

Policy papers

[41]

Alcohol & Public Health Research Unit . 1999. Advice for purchasing strategy on public health issues: reducing drug related harm. Auckland: Alcohol & Public Health Research Unit. <http://www.ndp.govt.nz/publications/publichealthserviceshandbook-alcohol.pdf> [accessed 2 May 2005].

This report recommends funding strategies to the Health Funding Agency (HFA) and evaluates different drug education programmes.

It points out that drug use in New Zealand is not high and did not increase over the 1990s.

Prevention efforts over the last decade have indicated that no one programme can address all aspects of substance abuse, and that effective approaches are those which are collaborative, draw on the experience of community groups, are tailored to the needs of each group, and are designed with input from those groups.

School-based programmes don't generally seem to work, and often use scare tactics and non-credible sources. DARE and Life Education are specifically mentioned as failures. Peer-led programmes are better. Family programmes are promising.

It recommends that the HFA fund programmes that focus on all drugs in an integrated approach, focusing on addressing norms and availability of drugs, and promoting alternative recreation options for youth. Also Maori-based, school-based, community-based programmes and 'fill in the gaps' programmes, such as funding material for dance party goers.

Discusses abstinence vs. harm reduction approaches, arguing that the former is suitable for non-users, but is not the only possible strategy. Reports on strategies that have been used:

- risk factor (identifying risks, from low-self esteem to parental drug abuse, etc) and trying to target those factors;
- social influence (providing information on negative social and psychological effects of drug use, and providing methods to resist the social influences to use drugs, and altering misperceptions about prevalence of use); and
- developmental: focusing on interactions within the family during childhood.

It is acknowledged that no one strategy will eliminate all abuse.

Media approaches can work if integrated into broader, interpersonal strategy. Slogan-based approaches don't work too well ("Just say no!"), nor do scare tactics. Supply reduction has been shown to have had some success in reducing drug use.

[42]

Alcohol Drug Association of New Zealand. [2004?]. *Drug related harm in New Zealand*. Christchurch, N.Z.: Alcohol Drug Association of New Zealand. <http://www.adanz.org.nz/index.cfm/harm> [accessed 3 June 2005].

Discusses the cost to New Zealand society of drug abuse. Economic costs are known only for alcohol and tobacco, and they are in the billions of dollars per year range.

Drink driving is a cause of over 100 deaths per year. Drug use, especially alcohol, is correlated with suicide attempts. Around 25% of workplace injuries are connected to drug use, again mainly alcohol.

Violence is also related to drug abuse. Again, mostly to alcohol, but there is also a connection to methamphetamine. There are also social costs of drug use.

Social tonics are a new trend in drug use. They are promoted as suitable for helping with methamphetamine withdrawal, but are probably of limited use. A sizeable number of young people are using these drugs. No problems with addiction have been noted, but users should be careful of variation between brands that may mean some pills are far stronger than others.

[43]

Alcohol Drug Association of New Zealand. 2005. *Ecstasy - MDMA*. Christchurch, N.Z.: Alcohol Drug Association of New Zealand. <http://www.adanz.org.nz/index.cfm/drugMDMA> [accessed 3 June 2005].

A good short introduction to ecstasy. Provides information on both the positive and negative effects, as well as discussing what is known about the potential long-term effects it may have on mental health. Provides some sensible advice for users on how to reduce harm.

[44]

Alcohol Drug Association of New Zealand. 2005. *Methamphetamine*. Christchurch, N.Z.: Alcohol Drug Association of New Zealand. <http://www.adanz.org.nz/index.cfm/drugmeth> [accessed 3 June 2005].

A good short introduction to methamphetamine. Provides information on both the positive and negative effects, as well as discussing what is known about the potential long-term effects it may have on mental health.

[45]

Allen & Clarke: Policy and Regulatory Specialists Ltd. 2003. *Effective drug education for young people: literature review and analysis*. Wellington: Ministry of Youth Development. <http://www.myd.govt.nz/pag.cfm?i=394> [accessed 3 March 2005].

Part of a review of best practice in drug and alcohol education. The review aims to improve understanding of the effects of drugs, and of what constitutes effective drug education. It also

aims to reduce drug use and enhance uptake of drug education programmes by schools and communities.

This research found that young people's drug use is shaped by "social, cultural and economic contexts". It found that young people with poor relationships with families and others are more at risk of drug-related harm, and that developing their strengths can reduce the risks of harm. Unsurprisingly, drug education that relates to young people's needs is more effective, and providing accurate information about drugs and drug use is a key part of effective drug education.

The research assumes that harm reduction should be the overall objective of any drug education programme, though it notes that this could include abstinence. It does note that there is evidence that abstinence-only programmes don't work. It provides a number of conclusions and recommendations about the most effective means of providing community drug education. For reasons of space, and because the report does not focus specifically on stimulants, these will not be analysed here.

[46]

Bellamy, Paul, and Jill McNab. 2003. *Methamphetamine ('speed' and 'P') in New Zealand*. Background note: information briefing service for members of Parliament; number 2003/05. Wellington, N.Z.: Parliamentary Library.

[available from the Parliamentary Library for Parliamentary staff only].

An overview of the chemistry, effects, legal status, and social and policy issues surrounding methamphetamine in New Zealand. Reports on the prevalence of methamphetamine use from the *Drugs in New Zealand* surveys [4, 12]. Notes the rise of use among middle-class professionals, "lower socio-economic Māori populations", university students and in the dance scene. Discusses the neuropharmacology of methamphetamine in simple terms. Explains the risk of death and dependency, and that there is little therapeutic use for methamphetamine. Describes the health risks posed by clandestine laboratories, and the links between methamphetamine and organised crime.

Describes the reclassification of methamphetamine to Class A, pointing out that the Green Party voted against this reclassification. Points out that methamphetamine is only Class B in most countries. Discusses control measures, pointing out the poor results obtained from school programmes, and the importance of law enforcement operations and moves to control precursors. Some treatment programmes have been successful in reducing recidivism.

[47]

Bowden, Matt. 2004. *Submission of Social Tonics Association of New Zealand to the Health Select Committee on the matter of Misuse of Drugs Amendment Bill (No 3) and the Supplementary Order Paper*. [Auckland, N.Z.]: [Social Tonics Association of New Zealand]. <http://www.stanz.org.nz/SOP%20Submission%20for%20STANZ%20%20-%20Jan%2020052.pdf> [accessed 4 April 2005].

