

ISSUES OF TOBACCO, ALCOHOL AND OTHER SUBSTANCE ABUSE FOR MĀORI

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Report commissioned by the Waitangi Tribunal for Stage 2
of the Health Services and Outcomes Kaupapa Inquiry (Wai 2575)

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Abbreviations

ACC – Accident Compensation Corporation

ADOM – Alcohol and Drug Outcome Measure

ALAC – Alcoholic Liquor Advisory Council (later known as the Alcohol Advisory Council)

AOD – alcohol and other drugs

AODT Court – Alcohol and Other Drug Treatment Court

ASAP – Achieving Smokefree Aotearoa by 2025 Plan

ASH – Action on Smoking and Health

ATAK – Aparangi Tautoko Auahi Kore

CADS – community alcohol and drug service

CBD – cannabidiol

DHB – District Health Board

FASD – Fetal Alcohol Spectrum Disorder

FCTC – World Health Organisation Framework Convention on Tobacco Control

GP – General practitioner

HPA – Health Promotion Agency

LAP – Local Alcohol Policy

MASC – Māori Affairs Select Committee

MDMA – Methylenedioxymethamphetamine (‘ecstasy’)

MOH – Ministry of Health

NCAT – National Committee for Addiction Treatment

NDP – National Drug Policy

NGO – Non-government organisation

NRT – Nicotine replacement therapy

NSAD – New Zealand Society on Alcohol and Drug Dependence

NTS – National Telehealth Service

PHARMAC – Pharmaceutical Management Agency

PHO – Primary Health Organisation

RTD – ready to drink

SHORE – Social and Health Outcomes Research and Evaluation, College of Health, Massey University

THC – delta-9-tetrahydrocannabinol

WHO – World Health Organisation

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1 – Introduction

This report sits within stage two of the Tribunal’s Health Services and Kaupapa Inquiry (Wai 2575). It outlines key legislative and policy developments, and Māori responses, to understand how the Crown has addressed issues of tobacco, alcohol and substance abuse for Māori. It provides an overview of how the Crown has prioritised and used available interventions and strategies, particularly over the past two decades. It focuses on the four broad themes identified in the pre-casebook discussion paper for the inquiry and set out in the commissioning direction for this report. They are:

- disparities (or inequity) in health outcomes for Māori;
- accessibility to health services for Māori;
- responsiveness of health services for Māori; and
- effectiveness of health services for Māori.¹

This report specifically focuses on how Crown actions or inactions have impacted on the disparities in the levels of tobacco, alcohol, and other drug-related harm experienced by Māori in comparison to non-Māori.

Background to this report

In November 2017, the Tribunal in the Health Services and Outcomes Kaupapa Inquiry announced that it would take a staged thematic approach to its inquiry into health kaupapa claims. The three stages will address:

- priority themes that demonstrate system issues (stage one);
- nationally significant system issues and themes that emerge (stage two); and
- remaining themes of national significance, including eligible historical claims (stage three).²

Stage one, which was reported on by the Tribunal in June 2019, inquired into the establishment and operation of New Zealand’s primary health care system.³ Stage two of the inquiry is concerned with three nationally significant issues: Māori mental health (including suicide and self-harm), Māori with disabilities, and alcohol, tobacco and substance abuse issues for Māori.

Following the release of a pre-casebook discussion paper and judicial conference in April and June 2018, respectively, presiding officer Judge Stephen Clark directed the research programme for stage

¹ Dr Therese Crocker, ‘Māori Health Services and Outcomes Inquiry (Wai 2575): Pre-casebook Discussion Paper: Part 2’, Waitangi Tribunal Unit, July 2018, p. 6.

² Wai 2575, #2.5.17.

³ Waitangi Tribunal, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*, Wellington, 2019.

two on 28 June 2018.⁴ Three Waitangi Tribunal-commissioned research reports have been completed to date:

- Dr Paula Therese King ‘Māori with Lived Experience of Disability Part I’, June 2019 (Wai 2575, #B23);
- Hector Kaiwai and Dr Tanya Allport ‘Māori with Disabilities (Part Two)’, June 2019 (Wai 2575, #B23); and
- Dr Timothy Gassin ‘Māori Mental Health’, August 2019 (Wai 2575, #B26).

This report constitutes the fourth report and addresses the priority theme of alcohol, tobacco and substance abuse issues for Māori. Dr Barry Rigby was initially commissioned to prepare the report in September 2018 (Wai 2575, #2.3.2). On 5 September 2019, Dr Rigby’s commission was cancelled as he was unable to complete the commission in time and I was commissioned to complete the report (Wai 2575, #2.3.10). I acknowledge the work of Dr Rigby. I was given full access to the responses and feedback on Dr Rigby’s earlier draft. I also attended the research hui for this report in January 2019. I also acknowledge the background research carried out by Nigel Robson on tobacco. I have checked all sources used and all the conclusions are mine. While I have had the benefit of this earlier work, I have completed this report in a very short time period.

On 29 November 2019 a draft of this report went out to parties. I would like to thank the claimants, counsel and the Crown for their feedback.

Relevant claim issues

Claimants in this inquiry primarily argue that, in relation to issues of alcohol, tobacco and substance abuse for Maori, the Crown has failed to address, and in some cases has actively contributed to, the disproportionately high rates of tobacco, alcohol and other drug abuse amongst Māori. Claimants note the higher rates of smoking (particularly among rangatahi Māori and wāhine Māori, including during pregnancy), the higher rates of hazardous drinking (particularly among wāhine Māori and rangatahi Māori) and the higher rates of drug use and dependency, especially for cannabis and methamphetamine.⁵

As a result, claimants stress that Māori suffer disproportionately in comparison to non-Māori from the poor health and social outcomes of addiction. Māori disproportionately experience tobacco, alcohol, and drug-attributable death and illness, including premature death, lung cancer, mental illness,

⁴ Wai 2575, #2.5.29, paras 4 & 14; Therese Crocker, ‘Māori Health Services and Outcomes Inquiry (Wai 2575) Pre-casebook Discussion Paper: Part 1’, April 2018, Waitangi Tribunal Unit (Wai 2575, #6.2.3).

⁵ For example, see Wai 88/89, Wai 558, Wai 762, Wai 884, Wai 966, Wai 1460, Wai 1781, Wai 1837, Wai 1941, Wai 2063, Wai 2179, Wai 2257, Wai 2494, Wai 2510, Wai 2534, Wai 2635, Wai 2641, Wai 2697, Wai 2718, Wai 2719, Wai 2723, Wai 2729, Wai 2829, Wai 2836, and Wai 2862.

cardiovascular disease, breast cancer, maternal risk factors, fetal alcohol spectrum disorder, sudden infant death syndrome, stroke, injuries caused by criminal behaviour (such as violence against wāhine Māori) and injuries caused by accidents (such as motor vehicle accidents).⁶ In addition to these health impacts, claimants also highlight the social harms of addiction on Māori communities, including whānau breakdowns, economic deprivation, criminal offending and reoffending, housing difficulties, employment issues and stigmatisation.⁷

Claimants further state that the Crown has failed to provide equitable health services, policies and legislative controls that work to address addiction inequalities experienced by Māori. Specifically, this includes failing to address the broader political, socio-economic and health conditions that contribute to addiction issues among Māori, including but not limited to colonisation, land loss, deprivation, the criminalisation of addiction, urbanisation, racial discrimination, unemployment, sexual abuse, mental illness and other trauma.⁸ It also includes failing to act on policy recommendations that could work to reduce harm, such as those made by the Law Commission and the Māori Affairs Select Committee in 2010.⁹

Claimants assert that the Crown has failed to adequately fund and deliver accessible addiction prevention services, rehabilitation services (including those for Māori in prisons), rehabilitation transition services, education, healthcare and other initiatives to address the high rates of addiction among Māori.¹⁰ Furthermore, claimants speak of a failure to work in partnership with Māori communities to develop policies and services that recognise a Māori worldview and target the underlying causes of addiction,¹¹ arguing that the most successful services have been those that are designed by Māori, for Māori.¹²

A list of relevant claims in relation to tobacco, alcohol and substance abuse along with a summary of issues raised is attached to this report as Appendix I.

⁶ For example, see Wai 58, Wai 88/89, Wai 844, Wai 874, Wai 884, Wai 966, Wai 1460, Wai 1837, Wai 1941, Wai 1957, Wai 2063, Wai 2121, Wai 2179, Wai 2217, Wai 2257, Wai 2624, Wai 2635, Wai 2718, Wai 2719, Wai 2723, Wai 2836, and Wai 2862.

⁷ For example, see Wai 884, Wai 1460, Wai 1544, Wai 1677, Wai 1941, Wai 2179, Wai 2635, Wai 2655, Wai 2670, Wai 2684, and Wai 2697.

⁸ For example, see Wai 58, Wai 762, Wai 1712, Wai 1957, Wai 2053, Wai 2063, and Wai 2173, Wai 2641, Wai 2673, Wai 2697, and Wai 2738.

⁹ For example, see Wai 2624 and Wai 2634.

¹⁰ For example, see Wai 179, Wai 844, Wai 996, Wai 2063, Wai 2499, Wai 2623, Wai 2635, Wai 2639, Wai 2643, Wai 2688, Wai 2697, Wai 2720, Wai 2848, Wai 2849. In relation to rehabilitation services for Māori in prison see, for example, Wai 2494, Wai 2684 and Wai 2738.

