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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 Pae Ora (Healthy Futures) Bill

Submitted to the Pae Ora Legislation Committee on 9 December 2021

The Drug Foundation is a charitable trust. We have been at the forefront of major alcohol and other drug debates for over 30 years, promoting healthy approaches to alcohol and other drugs for all New Zealanders.

Tēnā koe

New Zealand has high rates of drug use. Alcohol is both our most popular and our most harmful drug. While many experience low or no harm from the drug use, for a small groups of users, drug use - whether legal or illegal - can cause significant harm. Risks include illness, injury, addiction and even death. People who use drugs are generally failed by the health system. Disadvantaged people are more likely to experience harm from their own drug use and are most likely to want help with their drug use but not receive it.

There is not enough help available for people who want it and services are overextended and underfunded. People often have to wait until their problems become worse before they can access help.

We do not currently treat drug use as a health issue and so many people who are experiencing issues with their drug use don't turn to the health system for help. Some of those who do seek help in the health system experience stigma and shame from healthcare providers and don't get the support that they need. Stigma, shame, criminalisation and marginalisation also prevent them for accessing health care generally.

We need to focus more on health approaches to drugs and alcohol for the whole population, and provide support options long before an individual starts to experience serious problems. This is more effective and more compassionate – not to mention cheaper - than waiting to be the ambulance at the bottom of the cliff.

For these reasons, we support the overall direction of this Bill and the health system reforms to achieve an equitable, accessible, cohesive, Tiriti-based and people-centred system that improves health and wellbeing.

We have offered some suggestions to improve the Bill. In particular we would like to see the Tiriti clauses strengthened and improvements to the alcohol levy.

Our submission is structured as follows:

- **PART ONE.** The case for improving how the health system deals with drug use.
- **PART TWO.** Specific comments on the Bill.

Thank you for considering our submission. We also request the opportunity to make an oral submission.

Ngā mihi nui,

Sarah Helm

Executive Director

PART ONE – The case for improving how the health system deals with drug use

Drug use in Aotearoa New Zealand

We have high rates of drug use

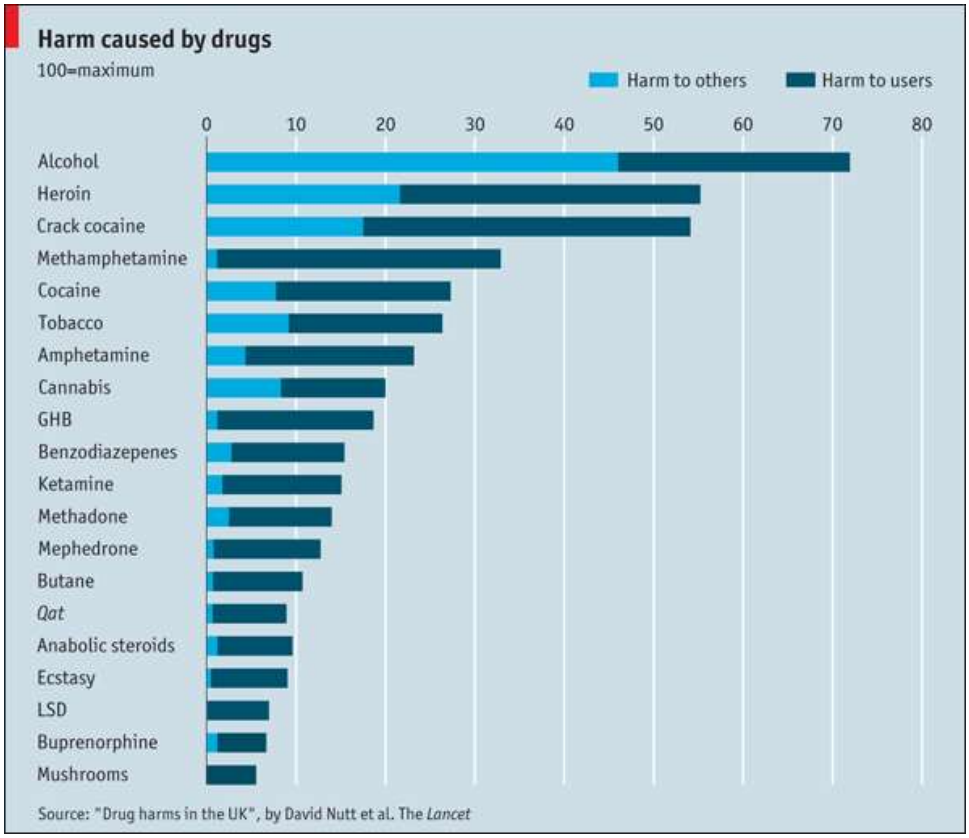
1. The drugs that cause most harm in NZ are alcohol and tobacco. Over 820,000 New Zealand adults drink hazardously.[i]
2. Of the population of New Zealand adults:
    - 79% drank alcohol in the past year.[i]
    - 11% currently smoke tobacco.[i]
    - 15% used cannabis in the past year.[i]
    - 1% used methamphetamine in the past year.[i]