Provides STANZ's submission on proposed amendments to drug legislation in New Zealand.

STANZ argues that the current system provides "an unhealthy black/white view" of some recreational drugs. Bowden advocates for evidence-based legislation and a "happy medium" between full criminalisation and a total laissez faire approach. He suggests that criminalisation would only create a black market for legal highs.

'Social tonic' is recommended as the appropriate terminology for BZP/TMFPP-based products.

The FDA ban on BZP is based on a misreading of earlier scientific research that makes BZP seem far more potent than it really is.

The current classification scheme under the Misuse of Drugs Act 1975 has classifications for drugs that pose a very high, high, or moderate risk of harm - but none for drugs that pose a low or minimal level of harm. Social tonics are safe, and are being blamed for hospital visits (not admissions) by users who have also consumed illegal drugs. The sale of pure BZP, which has also caused hospital admissions, is condemned, and it is noted that legislation exists to prevent this. Dr Lynn Theron of Auckland Hospital is quoted as saying that in 2003/4 14 people were admitted having taken social tonics, but all but one had also taken alcohol, and some had taken other drugs.

Relative risks of other drugs, as well as motor vehicle accidents and adverse pharmaceutical events are presented, and claimed to be much higher than that posed by social tonics.

STANZ discusses its Code of Practice, and argues that such a Code is a better option for regulation than placing social tonics in the Misuse of Drugs Act 1975: "[i]t is important from a social responsibility point of view to differentiate legal substances from illegal substances so that the perception is not created that one is an extension of the other." Any legislation to control social tonics should be separate from the Misuse of Drugs Act.

STANZ supports the *Guidelines for Safe Dance Parties* [60], including sanctioning members who refuse to adopt the *Guidelines* (especially providing cold running water).

[48]

Brady, Elizabeth. [c1995]. *Drugs used for other than medicinal purposes in New Zealand; Drug and alcohol issues pertaining to children and adolescents; vol. IV.* [Wellington, N.Z.]: [Specialist Education Services].

Reviews the effects of common recreational drugs. Discusses models of drug use and dependence, and how genetics and family background may play a role. Discusses assessment, treatment and prevention.

Has sections on amphetamines and ecstasy. Amphetamine is a bitter white powder, usually imported. It has some medical uses (treating Parkinson's, obesity, narcolepsy). Moderate users may present as restless, alert, euphoric, suffering from dizziness, headaches, irregular heartbeat or altered sex drive. Heavy users may experience agitation, panic, depression, hallucinations, fainting. Long-term users may experience nutritional problems, sleep loss, permanent anxiety, receding gums, high blood pressure and psychoses. Dependence is possible, withdrawal is difficult and may require medical treatment and ongoing counselling.

Ecstasy is “easily manufactured from 3-4 chemicals” and shares “psychoactive and physical effects of LSD”. (Both these statements are highly debatable). It leads to “euphoria, enhanced emotional/mental clarity, enhanced sensual experiences”. It is commonly used by “yuppies and young experimenters”, and not usually mixed with other drugs. The effects last for 6-24 hours (also debatable statements). Research on the long-term effects is inconclusive. There is no research on dependence, but tolerance appears to develop. Psychological dependence is possible, physical dependence unlikely.

The section on amphetamines is generally accurate, and that on ecstasy contains a number of errors or debatable points – obviously reflecting the fact that ecstasy was practically unknown in New Zealand at the time of writing, and little was known about it.

[49]

Expert Advisory Committee on Drugs. 2002. *Advice to the Minister on Methamphetamine*. Wellington, N.Z.: National Drug Policy. <http://www.ndp.govt.nz/committees/eacd/meth-paper.pdf> [accessed 21 April 2005].

Presents evidence on the risks of harm posed by methamphetamine, and recommends to Ministers that the drug should be re-classified as a Class A substance.

Rationale for reclassification include:

- the increase in stimulant use in the late 1990s,
- an increase in the number of users being hospitalised, or seeking counselling,
- increasing number of arrests for drug offences related to amphetamines, in seizures of drugs, and in clandestine laboratories located.

Recommendations for reducing the amount of methamphetamine a person needs to have in their possession before they can be charged with intent to supply are presented.

Police are likely to face increased violence due to the rise in methamphetamine use, both through gang turf wars, and through individuals being more violent as a result of the drug.

Reviews the chemistry of methamphetamine, the long-term effects, the risk of amphetamine psychosis, the fact that there are few accepted therapeutic uses for the drug. Reports the potential for overdose, which, although low, is real. All cases cited are from overseas, which is interesting as other reports have suggested there have been New Zealand cases. The risks of addiction, and the fact that no known treatment for dependence exists, are described. The increased likelihood of methamphetamine users engaging in unsafe sex is mentioned.

The manufacturing process is described, and the hazardous chemicals produced are named.

Every claim made in this paper is backed up with research evidence. It therefore provides a very good overview of the science behind recent government policy.

[50]

Expert Advisory Committee on Drugs. 2003. *EACD minutes*. Wellington, N.Z.: National Drug Policy. <http://www.ndp.govt.nz/committees/eacd/minutes.html> [accessed 14 April 2005].

The minutes from meetings of the Expert Advisory Committee on Drugs, established under the "Misuse of Drugs Amendment Act 2000....to provide expert advice to the Minister of Health regarding drug classification issues." The minutes are high-level and lack detail so aren't discussed further here.

[51]

Expert Advisory Committee on Drugs. 2004. *Advice to the Minister on benzyl-piperazine IBZP 2004*. [Wellington, N.Z.] National Drug Policy. <http://www.ndp.govt.nz/committees/eacd/BZPpaper20045663.pdf> [accessed 13 April 2005].

Provides advice to the Minister of Health on BZP, the main ingredient in social tonics. States that more information on the health effects and prevalence of BZP is needed.

Argues that BZP should not be marketed as a dietary supplement, and regulation, such as sale restrictions, should be considered. Claims that there is no schedule of the Misuse of Drugs Act 1975 into which BZP could be placed. Notes that restricting access to BZP may lead to users seeking more dangerous drugs as a substitute (see the Supplementary Order Paper to the Misuse of Drugs Act 1975). Advertising of social tonics is criticised for not taking into account their impact on younger people.