¹¹ For example, see Wai 762, Wai 2635, and Wai 2655.

¹² For example, see Wai 844.

Commission questions

This report is required, within the time available, to address the questions set out below. The full commission is attached to this report as Appendix II.

- (a) How does the contemporary health system, including legislation, policies and practices recognise and provide for the needs of Māori with alcohol, tobacco and substance abuse issues? To what extent, if any, does implementation and outcomes diverge from policy objectives?
- (b) To what extent does health policy and practice provide culturally appropriate health services and treatment for those Māori with alcohol, tobacco and substance abuse issues, or provide for Māori led and developed systems and methods of health care/kaupapa Māori?
- (c) To what extent have Crown acts or omissions, if any, contributed to disparities in health services and outcomes between Māori and non-Māori with alcohol, tobacco and substance abuse issues and how are these recognised and addressed?
- (d) What barriers, if any, do Māori with alcohol, tobacco and substance abuse issues experience in accessing health services and what are existing Crown policies and practices for recognising and addressing any such barriers?
- (e) How effective is current monitoring and data collection for identifying and addressing any disparities in health services and outcomes for Māori with alcohol, tobacco and substance abuse issues?
- (f) To what extent have Māori had opportunities to contribute to relevant policy and legislative developments?
- (g) What key historical developments have contributed to the current system of government health services for Māori with alcohol, tobacco and substance abuse issues and to Māori experiences and attitudes to health services?¹³

Report methodology

This report is focused, as required, on contemporary issues. It relies primarily on government, non-government organisation and academic research and publications to outline the Crown's legislative and policy framework and provision of services for issues of tobacco, alcohol and substance abuse for Māori within the wider New Zealand context. Key published sources include published histories of tobacco

¹³ Wai 2575, #2.3.2 and #2.3.10.

and alcohol control, and histories of the government's provision of health services, including for Māori with addiction needs.

Sources of primary documentation and reports from the Ministry of Health have been used where possible. Officials from the Ministry of Health have provided information on the current provision of stop smoking and addiction treatment services which were utilised for Chapter 4. Te Pou o Whakaaro Nui also provided Alcohol and Drug Outcome Measure (ADOM) information specific to Māori. Coronial Services provided ethnicity information on coronial cases relating to synthetic cannabis deaths from 1 June 2017 (discussed in Chapter 3). The Ministry of Justice provided preliminary ethnicity data on users of its Alcohol and Other Drug Treatment Court, and the Department of Corrections provided information on its drug treatment programmes. These are both discussed in Chapter 4.

Alcohol and other substance abuse is closely linked with mental health, both in terms of prevalence and service delivery and funding. The February 2018 report of the Mental Health Commissioner notes that over 70 per cent of people who use addiction services are estimated to have mental health conditions.¹⁴ However, this report focuses solely on tobacco, alcohol and other substance abuse issues for Māori. Readers should refer to Dr Tim Gassin's Māori Mental Health report commissioned for this inquiry (Wai 2575, #B26) for further information regarding Māori mental health issues.

Discussion of smoking in this report refers to tobacco smoking, the majority of which is smoking either manufactured or roll-your-own cigarettes. The use of e-cigarettes, such as vapes, is generally not included when discussing smoking rates.

Discussion of disparities in this report refers primarily to the differences – the gaps measured by statistics – between Māori and non-Māori in rates of tobacco, alcohol and other substance use and related harmful health outcomes.

The terms 'other substance(s)' and 'other drug(s)' are used interchangeably and mainly refer to illegal drugs.

Macrons for Māori words have been used throughout the report, except for when they do not appear in the original source or title.

Report structure

To understand the current context of addiction treatment and substance control, it is necessary to outline the evolution of the Crown's legislative and policy framework, which has regulated the supply and consumption of tobacco, alcohol and other drugs over time. It is also necessary to provide an outline of

¹⁴ Health and Disability Commission, 'New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner, February 2018, p. 9.

the legislative and policy framework that has underpinned the Crown's provision of addiction treatment services in New Zealand. Unearthing these two main threads helps shed light on the extent to which Māori have participated and contributed to the Crown's legislation and policies in the tobacco control and alcohol and other drug (AOD) sectors, how Māori have engaged with addiction services, and how Māori have developed community-based initiatives/kaupapa Māori treatment services for Māori with addiction needs in more recent times.

Following on from this introduction, Chapter 2 covers the period from 1840 up until 2000, when the New Zealand health system was transformed into its current state by the New Zealand Public Health and Disability Act 2000. The New Zealand Public Health and Disability Act 2000 has been chosen as the point to end the discussion of the historical context and begin outlining the current (post-2000) context of tobacco, alcohol and other drug legislation and policy, as it marks a point at which the Crown makes an explicit commitment in legislation 'to reduce health disparities by improving the health outcomes of Māori and other population groups'.¹⁵ Chapter 3 examines key legislative and policy developments to control tobacco, alcohol and other drug-related harm from 2000 onwards and outlines the context in which current addiction treatment services operate. Chapter 4 explains the current system of health services for Māori with addiction needs, as it exists today. It also discusses issues around the effectiveness of addiction treatment services for Māori, as well as barriers to Māori accessing these services. The current system of government health services for Māori with addiction needs forms part of the Crown's response to addressing these disparities for Māori. The final chapter, Chapter 5, sets out a conclusion summarising the main points identified.

Introduction to concepts and terms used in this report

It appears helpful at this point to provide some explanation of concepts and terms referred to throughout this report and in debates on the issues of addiction and substance abuse to help orientate the reader for the discussion that follows. This report is concerned with Crown legislation and policy frameworks and the provision of services (or what are generally referred to in the health sector as Crown interventions). It is generally accepted that there are a number of interventions available to the Crown to control the supply and demand of tobacco, alcohol and other drugs and minimise related harm for the benefit of individuals and wider society. Tobacco and alcohol are regulated substances, that is, they are legal but the government places restrictions on their sale, consumption, advertising and marketing. Illegal drugs or psychoactive substances present a different challenge, in that the intervention options available are more limited.

Broadly, the interventions generally considered available to the Crown involve:

¹⁵ New Zealand Public Health and Disability Act 2000, section 3 (1)(b).

1. supply control (reducing the availability of tobacco, alcohol and other drugs, including through legislation and regulations such as licensing requirements, restricted trading premises and hours, age restrictions, law/regulation enforcement and policing the manufacturing, selling, and trafficking of illegal drugs). Policy debates over control have swung over time between prohibition and criminalisation and efforts to minimise harm through controls for regulating for moderate use;
2. demand reduction (reducing the desire to use tobacco, alcohol and other drugs, including through health promotion, education campaigns, restrictions on sponsorship, advertising and marketing, increasing prices and tax); and
3. problem limitation (reducing existing drug-related harm by providing tobacco, alcohol and other drug treatment services; safer equipment and environments for drug use – such as needle exchange programmes and opioid substitution treatment; and research and workforce training).¹⁶

The addictive substances considered by this report – alcohol, tobacco and other drugs – are considered psychoactive substances because of their mood and/or perception-altering properties.¹⁷ Alcohol, a central nervous system depressant, is the most commonly used drug in New Zealand. Other depressants include opioids, such as opium, heroin, methadone, morphine, oxycodone and codeine, but are not as commonly used by New Zealanders recreationally.

Nicotine, which is contained in tobacco and tobacco products, is one of the most commonly used central nervous system stimulants. Other stimulants consist of substances such as amphetamines (which include methamphetamine/‘meth’, ‘P’ and speed), MDMA (ecstasy) and cocaine, as well as legal highs and party pills, which produce similar effects. However, surveys report that these other stimulants are only used by a relatively small percentage of New Zealanders.¹⁸

Hallucinogens cause sensory distortions (visual, auditory or tactile hallucinations) and can also cause similar effects to depressants and stimulants. The most common hallucinogen is LSD (lysergic acid diethylamide). Others include magic mushrooms (psilocybin), cactus (mescaline) and Thornapple/Angels Trumpet (datura).¹⁹

Natural cannabinoids containing THC (delta-9-tetrahydrocannabinol) and CBD (cannabidiol) are derived from the cannabis sativa and indica plants. Cannabinoids can produce depressant, stimulant and

¹⁶ National Drug Policy 1998, pp. 20-22, National Drug Policy 2007-2012, p. 5; National Drug Policy 2015-2020, pp. 5-6.

¹⁷ Matua Raki National Addiction Workforce Development, ‘A Guide to the Addiction Treatment Sector in Aotearoa New Zealand’, June 2014, pp. 7-9, <https://www.matuaraki.org.nz/uploads/files/resource-assets/a-guide-to-the-addiction-treatment-sector-in-Aotearoa-New-Zealand-June-2014.pdf>, accessed 3 Oct 2019.

