treatment works week

19 – 24 June 2005

Information Package

On

Drug Use in New Zealand

Updated 2005

Treatment Works Week

The following information on drug use in New Zealand has been compiled and updated over the last six years by ADANZ for the annual Treatment Works Week. It is a compilation of figures and information from a wide range of sources. Over the years as the information has been changed and updated every attempt has been made to include and adjust the list of sources and references, however some may have been lost in the process. ADANZ wishes to acknowledge and thank all contributors.

Treatment Works Week
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This document has not been formerly edited

treatment works week

Treatment Works Week highlights the value of prevention, early intervention and treatment in reducing the associated harm caused by alcohol and other drugs.

Treatment Works Week 2005 will be held from 19 – 24 June. The week will be opened by The Right Honourable Jim Anderton and Sandra Kirby, Deputy CEO of ALAC, at an event in Christchurch on 19 June 2005. This year will be the final Treatment Works Week.

The aim of Treatment Works Week is to make visible the role treatment services play in reducing drug problems and to focus on the consequent benefit to the whole community.

Treatment for alcohol and drug problems is better than no treatment. As a whole it produces net gains for the health care system and is, therefore, a worthwhile and efficient use of financial resources. It has been estimated that for every dollar invested, treatment saves about three dollars in medical spending for the health care purchaser.

There are other economic advantages that treatment might bring. It can result in reduced criminal activity and criminal justice costs, reduced social care and housing demands, reduced accidents as well as productivity and training gains for employers.

Added to these other individual benefits are improved social functioning, reduced arrests for intoxication, impaired driving etc. and reduced expenditure on alcohol and drugs, all of which can be considered as economic and health gains.

We know that alcohol and other drug prevention, education and treatment programmes;

- do work
- are cost effective
- do save lives, and
- contribute to the reduction of crime and illness.

We encourage alcohol and drug treatment organisations to plan a wide range of activities all around New Zealand. We want to educate and reinforce the message in our communities that there is help, support and that Treatment Works!

Treatment Works Week Finale

Treatment works Week is coordinated nationally by the Alcohol Drug Association New Zealand (ADANZ) on behalf of the Alcohol Advisory Council New Zealand (ALAC) who provide funding to support events for this national week.

ADANZ joins with treatment services in New Zealand to thank Alcohol Advisory Council for their support of this week over the past six years. Initial discussions have begun about an Alcohol and Other Drug/ Addiction Awareness Day to replace the national Treatment Works Week. We will keep you posted via our website **www.adanz.org.nz**

Why Does Treatment Work?

The treatment of people with alcohol and other drug (AOD) problems has evolved significantly over the past twenty years. Treatment, as we know it, is less than sixty years old. Treatment is a term used to describe a structured intervention to reduce alcohol and drug use and associated harms.

With increasing recognition of the diversity of people presenting to treatment services, the past fifteen years has seen the emergence of specialist treatment interventions developed for youth, women and indigenous peoples. Most recently, the AOD sector has moved to incorporate greater knowledge about co-existing disorders, that is, working with individuals who present to treatment services with both AOD and mental health concerns.

Recent Developments

Research findings in neuroscience continue to be excellent. We have a better sense about the locations in the brain where processes leading to addiction are initiated and sustained as well as a better sense of how our behaviour is affected. New genetic evidence helps us understand how genes influence vulnerability for addiction.

Recent research shows that advances in drugs such as Naltrexone and Acamprosate offer a number of therapeutic choices for assisting in the management of addictive behaviours, in particular with the use/misuse of alcohol and opiates.

Government drug-funding agency PHARMAC agreed to subsidize Naltrexone (ReVia) from 1 June 2004.

Naltrexone works by stopping people getting the "high" they normally expect from drinking alcohol. It has fewer side effects than the currently-listed treatment disulfiram, has been shown to get better results and can help people better manage a reduction in their drinking. This drug is prescribed by specialists attached to community Alcohol & Other Drug Services.

When self-help groups such as Narcotics Anonymous and Alcoholics Anonymous, and structured treatment interventions are provided together, treatment outcomes appear to be enhanced for many people.

The development of Kaupapa Māori services provides a different set of emphases to mainstream services. Kaupapa Māori services accentuate the interdependence between the individual and his or her spiritual, social and physical environment. Kaupapa Māori services offers choice to Māori and a guide for others who want treatment that places a value on independence, self control and self actualisation.

