police and Emergency Departments are forced to respond when situations escalate. They are not mental health or addictions specialists.

48. We need more on-call services. 24/7 phone helplines aren't always appropriate - sometimes people need face-to-face specialists. Services need support to respond outside of hours and be mobile.

Services need to be integrated across agencies, and wrap-around the person

Escalating issues could be avoided if agencies worked together

49. When co-existing issues are not dealt with together, the result can be disastrous for vulnerable populations.
50. A very recent example was Housing New Zealand Corporation's approach to methamphetamine use in state houses. Hundreds of vulnerable tenants were removed from their homes because residual traces of methamphetamine were detected. HNZN took a 'zero tolerance' approach - anyone who was suspected of either using methamphetamine or allowing it to be used in their property was evicted.
51. HNZN's 'zero tolerance' policy conflicted with New Zealand's National Drug Policy 2015-2020, which calls for compassionate, innovative and proportionate responses to drug issues and emphasises the need for secure housing to beat addiction. It also conflicted with the Ministry of Social Development's new 'Housing First' initiatives.
52. Agencies were not required to work together to help state tenants struggling with their drug use. Instead tenants were evicted. Other agencies were left to pick up the pieces for clients whose problems no doubt became much more acute without a secure place to live. This is neither an efficient nor a compassionate way to 'help' New Zealand's most vulnerable.

People with addictions often have co-existing problems³⁷ but agencies are not equipped to deal with this

53. Addiction is often inextricably linked with other issues in a person's life that contribute to or exacerbate hazardous substance use³⁸. Some examples are trauma, homelessness, mental health, poverty, unemployment and discrimination
54. The link between co-existing problems and addictions is often not acknowledged when it comes to providing solutions. Addiction services are usually not equipped to deal with multiple needs and treatment is offered in isolation. But many people will not be able to meaningfully engage with addiction treatment until other issues (particularly shelter and employment) are addressed³⁹. Any new system needs to put the person's needs and their whānau at the centre.

³⁷ Health and Disability Commissioner. (2018). *New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*. Retrieved from <https://www.hdc.org.nz/media/4688/mental-health-commissioners-monitoring-and-advocacy-report-2018.pdf>

³⁸ New Zealand Law Commission. (2011). *Controlling and Regulating Drugs: A review of the Misuse of Drugs Act 1975*. Wellington: Law Commission. Retrieved from <http://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20R122.pdf>

³⁹ Paino, M., Aletraris, L. & Roman, P. (2016). The relation between client characteristics and wraparound services in Substance Use Disorder Treatment Centres. *Journal of the Study of Alcohol and Drugs*, 77(1), 160-169. doi: 10.15288/jsad.2016.77.160

55. Ideally, treatment centres would house a range of services, including health, mental health and addictions, housing, youth workers, domestic violence support, and so on. This would enable co-existing problems to be addressed in one space.
56. Similarly, addiction services could be expanded to lend addiction support in other health or social settings. For example, satellite teams could be stationed at places frequented by vulnerable populations. Successful models of this already exist in New Zealand, such as that run by DCM Wellington. This is a homelessness hub which also houses satellite teams, including primary care and dental health.

Services need to be provided for as long as needed

57. Client timeframes need to be reconsidered or removed. Different people have different needs, and some may need support for longer than others. Some will relapse more than once before they are fully recovered. Services should be funded to provide support for as long as it is needed, avoiding multiple admissions for treatment.

Low threshold services should be much more common

58. Low threshold services are open to anyone who requests support, with no entry criteria. These services are essentially walk-ins – no sign ups, no need to fill in multiple forms, and no waitlist.
59. Low threshold services can vary widely. With services including youth workers, counselling and harm reduction on site, they offer a safe place where people can more easily access the help and treatment they need.
60. Removing or lowering client criteria, allowing drop-ins, and not enforcing abstinence (no drug use), all help to create a low-threshold service. A concerted effort should be made to reach the most marginalised or 'hard-to-reach' populations.