Most drug use is not harmful

3. While it's safest not to use alcohol and other drugs, most people are not harmed much, or at all, by their use. 4 in 5 people who used an illicit drug reported no harmful effects in that year. 7 out of 8 adults who use alcohol report no harmful effects in that year.[ii]

Not all drugs are created equal

4. In a study by the Independent Scientific Committee on Drugs, which ranked 20 drugs across 16 measures of harm, heroin, crack cocaine and crystal methamphetamine were deemed worst for individuals using them.[iii] Alcohol, heroin and crack cocaine ranked the worst in terms of impact on society, with alcohol ranked worst overall. Ecstasy and LSD were ranked among the least damaging.



Why do people take drugs?

5. People use alcohol and other drugs for many reasons, including: pleasure and recreation; spiritual discovery; performance enhancement; experimentation; peer pressure; or to self-medicate physical problems, emotional pain or trauma.[iv]

Why is some drug use harmful?

6. The likelihood of harmful use patterns developing depends on a range of social, cultural and genetic factors. Although chemical addiction can play a part, more significant factors contributing to substance use disorders are trauma and abuse, mental health problems, stress, poverty and housing insecurity.

Drugs can cause serious harm to some

7. For a small group of users, drug use - whether legal or illegal - can cause significant harm. Risks include illness, injury, addiction and even death, with the effects borne by whole communities:

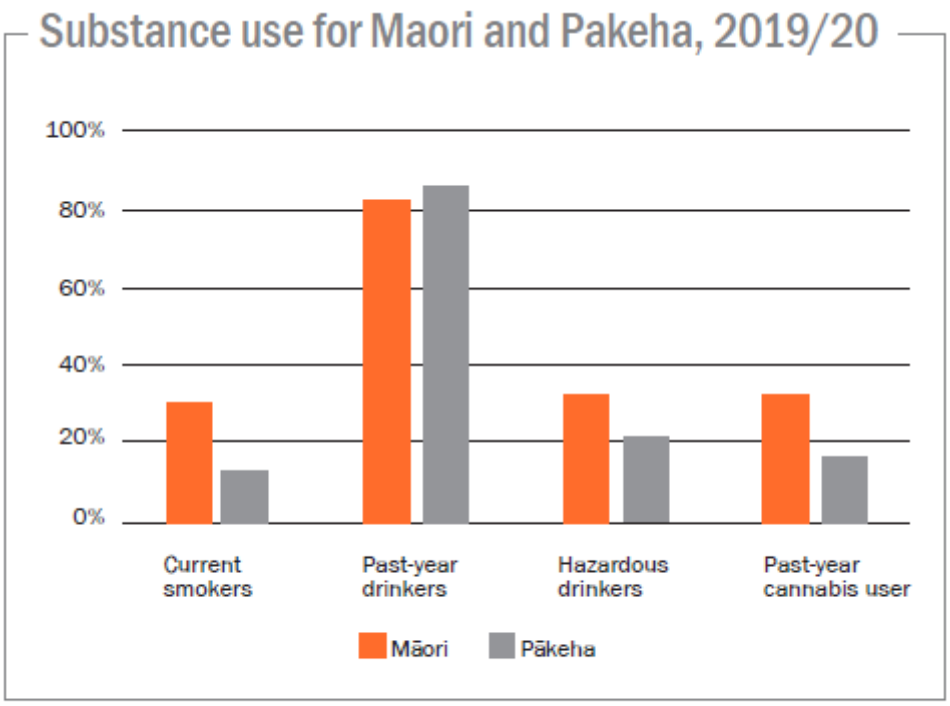
- Almost 1 in 3 New Zealand adults have a moderate to high risk of experiencing health and other problems from their substance use - mostly tobacco (20% of adults) and alcohol (15% of adults).[v]
- About 5000 people die each year from smoking and second-hand smoke.[vi]
- 1 out of 5 New Zealand adults drink in a way that risks physical or mental harm.[i]