Many Problems

Individuals experience many different kinds of problems associated with their consumption of alcohol and other drugs. Such problems range from the acute to the long slow decline and from the mild to the severe. The range of difficulties are in turn associated with differing consequences and with effects in different areas of one's life. The social and financial effects from people's misuse of alcohol and drugs have a ripple effect. Many family/whānau, friends and colleagues are affected, illustrating that with alcohol and other drugs, there is not one problem but many.

Working in Treatment

The question that is often put to those of us working in treatment: Does treatment work? And the answer is - Yes, it does!
There are many different methods of treatment for people with alcohol and other drug problems. Every possible effort is made to ensure that each individual receives the kind of treatment most likely to produce a positive outcome for him or her.

The specialised treatment sector is small. The 2004 National Telephone Survey of the Alcohol and Drug Workforce compared results with a similar survey conducted in 1998. The researchers estimated the current treatment workforce consisted of 800 workers. In comparing the 2004 workforce with the 1998 workforce, the survey found that the mean age of workers had increased from 42 to 47 years, with a marked drop in the number of workers aged under 35 years. The study showed an improvement in staff retention. Additionally, there was a substantial increase in the qualification level of the workforce, with a dramatic decrease in pre-tertiary qualifications accompanied by a large increase in those with post-graduate qualifications.

Workers from differing backgrounds provide treatment in an estimated 264 varied services for an estimated 30,000 people each year for a cost of approximately $74 million, this includes a range of intervention services, workforce development and research. These figures do not take into account people treated or money spent in private services or in correction facilities.

What Sorts of Treatment?

Although direct and relatively straightforward treatment within community settings can deal effectively with a substantial proportion of the population with alcohol or other drug problems, others will need specialised treatment.

People may receive a brief intervention if the problems are milder, encouraged to join a self-help group, get intensive counselling over a number of weeks, perhaps after a medical detoxification, and if the problems are severe, then residential treatment or a therapeutic community might be chosen.

For many people, good quality personalised information gained from a comprehensive assessment is sufficient to bring changes, perhaps abstinence or controlled use of their alcohol and other drugs.

Anecdotal evidence suggests consumers/ tangata whaiora might want help to resolve ambivalence about making changes, support, pragmatic problem management, access to essential resources and some help with decision making. Less than 10% ask for intensive counselling.

What does Treatment Works Mean?

No single treatment approach has been demonstrated to be superior to all others. There is no ‘cure’ for ‘addictions’, only changes in life style and thinking patterns that avoid the persistence of the problem. The overall goal of treatment is to reduce or eliminate the use of alcohol or other drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of associated problems.

In truth, the benefits of treatment may well be an effect of its power to support natural healing processes and support the individual and his or her environment in their efforts to manage a drinking or drug problem. Most treatment services are based on wisdom, tradition, clinical experience, and plausibility: all are valuable, indeed necessary, parts of any treatment effort.

Ian MacEwan
Senior Project Manager
National Addiction Treatment Workforce Development Programme

LEGAL DRUG USE

When used responsibly, most legal drugs (with the exception of tobacco) are not harmful. At the same time, legal drugs are responsible for most drug-related harm in New Zealand. In particular the emergence of legal party drugs and increased popularity of Nitrous Oxide has introduced a broader range of risks to people seeking legal drug alternatives.

Alcohol

Alcohol is the most commonly used drug in New Zealand and research shows that risky drinking is the most harmful pattern of drinking. A recent study defined binge drinking as the consumption of five or more standard drinks on any one occasion for 12-17 year olds and seven or more standard drinks for adults over 18.

Results from this study, *The Way We Drink* (BRC Marketing & Social Research and Alcohol Advisory Council), compares the use and attitudes of young people and adults in New Zealander in 2003. In this survey, of the 626 young people aged 12-17 years 82% had tried alcohol compared to 96% of the 1,157adults 18 years and over; 52% of young people and 81% of adults, a total of 78%, defined themselves as current drinkers.

Three percent of young people and 16% of adults drink every day or almost every day; 10% of young people and 26% of adults drink 2-3 times a week; 15% of young people and 22% of adults drink once a week. Nineteen percent of young people and 19% of adults drink once every 2 weeks. Fifty three percent of young people and 27% of adults drink less frequently.

With regard to risky drinking,of the young people, 33% drank a quantity of 5 drinks or more in their last drinking occasion, 38% and 27% of those were male and female respectively. Of a total of 24% of the adults who drank 7 or more glasses of alcohol in their last drinking occasion 32% were males and 17% females.