Notes that BZP has been trialled as an anti-depressant, but has no known human therapeutic use. Notes that users would not use it to an equivalent dose strength as amphetamine, because the side effects become unpleasant at lower doses than this. Notes drug treatment centres are not seeing clients needing help specifically for BZP, though some poly-drug users use it. Notes that the only case of death involving BZP can be attributed to MDMA, not BZP. Also notes anecdotal evidence that it may be problematic in combination with alcohol. Suggests that using BZP may start a pattern of abuse that leads to using harder drugs, but also that the opposite may occur (users may switch from harder drugs to BZP). Notes usage patterns and sales.

Notes there is no evidence of dependence or addiction, but suggests that mild psychological dependence, in order to overcome inhibitions or gain energy, is possible.

This last seems like a very probable, and often under-reported, reason why people develop drug dependencies.

Notes BZP is used as a substitute for illicit drugs due to the cost, risk of conviction, and poor quality of illegal drugs. Notes the Ministry of Health has met with industry, but says industry self-regulation is not recommended as long-term strategy.

Overall, an excellent, if short, piece of work. It seems to identify the status of social tonics in New Zealand society, and the authors are clearly aware of the issues around BZP.

[52]

Health Select Committee. 2005. *Misuse of Drugs Amendment Bill (No 3): Government Bill: As reported from the Health Committee*. [Wellington, N.Z.]: Office of the Clerk of the House of Representatives.

<http://www.clerk.parliament.govt.nz/Content/SelectCommitteeReports/186bar2.pdf> [accessed 3 June 2005].

The report of the Health Select Committee on the Misuse of Drugs Amendment (No 3) Bill. The Committee recommended that the Bill be passed, with some amendments. The Bill lowers the bar for presumption of supply in the case of methamphetamine, and creates new offences of importing precursor substances, along with new powers of search and seizure for precursors.

The Committee recommended the addition of a new Part 3 to the Bill, based on Associate Health Minister Jim Anderton's (2004) Supplementary Order Paper (SOP) [72], which recommended the creation of a new class of controlled substances, for drugs that were not considered a "high or moderate risk" to health, but were still considered to need regulation. BZP is a drug that would fit into this classification. The Committee did propose a tighter recommendation of such drugs than was given in the original SOP, in order to exclude various classes of substance that could be regulated through other legislation.

Specific recommendations on the sale of social tonics are proposed, including the suggestion that they not be sold from licensed premises, owing to possible negative interactions with alcohol.

This is sensible, but probably futile - users will presumably purchase the drugs elsewhere, and take them to the pub.

Manufacturing conditions are recommended, and a total advertising ban is suggested.

Several parties presented minority views: National and New Zealand First were concerned that restrictions on BZP did not go far enough, and believed that the current drug legislation was an appropriate way to control this substance. ACT criticised an amendment that would make it more difficult to downgrade a drug's classification than to upgrade it, as an attack on liberty. The Greens also disagreed with this change, arguing that it was introduced by United Future's Judy Turner because she was afraid that the Greens would use it to downgrade the status of cannabis.

[53]

Inter-Agency Committee on Drugs. 2004. *National drug policy: Inter-Agency Committee on Drugs (IACD): minutes*. Wellington, N.Z.: National Drug Policy.

<http://www.ndp.govt.nz/committees/iacd.html> [accessed 12 April 2005].

The IACD is a "monitoring group of officials [that] ensures that policies and programmes developed by government agencies are consistent and mutually supportive, [and] makes recommendations on new policy initiatives." The minutes of IACD meetings from 2000 to 2004 are available at the National Drug Policy website.

[54]

Inter-Agency Committee on Drugs. 2000-2004. *Drug Policy Update*: Ministry of Health. http://www.moh.govt.nz/moh.nsf/wpg_index/publications-drug+policy+update [accessed 27 May 2005].

A short quarterly newsletter, which aims to "promote, communicate and seek feedback on the National Drug Policy and initiatives undertaken under the policy". It contains articles on possible changes to legislation, on seizures of drugs, on conferences and similar topics.

[55]

Issues paper: towards a national drug and alcohol policy. 1995. [Wellington, N.Z.]: [Ministry of Health] Forward by Hon Jenny Shipley and Hon Maurice Williamson.

A short discussion paper providing scoping material for the development of a national drugs policy. It reviews the evidence on drug-related harm and sets out a possible approach for government. There is a description of legislation and programmes targeted at reducing drug harm.

The proposed policy structure is described, from high-level priorities to strategies and interventions to achieve desired outcomes. Suggested priorities focus almost exclusively on alcohol and tobacco, though in the 'other drugs' area there are suggestions to amend the Misuse of Drugs Act 1975 to align it more closely with the Medicines Act 1981, and to provide more funding for drug treatment workers.

[56]

Ministerial Action Group on Drugs. 2003. *Methamphetamine Action Plan*: [Wellington, N.Z.]: National Drug Policy. <http://www.ndp.govt.nz/publications/MethamphetamineActionPlan.pdf> [accessed 14 May 2005].

Outlines plans to reduce the "prevalence, use and harm associated with methamphetamine use, and outlines the nature and the magnitude of the methamphetamine problem in New Zealand." The goal is a whole of government approach, bringing together actions taken by individual government agencies and by NGOs.

Proposed actions include:

- controlling supply: through changing the Misuse of Drugs Act to allow police to seize precursors, and improved monitoring and surveillance;
- reducing demand: through education and public health programmes and encouraging "resilience and self-prohibition" among user groups;
- limiting the problems: greater resourcing for treatment services, focus on proven treatment methods (behavioural change), improved support and training for drug educators, police and health staff dealing with methamphetamine users;
- research: into dealing with clandestine laboratories, methamphetamine related morbidity, police statistics, research into treatment outcomes, more conferences/symposia.