The most disadvantaged are often the worst affected

8. Māori, Pacific people and people living in areas of socio-economic deprivation are more likely to experience harm from their own alcohol or drug use. Māori, Pacific people, and those living in deprived areas are most likely to want help with their drug use but not receive it.[vii]
9. 60% of community-based offenders have an identified alcohol or other drug problem and 87% of prisoners have experienced an alcohol or other drug problem in their lifetime.[viii]

Māori have different patterns of drug use and harms to Pākeha

10. Māori continue to disproportionately bear the burden of drug and alcohol harm. Māori are 2.8 times more likely to use tobacco and 2.2 times more likely to use cannabis than non-Māori. The disparity is greater in women for both substances.[i]
11. Māori and non-Māori have similar drinking rates, but Māori are 1.8 times more likely than non-Māori to drink hazardously (in a way that may cause harm).[i]



Source: 2019/20 New Zealand Health Survey

There is not enough help available

12. Around 50,000 New Zealanders receive support to reduce their alcohol or drug use each year,[ix] but estimates suggest that only about a third of those who could benefit from treatment are accessing it.[x]
13. Services are overextended and underfunded. People often have to wait until their problems have become acute before they can access help.
14. When people seek help but cannot access it, their window of opportunity is missed.

People who use drugs generally, and even more so the "hard to reach" are consistently failed by the health system

15. There is a small group of people with more severe problematic use or addiction issues who are consistently failed by the health system (and the educational, housing and social welfare systems). This group have generally suffered adversity and trauma, which has led to their current situation. They often suffer from serious co-morbid physical and mental health conditions.
16. This group is often described as "hard to reach". They have had bad experiences at the hands of the state and are generally distrustful of "the system". Mainstream services generally don't work for them. Some of them

may be Māori but both their and their whānau's experience of colonialism may be so severe that they are disconnected from their iwi, hapū or whānau Māori, meaning even kaupapa Māori services delivered within the iwi-hapū-whanāu framework may struggle to reach them.

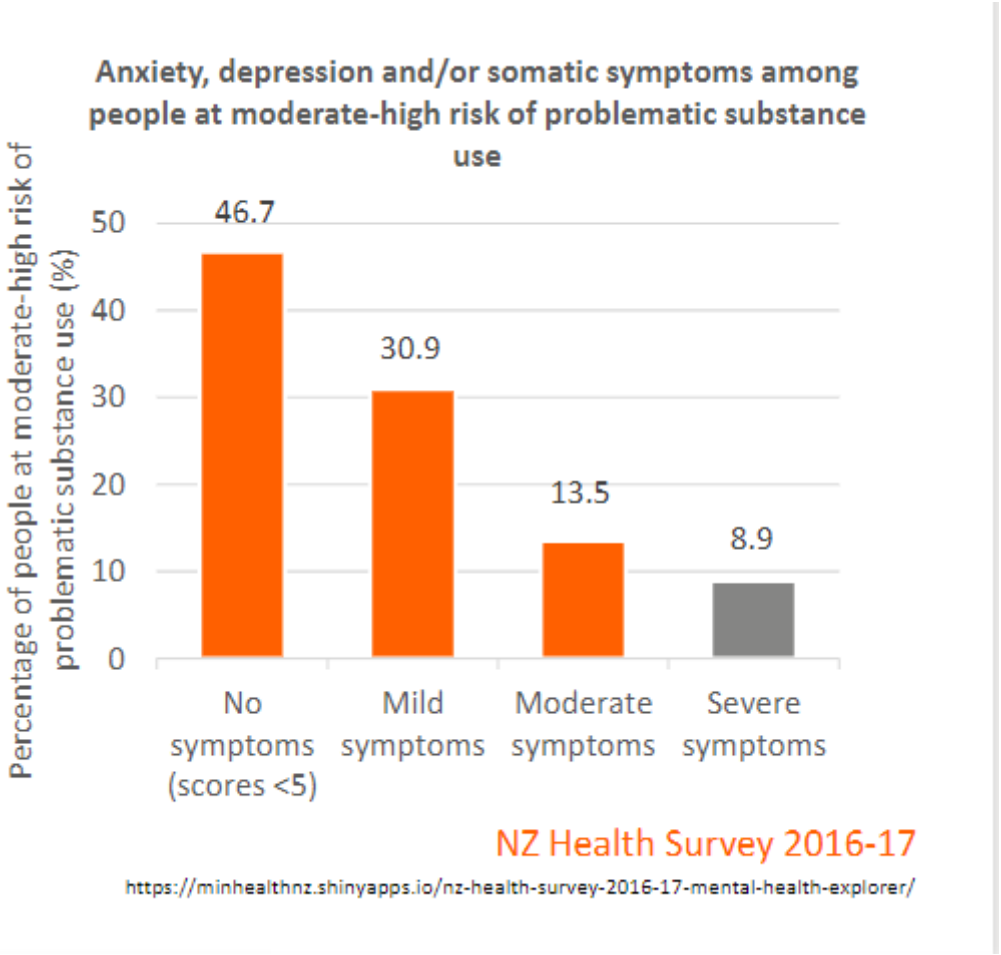
17. We are concerned with the health and wellbeing of this group of people because we acknowledge and respect the inherent dignity of every person. The health and wellbeing of this group also has broader public health consequences for other people in our society because we are fundamentally all connected. This was demonstrated very clearly in our COVID-19 Delta outbreak where we had to abandon an elimination strategy because COVID had become established in marginalised communities.