Figures from Statistics New Zealand (2005) state the total volume of alcoholic beverage available for consumption in the year ended December 2004 was 444.7 million litres, an increase of 1.9 percent compared with the year to December 2003. Wine and spirit production accounted for this increase. Total wine available increased by 5.9 percent and spirit and spirit-based drinks increased by 9.4 percent. There was a 0.2% decrease of available beer over the same period.

Legal Party Pills

Legal highs or ‘herbal’ highs have become the trend and the preferred choice of many young people. In New Zealand during 2003 over 1.5million party pill capsules were manufactured. Estimates place sales of ‘party pills’in NZ as high as 6 million capsules in the last 6 years.

Correspondingly, there are an increasing number of reports regarding people being admitted to hospital emergency departments experiencing high levels of anxiety, nausea, increased heart rates, hallucinations and life threatening seizures and who require close monitoring as the effects wear off.

At present these ‘party pills’ are legal, are advertised, marketed and sold on the internet as well as over the counter in many ordinary retail shops that are patronised by young people. Additionally, they are

openly available from stands and booths at dance parties and music events and often given away as prizes on radio stations.

The recent amendment to the Misuse of Drugs Act includes the introduction of a class 'D' and will allow for guidelines to be put in place to regulate pills and substances containing BZP and any other new drugs that fall within this category.

Party Pills are frequently described as a safe alternative to illegal party drugs such as methamphetamine and ecstasy. The synthetic chemical Benzylpiperazine (BZP) found in 'herbal' highs is a Central Nervous System stimulant with an effect similar, but less potent to hallucinogenic-amphetamines. The use of the term 'herbal' in the marketing of BZP pills has resulted in a perception that these drugs are a healthy, safe or natural alternative. They are only as natural as any medication a doctor would prescribe but their contents and dosage are less controlled. These pills are usually sold in containers of two or four and may state a dose of two tablets initially, however this should be treated with caution, due to variables such as uncontrolled manufacturing process, inappropriate packaging, and product bulking.

Nitrous Oxide (NOS)

There is increasing accessibility to inhalants such as nitrous oxide in commercial and social settings such as convenience stores, bars and night clubs. Nitrous oxide is the most likely of the gases to be abused. Also known as NOS it is most commonly sold in dairies, convenience stores and increasingly, 'party pill' or 'herbal high' shops.

Harms identified by the New Zealand Society of Anaesthetists of long term and high use of NOS include the potential for permanent damage to the spinal cord and depression of the body's immune function. When alcohol and NOS are mixed, vomiting and subsequent choking may result. Nitrous oxide for industrial, culinary, or motor racing use is not pure and may contain highly toxic levels of contaminants such as ammonia, nitric oxide, and nitrogen dioxide; inhaling these contaminants can be lethal if they are present in sufficient quantity. As an anaesthetic gas nitrous oxide depresses consciousness. Nitrous oxide also interferes with the metabolism of vitamin B_{12} and folate; this effect has been implicated in foetal damage in early pregnancy.

In April –this year the Ministry of Health warned that nitrous oxide imports would receive greater scrutiny. After a review of the law this month, the import, sale, possession and use of nitrous oxide as a "recreational drug", instead of as a prescription medicine was found to contravene the Medicines Act 1981. As such, the Medicines Act provides mechanisms to prevent the import, sale, possession, and use of nitrous oxide for inhalation for non-medical purposes.

Tobacco

Tobacco use has generally declined in the last twenty years and many current smokers want to quit or cut down their tobacco use. However, there has been an increase in smoking among young people 15-17 years. An estimated 19,000 young New Zealanders start smoking each year.

Smoking prevalence is generally highest amongst the 25-34 age group according to figures published in 2003 by the Ministry of Health's Occasional Report No. 20. In 2002 smoking prevalence was slightly greater than one in five people for the European/Other population, a decrease of 3% from the early 1990's level. Nearly half of Maori people (49.2%) were smokers at 2002, and more than one in three Pacific people (35.2%).

The downward trend of smoking prevalence in European/Other populations is not evident in Maori and Pacific people. In fact, Pacific peoples' cigarette smoking prevalence was higher than any year since 1990. At this time it is too early to ascertain whether this figure is the beginning of a new and upward trend.

The differences in smoking prevalence in these populations is partially accounted for by the Pacific and Maori populations being relatively younger, with prevalence being higher in younger age groups. Once adjusted for age the difference in smoking prevalence is reduced.