New Zealand urgently needs essential harm reduction services

61. Harm reduction is a pragmatic approach that acknowledges we live in a world where drugs exist.
62. Harm reduction does not mean endorsing the use of drugs. It simply acknowledges that abstinence is not a realistic goal for everyone. We need to work with people where they are at, and focus on reducing *preventable* drug-related harms, such as infection and death.
63. New Zealand has a long history of underinvestment in essential harm reduction services. Harm reduction is not only a crucial tool for those who continue to use drugs, it's also a path to recovery. These services are a gateway to other social and health services that might not otherwise be accessed.
64. The addictions sector is dominated by abstinence-based services. But abstinence-based programmes do not work for everyone. Harm reduction fills the gap. In New

Zealand, there are some excellent examples of harm reduction services, such as the Needle Exchange⁴⁰ and Opioid Substitution Therapy⁴¹. We can improve things drastically by adding:

- Drug checking services
- Drug consumption spaces
- Take-home naloxone to avoid overdoses
- Social detox programmes
- An early warning system that detects new and dangerous drugs.

Harm reduction initiatives save money and help prevent or minimise physical and social harms

65. Countries that have introduced harm reduction measures have seen striking results. Reports have shown a reduction in the harm caused by drugs, and no correlation with increased drug use⁴². Notably, in areas with good harm reduction programmes in place, there are fewer overdoses and blood-borne viruses, as well as reduced criminal offending and anti-social behaviour.

66. The benefits of harm reduction and treatment are consistently found to outweigh the costs. Harm reduction services have a cost benefit return ranging from \$1.5 to \$7 for every dollar invested⁴³.

We should be bold and innovative

67. The Addictions sector must not be afraid to try new things and learn from overseas success. For example:

- ‘Wet houses’ can provide long term positive outcomes for people with housing and addictions issues. Residents are able to drink in a safe environment, rather than being forced to choose between housing and their addiction. A wet house is currently planned for Wellington but we would like to see these across the country
- Insite⁴⁴ in Vancouver and Uniting⁴⁵ in Sydney both offer drug consumption spaces aimed at reducing overdose and providing a space in which vulnerable clients can more easily access services. Both provide world-class services that we could emulate in New Zealand

⁴⁰ <http://www.nznep.org.nz/>

⁴¹ <https://www.health.govt.nz/publication/new-zealand-practice-guidelines-opioid-substitution-treatment-2014>

⁴² For example, Need exchange: http://www.who.int/hiv/pub/prev_care/effectivenesssterileneedle.pdf;
Drug consumption rooms: https://uniting.org/_data/assets/pdf_file/0020/153209/Overview-of-International-literature.PDF

⁴³ Sense Partners. “Estimating the impact of drug policy options”. A 2018 draft report prepared for the New Zealand Drug Foundation.

⁴⁴ <http://www.vch.ca/public-health/harm-reduction/supervised-consumption-sites>

⁴⁵ <https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/our-story>

- In British Columbia, a service has been established where people can walk in off the street and start treatment for drug addiction within two hours
- Social housing and rehabilitation can be combined in purpose-built facilities⁴⁶. For example, in Vancouver a large new complex will soon provide a range of treatment options for opioid addiction, along with short-term housing for those who are undergoing treatment.

A range of treatment options are needed

68. Different interventions work for different people⁴⁷. For many years, the sector has been calling for a consumer-centred and integrated approach, which supports a range of health interventions from self-care through to more intensive interventions⁴⁸.

69. Effective treatment means a range of options to suit different people, such as

- Counselling
- E-therapy / computerised interventions
- Residential and detox facilities
- Kaupapa Māori and iwi-based services.

70. Support services are an essential piece of the equation. People with addictions often need ongoing support during or after their treatment. Most of our funding currently goes to more traditional treatment, such as counselling and residential facilities. While these services are extremely valuable, support services are often vital to recovery. For example, peer and whānau support can provide care, knowledge and experience that may not be available through more traditional approaches.