Current initiatives are reported, including:

- the reclassification of methamphetamine into Class A (allowing police to search without a

- warrant);
- a clear focus by police on the methamphetamine problem;
 - training of specialists to investigate clandestine laboratories;
 - working with pharmacists and the chemical industry to limit access to precursor chemicals;
 - a greater focus by Customs on precursors;
 - research; and
 - police work on the illicit drug monitoring system (IDMS)

Provides a review of the problem, with definitions: speed usually means methamphetamine (5-15% pure) but sometimes means amphetamine sulphate; P means pure methamphetamine (80-90% pure); ice means a smokeable version of methamphetamine, and therefore P and ice are not the same; ya ba is another name for methamphetamine.

Note that P has also been defined, by users and in the media, as the smokeable form of methamphetamine.

Seems generally realistic and evidence-based, although evidence is not really cited. Doesn't imply that every user will experience mental problems ("heavy users may display a number of psychoses").

Describes binges, followed by crashes. Binges last for 2-6 days, followed by a physical and mental crash, including depression, fatigue, cravings to use again.

Reports that methamphetamine use has caused death (including in New Zealand): "the individual started to have hallucinations, seizures, high blood pressure and high pulse rate. The individual then became hypertensive and began bleeding from all orifices and went into paralysis and could not be resuscitated. The cause of death was later determined to be irreversible shock, acute respiratory failure, hepatic necrosis and renal failure from acute methamphetamine and alcohol ingestion."

Dependence is cited as another possible problem. Claims that both physical and psychological withdrawal symptoms are possible, as well as rapid development of tolerance. Withdrawal can include strong physical cravings as well as delusions, hallucinations and paranoia or depression.

HIV through sharing needles, violence and the environmental risk of clandestine laboratories are all cited as public health risks of methamphetamine. However there is no data on hospital admissions (except in Auckland, which reported 36 admissions in 2002).

Seizures of methamphetamine greatly increased over 1996-2001, as did detection of clandestine laboratories. Links between violence and methamphetamine use (overseas) are cited - these are much higher than those in the Wilkins et al 2004 study [24]. Methamphetamine users might take part in crime more for the rush they get from it, compared to opiate users, who commit crime to fund their addiction.

Reports drug testing of inmates - 97% of all positive tests were for cannabis (although of course cannabis stays in one's system for much longer than any other substance).

A well-researched report, presenting research-based evidence, that should be a key resource in the methamphetamine debate.

[57]

Ministerial Committee on Drug Policy. [1999?]. *National Drug Policy Work Programme: cannabis and hard drugs*. Wellington, [N.Z.]: Ministry of Health.
<http://www.ndp.govt.nz/cannabis/ndpcannabis.pdf> [accessed 12 March 2005].

The Ministerial Committee on Drug Policy requested this work programme, with the goal that it would (a) "address the cannabis problem in the Far North and on the East Coast" and (b) "prevent the formation of a hard drugs market in New Zealand". "Hard drugs" includes both ecstasy and methamphetamine, and the report notes the distinctive nature of the ecstasy scene and the growth in the market for both drugs.

Provides background information on the drug scene and the policy response in New Zealand, and how the work programme was developed, including community consultation.

Recommendations include: research; police intelligence gathering; educational programmes; and legislative reviews. Work to improve drug treatment programmes and educate providers is proposed.

It is interesting to compare later reports and see that the same issues crop up. Researchers always complain of a lack of detailed knowledge about the New Zealand drug scene, and about the most effective ways to intervene with drug users.

Some of the proposals detailed in this report have been implemented, notably through the *Guidelines for Safe Dance Parties* [60] and legislative changes to enhance police powers to deal with drug offenders.

[58]

(MCDP), Ministerial Committee on Drug Policy. 1998-2004. *Ministerial Committee on Drug Policy (MCDP)*. Wellington, N.Z.: National Drug Policy.
<http://www.ndp.govt.nz/committees/mcdp.html> [accessed 8 June 2005].

The Ministerial Committee on Drug Policy meets at least twice a year, and is responsible for drug policy decisions in New Zealand.

This page gives details of Committee membership, minutes of Committee meetings, and links to papers prepared for the Committee. The material is mostly generic or high-level. None of the papers relate specifically to stimulants, though some discuss the National Drug Policy [59].

[59]

Ministry of Health. 1998. *National Drug Policy: A national drug policy for New Zealand 1998-2003*. Wellington, N.Z.: Ministry of Health.
<http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/3d31996cabb14acf4c25>

[666f003aee1f/\\$FILE/drugalc.pdf](#) [accessed 6 March 2005].

The government's policy for dealing with drug problems in New Zealand. The approach emphasises strong law enforcement, credible messages about drug-related harm, and effective health services. The over-riding commitment is to minimise drug-related harm through prevention and reduction of use, with a focus on upholding individual rights when these don't impinge on others.

Specific priorities are described: limiting harm of drugs in general, limiting tobacco and alcohol harm, restricting the prevalence and use of cannabis and other drugs, and reducing health risks, crime and social disruption associated with illicit drugs.

Strategic areas include research, health promotion, assessment and treatment, law enforcement and policy.

Supply control and demand reduction are the two key strategic approaches.

Key groups and settings are identified including young people, Maori, polydrug users, pregnant women, people with coexisting drug and mental health problems, schools, prisons. Different strategies are needed to target different groups. Key groups vary from strategy to strategy (e.g. pregnant women are a target group among cannabis users). Polydrug users, and people with mental health and drug problems, are key groups.

This report represents the first time all government policy on drugs has been brought together in one place. In the past, a lack of such coordination has led to a haphazard approach, and also meant that conflicts of interest could exist (for example, fear of police involvement may stop someone calling an ambulance).

Desired outcomes are listed:

1. enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of drug use: acceptance of harm minimisation as goal by government staff, increased involvement of the community, improved treatment options and expertise;
2. reducing the prevalence of cannabis and other illicit drugs: reduction of prevalence of use of cannabis, and especially among named groups, reduction in use of other drugs, reduction in drug use in prison,
3. reducing health risks, crime and social disruption associated with illegal drugs: preventing a hard drug market establishing in NZ, reduction in the availability of drugs, reduction in crime and violence, reduction in blood-borne viruses, reduction in abuse of pharmaceutical drugs and the non-medical use of steroids, reduction in volatile substance abuse.