¹⁸ Matua Raki National Addiction Workforce Development, ‘A Guide to the Addiction Treatment Sector in Aotearoa New Zealand’, June 2014, p. 7

¹⁹ Matua Raki National Addiction Workforce Development, ‘A Guide to the Addiction Treatment Sector in Aotearoa New Zealand’, June 2014, p. 8

hallucinogenic effects. Marijuana is the dried leaves and flowers of the cannabis plant, hashish is dried resin extracted from the plant, and hash oil is extracted from the leaves and flowers. Marijuana is commonly used in New Zealand. Synthetic cannabinoids are manufactured chemical compounds added to smokable plant material to appear like cannabis. Internationally, around 200 different types of synthetic cannabinoids have been identified, with some substances being much more potent than the THC found in natural cannabis.²⁰

The harm from tobacco use in New Zealand results in approximately 5,000 deaths per year through cancer, stroke and heart disease, making it the 'leading cause of preventable death and disease in New Zealand'.²¹ Five times as many people die per year from using tobacco than the total combined annual deaths from drowning, suicide and motor vehicle accidents.²²

The harms associated with excessive or inappropriate use of alcohol are widespread and include both direct and indirect health, justice, social and economic impacts. Health harms include higher risks of cancer and other diseases, mental health issues, alcoholism, fetal alcohol spectrum disorder and sexually transmitted infections. Harm from criminal activity in connection with alcohol use includes domestic violence, assault, murder and other crimes. Harm from accidental injury, disability or death due to intoxication can arise from vehicle accidents or accidents in the home. There are also wider social and economic harms associated with alcohol use, such as the impacts upon victims of crime and whānau of those with alcohol addiction, as well as effects on educational achievement and productivity in the workplace.²³

Although not consumed as widely as alcohol, other drugs cause similar types of harm to alcohol.²⁴ The perception of drug-related harm is also magnified by the fact that the substances are illegal, and therefore associated with crime, policing and law enforcement, the criminal black market and associated activities. As discussed throughout this report, one of the recent policy debates has been the theme of the criminalisation of Māori in connection with low-level illegal drug use and possession, rather than an emphasis on addiction and health.

The way in which people use tobacco, alcohol and other drugs, the level of harm experienced and the types of intervention and/or treatment required occurs on a continuum, as not every instance of alcohol or other drug use is generally considered to cause harm. The case is reportedly different for tobacco,

²⁰ Institute of Environmental Science and Research (ESR), 'The evolution of synthetic cannabinoids', accessed 3 Oct 2019, <https://www.esr.cri.nz/home/about-esr/our-science-in-action/the-evolution-of-synthetic-cannabinoids/>

²¹ 'Health effects', Smokefree website, Health Promotion Agency, <https://www.smokefree.org.nz/smoking-its-effects/health-effects> accessed 9 Dec 2019, last updated 9 Jun 2019.

²² 'Health effects', Smokefree website, HPA, <https://www.smokefree.org.nz/smoking-its-effects/health-effects> accessed 9 Dec 2019, last updated 9 Jun 2019.

²³ New Zealand Law Commission, *Alcohol in our lives: Curbing the harm, A report on the review of the regulatory framework for the sale and supply of liquor*, Wellington, 2010, p. 7.

²⁴ New Zealand Law Commission, *Controlling and Regulating Drugs*, IP16, Wellington: New Zealand Law Commission 2010, pp. 20-21.

however, as expressed in the television campaign slogan ‘every cigarette is doing you damage’ launched in New Zealand in 2000.²⁵

At one end of the scale is abstinence (meaning no substance use) or low risk substance use, which requires no treatment or only brief intervention. Then there is hazardous or harmful/high risk use that may require brief interventions or intensive treatment. Severe substance use disorder and dependence requires intensive specialist treatment and intervention.²⁶ The abstinence to addiction and addiction-related harm continuum is depicted in **Figure 1** and **Figure 2** below. Problem gambling (a behavioural addiction) is also included in the diagrams below but is not covered by this report as it falls outside the scope of the commission (further detailed below). However, it is noted that feedback on the draft of this report raised issues in relation to the importance of the issue of problem gambling for Māori.

No use	No treatment required/ Public or population health & prevention initiatives apply
Low risk use	
Hazardous use	Likely to benefit from less intensive treatment options, need treatment but do not necessarily need specialist treatment
Harmful use	
Mild dependence	
Dependence/ pathological gambling	Need intensive, specialist treatment options

Figure 1: The abstinence to addiction continuum

(Source: National Committee for Addiction Treatment (NCAT), ‘Investing in Addiction Treatment: A resource for funders, planners, purchasers and policy makers’, 2008, Christchurch, p. 4.)

²⁵ ‘Every cigarette is doing you damage’ was a TV campaign launched in Australia in the late 1990s and then adapted for New Zealand by The Quit Group. See ‘TV Campaigns’, Quitline website, <https://quit.org.nz/media>, accessed 9 Dec 2019.

²⁶ Matua Raki National Addiction Workforce Development, ‘A Guide to the Addiction Treatment Sector in Aotearoa New Zealand’, June 2014, p. 6.

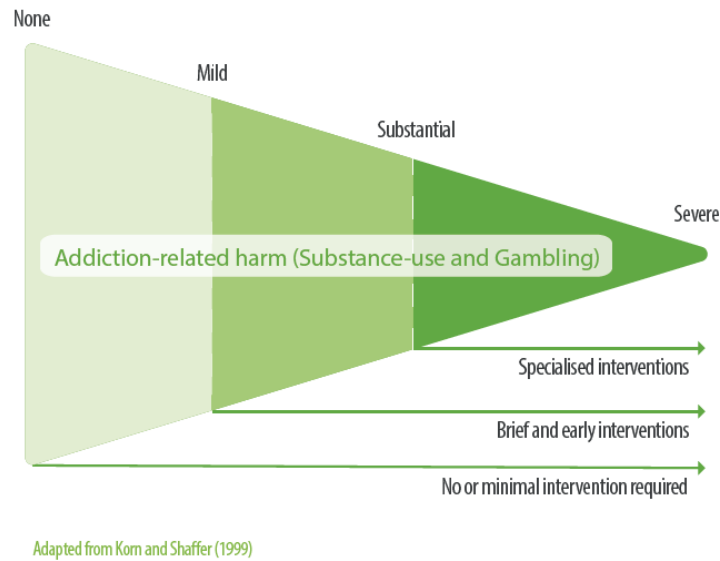


Figure 2: Addiction-related harm continuum and intervention

(Source: Matua Raki National Addiction Workforce Development, 'A Guide to the Addiction Treatment Sector in Aotearoa New Zealand', June 2014, p. 6.)

The report of the 2018 government inquiry into mental health and addiction also noted that there are a range of wider social determinants of health that can influence peoples' mental health, addiction and wellbeing. The report identified some of the social determinants most relevant to mental health and addiction, including educational underachievement, unemployment, child abuse and neglect, criminal offending and reoffending, family violence and homelessness.²⁷ The inquiry recommended that a whole of government (as opposed to just a health sector) approach to wellbeing was therefore necessary.²⁸ While some of these social determinants are mentioned throughout this report, the report's focus is on the Crown's legislation, policy and practices relevant to controlling and minimising tobacco, alcohol and other drug-related harm for Māori.

²⁷ 'He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction', November 2018, pp. 13.

²⁸ 'He Ara Oranga', pp. 144.

2 – Historical context: Tobacco, alcohol, and other substance abuse legislation, policy and Māori response, 1840 to 2000

Introduction

In contrast to some indigenous peoples around the world, it appears that Māori did not traditionally consume tobacco, alcohol or other drugs prior to the arrival of Pākehā in Aotearoa.²⁹ According to historical accounts, with the arrival of Pākehā, Māori quickly took up smoking tobacco from the early 1800s, but did not commonly consume alcohol until the 1850s and 1860s.³⁰ In the nineteenth century, tobacco was often used as a trade or koha item by both Māori and Pākehā, including in land transactions between the Crown and Māori, as well as at signings of the Treaty of Waitangi.³¹ Alcohol was also used as a koha item, but in recognition of the harm caused, its sale or supply in connection with land sales was outlawed from a relatively early period, such as by the Native Lands Frauds Prevention Act 1870. Māori use of other drugs or psychoactive substances – mainly cannabis – was not commonly documented until the decades after the Second World War when many Māori migrated from rural areas to the larger urban cities.³²

Recognition of the harmful health outcomes associated with using these substances also varied over time. For many decades, addiction and substance abuse were seen largely as private, moral failings or (where laws were breached) as criminal activity. It was also recognised that the impacts and outcomes for Māori were disproportionate to those for non-Māori. Those disparities were confirmed by research. In the case of tobacco consumption, for example, tobacco smoking rates across New Zealand's population between 1945 and 1961 were at 50 per cent of all men and 35 per cent of women, with the rates for Māori estimated to be significantly higher.³³ The associated health effects of higher smoking rates amongst Māori are also reflected in research from the early 1970s, which found Māori women suffered the highest female rate of lung cancer in the world.³⁴ A 1984 study also revealed that part of the higher mortality rate of Māori compared to non-Māori was due to higher Māori smoking rates.³⁵

²⁹Marten Hutt, 'Te Iwi Maori me te Inu Waipiro: He Tuhituhinga Hitori: Maori & Alcohol: A History', Wellington, 1999, second edition 2003, p. 3. <http://www.ahw.org.nz/Portals/5/Resources/Documents-other/2017/Maori%20%26%20Alcohol%20%20history.pdf>.

³⁰ Hutt, pp. 24-26; John Broughton, *Puffing up a storm: 'Kapai te torori!'* Dunedin, Ngai Tahu Maori Health Research Unit, University of Otago, 1996, p. 36; Megan Cook, 'Māori smoking, alcohol and drugs – tūpeka, waipiro me te tarukino - Māori use of drugs', Te Ara - the Encyclopedia of New Zealand, <https://teara.govt.nz/en/maori-smoking-alcohol-and-drugs-tupeka-waipiro-me-te-tarukino> (accessed 21 Oct 2019).