18. In our view, the success of any health system changes should be measured by how effective it is at improving the health and wellbeing of this "hard to reach" group who are marginalised from the health system.

People should be able to access a full range of evidence-based support options for drug and alcohol use at the time they need them.

19. People face long waiting lists and struggle to access the support they need. There is often little support and information available until someone presents with addiction or is picked up by the criminal justice system. And even then, people continue to face long waiting lists for treatment, despite a welcome increase in funding in the 2019 Budget. The combination of the growing housing crisis and the economic fallout from Covid will continue to exacerbate this existing need.

20. 1.2 M New Zealanders are estimated to be at moderate-high risk of problematic substance use, according to the NZ Health Survey. Yet nearly half of those will experience no clear symptoms to indicate they may be at risk. When we start the conversation when people are 'struggling' we miss most of the people we are trying to reach.[iii]



21. Of the 8.9% - or roughly 100,000 people - who experience severe symptoms, only around half receive support each year, meaning that even for people who are struggling, our services fall well short of what is needed.

We can make a real impact by targeting all levels of use

22. As the Mental Health and Addictions Report, *He Ara Oranga*, recommends, we need to focus more on healthy approaches to drugs and alcohol for the whole population, and provide support options well before an individual starts to experience serious problems. This is more effective and more compassionate – not to mention cheaper - than waiting to be the ambulance at the bottom of the cliff.

To improve the wellbeing of people who may use drugs or be at risk of drug-related harms, we seek the following outcomes:

- Information Everyone has the information they need to be able to live healthy lives, avoid preventable health issues, and reduce the risk of drug-related harm.

- **Support** People who use drugs have support from those around them to live healthy and successful lives, regardless of what stage they're at in their drug use.
- **Community connection and stigma** Shame and criminal sanctions do not prevent people from being part of:
  - communities, workplaces, education or family; or
  - from accessing and sharing information and support.
- **Health services** People get accessible, relevant, and timely support without needing to be in crisis, so they can prevent harm (incidents, addictions, and long-term problems).

  Health issues are managed or prevented through a range of primary and secondary services that are available and appropriate for people who use drugs.

  All people in crisis have effective treatment that is accessible, relevant, and timely.
- **System that understands what causes harm from drug use and focuses on reducing that harm** Effective support is provided to people who are more likely to experience harm from drug use (e.g. those with experiences of trauma, experiencing long-term strain and stress, poverty, groups who already experience discrimination)

  Resources are mobilised around new and emerging harms (e.g. new psychoactive substances, surges in acute drug harm)

Māori need access to kaupapa Māori approaches

23. Long-term solutions for Māori are set out in *Whakamaua*, the Māori Health Action Plan,[xi] which recommends:
    - increasing access to and choice of kaupapa Māori primary mental health and addiction services;
    - increasing the capacity and capability of the Māori health sector;
    - expanding access to rongoā Māori; and
    - increasing provider innovation to develop and spread effective kaupapa Māori and whānau-centred services.
24. Building the workforce will require long-term investment and focus. Ensuring Māori lead the development and implementation of the action plan process is absolutely essential. For this reason, we strongly support the creation of the Māori Health Authority.