Treatment needs to be culturally appropriate

71. The New Zealand Public Health and Disability Act 2000⁴⁹ recognises and respects the principles of the Treaty of Waitangi, with the view to improving health outcomes for Māori.

72. Māori and Pacific Islanders are statistically more likely to want help for their alcohol and drug use but not receive it⁵⁰. Services need to be culturally responsive to serve these populations effectively.

⁴⁶ <http://dailyhive.com/vancouver/1636-clark-drive-and-1321-1395-east-1st-avenue-vancouver-drug-rehabilitation-centre#.WvhMGoNxDuU.facebook>

⁴⁷ Gossop, M. (2006). *Treating drug misuse problems: evidence of effectiveness*. London, UK: National Treatment Agency for Substance Misuse, National Addictions Centre, National Health Service.

⁴⁸ Matua Raki. (2015). *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services*. Auckland: Te Pou. Retrieved from <https://www.tepou.co.nz/uploads/files/resource-assets/full-report-of-the-adult-mental-health-and-addiction-workforce-2014-survey-of-Vote-Health-funded-services-v2.pdf>

⁴⁹ <http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html>

⁵⁰ Mental Health Commission. (2012). *National indicators 2012: Measuring mental health and addiction in New Zealand*. Wellington, NZ: Mental Health Commission. Retrieved from <https://www.hdc.org.nz/media/2769/national-indicators-2012.pdf>

73. Māori Mental Health and Addiction services have many unique aspects that set them apart from other addiction treatment programmes⁵¹. One of these is meeting the needs and aspirations of Māori, using Māori models of health⁵².
74. Healing from addiction for Māori can look different from Western approaches. It requires an appropriate cultural intervention recognising the relationship between Te Taha Hinengaro (mental health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health) and Te Taha Whānau (family health).
75. Special attention must be paid to the needs of Pacific people and Māori with addictions within treatment delivery. Kaupapa Māori services, iwi-based services and whānau support must all be properly funded.

Prevention and education must be a primary focus

76. We need to acknowledge that alcohol and other drugs are part of our society. Every person will make their own decision whether or not to consume alcohol and other drugs. We need to prepare them to make good decisions and minimise potential harms.

Young people need to develop skills and access support early

77. Strengthening health education would have life-long benefits. Young people need to develop critical thinking skills relating to wellbeing, decision making, and substance use, especially messages around harm reduction. This can be achieved through whole-school approaches, such as the Drug Foundation pilot programme Tūturu⁵³. This programme focuses on reducing alcohol and other drug-related harm and keeping students in school.
78. Young people need education and prevention specifically tailored to them. The young people experiencing the most harm from alcohol and other drugs say they do not see mainstream messages or services as relevant to them. Methods such as peer crowds⁵⁴ will help target at-risk young people to make sure they can access support earlier.
79. To make prevention and education a priority, we recommend:
- Stop schools suspending or expelling students for alcohol and other drug issues
 - Strengthen implementation of the health learning area of the New Zealand curriculum
 - Use evaluated approaches, such as Tūturu, to keep young people in schools.

⁵¹ Te Rau Matatini. (2015). *Kaupapa Māori Mental Health and Addiction Services: Best Practice Framework*. Wellington: Te Rau Matatini. Retrieved from <https://www.mentalhealth.org.nz/assets/ResourceFinder/Te-Rau-Matatini-Kaupapa-Maori-Mental-Health-and-Addiction-Best-Practice-...-MOH-and-Te-Pou-2016.pdf>

⁵² Ibid.

⁵³ <https://www.drugfoundation.org.nz/info/schools/a-whole-school-approach/>

⁵⁴ A 2016 study identified groupings of young New Zealanders with shared lifestyles and influences, called peer crowds. <https://www.drugfoundation.org.nz/policy-and-advocacy/peer-crowds/>

- Fund highly targeted initiatives based on peer crowd study
- Fund research, such as the Youth 2000 study
- Invest in youth services that can work in partnerships with schools.