³¹ Broughton, pp. 16, 23.

³² Cook, 'Māori smoking, alcohol and drugs'.

³³ Scott Trainor, *Tobacco Control in New Zealand: A History*, Cancer Control Council of New Zealand, 2008, pp. 9, 15.

³⁴ Trainor, p. 17, citing Hay, D (1972). Smoking and health: The 1972 situation. *New Zealand Medical Journal*, 76, 4-12.

³⁵ George Thomson and Nicholas Wilson, 'Resource Document: A Brief History of Tobacco Control in New Zealand, commissioned by the AFPHM (NZ), January 1997, p. 23.

Other research suggests that between 1989 and 1993, tobacco smoking accounted for a third of all Māori deaths.³⁶ Māori also suffered disproportionately in comparison to non-Māori from alcohol and drug-related harm. Between 1971 and 1990, Māori substance use morbidity (based on hospital admissions data) was twice the rate of non-Māori.³⁷ By 2000, statistics continued to indicate that Māori were still experiencing tobacco, alcohol and other drug-related harm disproportionately in comparison to non-Māori. In 2000, the rate of smoking amongst Māori was 49 per cent, more than double that of non-Māori (excluding Pacific Islanders)³⁸ and Māori had almost three times the rate of lung cancer registrations than non-Māori.³⁹ The research for other kinds of alcohol and substance abuse revealed similar trends. In 1998, the rate of Māori hospitalised for alcohol-related conditions was approximately 1.5 times the rate for non-Māori, and more than 3 times the rate of non-Māori for cannabis-related conditions.⁴⁰ The government's first National Drug Policy in 1998 recognised the disproportionate harm experienced by Māori and acknowledged the government's Treaty responsibilities to ensure Māori enjoyed the same levels of health outcomes as non-Māori.⁴¹

The current system of government health services for Māori with addiction needs (which is the focus of Chapter 4 of this report) forms part of the Crown's response to addressing these recognised disparities for Māori. Before considering the current context of addiction treatment and substance control in more detail, it is helpful to briefly consider how the Crown's legislative and policy framework for control of the supply and consumption of tobacco, alcohol and other drugs has evolved to this point. Alongside of this is the development of the Crown's provision of addiction treatment services in New Zealand. Outlining the development of these two main threads of legislative and policy development helps shed light on Māori responses and participation in the tobacco control and alcohol and other drug (AOD) sectors, how Māori have engaged with addiction services, and how Māori have developed community-based initiatives/kaupapa Māori treatment services for Māori with addiction needs in more recent times.

This chapter provides an overview of government efforts to control tobacco smoking in New Zealand from the 1960s (when such controls were first introduced), through to the passage of the Smoke-free Environments Act 1990, and the beginning of smoking cessation services targeting Māori in the late 1990s. It then moves on to examine alcohol control since 1840, and highlights government legislation aimed specifically at controlling liquor with regard to Māori communities. The way in which the

³⁶ Marewa Glover, 'The Effectiveness of a Maori Noho Marae Smoking Cessation Intervention: Utilising a Kaupapa Maori Methodology', PhD thesis, University of Auckland, November 2000, p.1, citing Laugesen M, Clements M. 1998. *Cigarette Smoking Mortality among Maori*. Wellington: Ministry of Maori Development.

³⁷ T Cave, P Robertson, S Pitama and T Huriwai, 'He Tētē Kura: Māori Addiction Treatment: 1980 - 2008, Christchurch, 2008, p. 25, citing Pōmare, E.W., Keefe-Ormsby, V., Pearce, N., Reid, P., Robson, B. & Watene Haydon, N. (1995). *Maori Standards of Health II: A study of the years 1970 – 1991*, Wellington: Wellington School of Medicine.

³⁸ Ministry of Health, Tobacco Trends 2006: Monitoring tobacco use in New Zealand, Wellington, Dec 2006, p. 39.

³⁹ Non-Māori: 28.06 Māori 82.6 total registrations (ASR-WHO), data retrieved from TCDR Tobacco Control Data Repository, HPA, https://tcdata.org.nz/Cancer%20data/Cancer_03.html, accessed 14 Nov 2019.

⁴⁰ 'New Zealand Health Strategy, DHB Toolkit: Minimising Alcohol and Other Drug Related Harm', 2001, p. 16.

⁴¹ National Drug Policy 1998, p. 14 in relation to alcohol and tobacco, see also p. 38 in relation to other drugs.

government has attempted to control drugs and other psychoactive substances since 1840 is then discussed, followed by a summary of the types of alcohol and other drug addiction treatment services that have been available in New Zealand since 1910. The chapter ends by introducing the government's first 1998 National Drug Policy, which identified Māori as a key group most at risk of drug-related harm and sets out the government's priorities and strategies for reducing tobacco, alcohol and drug-related harm for all New Zealanders and for Māori in particular. The summary at the end of this chapter highlights the main trends with respect to each of the three substance areas in terms of harm prevention and treatment.

This chapter concludes at the end of the 1990s just prior to the introduction of the New Zealand Public Health and Disability Act 2000. This Act, as discussed in Chapter 3, reformed New Zealand's public health system. The Act also makes an explicit commitment by the Crown to reduce health disparities by improving the health outcomes of Māori and other population groups. It therefore provides a useful framework for the discussion that follows in Chapter 3.

Tobacco control

Government efforts to control and regulate tobacco smoking in New Zealand did not begin until the 1960s when the harm from smoking tobacco became irrefutable. However, tobacco itself was introduced and regulated from a very early period and government acceptance and even encouragement of this played a role in normalising tobacco smoking and encouraging the development of a local tobacco industry. Researchers credit the issuing of cigarettes to New Zealand soldiers during the First and Second World Wars, along with the marketing efforts of the tobacco industry, with the rise in popularity and normalisation of smoking tobacco from the 1920s onwards.⁴² From the 1920s to the late 1940s when the ill effects of smoking were not well known, smoking tobacco was considered a relatively harmless activity that also helped relieve stress.⁴³ The government considered tobacco as a commodity, encouraging Māori in the upper-Whanganui district to grow tobacco as an economic crop as early as 1873, for example, and assisting tobacco farmers in the 1920s through to the late 1940s with trade tariffs and research to improve local tobacco production.⁴⁴ Tobacco was also an important source of tax and custom revenue from the early period.

Tobacco consumption in New Zealand (by weight per person) peaked in the 1950s with, as mentioned previously, smoking rates across the population for the period from 1945-1961 estimated at 50 per cent of all men and 35 per cent of women. The smoking rate for Māori during this time is estimated as being

⁴² Trainor, p. 8.

⁴³ Thomson and Wilson, p. 8.

⁴⁴ Trainor, p. 10, citing Thomson, G., & Wilson, N. (1999, March 26). Tobacco control in New Zealand from 1945 to 1961. *New Zealand Medical Journal*, 112(1084), 101-3; Report of Resident Magistrate, 10 May 1873, *Appendices to the Journals of the House of Representatives* (AJHR), 1873, G-1, p. 18.

even higher.⁴⁵ Actual data on smoking prevalence rates was not collected prior to the censuses of 1976 and 1981, but from 1983 smoking rates were recorded regularly and by ethnicity from 1990.⁴⁶

Research notes that significant evidence about the harmful health effects of smoking tobacco began to emerge in the United States and Britain from the 1930s. However, knowledge about these links was mainly confined to the medical profession and was not widely known to the public until the 1960s.⁴⁷ By the 1950s, New Zealand's Department of Health (the predecessor agency to the Ministry of Health) had started noting the link between smoking and the risk of lung cancer in some of the health education material it issued.⁴⁸

The year 1962 marked the beginning of a major change in the New Zealand government's official policy and understanding of smoking and its health-related effects, although it took another decade or two before practical widespread changes were made. In 1962 the report of the United Kingdom Royal College of Physicians on the harmful health effects of smoking was published. As a result, the New Zealand government implemented an anti-smoking campaign in 1962 and introduced the first restrictions on the advertisement of tobacco and cigarettes in 1962 and 1963.⁴⁹ The findings of the 1962 report were supported by the report of the United States Surgeon General in 1964, which linked smoking with cancer and other diseases.⁵⁰ These international studies sparked much debate and further research and studies in New Zealand on the effects of smoking on health, which led to widespread acceptance (by both the medical profession and society generally) of the harm caused by smoking and second hand smoke, particularly amongst young people, pregnant women and Māori.⁵¹ Smoking-related harm amongst these groups remains a major issue of concern in tobacco control policy in New Zealand today, half-a-century later.

Early research and studies on the health effects of smoking for Māori also confirmed the disproportionate impacts Māori were suffering. Studies include a 1972 article by David Hay published in the *New Zealand Medical Journal*. This drew attention to the fact that Māori women suffered from the highest female rate of lung cancer in the world.⁵² In 1980, Dr Eru Pomare noted in his research the link between Māori ill-health and smoking.⁵³ The same year the Department of Health Advisory

⁴⁵ Trainor, pp. 9. See also 'History of Tobacco Control' Smokefree HPA website <https://www.smokefree.org.nz/smokefree-resources/interactive-tools/history-of-tobacco-control>.

⁴⁶ Trainor, p. 10.

⁴⁷ Trainor, p. 10.

⁴⁸ Trainor, p. 11.