Funding for increased support for people who use drugs can be found by changing our drug laws and shifting to a health-based approach

25. Taking a health-based approach to drugs means understanding what causes drug harm and focussing on that. If we only deal with acute issues, and pretend all use is problematic, we push drug harm under the radar until it manifests in crisis situations. To support a shift to a health-based approach, our drug laws need to be updated because they are preventing this shift from happening and compounding stigma.
26. A criminal law approach to drug use also requires large sums of money for policing, courts and prison. A shift away from criminalisation would see money freed up in the justice sector which could be better spent on a health-based approach.
27. There are some shifts towards a health-based approach to drug use, which is more encompassing of harm reduction and demand reduction. Progress has been met with public support – for example, moves to legalise drug-checking.
28. In particular there has been increased investment in addictions treatment, investment in the Tūturu whole school programme, and changes to the Misuse of Drugs Act 1975 to reduce the number of people entering the criminal justice system with low level drug charges.
29. In establishing a funding model that truly meets needs, one challenge will be to ensure that funding is available for innovation. We don't have all the answers yet about what works best. The system needs to be responsive, agile and evidence-based.

PART TWO – Specific comments on the Bill

The term "consumer" is problematic and confusing and doesn't encompass all lived experience

30. The term "consumer" is used throughout the Bill to refer to people who use or have used health services. We do not support the term "consumer" because it implies a market-based system and fails to connote people's intrinsic humanity. It also implies a passivity and a lack of agency in a person's or whānau involvement in their own health care.

Lived experience involvement in the health system is important

31. Lived experience is important for the co-design of quality health services[1]. "People with lived experience" is not a synonym for "consumer". In some situations, people with lived experience have not received health services and wouldn't be classified as "consumers". It is very important to capture the perspective of these people as they can highlight deficits in current services.
32. In addition to lived experience of other health conditions, it is important to include the perspectives of people with lived experience of drug use across the entire health system. This will help shift the health system so that it can meet the needs of people impacted by drug use and addiction.
33. Peers or those with lived experience are also an important part of the workforce in providing support to people who use drugs but we acknowledge that this model is not appropriate in every part of the health system.
34. In the drug and alcohol space, various terms are used to refer to people who have experienced drug harm and treatment such as "people with lived experience", "peers", or "tangata whaiora". We recommend that a consistent term such as "lived experience" is used to replace "consumer" in the Bill, especially in re-naming the "Code of Consumer Participation" in clauses 53 and 54. The only exception to this is clauses 7(c)(ii) and 47(3).
35. Clauses 7(c)(ii) and 47(3) clearly refer to current consumers of health services. We recommend that a different term is used to replace these two uses of "consumer". Alternatives include "citizen" (though not all who receive services are New Zealand citizens) and "patient" (though patient connotes illness and excludes people with disabilities). Even "client" is better than "consumer".

[1] See discussion below on co-design in clause 7.

The purpose of the Bill should include the elimination of health disparities (clause 3)

36. We are broadly supportive of the purpose of the Act

37. Clause 3(b) as currently drafted is slightly illogical. If the purpose of the Act is to "achieve equity" then this must be done "by **eliminating** health disparities" not just "reducing health disparities". We recommend that the drafting of 3(b) is changed to:

    *"achieving equity by **eliminating** health disparities among New Zealand's population groups, in particular for Māori".*

38. The overall tone of clause 3 connotes passivity amongst those receiving healthcare. Words such as "empower" or "uplift" would provide a stronger sense of agency in those receiving healthcare.

The Tiriti references can be improved (clause 6)

39. The current drafting of this clause (and other clauses of the Bill) with the use of brackets around "the Treaty of Waitangi" implies that "the Treaty of Waitangi" is a translation of "Te Tiriti o Waitangi". The Treaty is not a translation of Te Tiriti. They are two different documents with Te Tiriti taking precedence, according to standard legal conventions of interpretation. We recommend that the drafting should acknowledge that the two documents are separate and not translations of each other.

40. We welcome the intention to give effect to the principles of Te Tiriti as this goes much further than the New Zealand Public Health and Disability Act 2000. However, honouring Te Tiriti requires giving effect to the articles of Te Tiriti, rather than principles. This clause should outline how the Bill gives effect to the articles of Te Tiriti.