Future directions include:

- research;
- health promotion (value of remaining drug free, preventing or minimising drug harm, school and workplace programmes, information for at-risk groups);
- treatment (better services for at-risk groups);
- law enforcement (increased cooperation among law enforcement agencies, community policing to reduce drug-related crime, development of drug intelligence systems);

- policy and legislative development (allowing greater surveillance, diversion of precursor chemicals, review of the classification of methamphetamine under the Misuse of Drugs Act 1975, review of drug education and treatment programmes).

The strategy is based on the principles of:

- cost-effectiveness;
- equity;
- harm prevention and reduction;
- upholding individual rights (a specific example is choosing a health promotion approach over law enforcement, if only one can be chosen);
- developing strategies acceptable to Maori.

New bodies are created to oversee this work: a Ministerial Committee, a monitoring group (including Ministries of Health, Education, Justice, Department of Corrections, Te Puni Kokiri, Police, and others), and regular reports from all relevant government agencies.

Provides background information on drugs in New Zealand, focusing on harm to health, crime, and social disruption. Considers legislation, and sets out NZ and international law that relates to this issue. Notes law enforcement staff need to be trained about health risks, so their work doesn't contradict what health workers are trying to do.

It is worth noting that the official government strategy strongly emphasises harm reduction ahead of law enforcement. In contrast, most media attention is focused on legislative and law enforcement measures to control drug use.

[60]

Ministry of Health. 1999. *Guidelines for SAFE dance parties: the big book*. Wellington, N.Z.: Ministry of Health.

[http://www.moh.govt.nz/moh.nsf/0/77E8B252DFAB984B4C25683F001425B9/\\$File/guidelinesforsafedanceparties-thebigbook.pdf](http://www.moh.govt.nz/moh.nsf/0/77E8B252DFAB984B4C25683F001425B9/$File/guidelinesforsafedanceparties-thebigbook.pdf) [accessed 6 March 2005].

Ministry of Health guidelines for operators of dance parties, that do not endorse drug use but aim to reduce the hazards of drugs for those who choose to use them.

They are voluntary guidelines and are not intended to be rigidly applied across all venues and events.

They suggest organisers need to plan for problems associated with alcohol, heat stroke, dehydration, paranoia, and disorientation/anxiety.

Specific recommendations include:

- make free drinking water available;
- control temperature and humidity, provide chill-out areas,
- allow people to take off clothes to stay cool;
- prevent overcrowding;
- ensure staff have first aid knowledge;

- adhere to host responsibility principles (with relation to alcohol);
- ensure there is adequate car parking space, consider providing transport;
- provide first aid facilities,
- provide drug information;
- liaise with emergency services.

This is generally a very sensible document. It follows the government's policy of harm minimisation, and expects dance party promoters to support this. Many of the guidelines are common sense, and would apply whether or not any patrons of the event were using drugs. Those that are specifically drug-related accord with the research evidence on harm minimisation. The only weakness in the guidelines is that they are guidelines only, there is no way for the Ministry to enforce them.

[61]

Ministry of Health. 2002. *Public health services handbook service specification for the prevention of alcohol and other drug related harm*. Wellington, N.Z.: Ministry of Health. <http://www.ndp.govt.nz/publications/publichealthserviceshandbook-alcohol.pdf> [accessed 6 March 2005].

A short guide explaining how the Ministry Of Health funds public health services.

Focus is on community action approaches and environmental strategies, with a lesser focus on health education and other demand reduction strategies. The report claims "clear evidence" shows this is the correct approach.

The community-based policies include implementation and monitoring of policies in communities (councils, schools, marae etc), including developing policies for raves (e.g. *Guidelines for Safe Dance Parties*). The focus is on community members advocating and developing strategies; youth development initiatives (broad ones); early intervention; diversion and community sentencing for young people involved in illicit drug crime; increasing level of awareness of drug-related harm, including for pregnant women; strengthen knowledge in the health sector, monitor programmes, and research effects of drug harm.

It is interesting to compare this approach with how anti-drug efforts are portrayed in the media, where the focus is on punitive and criminal justice approaches to drug use.

[62]

Ministry of Health. 2002. *[Safe dance parties: the small book]*. Wellington: Ministry of Health. [http://www.moh.govt.nz/moh.nsf/0/E3FE49B379C52CA74C25683F0016A782/\\$File/safedanceparties-thessmallbook.pdf](http://www.moh.govt.nz/moh.nsf/0/E3FE49B379C52CA74C25683F0016A782/$File/safedanceparties-thessmallbook.pdf) [accessed 6 March 2005].

A brochure that sets out basic advice on safe party going. It is targeted at party goers, rather than organisers (see [60]). It features minimal text and bright colours. It discusses the risks of various drugs, including the legal risks, and suggests users keep their friends informed as to what they have taken, and stay around people while under the influence.

Advice includes staying with trusted friends, taking a designated driver, and having a back-up transport plan. It suggests checking out the venue on first arriving, in order to identify layout, toilets, security guards, water, exits and meeting points. Means of avoiding heat stroke and drink spiking are suggested. The advice is simple and easy to follow, and backed up with reasons. There are some suggestions on safe sex, but they basically equate to 'carry condoms' and 'be aware of the risk of rape', which aren't especially helpful.

It suggests a checklist of things to take to a rave, all of which are sensible, although many venues wouldn't let customers bring water bottles into the rave (there is the risk that the 'water' is really alcohol, or contains drugs). There are some basic descriptions of common drugs, and good advice not to mix drugs (even noting that alcohol "cancels out the subtle effects" of ecstasy, and that taking ecstasy and speed together can be stronger than taking twice as much of one drug). This is quite useful knowledge and probably gets across the harm minimisation message better than suggesting abstinence, or even just pointing out the negative effects of a drug.

While no sources are cited, the information concurs with commonly accepted medical knowledge, making it a useful resource.

[63]

Ministry of Youth Development. 2004. *Strengthening drug education in school communities: best practice handbook for design, delivery and evaluation: years 7-13: for principals, health teachers, drug education providers and funders of drug education*. Wellington, N.Z.: Ministry of Youth Development. <http://www.myd.govt.nz/media/pdf/handbook.pdf> [accessed 3 May 2005].

This handbook expands on the drug education guidelines by providing processes for evaluating drug education and for assessing external providers for their ability to provide drug education based on evidence-based best practice. It provides a detailed description of drug education best practice; a programme plan and evaluation guidelines; and a checklist of quality expectations for external providers. The clearly stated goal is harm reduction, with a realistic, evidence-based approach to information. A number of specific exercises are suggested for students to undertake. Social tonics, ecstasy and methamphetamine are mentioned briefly in passing.