⁴⁹ Such as the ban on television and radio advertising of cigarettes in 1963, and a voluntary arrangement in 1962 with the tobacco industry not to target young people with their tobacco products, although it is noted that this agreement was not adhered to by tobacco companies, who implemented more subtle ways of advertising their products to young people. See Trainor, pp. 18-19.

⁵⁰ Trainor, p. 16.

⁵¹ Trainor, p. 17.

⁵² Trainor, p. 17, citing Hay.

⁵³ Thomson and Wilson, p. 15, citing Dow DA. *Safeguarding the public health - a history of the New Zealand Department of Health*. Wellington: Victoria University Press, 1995, p. 233.

Committee on Smoking stated that the general tobacco education and health promotion campaigns at the time might not be effective for Māori.⁵⁴ A 1984 study confirmed that part of the reason for the higher mortality rate of Māori compared to non-Māori was due to higher Māori rates of smoking tobacco.⁵⁵

In response to general research findings, the government began implementing a range of new tobacco smoking control measures. These included more legal controls, voluntary agreements with the tobacco industry, health promotion and policy, and increases in taxation. The main actions the government took were:

- a Department of Health national anti-smoking campaign in conjunction with the National Heart Foundation and the Tuberculosis and Chest Disease Society in 1970;
- warning notices on tobacco packaging and restrictions on advertising in cinemas and on billboards (both voluntary) in 1973;
- restrictions on smoking on aircraft in 1974;
- the establishment of the Advisory Committee on Smoking and Health in 1976 (which by 1980 included a representative from the Department of Māori Affairs);
- tobacco being considered a toxic substance under The Toxic Substances Act 1979;
- an increase of 15 per cent in the tobacco tax in 1979⁵⁶; and
- a Department of Health mass media campaign in 1979 and 1980.

Tobacco smoking control measures in the 1980s were further strengthened with the following initiatives:

- the Department of Health appointment of a Principal Medical Officer to focus on tobacco control and monitoring in 1984;⁵⁷
- anti-smoking television campaigns in 1984, 1986 and 1988;⁵⁸
- a goal to have 80 per cent of adults smoke-free by 1990 adopted by the Department of Health in 1985;⁵⁹
- a tax-induced rise of 53 per cent in the prices of tobacco in 1986;⁶⁰
- further warnings on tobacco cigarette packaging in 1987;
- the prohibition of chewing tobacco due to the associated risk of cancer of the mouth in 1987;⁶¹

⁵⁴ Thomson and Wilson, p. 15.

⁵⁵ Thomson and Wilson, p. 23.

⁵⁶ Thomson and Wilson, pp. 15-18.

⁵⁷ Thomson and Wilson, p. 26.

⁵⁸ Thomson and Wilson, p. 30.

⁵⁹ Thomson and Wilson, p. 26.

⁶⁰ Thomson and Wilson, p. 29.

⁶¹ Thomson and Wilson, p. 29.

- further tobacco tax price increases throughout 1988 (resulting in a doubling of the real price of tobacco between 1986 and 1991);⁶²
- the end of Reserve Bank credits for tobacco growers 1988;
- domestic airlines banning smoking on aircraft in 1988⁶³; and
- sale of tobacco to children under 16 years of age being prohibited by The Toxic Substances Regulations Amendment of April 1988.⁶⁴

The government's general tobacco control measures described above were supported by the efforts of non-government organisations and advocacy groups during the 1970s and 80s, such as the Cancer Society and Heart Foundation, and reflected similar changes occurring internationally.⁶⁵

The result of the raft of measures put in place in the 1970s and 80s was a decrease in overall smoking prevalence rates in New Zealand between 1976 and 1989. From 1976 to 1981 the smoking prevalence rate fell from 36 per cent to 32 per cent for the general population. However, for Māori there was only a small decrease of two per cent in smoking prevalence from 58 to 56 per cent over the same five-year period.⁶⁶ The 1980s also saw a reduction in smoking prevalence rates from 32 per cent of the total population in 1984 to 27 per cent in 1989. Māori smoking rates decreased but were still almost double the rate of the general population.⁶⁷

Most significantly, during the 1970s and 80s, despite Crown knowledge of the very high rates of Māori smoking and several decades of tobacco control, none of these measures targeted Māori specifically. It was not until the 1990s, in response to demands from Māori, that the government launched campaigns aimed at reducing the Māori smoking rate. In 1993, around 50 Māori smoke-free advocates from across New Zealand met at Turangawaewae Marae to discuss strategies for reducing the rate of Māori smoking at a national level. The hui was part of the government's national consultation with Māori on an appropriate national strategy to reduce the Māori smoking rate.⁶⁸ In the report back on the hui, the Public Health Commission advised the Minister of Health that smoking among Māori was a significant problem and that the rates of lung cancer amongst Māori women remained the highest in the world. The commission stated that 'a concerted effort is needed if these problems are to be effectively addressed'.⁶⁹

⁶² Thomson and Wilson, p. 29.

⁶³ Thomson and Wilson, p. 30.

⁶⁴ Thomson and Wilson, p. 30.

⁶⁵ Trainor, pp. 19, 25-26.

⁶⁶ Trainor, p. 15.

⁶⁷ Trainor, p. 21.

⁶⁸ Public Health Commission, *Maori Smokefree: Report on the Hui for Maori Smokefree Programme Development*, April 1994, p.1. The Hui was held 28-29 October 1993 at Turangawaewae Marae, Ngaruawahia.

⁶⁹ Public Health Commission, p.1.

Hui participants were of the view that smokefree promotion had not been effective for Māori.⁷⁰ The report of the hui stated that:

It was acknowledged that if Māori had the same problems and the same challenges for smokefree as Pākehā had, there would have been the same decrease in negative statistics for Māori as there has been for Pākehā. But this has not happened.⁷¹

The report noted that at the time there were a number of smokefree initiatives in the participants' areas - many of them developed by Māori for Māori - including:

- five to seven-day noho marae stop smoking courses;
- smokefree marae policies;
- displaying smokefree signage;
- education and resource initiatives such as resource books and Asthma Foundation kits for kindergartens, smokefree education programmes at intermediate and secondary schools, at training colleges, Training Opportunities Programmes, and for fathers in prisons;
- a local smokefree committee in Hawkes Bay visiting local premises such as bars, restaurants and dairies to ensure compliance with the Smoke-free Environments Act 1990; and
- \$50,000 funding to Te Hotu Manawa (a national Māori health provider) to promote smokefree health education resources, initiatives and activities for Māori across the country.⁷²

The Smoke-free Environments Act 1990

The government continued to strengthen tobacco control in New Zealand in the 1990s through the passage of the Smoke-free Environments Act 1990. The Act represented an important government commitment to reduce the harm of tobacco smoking amongst the general New Zealand population. The Smoke-free Environments Act 1990 remains in place today and forms the basis of the government's current tobacco control programme, which ultimately aims to phase out tobacco smoking in New Zealand – a goal supported by Māori smoke-free advocates, Māori health professionals and Māori politicians alike. The 1990 Act consolidated earlier legislation and placed further restrictions on tobacco in a number of environments, including workplaces, public transport, and cafes and restaurants. The Act was intended to counter the normalisation of smoking that the tobacco industry had achieved over decades of marketing.⁷³ The Act regulated the marketing of tobacco products and phased out commercial sponsorship by tobacco companies, banned the sale of tobacco to children under age 16 (raised to age 18 in 1998), established the Health Sponsorship Council (to replace sponsorship of health-

⁷⁰ Public Health Commission, p.4.

⁷¹ Public Health Commission, p.4.

⁷² Public Health Commission, p.4.

⁷³ Trainor, p. 33.

related activities provided by the tobacco industry and to promote healthy living), and established the Smoke-free brand. The Act also required tobacco companies to disclose the contents of their tobacco products and enabled regulation of their tobacco products.⁷⁴ Key tobacco control initiatives implemented by the government in the 1990s following the passing of the Act included price increases on tobacco to decrease its affordability, and smoke-free campaigns run the by Health Sponsorship Council.⁷⁵

Throughout the 1990s, the issue of high Māori smoking rates, already known from the 1970s, continued to feature in smoking prevalence data and studies. A 1993 international data comparison showed lung cancer rates in Māori men and women were still the highest in the world.⁷⁶ In 1996 a Māori smoking survey was conducted by Te Ropu Rangahau Hauora a Eru Pomare at Wellington School of Medicine.⁷⁷ In the context of these studies highlighting the negative health effects of smoking for Māori, and greater calls by Māori for support from the Crown to address the problem, government tobacco control initiatives finally began to also target Māori and encourage Māori participation in providing initiatives. These initiatives can be summarised as follows:

- the establishment of a contract in 1993 between the Ministry of Health and Te Hotu Manawa Māori to work on smoke-free initiatives for Māori;⁷⁸
- a Ministry of Health contract with Te Hotu Manawa Māori in 1994 to deliver a three-year national smokefree coordination service (the Auahi Kore programme), including developing a national smokefree networking structure;⁷⁹
- the development and promotion of rangatahi smokefree resources by the Public Health Commission;
- a multimedia smoking reduction campaign targeting youth, women and Māori, launched in 1996 by the Ministry of Health;⁸⁰
- the establishment of Aparangi Tautoko Auahi Kore (ATAK) Māori smokefree coalition (later Te Reo Marama) in 1998;⁸¹
- the pilot of the Quitline Programme in the Bay of Plenty and Waikato in 1998. Quitline was formed as an initiative by the Health Sponsorship Council, Te Hotu Manawa and the Cancer Society of New Zealand;⁸²

⁷⁴ Trainor, p. 27.