The Health System Principles can be refined (clause 7)

41. We are generally supportive of the health system principles and have some suggestions for improving them.

Co-design should be recognised in the principles

42. Evidence[xii] shows that services and programmes are best delivered through co-design, working with people with lived experience; and/or former, or current patients/"consumers". We recommend Clause 7(1)(b) be re-drafted as:

*"the health system should engage with Māori, other population groups, **and people with lived experience** to **co-design** and deliver services and programmes that reflect their needs and aspirations, for example, by engaging with Māori to develop, deliver, and monitor services and programmes designed to raise hauora Māori outcomes".*

Cultural competence is better than cultural safety

43. In our view, "culturally safe" is a minimum standard to ensure that someone doesn't feel actively discriminated against. The ideal, which should be enshrined as a principle, is "culturally competent". We recommend that clause 7(1)(d) is re-drafted as follows:

*"providing services that are culturally **competent** and culturally responsive to people's needs.*

Harm reduction is an important principle

44. We strongly support a harm reduction approach to alcohol and other drug issues. Harm reduction is relevant to a number of public health issues and should be more explicitly acknowledged in the legislation. We recommend the following drafting change to clause 7(e)(i) to reflect this:

*"adopting population health approaches that prevent, reduce, or delay the onset of health needs **or harms**"*

Treating mental and physical health equitably

45. We support holistic care. Addiction is often treated as a mental health diagnosis but substance use generally can be linked to important physical health impacts (both acute injury and chronic harm) which also require treatment. Substance use issues benefit from an approach that integrates physical and mental health.
46. The term "diagnosis" can be problematic in the mental health space because some diagnoses are stigmatising. The DSM (Diagnostic and Statistical Manual) frequently changes diagnoses when there are shifts in social or cultural understandings of mental health. "Identify" or a similar word is preferable to "diagnose".
47. We recommend that clause 7(e)(iii) is split into two as the first part focuses on improvements, which can include wellbeing measures while the second part is focussed on dealing with problems.
48. Our proposed drafting is:

*7(1)(e)(iii) working to **equitably** improve both mental and physical health **and wellbeing**; and*

7(1)(e)(iv) ***identifying*** *and treating mental and physical health problems* ***in an equitable, holistic and integrated way****;*

The Government Policy Statement should explicitly include groups with specific needs (clause 32)

49. The Government Policy Statement should include an explicit priority for improving the health outcomes of other specific groups and communities. Groups that have very specific needs which need to be explicitly included are:
    - rainbow and takatāpui communities
    - people who have been marginalised from the health system or who experience multiple forms of disadvantage
    - people who use psychoactive substances
50. As discussed in Part One of this submission, the health and wellbeing of those marginalised from the health system is important for
51. We recommend that the drafting explicitly include these groups alongside Pacific people, disabled people, rural communities and other populations in clause 32(1)(d).

Reporting should have an equity focus (clause 46)

52. We recommend that there is a requirement for the annual performance report to include measures or indicators on progress towards achieving the purposes of the Act (clause 3). In particular we believe that reporting against equity objectives is important for reducing health disparities.

Locality plans should include lived both experience and communities (clause 49)

53. In developing locality plans, Health New Zealand should be required to consult both "consumers"[2] **and** communities within the locality. One is not a substitute for the other and they may have very different views from each other. For example, geographical community representatives may have very stigmatised and ill-informed views on appropriate addiction treatment programmes whereas those with lived experience of addiction would have a very different and useful view.

[2] See discussion above on the term "consumers"

54. We recommend that clause 49(3)(a) is amended to:

"consult **people with lived experience and** communities within the locality".

Levies for alcohol-related purposes can be improved (clause 96 and schedule 5

55. "Alcohol is regulated but is widely available and used in our society. It isn't seen as a drug and our regulation approaches to it are inconsistent and fail to deal with the harm it produces." *Turuki! Turuki! Final report of the Safer and Effective Justice Review*[xiii]

56. Alcohol has never been cheaper, more heavily promoted, or easier to buy. Alcohol is also almost certainly the most harmful psychoactive substance in New Zealand. An Australian drug harms ranking study ranked alcohol as the most harmful drug when harm to users and harm to others was combined. Alcohol consistently tops rankings of harm across the world. Alcohol harm is one of our biggest preventable public health disasters.