[64]

National Drug Policy. 2001. *New Zealand country report: Report prepared for the 44th Session of the Commission on Narcotic Drugs Vienna: March 2001*. Wellington, N.Z.: Ministry of Health. <http://www.ndp.govt.nz/publications/NZCtyRpt03B.pdf> [accessed 4 May 2005]

Reports on the drug situation in New Zealand as at March 2001. By international standards New Zealand has few drug problems. Alcohol, tobacco and cannabis are the major causes of drug harm in New Zealand, but there has been a recent rise in the use of amphetamines. Seizures of ecstasy and methamphetamine are reported. The social and economic cost of drug use is noted, mainly in regard to opiate addicts on the methadone programme, or injecting drug users who experience health problems through sharing needles. Discusses government strategies - the National Drug Policy [59] and the various committees that have been formed to focus on this issue. Discusses changes to regulations, enhanced drug monitoring, and education programmes.

[65]

National Drug Policy. 2003. *New Zealand country report: report prepared for the 46th Session of the Commission on Narcotic Drugs, Vienna, April 2003*. Wellington, N.Z.: Ministry of Health. <http://www.ndp.govt.nz/publications/NZCtyRpt03B.pdf> [accessed 3 May 2005].

Reports on the drug situation in New Zealand as at 2003. Cannabis remains the most popular illegal drug, but use of methamphetamine is increasing. Says that law enforcement agencies are noticing an increase in crime, especially violent crime, associated with methamphetamine, and that public health agencies are noticing methamphetamine-related problems. Describes the price and purity of methamphetamine available in New Zealand. Suggests that the use of ecstasy is also increasing, as are ecstasy-related problems. Describes Customs successes in intercepting shipments of illegal drugs, and precursors such as pseudoephedrine. Describes government response to these issues, including the *Action Plan on Alcohol and Illicit Drugs* [66] and the *Methamphetamine Action Plan* [56]. Describes demand reduction and supply control efforts, and details New Zealand's treaty compliance and attempts at regional cooperation.

[66]

National Drug Policy. 2004. *Action plan on alcohol and illicit drugs as at March 2004*. [Wellington, N.Z.]: National Drug Policy. <http://www.ndp.govt.nz/publications/DrugActionPlan.pdf> [accessed 6 May 2005].

Briefly summarises the National Drug Policy's action plan on drugs.

The plan aims at harm minimisation through:

- demand reduction, including providing information on harm caused by drugs;
- supply control: targeting importing and manufacturing, and disrupting organised crime; and
- problem limitation (e.g. harm reduction): effective assessment of needs, and early treatment intervention.

The plan lists specific projects:

- **education** (information gathering, resource development, publishing standards and guidelines);
- **review** of the effectiveness of education programmes;
- **research** into school-based programmes and development of new materials;
- **enforcement**: the re-classification of methamphetamine as a Class A drug, amendments to the Misuse of Drugs Act 1975 to prevent importation of precursors, amendments to the Proceeds of Crimes Act 1991 to allow greater confiscation of profits, the introduction of the Counter Terrorism Bill, allowing installation of tracking devices by police, enhanced border control techniques for customs;
- **treatment**: reviews and stock takes of what services are available;
- **research**: various research projects including Wilkins et al [24].

Compared with earlier policy reports [e.g. 59] this one focuses more on legal strategies and supply reduction/enforcement strategies. The demand reduction or treatment strategies are still at an evaluatory stage.

[67]

New Zealand Drug Foundation. [2003]. *Drugs in focus: a guide to alcohol and other drugs*. Wellington, [N.Z.]: New Zealand Drug Foundation.

Provides information on drugs: effects, legal issues, helping abusers, pregnancy, driving, and information on specific drugs. It is well-written and accurate, though hardly "comprehensive", as it is only 33 pages long.

Overall, the information is basic, but well-presented and accurate, describing both the positive and negative effects of ecstasy and methamphetamine, meaning it avoids being seen as scaremongering.

[68]

New Zealand Police. 2004. [*Safety tips: methamphetamine*]. [Wellington, N.Z.]: New Zealand Police. <http://www.police.govt.nz/safety/meth.php> [accessed 2 June 2005].

Basic information for the general public on methamphetamine and its effects. Most of the article describes the manufacturing process, including hazards and environmental pollution. Advice on recognising clandestine laboratories, such as strange smells, vapour, windows covered, is provided.

A summary of what Police are doing to deal with the problem is included. This naturally focuses on law enforcement activities. The Police focus is on supply control, through shutting down clandestine laboratories, intercepting precursor chemicals, and working with Customs to prevent the importation of drugs.

[69]

Scott, Tom, and Trevor Grice. 2005. *The great brain robbery*. 2nd ed. Crows Nest, NSW: Allen & Unwin.

A humorous, easy-to-read but sometimes simplistic guide to drugs, aimed at parents and children. Covers material such as how to know if a child is using drugs, how to intervene, and how children can say no to drugs.

Includes a short guide to each drug, which contain some errors. Ecstasy and methamphetamine are incorrectly grouped together with GHB as 'designer drugs' (especially odd as there is a separate section on amphetamines). Unsupported and dubious claims include:

- that ecstasy use leads to dependence;
- that the average life expectancy of a P user is 6 years;
- that P is typically manufactured by the 'Nazi method' (which introduces obviously negative associations).

The authors criticise ecstasy for being unnatural, then claim that being natural doesn't make social tonics safe. The short write-up of social tonics is fair, noting that there is little research to

support or disprove claims that they are harmful.

Overall the book takes a 'just say no' approach, and is often sensationalist in its depiction of drugs. This goes against expert advice on drug education [e.g. 63], which suggests education should be realistic and follow a harm minimisation approach.

[70]

Social Tonics Association of New Zealand. 2005. BZP drink withdrawn from dairies, highlights need for control. [Auckland, N.Z.]: Social Tonics Association of New Zealand.

<http://www.stanz.org.nz/images/BZP%20drink%20withdrawn%20from%20dairies.%20highlights%20need%20for%20control.pdf> [accessed 4 May 2005].