⁷⁵ For further detail on what these measures were see Trainor, pp. 27-30.

⁷⁶ Thomson and Wilson, p. 56.

⁷⁷ Thomson and Wilson, p. 56.

⁷⁸ Thomson and Wilson, p. 60.

⁷⁹ Trainor, pp. 27-28, Thomson and Wilson, pp. 60, 62.

⁸⁰ Thomson and Wilson, p. 60.

⁸¹ Trainor, p. 29.

⁸² Trainor, p. 35.

- the launch of the Aukati Kai Paipa smoking cessation programme for Māori as a 2-year pilot in 1999⁸³; and
- the funding of Quitline as a national stop smoking service alongside the Quit/Me Mutu campaign in 1999.⁸⁴

In 1994, the Public Health Commission set a goal of a 20 per cent or less adult smoking prevalence rate by the year 2000.⁸⁵ However, despite the Smoke-free Environments Act 1990 and further campaigns and tobacco control measures during the 1990s, there was no change in smoking prevalence, which remained roughly 26 per cent for the total population between 1991 and 1999.⁸⁶ For Māori, the smoking rate remained much higher, fluctuating from 50 per cent in 1991, up to 54 per cent in 1993, and back down to 51 per cent by 1999. The failure to bring down smoking rates generally and especially for Māori was despite a decrease in the supply of tobacco products in New Zealand. The number of tobacco cigarette smokers remained roughly the same, but the amount of tobacco consumed decreased. This trend is explained by the Cancer Control Council in their history of tobacco control in New Zealand as possibly indicating that, rather than quitting smoking, people were cutting back on the amount of tobacco they smoked.⁸⁷ The Cancer Control Council were also of the view that a ‘package’ of interventions (such as tobacco tax increases, anti-smoking campaigns, legislation and stop smoking support services) was needed to bring down smoking prevalence rates, rather than just measures focused on single issues (such as tobacco tax increases alone).⁸⁸

Stop smoking services, 1990-2000

One of the missing interventions identified was support to stop people smoking tobacco. Up until the government began funding national stop smoking services in 1999, most New Zealanders quit smoking on their own without help or treatment.⁸⁹ There were a small number of local stop smoking programmes operating throughout New Zealand in the 1990s. These programmes were run by non-government organisations such as the Seventh Day Adventist Church, as well as several Māori stop smoking programmes, including: the Kiwi Stop Smoking Programme delivered by Aotearoa Smokefree; ‘Karakia’ – a marae based stop smoking programme delivered by Tahuna Marae’s ‘Health Through the Marae’ holistic lifestyle programme; and the ‘Noho Marae Smoking Cessation Programme’ – a residential five to seven day programme developed in 1992 by wāhine Māori in Taranaki.⁹⁰ There were also a number of stop-smoking pilots, such as the Taranaki Stop Smoking Pilot Project, and The

⁸³ Trainor, p. 29.

⁸⁴ Trainor, p. 34.

⁸⁵ Trainor, p. 28.

⁸⁶ Trainor, p. 30.

⁸⁷ Trainor, p. 31.

⁸⁸ Trainor, p. 32.

⁸⁹ Marewa Glover, ‘The Effectiveness of a Maori Noho Marae Smoking Cessation Intervention: Utilising a Kaupapa Maori Methodology’, PhD thesis, University of Auckland, November 2000, p. 70.

⁹⁰ Glover, 2000, pp. 3, 93.

Smokescreen Programme trialled in North Canterbury.⁹¹ It is not clear from the sources consulted how these programmes and pilots were funded, and whether participants were charged a fee for the service. According to Marewa Glover, a smokefree advocate and academic researcher, Māori had been making the call for more support to quit smoking since the early 1990s.⁹² Speaking about this time, she noted ‘The dearth of smoking cessation support reflects a lack of funding, not a lack of demand’.⁹³

In 1999, the government launched the national Quitline phone service after trials in Waikato and the Bay of Plenty the year before.⁹⁴ Nicotine replacement therapy was subsidised by the government from 2000.⁹⁵ Māori smokers wanting to quit smoking seemed to make good use of the Quitline service initially with a third of callers being Māori.⁹⁶ Quitline is still in operation today and is discussed further in Chapter 4. Statistics for smoking prevalence showed a decrease from 26 per cent of the total population in 1999, to 21 per cent in 2009. Māori showed a more marked decrease, although overall rates remained stubbornly higher (from 51 per cent for Māori in 1999 to 44 per cent by 2009).⁹⁷ Smoking cessation services, in combination with existing tobacco control measures, coincided with a decrease of 7 percentage points in the Māori smoking rate and a decrease of 5 percentage points across the total population in the first decade they were introduced.

Alcohol control, 1840-2000

There is a long history of government attempts to control the supply and consumption of alcohol in New Zealand, including the consumption of alcohol by Māori specifically. Those attempts began from a relatively early period and have ranged between some forms of attempted prohibition and periods of relatively light regulation and control. For Māori historically, the widespread introduction of alcohol occurred alongside colonisation. Government efforts (or lack of) to control alcohol in Māori communities has been a long standing, often contentious, issue. For some iwi and hapū, such as those associated with the Kingitanga and Rohe Pōtae, the issue of alcohol control in the 1880s also became synonymous with their attempts to exercise tino rangatiratanga over their lands and people.⁹⁸

New Zealand governments have been heavily involved in a complicated variety of efforts to manage and control the use, supply and consumption of alcohol in New Zealand. This complexity reflects the ingrained use of alcohol in society, changes in public perceptions and demands concerning the harm

⁹¹ Glover, 2000, p. 72.

⁹² Glover, 2000, p. 2.

⁹³ Glover, 2000, p. 73.

⁹⁴ Trainor, p. 29.

⁹⁵ ‘Celebrating 16 Years of Quitline’ https://quit.org.nz/-/media/Images/Quitline/PDFs-and-Docs/The-Quit-Group/qtl8005_celebration-doc_low-res_web.pdf?la=en, accessed 27 Oct 2019.

⁹⁶ Glover, 2000, p. 72 citing Quit Group April 1999.

⁹⁷ 1999 smoking prevalence rate from Trainor, p. 30, citing Ministry of Health ‘Tobacco Trends 2006: Monitoring Tobacco Use in New Zealand’. 2009 smoking rate based Ministry of Health ‘Māori Smoking and Tobacco Use 2011’, p. 1, citing Ministry of Health, ‘Tobacco Use in New Zealand: Key Findings from the 2009 Tobacco Use Survey, 2010.

⁹⁸ Cathy Marr, ‘Te Rohe Pōtae Political Engagement 1864-1886’, commissioned by the Waitangi Tribunal, Nov 2011, Wai 898, #A78.

caused by alcohol and the need for regulation. The main features of the way New Zealand has historically attempted to manage alcohol (which largely persist today) include: the licensing system, where a license is required to sell alcohol; restrictions on opening days and hours of licensed premises, such as bars and bottle stores; and the age at which people can drink in bars and purchase takeaway liquor. How well regulations and restrictions have been enforced has long been a matter of debate. Local authorities, such as provincial councils and later district licensing committees, Māori Councils and local government bodies, have also, at various times, been able to control the grant of licenses and/or impose their own restrictions on alcohol, such as banning the sale of alcohol on Sundays and banning or reducing the number of liquor outlets in their area.⁹⁹ In the case of the Māori Councils constituted under the Maori Councils Act 1900, such as the Horouta Council on the East Coast, this included a ban on bringing alcohol onto marae.¹⁰⁰ Alcohol has also always been a source of revenue for the Crown, with custom duties and alcohol excise taxes being charged since 1842.¹⁰¹

A key influence and driver of the Crown's alcohol control policies over time has been the role of local and national advocacy groups, including those aligned with the temperance and prohibition movements. Based on ideas and social movements occurring in Britain and the United States, these advocacy groups called for moderation, abstinence and, at times, a complete ban of alcohol consumption in New Zealand society. For example, the Women's Christian Temperance Union and the New Zealand Alliance for Suppression and Abolition of the Liquor Traffic campaigned for prohibition in 1885 and 1886, respectively. The wishes of Rohe Pōtae and Kingitanga leaders to curb alcohol-related harm in their district was supported by temperance movement campaigners. For a lengthy period, the legal sale of alcohol was banned in the Rohe Pōtae in 1884, rendering it a 'dry' district.¹⁰²

Since alcohol was introduced to Aotearoa, Crown policies and legislation have also ranged between attempts to regulate/control the sale and consumption of alcohol in Māori communities to minimise any harmful health and social effects, to outright bans. Māori too have sought to control its supply and consumption. As early as the 1830s, there were attempts by local Māori and Pākehā to keep alcohol out of the Hokianga.¹⁰³

There is a lengthy history of government provisions to control alcohol targeted specially at Māori, including a greater propensity to provide for prohibition. The Crown's first official attempt to control

⁹⁹ Paul Christoffel, 'Liquor laws - The temperance influence', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/liquor-laws/page-2> (accessed 11 November 2019), Story by Paul Christoffel, published 5 Sep 2013, updated 15 Dec 2014.

¹⁰⁰ Hutt, p. 52.