57. A 2010 Law Commission Review characterised our alcohol laws as the "unbridled commercialisation of alcohol".[xiv] The Commission put forward a comprehensive suite of proposals, warning that "picking and choosing among the various elements…will lessen the power of the package to reduce harm".[xiii]

58. This is exactly what happened. We have made progress on a few isolated issues, but a comprehensive overhaul of our laws has not yet taken place, and alcohol harm remains sky high.

59. Critical policy solutions proposed by the Law Commission to reduce the harm caused by alcohol include: stricter rules around licensing and opening hours; imposing excise taxes to raise prices; and an end to alcohol advertising, sponsorship and promotions that increase consumption.

60. We also need to invest more into understanding the scale of foetal alcohol spectrum disorder (FASD) in this country, and building capacity to respond to it. There is still no good data on the prevalence of FASD in New Zealand, though the Ministry of Health estimates as many as 3% of births may be affected, at an annual cost of much as $450 million.[xv] Many other gaps remain to fill from the government's 2016-19 action plan, which has now lapsed.

61. We strongly support a levy being placed on alcohol as this increases the price and reduces consumption. The funds raised can also be used by Health NZ and the Māori Health Authority for harm reduction activities. We are however concerned that Health NZ and the Māori Health Authority may neglect functions in this area because of their broad span of operations.

The legislation should specify some activities that part of the levy must be spent on

62. When the Alcohol Advisory Council was disbanded and some of its functions transferred to the Health Promotion Agency, a number of important functions were lost. Other functions were on a much smaller scale because the Health Promotion Agency had other (non-alcohol related) functions and a reduced budget. To ensure that Health NZ continues and enhances work on alcohol-related harm reduction, we recommend that the legislation prescribe that a portion of the levy must be spent on alcohol harm reduction activities. The functions of the Alcohol Advisory Council in the now-repealed Alcohol Advisory Council Act 1976 provide a useful list which can be used with some updating and modernisation of the language.

63. We recommend that clause 96 require that some of the levy must be spent on the following activities:

    a) Research on:
        a. the use of alcohol in New Zealand
        b. Public attitudes to alcohol in New Zealand
        c. Harms arising from alcohol use in New Zealand
        d. Measures to reduce alcohol harm in New Zealand
        e. The effectiveness of existing and new treatment for people adversely affected by the use of alcohol
    b) Public information and education campaigns to inform and educate the public about the harms of alcohol and provide harm minimisation advice
    c) Developing and supporting approaches to reduce alcohol harm for those at risk of hazardous use
    d) Providing treatment for people adversely affected by the use of alcohol
    e) Advocating for appropriate regulation of the sale and advertising of alcohol

The legislation needs to enable the levy to be spent by the appropriate entity

64. The legislative scheme allows for the recovery of levies for the Ministry's costs from addressing alcohol-related harms. The Health Promotion Agency (HPA) is disestablished under this Bill and its functions are transferred to Health NZ. Given that Health NZ would take on the HPA's alcohol-related work and bears the majority of costs for alcohol-related harms, the levy should be designed to reimburse Health NZ, not the Ministry of Health. The Māori Health Authority will also have to address alcohol-related harm and should also receive funding from the levy. This appears to be a drafting error with relatively serious financial consequences for Health NZ and the Māori

Health Authority. We recommend that this is corrected and re-drafted so that Health NZ and the Māori Health Authority receive the levy.

SUMMARY OF RECOMMENDATIONS

General recommendations

1. Treat drug use as a health issue.
2. Provide health approaches to drugs and alcohol for the whole population.
3. Provide support options long before an individual starts to experience serious problems with drug or alcohol use.
4. Improve outcomes for marginalised groups who have previously been failed by the health system, and create accountability in the system for this.
5. Provide kaupapa Māori services to Māori who use drugs or alcohol.
6. Repeal the Misuse of Drugs Act 1976. Rewrite our drug laws taking a health-based approach focussed on harm reduction.
7. Include the perspectives of people with lived experience of drug use across the entire health system.