Non-medical use of prescription drugs and over-the-counter medications

There is very little data about non-medical use of prescription drugs and over-the-counter medications. Benzodiazepines (tranquilisers), analgesics, steroids, ritalin, morphine and codeine products are the major drugs in this category. Studies of substance abuse services in New Zealand suggest that more than half the drugs abused come from legal prescriptions.

Benzodiazepines are a popular drug of misuse, with men more commonly reporting use for recreational purposes than women. Some 2.3% of those surveyed in 1998 reported trying benzodiazepines (3% of men and 1.5% of women), while 0.6% reported being current users.

ILLICIT DRUG USE

Statistics about illicit drug use are difficult to obtain and validate. Other than cannabis, most illicit drugs are used regularly by a very small percentage of the population. However comparing figures from 1998-2001 the Alcohol and Public Health Research Unit (APHRU) 2002 state that the number of people who had used illegal drugs other than cannabis, such as ecstasy, amphetamines and methamphetamine increased.

Cannabis

The National Drug Policy review notes that cannabis is undoubtedly the most widely used illicit drug and the third most popular drug in New Zealand, after alcohol and tobacco.

According to figures from Drug Use in NZ (APHRU, 2002) there are no significant changes in the patterns of use of cannabis. Half of those surveyed in 2002 had tried cannabis compared to 52% in 2001. Of those who had tried cannabis 30% had done so before the age of 15.

The highest average number of 'joints' smoked by age group was found in the 15 -17 year olds. In 1998 this was 0.87 'joints' compared to 0.83 'joints' in the same age group in 2001.

The Report of the New Zealand Police for the year ended 30 June 2004 states, that in a major operation against cannabis growers and suppliers carried out between November and April 619 people were arrested on a range of charges. An estimated 115,000 plants and 92 kilograms of dry cannabis plant material recovered and destroyed.

Hallucinogens

The most commonly used hallucinogens from the 1998 survey are LSD, hallucinogenic mushrooms and ecstasy. Around 13% of respondents had tried at least one of these drugs, with 6% having done so in the last year, and 4% reporting being current users.

The percentage of those who had used ecstasy had increased from 0.4% in 1990 to 2% in 1998. Men aged 18-24 had the highest level of ecstasy use at around 9% of those surveyed. There has been a significant increase in the number of people who report having used some type of hallucinogen, 12% in 1998 to 15% in 2001.

Stimulants

Stimulants include drugs such as amphetamines and cocaine. Around 9% of those surveyed in 1998 had tried at least one stimulant. Three percent had used stimulants in the past year and 2% were current users. As with other drugs greater proportions of men (9%) than women (6%) reported trying stimulants and the highest users of stimulants were men aged 18-19 years (12%).

The National Drug Survey found that 3.4% of people had used MDMA (ecstasy) in the twelve months prior to the 2001 survey, compared to 1.5% of people surveyed in 1998. In 2001 ecstasy had become the most commonly used hallucinogenic drug. In 2001 5.4% had ever tried ecstasy compared to 3% in 1998. Current users accounted for 2.3% in 2001 an increase from 1% in 1998.

In 2003, the NZ Customs Service seized 249,000 tablets (or powder equivalent) of MDMA. There has been a 2600% increase in the level of seizures since 2000. It also indicates that international trafficking of MDMA into New Zealand has also increased since 1998.

The findings from the 2003 drug treatment workers survey, confirm that amphetamine use is now impacting on alcohol and drug treatment services to the extent that about one in five patients now cite amphetamine, alone or in combination with other drugs, as their main substance use problem. This confirms that increases in amphetamine use in the general population, identified in other research over the last five years, are now translating into a sizable increase in treatment demand for this drug type.

Methamphetamine (P)

According to a United Nations Survey 3.4% of New Zealanders were users of Methamphetamine in 2001, second only to Thailand. Referrals for Methamphetamine use have jumped from 5.8% in 1999 to 23% in 2003 in Auckland. Christchurch Hospital staff have reported a rise in the number of people presenting at the emergency department with methamphetamine-related problems. In Auckland, emergency department admissions showed that 36 people presented with methamphetamine related conditions between 1 January 2002 and 31 October 2002.

Both the Centre for Social and Health Outcomes Research and Evaluation (SHORE) and The National Addiction Centre (NAC) in Christchurch have been conducting research. The following information is taken from The Socio-Economic Impact of Amphetamine Type Stimulants (ATS) in New Zealand Final Report (SHORE, 2004).