¹⁰¹ Brett McEwan, Maxine Campbell, Antonia Lyons, David Swain, *Pleasure, Profit and Pain: Alcohol in New Zealand and the Contemporary Culture of Intoxication*, Hamilton, 2013, p. 6.

¹⁰² Paul Christoffel, 'Liquor laws - The temperance influence', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/liquor-laws/page-2> (accessed 11 November 2019), Story by Paul Christoffel, published 5 Sep 2013, updated 15 Dec 2014.

¹⁰³ Hutt, p. 19.

the supply of alcohol to Māori after the signing of the Treaty was an 1847 Ordinance to Prohibit the Sale of Spirits to Natives, which banned the supply, including gifting, of alcohol to Māori. That Act remained in place until 1881, thereby establishing a system by which Māori were regularly banned from better regulated establishments. At the same time, historians have noted that the Ordinance was poorly policed and enforced in practice.¹⁰⁴ The result was that Māori were more likely to be subject to more illicit ‘sly-grog’ alcohol suppliers.

As warfare, land confiscation and Pākehā settlement displaced Māori from their traditional lands and communities, and alcohol consumption and harmful health impacts amongst Māori became a more obvious problem, the government responded with further efforts to restrict the supply of alcohol in Māori communities. For example, The Native Districts Regulation Act 1858 enabled Native districts to be proclaimed as dry zones (although bush licenses for settlers were still permitted). The Act was proclaimed in the Upper Waikato in 1861 and the Bay of Islands in 1863.¹⁰⁵

The consumption of alcohol by Māori increased during the height of the New Zealand Wars in the 1860s.¹⁰⁶ Kupapa who fought in alignment with the Crown during the wars were issued rum as part of their daily rations, which contemporary observers suggest may have contributed to an increase in Māori taste for and habit of consuming spirits.¹⁰⁷

Māori continued to attempt to create and enforce their own liquor restrictions in their rohe. For example, in the Bay of Islands in the early 1860s the local runanga issued its own restrictions on Māori acquiring alcohol, as well as rewards for Māori informants.¹⁰⁸ Rohe Pōtae (King Country) Māori attempted to prevent liquor from entering their district. Māori from different parts of the country also petitioned Parliament for greater alcohol control measures. For example, a petition from six rangatira from Te Arawa in 1866 asked that no liquor license be issued on their lands.¹⁰⁹ Similarly, in 1879, iwi across the South Island petitioned for a total ban on alcohol in the southern provinces.¹¹⁰

Perhaps the most well-documented and relatively successful attempts by Māori to control liquor in their rohe during the 1860s and beyond are those of Rohe Pōtae Māori and the Kingitanga, for whom liquor control was a long-standing issue. Their stance on banning liquor became virtually synonymous with their expression of tino rangatiratanga over their lands within the external boundary of the Rohe Pōtae.

¹⁰⁴ Hutt, p. 19; McDowell, p. 105.

¹⁰⁵ Hutt, p. 29.

¹⁰⁶ Hutt, pp. 27-30.

¹⁰⁷ Hutt, p. 29, citing John Miller, *Early Victorian New Zealand. A Study of Racial Tension and Social Attitudes 1839-1852* [1958] (Oxford University Press, Wellington, 1974), p. 167. See report by W.G. Mair (Native Officer, Alexandra), in *AJHR*, 1872, F-3.

¹⁰⁸ Hutt, p. 28, citing Alan Ward, *A Show of Justice. Racial ‘Amalgamation’ in Nineteenth-Century New Zealand* [1974] (Auckland University Press/Oxford University Press, Auckland, 1983), p. 144.

¹⁰⁹ Hutt, pp. 29, citing *AJHR* 1866. Schedule of Petitions. Quoted in Paul Frederick McKimney, ‘The Temperance Movement in New Zealand, 1835-1894’ (M.A., University of Auckland, 1968), p. 209.

¹¹⁰ Hutt, p. 30, citing Stevan Eldred-Grigg, *Pleasures of the Flesh. Sex and Drugs in Colonial New Zealand 1840-1915* (Reed, Wellington, 1984), p. 87.

The first official recognition of their district boundary (and their authority within it) was as a licensing control district in the mid-1880s. Rohe Pōtae Māori also faced problems arising from attempting some form of liquor prohibition from an early period, as their district then became subject to illicit liquor supply and widespread avoidance of liquor control efforts. Nevertheless, much of the district continued to support stricter-than-usual alcohol controls through to the 1950s.¹¹¹

The Crown continued to pass legislation providing for the establishment of 'dry' Native districts in the latter part of the nineteenth century, although again with a more mixed record in practical enforcement. Part of the pressure for the government to act came from the obvious links between the harmful effects of alcohol and the Native Land Court process for determining title to Māori land, which was provided from the 1860s. The Native Land Court process saw Native Land Court towns becoming notorious for encouraging drunkenness and shady land purchasing.¹¹²

The Outlying Districts Sale of Spirits Act 1870 established twelve new Native Licensing Districts in areas outside of established Pākehā towns where Māori made up at least two-thirds of the population and gave the Governor powers to restrict licenses and impose harsher penalties for alcohol-related offences in these districts.¹¹³ The Native Lands Frauds Prevention Act 1870 prohibited the use of alcohol in connection with land sales. Further legislation in the late 1870s and early 1880s, such as The Native Licensing Act 1878 and The Licensing Act 1881, continued to provide for tougher restrictions for alcohol licenses and to penalise alcohol-related offences within Native districts. Again, these laws were seriously weakened in practice because of a lack of enforcement.¹¹⁴

The premise for targeting Māori was also infused with early assumptions that abuse of alcohol was largely a moral and criminal failing, easily extended to assumptions that Māori as a race were unable to handle liquor or more prone to moral failing and addiction. Some of these attitudes found their way more explicitly into liquor controls. From 1880, the Crown passed further legislation to control the supply of alcohol to Māori, including The Alcoholic Liquors Sale and Control Amendment Act 1895, which banned the sale of alcohol to Māori women (unless they were married to a European), and the Licensing Amendment Act 1904, which prohibited Māori from purchasing take-away alcohol in the majority of the North Island.¹¹⁵ These Māori-specific provisions remained in force until after the Second World War. These laws also formed part of a larger series of liquor laws aimed at controlling obvious

¹¹¹ Marr, pp. 131-132, 1029-1030; for the period up to the 1950s see also Hutt, pp. 95-108.

¹¹² Richard Boast, *Buying the Land, Selling the Land: Governments and Maori Land in the North Island 1865-1921*, Wellington, 2008, p. 77.

¹¹³ McDowell, p. 104.

¹¹⁴ Marr, pp. 313, 620; McDowell, p. 105; Hutt, p. 43. Further detail about the particular operation of these Acts in the Rohe Pōtae (King Country) can be found in Cathy Marr, 'Te Rohe Pōtae Political Engagement 1864-1886', commissioned by the Waitangi Tribunal, Nov 2011, Wai 898, #A78.

¹¹⁵ Megan Cook, 'Māori smoking, alcohol and drugs – tūpeka, waipiro me te tarukino - Māori use of alcohol', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/maori-smoking-alcohol-and-drugs-tupeka-waipiro-me-te-tarukino/page-2> (accessed 24 October 2019) Story by Megan Cook, published 5 Sep 2013.

drunkenness, such as The Licensing Act 1881, and The Alcoholic Liquors Sale Control Act 1893, which were strongly lobbied for by temperance organisations and worked to limit the number of licensed premises within local communities.¹¹⁶ These wider laws applied to all New Zealanders, Māori and non-Māori.¹¹⁷

Alcohol – like tobacco – was commonly, often heavily, consumed by military personnel, including Māori serving in the First (1914-1918) and Second (1939-1945) World Wars.¹¹⁸ After the Second World War, racially-based restrictions on Māori access to alcohol were removed by The Licensing Amendment Act 1948. This occurred amongst broader moves to integrate or assimilate Māori into Pākehā society. The removal of these restrictions caused debates within Māori communities. They were generally supported by Māori returned servicemen who wanted to be treated equally with their Pākehā comrades. Other Māori, such as Te Puea Hērangi and King Korokī who represented the Kingitanga, opposed the reforms, as they remained worried about the effects of alcohol on Maori in general, especially as Māori moved to urban areas.¹¹⁹ Coupled with post-War Māori urbanisation, further increases in Māori consumption of alcohol and public reaction to perceptions of Māori drinking, problems continued to cause concern amongst government officials into the 1950s.¹²⁰

From the 1950s through to the 1980s, official concerns about heavy levels of Māori alcohol consumption continued, the harmful health effects of which were now more closely linked and better understood. The continued concerns were also linked to the ongoing urbanisation of Māori and the increase in availability and opportunities for Māori to drink in the cities.¹²¹ The government responded to long-standing Māori concerns to participate in alcohol control in their own communities with measures such as powers for Māori wardens under the Māori Social and Economic Advancement Act 1945. These powers for Māori wardens to control alcohol were transferred to The Māori Community Development Act 1962, which still operates today. The 1962 Act gives Māori wardens the power (within the areas they are authorised to act) to control Māori alcohol consumption on licensed premises or at Māori gatherings or meeting places, including warning licensees to stop serving alcohol to intoxicated Māori, ordering any intoxicated Māori to leave licensed premises and seizing liquor and car keys from intoxicated Māori at Māori gatherings and meeting places.¹²² However, it appears that the

¹¹⁶ McEwan et al., p. 7.