Changing New Zealand's approach to addiction will prepare us for new challenges

80. New Zealand faces ongoing risk from new and deadly drug trends. The sudden spike in deaths caused by synthetic substances over the past year is one, as is the risk of fentanyl and carfentanyl hitting our shores.
81. To be prepared to meet these challenges we must develop a robust and holistic addictions sector. We need quality harm reduction, proper education, low-threshold and outreach services – all in the context of health drug law reform. We must not miss the opportunity to not only *learn* from this enquiry, but to *implement* findings promptly and with adequate financial support.

KEY RECOMMENDATIONS

Build in accountability

- Re-establish the Mental Health Commission
- Establish systems and structures to ensure DHBs and other agencies commission appropriate addiction services.

Reform our laws to treat drug use as a health issue

- Remove criminal penalties for the possession, use and social supply of all drugs
- Develop a strictly regulated cannabis market
- Put more resources into prevention, education and treatment
- Remove legal barriers to harm-reduction services such as supervised consumption rooms and drug checking.

Fund a destigmatisation campaign to reduce barriers to help seeking and receiving quality treatment

Invest more effectively in alcohol and other drug education, prevention, harm reduction and treatment

- Double the funding for treatment services to eliminate waiting lists
- Fund crucial harm reduction services, like drug checking services and drug consumption spaces
- Ensure a full range of treatment options are funded, including community, iwi, whānau-based and peer support services
- Build in addictions services within other settings, such as the housing first approaches
- Remove all barriers to accessing services
- Support services to provide wrap-around support
- Remove criteria and fund low-threshold services
- Make sure services are culturally appropriate and kaupapa Māori services are properly resourced
- Increase investment in evidence-based alcohol and other drug prevention and education.

Appendix 1: Summary of education and prevention, harm reduction and treatment that are needed in New Zealand⁵⁵

Prevention and education

Service / programme	What it is	Benefits	Cost-benefit
De-stigmatisation campaign	Raise awareness of drug use, challenge myths and stereotypes and increase access to help.	Similar campaigns show positive results. Public attitudes to mental illness improved while the NZ campaign 'Like Minds Like Mine' was running ⁵⁶ .	New Zealand's mental health destigmatisation campaign was calculated to have a cost-benefit ratio of 13.8:1, implying expenditure of \$52 million had generated an economic benefit of approximately \$720 million ⁵⁷ .
Alcohol and other drugs prevention/education programmes	Programmes that prepare people to make good decisions about alcohol and other drugs, and help reduce harms.	Alcohol and other drugs prevention/education programmes range in quality. Good programmes can: - inform people about the risks of alcohol and drugs - help them make good decisions about using alcohol and other drugs, and develop skills to reduce avoidable harms	Cost-benefit analysis from America on a range of drug use prevention programmes show a \$4 to \$10 return for every dollar spent ⁵⁸ .
Large scale health promotion campaign	Promote wellbeing, help seeking and self-help.	- Early identification of any issues - People can make changes as early as possible - Changes can be made without needing professional support	Saves money down the line by reducing the need for professional help and stopping problems before they become more serious.

⁵⁵ This is not a comprehensive list – some interventions may not be mentioned here

⁵⁶ <https://www.likeminds.org.nz/assets/National-Plans/like-minds-like-mine-national-plan-2014-2019-may14.pdf>

⁵⁷ Vaithianathan, R., Pram, K. et al. (2010). *Cost benefit analysis of the New Zealand National mental health destigmatisation programme ("Like-Minds Programme")*. Retrieved from <https://www.mentalhealth.org.nz/assets/ResourceFinder/like-minds-cost-benefit-analysis.pdf>

⁵⁸ <https://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents-in-brief/chapter-3-applying-prevention-principles-to-drug-abuse-prevention-programs/what-ar-0>