STANZ claims that the sale of a soft drink containing BZP is inappropriate. STANZ says that research has 'proven' that BZP-based substances are safe (a debatable point), but that it should not be sold where children could access it. The soft drink manufacturer has voluntarily withdrawn it from sale in dairies, but is continuing to sell it in specialty shops and nightclubs - "places where adults go". STANZ's Matt Bowden claims that the social tonics are reducing the market for illicit drugs.

[71]

Social Tonics Association of New Zealand. 2005. *Code of Practice for the Manufacture, Labelling, Distribution and Marketing of Social Tonics in New Zealand*. [Auckland, N.Z.]: Social Tonics Association of New Zealand. <http://www.stanz.org.nz/Code%20of%20Practice%20-%20%20Post%20Consultation%20Final%20Draft.pdf> [accessed 2 June 2005].

Manufacturing, distribution and marketing of social tonics must display social responsibility, in order to protect consumers and help them make informed choices about using social tonics. The guidelines fill a gap left by legislation, which does not classify social tonics other than as food supplements. There is no evidence that social tonics do cause harm, but there is a perception of risk.

The Code complies with government goals of harm reduction. It includes a risk management classification system, which will classify every substance, and recommend appropriate responses, from warning labels to requirements on ingredients to prohibition. STANZ will also offer quality marks for suppliers. Sets out good manufacturing, marketing and advertising principles.

Discusses an online, industry-based reporting system that will enable users to log issues, and the industry to investigate them.

Contains sensible recommendations, without providing much detail about appropriate manufacturing and advertising requirements. Somewhat defensive about any suggestion that social tonics might have caused adverse health incidents.

[72]

House of Representatives. 2004. *Supplementary Order Paper: Misuse of Drugs Amendment Bill (No 3): Proposed amendments*. <http://www.stanz.org.nz/SOP.pdf> [accessed 2 June 2005].

Presents proposed amendments to the Misuse of Drugs Act 1975.

The amendments would create a new class of drugs, that could be placed under certain restrictions relating to age, advertising, labelling, or signage.

The Expert Advisory Committee on Drugs would have power to evaluate substances and recommend restrictions. The government must consider certain issues before imposing restrictions on a substance, such as lawful uses for the substance, the practicalities of regulation, the risk that changing restrictions would increase abuse of the substance, or would lead users to seek out an alternative and more dangerous substance as a substitute.

Penalties, mainly fines, can be imposed for failing to comply with any of these restrictions. Some classes of people who will be forbidden from selling the substances, and an enforcement regime.

The proposals seem sensible. The amendment provides clear justification for the continued sale of social tonics, which STANZ argues have the benefit of keeping users away from harder, illicit drugs. This is a stated reason to avoid placing restrictions on a substance.

[73]

Turner, Judy. 2004. Meth makers, dealers should pay for endangering children. [Wellington, N.Z.]: United Future New Zealand. http://www.unitedfuture.org.nz/press/show_item.php?t=0&i=881 [accessed 12 April 2005].

The United Future policy on drugs, which includes the provision that "[m]ethamphetamine manufacturers and dealers should have the damage and danger of their products to children and unborn children factored into their jail sentence". The argument is that if the dealers had not sold the drug, the user could not use it and endanger their children.

How exactly the manufacturer of the drugs used by an individual user will be identified is not discussed – perhaps there is an assumption that all manufacturers have caused harm to someone, somewhere.

[74]

United Nations Office on Drugs and Crime. 2003. *Global illicit drug trends 2003*. Vienna: Office of Drugs and Crime. http://www.unodc.org/pdf/trends2003_www_E.pdf [accessed 3 April 2005].

Provides global statistics for sale, use and trafficking of all kinds of illicit drugs. New Zealand's reported use of methamphetamine and ecstasy is one of the highest in the world (3.4% of the population in the last year for each substance). However the report does not cite New Zealand sources, but was compiled with reference to Australian research. Its accuracy has therefore been called into question [88, 124, 164].

[75]

United Nations Office on Drugs and Crime. 2004. *2004 world drug report: volume 1: analysis*. Vienna: Office of Drugs and Crime. http://www.unodc.org/pdf/WDR_2004/volume_1.pdf [accessed 3 April 2005].

Provides statistics and information on the worldwide use of illicit drugs. Results from the *Drugs in New Zealand* surveys [4, 12] are presented. New Zealand has a relatively high rate of use of both methamphetamine and ecstasy. The report suggests that this may be due to a greater willingness to discuss drug use in this country, as doing so may be perceived as being relatively safe.

[76]

Webb, Michael. 1998. 'E' is for - emerging drug policy issue. *Social Policy Journal of New Zealand* (10):86-100.

A comprehensive review of the policy issues surrounding ecstasy in New Zealand. Most people think of opiates and marijuana when they think of illicit drugs, but amphetamine type substances are a growing issue. 9500 pills were seized in 1997, compared with 871 in all years combined up till then.

There is little information on usage rates, though it will probably settle at 1% of the population taking one pill every 2 or 3 months, with 2-3% having ever tried ecstasy. Use of the drug is largely self-limiting, due to its cost and the fact that users experience diminishing returns: the highs become less euphoric, and the lows become worse. Most users are fully functioning, and not involved in crime.

But there are still risks: pills sold as ecstasy might contain something else. There is a risk of polydrug use. Heavy use can lead to depression, psychological dependency (where users feel they are unable to experience intimacy without the drug). Organised crime may become involved in the sale or manufacture of ecstasy.

Government response should include Customs and Police focusing on stopping importation of ecstasy. The Ministry of Health can help with information. Legislative changes can help Police deal with manufacturers and suppliers. Providing harm reduction information is a key goal. Many users rely on hearsay for their drug information. Harm reduction information could be provided in dance magazines, or on the labels of water bottles sold in clubs.

The history and effects of ecstasy are discussed in detail.

This is a groundbreaking piece of work. Webb's recommendations led to the Ministry of Health's Guidelines for safe dance parties [60], and have clearly informed much of policy thinking on this subject over subsequent years.

[77]

Webb, Michael. 1999. The 'A-B-C' of E. *New Zealand Law Journal* (Dec):443-445.