ATS drug users were disproportionately male and aged 18-29, heaviest use being among 20-24 year olds. However, several characteristics of the ATS using population set them apart from other illicit drug using populations. ATS drug users had high levels of full time employment, came from a range of occupational backgrounds including professionals, earned mid-level incomes and had relatively high levels of educational achievement. Large numbers of ATS drug users, including frequent users, were European. Disproportionately more ATS users lived in urban settings, in the upper half of the North Island and in Auckland.

Informant groups of law enforcement officers, treatment workers and current drug users were asked if they had noticed any change in the number of people using methamphetamine in the last six months.

Nearly all of the enforcement informants (98%) thought the number of people using methamphetamine had increased in the last six months. Similarly, the overwhelming majority of treatment informants (80%) thought the number of people presenting for methamphetamine problems in the last six months had increased. User informants presented a slightly different picture. While the majority of user informants (57%) thought the number of people using methamphetamine had increased, 21% believed there had been a decrease in use in the last six months.

The new user populations most commonly reported by all three informant groups were 'teenage users' and 'business people'. User informants also noted more 'young women', 'lower socio-economic' and 'Maori/Polynesian' users. Treatment key informants noticed more 'young women' users. A Massey University 2002 study found the biggest increase in Methamphetamine use among 15-17 year olds.

The SHORE report found that approximately one third of those who had used an ATS drug in the last year reported experiencing harm in at least one area of their lives from the use of ATS drugs. About half of the frequent methamphetamine users interviewed reported harm in the areas of 'friendship and social life' (55%), 'health' (55%), and 'energy and vitality' (53%) from their methamphetamine use.

The harms that frequent methamphetamine users most often rated as 'very serious' or 'extremely serious' were in the areas of 'work and work opportunities', 'outlook on life', and 'friendship and social life'.

The most serious problems reported by frequent methamphetamine users were psychological rather than physical. About 40% of frequent methamphetamine users reported pre-existing psychological problems. Levels of psychological problems increased after using methamphetamine with about two-thirds of frequent methamphetamine users reporting 'anxiety', 'mood swings', 'short temper', 'paranoia', and 'depression'. Twenty-one percent of frequent methamphetamine users reported 'suicidal thoughts' and 13% 'suicide attempts' after using the drug.

Methamphetamine is manufactured using the precursor ingredients ephedrine and pseudoephedrine. China is one of the largest producers in the world of medications containing these drugs and the source of the majority of illegal importation. A report from the New Zealand Customs service states that 1.8 million ephedrine and pseuodoephedrine tablets in 525 cases were seized during 2004. Already, over 230,000 tablets in 119 cases have been seized in 2005 as at March 30.

In the year ending June 2004 the NZ police busted, seven clandestine laboratories along with 71 grams of methamphetamine. The range of charges faced by the offenders clearly illustrated that people involved in one line of drugs are often operating in others, either as growers and manufacturers or as suppliers and distributors.

Opiates

Opiates include heroin, home-bake, morphine and poppies. Around 4% of those surveyed reported they had tried at least one of these drugs. Around l% had used opiates in the last year while 0.6% were current users.

Gambling

In 2004 gambling was moved from Public Health to Mental Health, a move that over time will change the way treatment services integrate substance and gambling interventions.
Numbers of new clients for problem gambling treatment services in New Zealand

- 2001 = 5277
- 2002 = 6171

- 2003 = 6730.

Approximately 90% of these new clients cite pokies (casino and non-casino) as the primary cause of their gambling.

The Problem Gambling Foundation point out that

- $35 million is gambled every day in New Zealand
- $5.5 million is lost every day by gamblers
- Gambling machines are the primary mode of problem gambling
- In June 2004, there were 22,497 pokie machines in New Zealand
- $11.6 billion was the gross annual turnover for gambling in 2002

Amongst those individuals whose gambling is identified as pathological, almost half drank in a hazardous or harmful way, compared to those whose gambling was considered less serious. There is also evidence to link problem gambling, alcohol and suicide Penfold (2004).

ADDICTION RELATED HARM

Knowing about addiction, behaviour and how many people use various drugs does not indicate the extent or nature of addiction related harm. What becomes important in measuring the extent of this harm is the pattern of behaviour and the impact of drug use or gambling on the individual, their family, friends and community.

Attributing a cost to drug-related harm or gambling is complex with no clear method existing therefore estimates vary widely. The following economic, social and health costs are based upon research conducted in New Zealand over the last few years.

Economic Costs

A New Zealand study by Brian Easton estimated net tangible costs of alcohol abuse in 1990 at $2.9 billion. According to Easton's study the net tangible cost of smoking in New Zealand for the same year was $1.2 billion. Net tangible costs are based upon a range of drug related harms including premature death, lost productivity, reduced working efficiency, excess unemployment, increased hospital and other health costs, increased law enforcement costs etc.