Service / programme	What it is	Benefits	Cost-benefit
Whole-schools approach ⁵⁹	NZ school-wide approach to: - support young people to remain engaged in education - reduce substance related harm.	Remaining engaged in education leads to multiple benefits, including increased income opportunities and better health ⁶⁰	There is evidence that keeping young people engaged in education will lead to considerable long term benefits. The OECD estimates ~NZD \$69-78,000 public/private benefit for every person who attains upper secondary or post secondary education ⁶¹ . Cost-benefit analysis from the USA showed that every \$1 spent effective school prevention programmes can save \$18 ⁶² .

⁵⁹ For example, the 'Whole School Approach' is an evidence-informed programme being piloted by the Drug Foundation, supported by the Health Promotion Agency, the Ministry of Education and the Ministry of Health. More information available at: <https://www.drugfoundation.org.nz/assets/uploads/healthy-approaches-to-AOD-in-schools.pdf>

⁶⁰ [http://www.oecd.org/education/eag2013%20\(eng\)-FINAL%2020%20June%202013.pdf](http://www.oecd.org/education/eag2013%20(eng)-FINAL%2020%20June%202013.pdf)

⁶¹ Ibid.

⁶² U.S. Substance Abuse and Mental Health Service Administration. (2008). *Substance Abuse Prevention Dollars and Cents: A cost-benefit analysis*. Retrieved from <https://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf>

Harm reduction

Service / programme	What it is	Benefits	Cost-benefit
More investment in our existing Needle exchange programme, particularly in prisons	Provides clean injecting equipment to stop blood-borne diseases spreading, and provides information and advice.	- Improved injection-related practices (e.g. reduction in needle sharing/borrowing) ⁶³ - Reduction in blood borne infections, such as HIV and Hep C ⁶⁴ . - Promotes drug treatment ⁶⁵	Needle Exchange programmes are very cost effective. One Australian study estimated a future saving of \$1.3-5 ⁶⁶ for every \$1 spent.
Medically supervised drug consumption rooms	A space where people who use drugs can take them under the supervision of medical practitioners.	- Reduces overdose, risk of blood-borne diseases and infections - Access point to other social and health services - Reduces crime, discarded drug utensils etc ⁶⁷ .	Canada reports a benefit-cost of \$5.12 for every \$1 spent ⁶⁸ .
Social detox programmes	A place that someone can withdraw from substances while being monitored and managed without using detoxification medication.	- Abstinence is not a requirement - Low-threshold - Pathway into other services	- Cheaper than other services because it doesn't require medical staff
Take-home Naloxone kits	Naloxone can be used in an emergency to reverse a drug overdose	- Reverses drug overdoses - Reduces the number of drug-related deaths ⁶⁹	One study predicted naloxone take-home kits would prevent 6.6% of overdose deaths and was cost-effective ⁷⁰ .

⁶³ Wilson, D. P., Donald, B., Shattock, A. J., Wilson, D. & Fraser-Hurt, N. (2015). The cost-effectiveness of harm reduction. *International Journal of Drug Policy*, 26(1), S5-11. doi: 10.1016/j.drugpo.2014.11.007

⁶⁴ Ibid.

⁶⁵ Wilson, D. P., Donald, B., Shattock, A. J., Wilson, D. & Fraser-Hurt, N. (2015). The cost-effectiveness of harm reduction. *International Journal of Drug Policy*, 26(1), S5-11. doi: 10.1016/j.drugpo.2014.11.007

⁶⁶ Kwon, J. A. (2012). Estimating the cost-effectiveness of needle-syringe programs in Australia. *AIDS*, 26(17), 2201-2210. doi: 10.1097/QAD.0b013e3283578b5d.