Webb argues that New Zealand's proposal to re-classify ecstasy to Class A is based around a moral panic driven by a view of drug dealers as evil, and by the death of Ngaire O'Neill. Ecstasy has very low risks of death, addiction, and mental illness. The risk of death is estimated at 1 in 3 million per use, based on UK figures. There is no need for a panic about ecstasy when far more harmful drugs, such as tobacco, are available.

He argues that from a legal point of view there is no need to re-classify the drug. Dealers and importers are already receiving penalties at the top end of the scale for Class B drugs. It is unlikely that users would choose to use ecstasy, or dealers choose to sell it, merely because it is a Class B drug. Users are unlikely to understand the penalties for different drug classes. So the change will have little deterrent effect. The government should focus on demand reduction, rather than supply reduction.

[78]

Webb, Michael. 1999. New Zealand's National Drug Policy. *Drug and Alcohol Review* 18 (4):435-440.

Reports on the development of New Zealand's National Drug Policy [59], "one of the clearest articulations of harm minimization as the philosophical thrust behind any country's drug-related efforts". Discusses how the policy was born from the mental health strategy developed under Prime Minister Jenny Shipley, and how it was held up by inter-agency discussions, political considerations ahead of the 1996 general election, and the issue of assigning portfolios after that election.

Sets out policy priorities, and the desired outcomes for each of those priorities (for example, "reduction in the transmission of blood-borne viruses via injecting drug use"). Key groups and settings are named. Notes the gaps in official knowledge about drug use. Describes the establishment of the Ministers' and officials' committees on drugs. Argues that the establishment of these committees is the biggest success of the NDP so far, and that anything else accomplished would have been achieved anyway as part of agencies' core functions. Argues that the NDP may prove to be a Trojan Horse for increased funding for drug and alcohol services. Also seen as important is the NDP's success in 'locking in' harm minimisation as the organising philosophy behind drug-related efforts by public sector agencies.

[79]

Wilkins, Chris. 2002. Designer amphetamines in New Zealand: policy challenges and initiatives. *Social Policy Journal of New Zealand* 19:14-27.

A comprehensive discussion of policy issues surrounding ecstasy and methamphetamine in New Zealand.

Reviews the drug situation in New Zealand – seizures, arrests, drug-related crime and psychiatric patients with drug problems all increased sharply in the late 1990s. Methamphetamine had

previously been confined to 'white' motorcycle gangs who smuggled it in. It was not manufactured due to low demand and a lack of technical knowledge. But with the rise of interest in ecstasy and methamphetamine, beginning in the rave scene, and the advent of the internet, demand had increased and recipes were available.

Discusses the effects of methamphetamine and ecstasy. A detailed and accurate review. Describes the health risks posed by clandestine laboratories.

Designer drugs are described as synthetic drugs that are new substances, not simply copies of plant-based drugs, and have been modified to get around legal restrictions or controls on precursor chemicals. Synthetic drugs have advantages for manufacturers. They are easy to make, can be made quickly (in days rather than the months it takes for cannabis to grow). They can be made year-round, in small scale labs. The precursors are often not illegal – only the end product is illegal (whereas for cannabis, all parts of the plant are illegal). Users may prefer them – seeing them as less dangerous, especially because they do not have to be injected or smoked. They may be associated with affluence, success and modernity.

Recommends a number of policy initiatives, many of which have been adopted:

- revisiting classification of drugs (MDEA is only class C, which may be too low; amphetamine sulphate, methamphetamine, and MDMA are all class B – we should differentiate among them);
- reclassifying analogues: they have a de facto classification of class C – but some are more harmful than the drugs they are analogues of;
- presumption of supply for methamphetamine is too high and should be lowered to be consistent with MDMA and cocaine;
- police should have power to search for methamphetamine without a warrant;
- a new offence of 'intent to manufacture methamphetamine' should be created;
- greater control should be exercised over precursors;
- greater research should be conducted – all drugs seized should be tested, to discover exactly what they are and how they were manufactured; more frequent surveys of drug users should be conducted;
- drug use among violent offenders should be studied.

Many of these suggestions have been adopted: methamphetamine has been re-classified upwards, and the presumption of supply has dropped. Precursors have been brought under stricter control. Wilkins and his colleagues have conducted research along the lines that he suggested [23]²⁵

Although this is a detailed and perceptive work, it's worth pointing out that a lot of Wilkins' conclusions are based on mass media news stories, including [112, 160] and articles by Bridget Martin, author of [140].

²⁵ Wilkins also seems to be conducting research with regular drug users. At the time of writing, leaflets asking regular ecstasy and methamphetamine users to contact Wilkins' research team can be found in many Wellington shops.

[80]

Wilkins, Chris, and F. Scrimgeour. 2000. Economics and the Legalisation of Drugs. *Agenda* 7:334-344.

Reviews and critiques the economic approaches to the debate over drug legalisation. These approaches differ from conventional approaches to this issue, which take either a libertarian stance (arguing that drug use should be legalised, as consequences fall primarily on the user), or a prohibitionist one (arguing either that drug use impacts society as a whole, or that there are moral reasons to prohibit drug use).

Economic approaches take a cost-benefit approach to the issue, analysing the social benefits and social costs of legalisation or of loosening drug laws. Two main approaches are discussed, a simple cost-benefit approach, and a Pigouvian approach, which looks at the marginal social costs of drug use, compared with the marginal private benefits. The former is considered to be too simple, because it would classify a moderately harmful, but widely used, substance as having a high social cost, and therefore suggest it should be banned. The latter approach is recommended, though it has flaws, such as only taking into account the costs that drug use places on society, without considering the costs of prohibition.

[81]

Williams, Dale (ed). 1994. *DARE to support your kids: a drug education programme for parents and caregivers of nine to twelve year-olds: a guide for facilitators*. [Wellington, N.Z.?]: New Zealand Police.

Provides guidance for facilitators running drug education programmes. Much of the content is problematic or disputable.

'Other' drugs are grouped together as "polypills" - a meaningless and confusing name, apparently made up by the report writers. "Polypill users are a very distinctive breed. They tend to identify with groups such as cults, or they are isolated beings ("loners"). They usually have many more emotional, behavioural and psychological problems." Other, equally unsound claims are made throughout. The booklet presents wild conjecture or deliberate misinformation as fact, and goes against all the principles of good drug education programmes (see e.g. [63]).