New Zealand spends approximately $74 million on drug treatment services each year and the government collects more than $1 billion in alcohol and tobacco taxes and excise.

A report commissioned by ALAC in 2002 show that fiscal costs for alcohol misuse (2002/03) are:

- Public health $655 million, (7.8% of public health budget)
- Production losses $1165 million (0.9% of GDP)
- Other government spending costs $330 million (0.8% of government spending).

Newly identified costs are

- Crime and related costs $240 million (20% of the law and order vote?)
- Social welfare spending $200 million (10% of selected benefits?)

These figures equate to the gross fiscal cost of $2150-2590 million compared to the Revenue from excise duty of $510 million (incl GST).

ALAC estimates that the cost to Government is six times more than the revenue from taxes.

Social Costs

The latest social cost of drinking related crashes was about $760 million (about 23% of the social cost associated with all injury crashes).

Drugs have a major impact on crime, violence, accidents, family functioning, and productivity, not to mention the loss of human life and human potential. For instance, the latest Drinking in New Zealand survey found that 8% of men and 5% of women had been assaulted in the last year by someone under the influence of alcohol.

In the 1998 national survey self-reported harmful effects highlighted by users of alcohol and cannabis included loss of energy and vitality, financial and health problems and adverse effects on relationships with family and friends. Eighteen percent of current cannabis users identified it as having harmful effects on their friendships and social life.

It is estimated that on average for every person who seeks treatment for alcohol and other drugs use, there are 10 significant others whose lives are affected.

Suicide

- Dependency on gambling, alcohol and other drugs has been associated with increased risk of suicidal behaviours.

- Research evidence suggests a stronger impact of alcohol abuse on attempted suicide rather than completed suicide after controlling for psychiatric morbidity.
- Between 20-50% of young people are intoxicated at the time of their death by suicide.
- 25% of young people presenting to general hospitals following a suicide attempt, have involved some level of harmful or dependent use of alcohol.

Drowning

- Drowning is the third cause of injury deaths across all age groups internationally and in New Zealand. A study in the Auckland region found that between 1988 and 1997 those people that had drowned, 40% had positive blood alcohol levels.
- One quarter of European/Pakeha students (24.7%) and one third of Maori students (32.4%) either or sometimes or frequently used alcohol/drugs in association with swimming activity, whereas most Asian students (85.9%) and Pacific Island students (81.2%) never used alcohol/drugs.
- When doing other aquatic recreational activities, one fifth of all students (18.9%) reported that they never wore lifejackets, or had used alcohol/drugs during aquatic recreation (21.0%).

A recent report on the circumstances surrounding drowning in those under 25 in New Zealand (1980-2002) showed that young people aged 15-19 years drowned predominantly in MVAs and 28% of deaths in this age group involved alcohol.

Workplace

Limited information is available on workplace injuries in New Zealand, the following figures are from 2001. Evidence usually refers to loss of productivity.

- 20-25% of occupational injuries involve intoxicated workers.
- Reduced productivity in the workplace due to alcohol misuse represents a significant cost to industry.

- The cost of alcohol related productivity among the working population of New Zealand is estimated to be $57million per year.
- The cost of impaired work performance is estimated to be $41 million nationally.

Health Costs

Over 35% of injuries in the emergency department at Auckland Hospital are the direct result of alcohol, the majority affecting young men as reported by Casswell and Humphreys in 2003. When the legal purchase age for alcohol dropped from 20 to 18 years, the same emergency department reported a dramatic rise in the number of drunken teenagers needing treatment.

In a recent report by the Alcohol Advisory Council of New Zealand `The Burden of Death, Disease and Disability Due to Alcohol in New Zealand', It was estimated that 1040 (3.9%) of all deaths in New Zealand during 2000 were attributable to alcohol consumption and most of those were middle aged people; men in the 15-44 year age group were four to five times more likely to be included in this figure. Māori had four times the alcohol-related mortality of non-Māori.

MoH figures show that tobacco causes the greatest range of health-related harm of all drugs used in New Zealand. Health effects include lung cancer, chronic obstructive respiratory disease, sudden infant death syndrome and heart disease. In addition, there is strong evidence of the negative health effects of second-hand smoke (SHS). Annually, approximately 4300-4600 deaths in New Zealand are attributable to tobacco, including approximately 390 deaths caused by second hand smoke.