⁶⁷ Australian Alcohol and Drug Foundation (2017). *Medically supervised injecting centres*. Retrieved from <https://adf.org.au/insights/medically-supervised-injecting-centres/>

⁶⁸ Andersen, M. A. & Boyd, N. (2010). A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility. *International Journal of Drug Policy*, 21(1), 70-76. doi: 10.1016/j.drugpo.2009.03.004

⁶⁹ Langham, S., Wright, A., Kenworthy, J., Grieve, R & Dunlop, W.C N. Cost-effectiveness of take-home naloxone for the prevention of overdose fatalities among heroin users in the United Kingdom. *Value in Health: The Journal of the International Society of Pharmacoeconomics and Outcomes Research*, 21(4), 407-415. doi: 10.1016/j.jval.2017.07.014

⁷⁰ Ibid.

Service / programme	What it is	Benefits	Cost-benefit
Drug checking services	People who have already purchased illicit drugs can check what is in them. People can then make more informed and safer decisions.	<ul style="list-style-type: none"> - Tailored harm reduction advice to stay safer - Reduces the number of people who intend taking drugs after finding out the substance wasn't what they thought it was⁷¹. 	
Early intervention services	Regular screening for alcohol and other drug issues, followed by brief intervention. It can help people identify problems early and access support.	<ul style="list-style-type: none"> - Identifies any problems early and connects people to services⁷². 	<p>Treatment, including early intervention and screen tools, are cost-effective⁷³.</p> <p>Intervention as early as possible will help save money down the line because it prevents future issues.</p>
Develop and maintain an Early Warning System	Designed to detect and publish information about current drugs so people can make informed decisions before taking them.	<ul style="list-style-type: none"> - All stakeholders are aware of dangerous drug trends, and new drugs. - Users can make better decisions and health responses can be more targeted. - Tailored harm-reduction advice can be disseminated. 	

⁷¹ NZ Drug Foundation (2017). *Festival drug checking trial: Summary of results (2017)*. Retrieved from <https://www.drugfoundation.org.nz/info/being-safer/party-drug-checking/festival-drug-checking-trial-summary-of-results/>

⁷² Matua Rāki. (2012). *Brief intervention guide: Addressing risk and harm relating to alcohol, tobacco, other drugs and gambling*. Wellington: Matua Rāki. Retrieved from <https://www.matuaraki.org.nz/uploads/files/resource-assets/brief-intervention-guidelines.pdf>

⁷³ Office of Nation Drug Control Policy. (2012). *Fact sheet: Cost benefit of investing early in substance abuse treatment*. Retrieved from https://obamawhitehouse.archives.gov/sites/default/files/ondcp/Fact_Sheets/investing_in_treatment_5-23-12.pdf

Treatment and recovery

Service / programme	What it is	Benefits	Cost-benefit
More beds in residential and detox places (including those that can work under Substance Addiction and Compulsory Treatment legislation)	Live-in services where people can make changes relating to their alcohol and other drug use.	There are a range of residential treatment models. Depending on the model, benefits include: <ul style="list-style-type: none"> - A place to detox - Learning tools to live drug-free - Reducing drug use - Better participation in employment, training, education, and economic activity 	One NZ-based residential facility showed a \$2 return for every \$1 spent ⁷⁴ .
Opioid Substitution Therapy	People using opioids problematically can obtain medication from a safe source and reduce their dependence over time.	Opioid substitution therapy can reduce HIV risk, overdose, criminal activity, illicit opioid use, and financial strain ⁷⁵ .	WHO reported total cost savings up to 12:1. And an NZ study showed \$25,000 saved per life year ⁷⁶ .
Low threshold services	Services that have no entry criteria and do not impose abstinence-only models. Services can include: counselling, peer support, and social workers etc.	Reduces traditional barriers to accessing services. People can get help and treatment where they wouldn't otherwise.	Not available because services can vary greatly.
E-therapy /computerised intervention	Help delivered through technology, e.g. online, apps, and text.	<ul style="list-style-type: none"> - Reduce barriers to accessing help, e.g. location, cost - Can be used in a range of settings, e.g. schools, home etc - Anonymity - Can support changes in short-term use⁷⁷ 	Not available because the types of intervention and mode of delivery can differ greatly.