Proposed changes to the Bill

1. Replace the references “consumer” in the Bill with “people with lived experience” or a similar term, except in clauses 7(c)(ii) and 47(3) change them to “patient” or “client”.
2. Change clause 3(b) to have eliminating health disparities as a purpose of the Bill.
3. The drafting of clause 6 should acknowledge that Te Tiriti o Waitangi and The Treaty of Waitangi documents are separate and not translations of each other. Te Tiriti takes precedence.
4. Te Tiriti requires giving effect to the articles of Te Tiriti, rather than principles. Clause 6 should outline how the Bill gives effect to the articles of Te Tiriti.
5. Clause 7(1)(b) should be re-drafted to include co-design
6. Clause 7(1)(d) should be re-drafted to include cultural competence instead of cultural safety
7. Clause 7(e)(i) should include harm reduction
8. Clause 7(1)(e)(iii) should include an equitable, holistic and integrated approach between mental and physical health. The term “diagnosis” should not be used.

9. The Government Policy Statement should include in clause 32(1)(d) references to:
    - rainbow and takatāpui communities;
    - people who have been marginalised from the health system or who experience multiple forms of disadvantage; and
    - people who use psychoactive substances.
10. Clause 46 should include reporting against equity objectives.
11. Clause 49(3)(a) should require consultation of both "consumers"/people with lived experience and communities within the locality.
12. Clause 96 should be amended to enable Health NZ and the Māori Health Authority to receive the levy.
13. Clause 96 should include explicit activities that a portion of the alcohol-levy should be spent on. We suggest:
    a) Research on:
        a. the use of alcohol in New Zealand
        b. Public attitudes to alcohol in New Zealand
        c. Harms arising from alcohol use in New Zealand
        d. Measures to reduce alcohol harm in New Zealand
        e. The effectiveness of existing and new treatment for people adversely affected by the use of alcohol
    b) Public information and education campaigns to inform and educate the public about the harms of alcohol and provide harm minimisation advice
    c) Developing and supporting approaches to reduce alcohol harm for those at risk of hazardous use
    d) Providing treatment for people adversely affected by the use of alcohol
    e) Advocating for appropriate regulation of the sale and advertising of alcohol

[i] Ministry of Health. (2021). Annual Update of Key Results 2020/21: New Zealand Health Survey. Retrieved from https://minhealthnz.shinyapps.io/nz-health-survey-2020-21-annual-data-explorer/

[ii] 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.

[iii] Nutt, D. J., King, L. A., & Phillips, L. D. (2010). Drug harms in the UK: a multicriteria decision analysis. *The Lancet*, *376*(9752), 1558-1565.

[iv] Denning, P. & Little, J. (2017). Over the influence (2nd ed.). The Guilford Press: NY.

[v] Ministry of Health (2020). Mental Health Data Explorer 2016/17: New Zealand Health Survey [Data File]. Retrieved from https://minhealthnz.shinyapps.io/nz-health-survey-2016-17-mental-health-explorer/.

[vi] Ministry of Health. (2017). Health effects of smoking. Retrieved from: http://www.health.govt.nz/your-health/healthy-living/addictions/smoking/health-effects-smoking

[vii] Mental Health Commission. (2011). National Indicators 2011. Measuring mental health and addiction in New Zealand. Mental Health Commission: Wellington.

[viii] Department of Corrections (2020). Alcohol and other drug treatment programmes. Obtained 4 August 2020 under the Official Information Act 1982

[ix] Ministry of Health (2020). Alcohol and drug treatment data [data file]. Obtained 30 July 2020 under the Official Information Act 1982.

[x] Health and Disability Commissioner (2020). Aotearoa New Zealand's mental health services and addiction services: The monitoring and advocacy report of the Mental Health Commissioner Mental Health Commissioner's monitoring report (page 103). Auckland: Health and Disability Commissioner.

[xi] Ministry of Health. 2020. Whakamaua: Māori Health Action Plan 2020–2025. Wellington: Ministry of Health

[xii] For an overview of the evidence see: King's Fund Further reading resources on experience-based co-design from Evidence-based co-design toolkit https://www.kingsfund.org.uk/sites/default/files/field/field_document/EBCD-further-resources.pdf

[xiii]Te Uepū Hāpai i te Ora – Safe and Effective Justice Advisory Group (2019). Turuki! Turuki! Moving together. Wellington: Te Uepū Hāpai i te Ora – Safe and Effective Justice Advisory Group.

[xiv] Law Commission (2010). Alcohol in our lives: Curbing the harm. A report on the review of the regulatory framework for the sale and supple of liquor. Wellington: Law Commission.

[xv] FASD Working Group (2016). Taking Action on Fetal Alcohol Spectrum Disorder: 2016–2019: An action plan. Wellington: Ministry of Health.