Drink Driving

If you drink and drive (with a blood alcohol level over 80mg per 100ml) you are three times more likely to be involved in a crash than a sober driver. Contrary to popular opinion, people with a high blood alcohol level are more likely to be injured or killed in a crash than those who are sober.

The first health study of secondary school students carried out by the University of Auckland, National Secondary School Health Survey (2000), revealed that 27% of teenagers had ridden in a car driven by a potentially drunk driver in the previous month.

In 2003 drinking and driving contributed to 124 fatal crashes, 370 serious injury crashes and 859 minor injury crashes. Twenty-seven percent of all road deaths were due to drinking-related crashes. Drinking and driving contributed to 141 deaths, 555 serious injuries and 1398 minor injuries. Over 80 per cent of drivers with excess blood alcohol levels involved in fatal crashes were male.

Drunk drivers were responsible for killing 38 of their own passengers, 26 other drivers, passengers, cyclists and pedestrians, and 77 of these drunk drivers were themselves killed.

The combination of alcohol and speed during the period 2001-2003 contributed to 19% of fatal crashes. Alcohol and speed are factors in 47% of all fatal crashes. Over 2 million people were breath tested by Police in 2003.

Anti-social Behaviour, Violence & Drug Related Offending

In 2004, Police statistics show that of the recorded crime, 54,451 offences were for antisocial and violent behaviour related to drugs. This is a reduction of 7.4% compared to the previous year.

Non-cannabis related drug crimes such as those involving amphetamine type stimulants increased by 24.8%. Last year Police put 200 clandestine methamphetamine laboratories out of action compared to 147 in 2002.

During 2004 there were 16,409 cannabis related offences this relates to a 17.5% decrease from 2003.

Police figures for 2004 show that Sale of Liquor Act offences increased by 138%, an increase from 1,801 to 4.293 offences, primarily due to the introduction of a new offence code 'breach of liquor ban – local government.'

Disorder increased by 5.8%. Alcohol related strategies implemented in some districts are proving effective in combating disorder and these strategies will be further developed at district and national level.

The following figures from APHRU (2002) illustrate the links between alcohol and violence

- 63,000 men got into a fight because of drinking alcohol.
- 115,000 men and 62,000 women reported being assaulted in the previous twelve months by someone who had been drinking alcohol.
- Young people who abuse alcohol had 3.2 times the odds of violent offending.
- 11% of women (equivalent to 124,000 women nationally) reported being sexually harassed by someone who had been drinking alcohol.

The Christchurch Health and Development Study showed that young people who abuse alcohol had 3.2 times the odds of violent offending. The researchers argued that this goes beyond risk factors which may contribute to both drinking and violent behaviour and suggested a direct cause and effect association between adolescent alcohol misuse and increased risk of violent offending.

Treatment Census Data

Since 2000 information has been supplied by the DHB providers and a limited number of non-governmental organisations (NGO) to the Mental Health Information National Collection. Based on the limited information collected to date, of the total number (85,626) of people seen by mental health service teams during 2001 (17,104), 15% were seen by the alcohol and other drug teams, with a total of 141,957 contacts up to 2003.

The New Zealand Health Information Service (NZHIS) report that between 1 January and 30 June 2003, 0.3% of the total population was treated by alcohol and other drug services, most through DHB Community Alcohol and Drug Services (CADS). NGOs and self-help groups provide a significant amount of support also, however that information is not included in the figures provided to the NZHIS.

The average number of people treated per month was 5,270. Of these people, 21% were recorded as Māori, 2% were Pacific, 0.7% was Asian and 76% were European and Other.

In 2001, 3,477 clients saw methadone treatment specialist services. Substance abuse residential services reported 343 clients and 9,860 bed days. As more NGOs provide information it is expected that these numbers are likely to increase.

This information identifies the lack of data collection to allow an accurate gauge of the extent of alcohol and other problems in New Zealand. With the new MHINC data collection system it is likely that more reliable treatment data will become available over the next 2 years.

REFERENCES

Adamson, S and Sellman, D (1998) The patterns of intravenous drug use and associated criminal activity in patients on a methadone waiting list. Drug and Alcohol Review 17:159-166).

Adamson, S and Sellman, D & De Zwart K. (2004) National Telephone Survey of the Alcohol and Drug Workforce.In Adamson SJ (ed). New Zealand Treatment Research Monograph, Alcohol Drugs Addiction. Research Proceedings from the Cutting Edge Conference, September 2004.