⁷⁴ King, J. & Stephenson, B. (2016). *Review of outcomes of clients of Higher Ground*. Retrieved from <http://www.higherground.org.nz/wp-content/uploads/2016/03/Review-of-Outcomes-for-clients-of-Higher-Ground-2016.pdf>

⁷⁵ Kermode, M., Crofts, N., Kumar, M. S. & Dorabjee, J. (2011). Opioid substitution therapy in resource-poor setting. *Bulletin of the World Health Organisation*, 89, 243-243. doi: 10.2471/BLT.11.086850

⁷⁶ Ministry of Health (2010). *National opioid substitution treatment providers training programme*. Wellington, Ministry of Health. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/national-opioid-substitution-training-programme.pdf>

⁷⁷ Smedslund, G., Wollscheid, S., Fang, L., Nilsen, W., Steiro, A. & Larun, L. (2017). *Effect of early, brief computerized interventions on risky alcohol and cannabis use among young people*. Retrieved from <https://www.campbellcollaboration.org/library/computerised-interventions-youth-alcohol-cannabis-use.html>

Service / programme	What it is	Benefits	Cost-benefit
Counselling (including co-existing problems)	Counselling includes: - Hot lines - Face-to-face - Group therapy	- Tailored approach - Can focus on underlying causes of alcohol and other drug use	Not available because services can vary so greatly.
Kaupapa Māori services	Māori Mental Health and Addiction services use a holistic approach to recovery and integrate Māori health models. They aim to meet the needs and aspirations of Māori, using Māori models of health ⁷⁸ .	- Culturally appropriate - Often include whānau ⁷⁹ - Better retention rates for Māori clients than other services ⁸⁰	
Peer support (and whānau support) services	Those with lived experience helping others to recover from their alcohol and drug use. There is a variety of peer-support models. E.g. - drop-in centres - online - in person - Al Anon, Narcotics Anonymous	- Increased self-esteem and purpose - Longer periods of wellbeing - Greater social network - Less utilisation of inpatient care - Increased motivation to make life changes ⁸¹ - Higher rates of abstinence ⁸²	Wide variation of services makes it hard to know exact cost-benefit. But costs can be kept reasonably low because it is often based on volunteers.
Continue to improve treatment programmes in prison, including Drug Treatment Units	A range of programmes, workshops etc and units are similar residential services, they focused on learning skills to maintain abstinence.	- Skill development - Tools to reduce alcohol and drug use - Special Treatment Units have contributed to a reduction in reconviction ⁸³ .	

⁷⁸ Te Rau Matatini. (2015). *Kaupapa Māori Mental Health and Addiction Services: Best Practice Framework*. Wellington: <https://www.mentalhealth.org.nz/assets/ResourceFinder/Te-Rau-Matatini-Kaupapa-Maori-Mental-Health-and-Addiction-Best-Practice-...-MOH-and-Te-Pou-2016.pdf>

⁷⁹ Ibid.

⁸⁰ <https://www.matuaraki.org.nz/uploads/files/resource-assets/hui-final-draft-report-to-NCAT.pdf>

⁸¹ Mental Health Commission. *Power of peer support services in mental health and addictions*. Retrieved from <https://www.mentalhealth.org.nz/assets/ResourceFinder/MHC-power-of-peer-support-services.pdf>

⁸² Tracy, K. & Wallace, S. P. (2016). Benefits of peer support groups in the treatment of addiction. *Substance Abuse and Rehabilitation*, 7, 143. doi: 10.2147/SAR.S81535

⁸³ Department of Corrections. (2017). *Annual Report 2016/17*. Retrieved from http://www.corrections.govt.nz/_data/assets/pdf_file/0006/898629/Annual_Report_2016-17.pdf