APHRU (2002)Alcohol and Violence - What's the connection?
http://www.aphru.ac.nz/hot/violence.htm

De Bonnaire, C, McMillen, P. Kalafatelis, E; (2004) The way we drink. The current attitudes & behaviours of New Zealanders (aged 12 plus) towards drinking alcohol. March 2004. BRC Marketing Research and Alcohol Liquor Advisory Council. http://www.alcohol.org.nz

Casswell, S and Field, A (1999) Drug Use in NZ : national survey 1998, Alcohol and Public Health Research Unit, University of Auckland

Crown Public Health (1998), Christchurch

Drinking in New Zealand: National survey comparison 1995 & 2000, APHRU, University of Auckland

Easton, B. (1997) The Social Costs of Tobacco Use and Alcohol Misuse, Health Research Council and Public Health Commission, Wellington

Easton, B. (2002) in Taxing Harm: Modernising Alcohol Excise Duties. ALAC

Foundation for Drug Education (1998), Cannabis – What's the Real Deal?

Injury Prevention Research Centre IPRC Fact Sheet No 41 Alcohol and Injuries
www.auckland.ac.nz/ipc.index.htm

Injury Prevention Research Centre (2001) Partners Abuse and Child Abuse in NZ, IPRC, Fact Sheet, no. 43.

Injury Prevention Research Centre (2001) Alcohol and Injuries, IPRC, Fact Sheet no. 41.

Land Transport Safety Authority (2001) Crash facts Alcohol, LTSA, Wellington

Land Transport Safety Authority 2003 statistics available on http://www.ltsa.govt.nz/.

Mental Health Commission (2004) Report on progress 2002-2003. Towards implementing the blueprint for mental health services in NZ (April 2004). ISBN:0-478-11392-7
http://www.mhc.govt.nz

Ministerial Action Group on Drugs (2003) Methamphetamine action plan
http://www.ndp.govt.nz/pubs/MethamphetamineActionPlan.pdf

Ministry of Health (2002) Health & Independence Report 2002: Director-General's report on the state of public health. ISBN 0-478-25591-8; ISBN 0-478-25592-6 HP 3595; http://www.moh.govt.nz

Ministry of Health and Cancer Society of NZ (1996)

Ministry of Health (1999) Draft, Drug Statistics publication V2.1 Alcohol

Ministry of Health (1999) Treatment Gap Definition Exercise, Wellington

NZ Medical Council (1991) The Misuse of Addictive Prescription Drugs, Wellington

Nutt, David (2004) Advances in treatment for alcohol & opioid: Seminar

Oakley-Brown, M et al,(1991) Christchurch Epidemiological Study Part II six month and other prevalence of specific psychological disorders. Australia and New Zealand Journal of Psychiatry, 89, 23:327-340

Office of the Police Commissioner (2005) New Zealand Crime Statistics 2004 March 2005 A Summary of Recorded and Resolved

Offence Statistics http://www.police.govt.nz/service/statistics/2004/calendar/stats-national-20041231.pdf

Penfold A (2004) Problem gambling and suicide: The relationship between problem gambling, alcohol misuse and suicide in a population presenting following an episode of self-harm. A thesis submitted in partial fulfilment of the requirements for the degree of Master of Health Sciences, The University of Auckland, 2004. Abacus Counselling and Training Service Ltd. Full Thesis available on www.acts.co.nz

McDonald G, Taylor B, Carter M, Circumstances surrounding drowning in those under 25 years in New Zealand (1980-2002) Child and Youth Mortality Review Committee (CYMRC) and Water Safety New Zealand. www.watersafety.org.nz/pdfs/CYMRC%20Report%2080-02.pdf

Pharmac (2004) Media Release. http://www.pharmac.govt.nz/pdf/100504.pdf

Sellman D, Adamson S, Robertson P, Sullivan S & Coverdale J (2002) Gambling in Mild-moderated alcohol-dependent outpatients. J Substance Use & Misuse 37(2):199-213

SHORE (2004)The Socio-Economic Impact of Amphetamine Type Stimulants in New Zealand Final Report

Statistics NZ (2005) http://www.stats.govt.nz/products-and-services/info-releases/alcohol-tobacco-info-releases.htm

Sullivan S (1999) Alcohol and Problem Gambling: a hidden partner in dual diagnosis. Australasian Symposium on Professional
Education and Training on Alcohol and Drug Other Drugs (Adelaide). ALAC &NCETA, May 1999

Wyllie, A (1996) Drinking in NZ: a national survey 1995, Alcohol and Public Health Research Unit, University of Auckland)