¹¹⁷ Further information on liquor legislation from the 1840s to today can be found in Paul Christoffel, 'Liquor laws', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/liquor-laws/print> (accessed 24 October 2019). Story by Paul Christoffel, published 5 Sep 2013, updated 15 Dec 2014.

¹¹⁸ Kesaia Walker, 'Health and Social Impacts of Māori Military Service for the Crown, 1845-present' August 2018, Wai 2500 #A251.

¹¹⁹ Hutt, p. 73, citing Michael King, *Te Puea* [1977] (Sceptre, Auckland, 1990), pp. 252-253.

¹²⁰ Hutt, p. 76, citing Wira Gardiner, *Te Mura o Te Ahi. The Story of the Maori Battalion* (Reed, Auckland, 1992), p. 183.

¹²¹ Hutt, pp. 76-77.

¹²² Waitangi Tribunal, *Whaia Te Mana Motuhake: In Pursuit of Mana Motuhake: Report on the Māori Community Development Act Claim*, pre-publication version, Wellington, 2014, p. 4.

role of Māori wardens in relation to alcohol has become less of a focus over time.¹²³ The role of Māori wardens historically in relation to controlling alcohol and the way in which their role has changed is discussed in more detail in the Waitangi Tribunal's 2014 report *Whaia Te Mana Motuhake: In Pursuit of Mana Motuhake: Report on the Māori Community Development Act Claim*.¹²⁴

In the 1970s, concerns about the nation's problematic drinking culture in general resulted in the appointment of a Royal Commission in 1974 to investigate the matter.¹²⁵ The commission found that New Zealand's drinking culture had transformed into one that increasingly accepted and tolerated drunken behaviour.¹²⁶ One of the Commission's recommendations led to the establishment of the Alcoholic Liquor Advisory Council (ALAC) in 1976 as an independent Crown entity to coordinate a nationwide approach to alcohol issues. ALAC was tasked with developing alcohol policy and advice, educational material and undertaking research, surveys and national health promotion campaigns, as well as funding treatment services in its earlier days.¹²⁷ ALAC's role in the context of treatment services is discussed later in this chapter.

During the 1960s and 1970s, an increasingly affluent and well-travelled New Zealand public began to reject more restrictive liquor controls and thinking on reforms turned to efforts to moderate drinking behaviour. In response, the government began providing legislative reform that loosened restrictions on the availability and supply of alcohol, such as the end of six-o'clock closing in 1967, and increases in the number of liquor licenses, licensed hours and premises that could serve alcohol, such as restaurants, taverns, cabarets and sports clubs. Many of the reforms were based on encouraging more moderate drinking of alcohol alongside entertainment and food.¹²⁸ Such efforts have only had limited success in addressing drinking cultures and related harmful outcomes.

The government conducted a review of New Zealand's alcohol laws in 1986.¹²⁹ While the 1974 Royal Commission had expressed concerns about perceptions of New Zealand's deteriorating drinking culture, the 1986 review recommended further liberalisation of alcohol legislation to again encourage a more moderate approach to alcohol consumption. In 1989, the government enacted the Sale of Liquor Act. This Act was intended to reform New Zealand from a 'dry' culture of heavy – mainly weekend –

¹²³ Stuff, 'Scrap Maori wardens' powers over drunken Maori but keep the wardens themselves', 6 Jan 2016, <https://www.stuff.co.nz/dominion-post/75670024/scrap-maori-wardens-powers-over-drunken-maori-but-keep-the-wardens-themselves>, accessed 13 Dec 2019.

¹²⁴ Waitangi Tribunal, *Whaia Te Mana Motuhake: In Pursuit of Mana Motuhake: Report on the Māori Community Development Act Claim*, pre-publication version, Wellington, 2014, pp. 14-15.

¹²⁵ McEwan et al., p. 84.

¹²⁶ McEwan et al., p. 38.

¹²⁷ McEwan et al., p. 85.

¹²⁸ McEwan et al., p. 23; see also Paul Christoffel, 'Liquor laws', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/liquor-laws/print> (accessed 24 October 2019). Story by Paul Christoffel, published 5 Sep 2013, updated 15 Dec 2014.

¹²⁹ McEwan et al., p. 28.

drinking, to one more akin to a ‘wet’ South European style drinking culture where alcohol was more moderately consumed alongside food and entertainment.¹³⁰

The Sale of Liquor Act 1989 reduced the type of liquor licenses down from 29 to just four and gave local government the power to make decisions about liquor licenses and trading hours in their district.¹³¹ Amendments in the 1990s enabled supermarkets and grocery stores to sell beer and wine. In 1999, just prior to the millennium celebrations in New Zealand, a number of further changes were made, including 24-hour trading, Sunday trading, and lowering the purchase age from 20 to 18.¹³² However, without a public campaign to encourage different drinking behaviours, the net effect of the Act and its amendments has been a proliferation of off-license premises (bottle stores, grocery stores and supermarkets), leading to a substantial increase in liquor outlet density in New Zealand and making alcohol more widely available than ever before.¹³³ In the 2000s, alcohol-focused community groups raised urgent concerns about research indicating a rise in alcohol consumption and the country’s drinking culture, particularly amongst young people.¹³⁴ These debates are still ongoing today.

Controls of other addictive substances

Illegal drugs and other psychoactive substances, like alcohol, have long been the subject of regulatory legislation in New Zealand, such as opium in 1866, morphine in 1908, and heroin, cocaine and cannabis (sometimes referred to as ‘Indian hemp’) in the 1920s.¹³⁵ However, the use of and addiction to drugs and other psychoactive substances was not officially recognised as a major issue affecting Māori until the 1970s, when drug use and addiction increased generally across New Zealand. Key legislation during this period included The Misuse of Drugs Act 1975, which still governs drugs today from a justice/criminal perspective and the Alcoholism and Drug Addiction Act 1966. The 1966 Act provided for compulsory treatment of alcoholics from a health perspective and is discussed further below. This Act was recently repealed and replaced by the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

¹³⁰ McEwan et al., p. 101.

¹³¹ Paul Christoffel, 'Liquor laws - Radical reform', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/liquor-laws/page-4> (accessed 31 October 2019) Story by Paul Christoffel, published 5 Sep 2013, updated 15 Dec 2014.

¹³² McEwan et al., p. 28; Paul Christoffel, 'Liquor laws - Radical reform', Te Ara - the Encyclopedia of New Zealand, <http://www.TeAra.govt.nz/en/liquor-laws/page-4> (accessed 31 October 2019) Story by Paul Christoffel, published 5 Sep 2013, updated 15 Dec 2014.

¹³³ In the early 1990s off-license premises numbered around 1600. In the 2010s, there were over 4,000 off-licenses. See McEwan et al., p. 61.

¹³⁴ McEwan et al., p. 101.

¹³⁵ New Zealand Law Commission, *Controlling and Regulating Drugs*, IP16, Wellington: New Zealand Law Commission 2010, p. 45.

In the nineteenth century, drugs such as opium and morphine were widely available as medicines and their consumption was gradually regulated, rather than prohibited by legislation.¹³⁶ At first their addictive properties were not well understood, and misuse continued to be perceived as a largely private and moral problem. In the early 1900s, the medical profession began to consider whether some of these drugs/medicines contained addictive substances and could cause harm.¹³⁷ In 1908, the government followed international trends and consolidated previous opium legislation under the Opium Act 1908 and implemented the international Opium Convention in 1912 by further regulating the importation and distribution of opium and other drugs. In 1924, the government also signed up to the International Convention relating to Opium and Other Dangerous Drugs which controlled the manufacture, sale, importing, exporting and distribution of a range of drugs. In 1925, cannabis was added to the list of controlled drugs under the Convention.¹³⁸

A further result of New Zealand's adherence to the 1924 Convention was the passing of The Dangerous Drugs Act 1927, which included a schedule of psychoactive substances under the Act, including cannabis. The Act's overall response was to criminalise the issue by making it a criminal offence to manufacture, sell or distribute what was considered to be a dangerous drug without a license.¹³⁹

In the following decades, New Zealand continued to follow the lead of international conventions on drugs and responded with provisions providing for criminalisation of use and distribution. This included signing up to the Single Convention on Narcotic Drugs 1961, which the government implemented through the Narcotics Act 1965. The 1965 Act included cocaine, cannabis, LSD and other hallucinogens and made it illegal to possess any of these drugs.¹⁴⁰

In the 1960s, alcoholism also became officially recognised as an addiction illness and in 1966 the government passed the Alcoholism and Drug Addiction Act, which provided for alcoholics and drug addicts to be committed and detained under the Act to receive compulsory assessment, detox and treatment in certified institutional settings.¹⁴¹

The 1960s also saw a twofold increase in hospitalisations for drug dependence.¹⁴² Statistics for Māori rates of hospitalisation for similar issues have not been located for the same period. In the late 1960s, the government reviewed its drug laws in consideration of growing public concerns about drug abuse

¹³⁶ For example, The Sale of Poisons Act 1866 and the later Sale of Poisons Act 1908 regulated the sale of opium and morphine, such as restricting the amounts that could be prescribed or sold. NZLC IP 16, 2010, pp. 44-45.

¹³⁷ NZLC IP 16, 2010, p. 44.

¹³⁸ NZLC IP 16, 2010, pp. 46-47.

¹³⁹ NZLC IP 16, 2010, pp. 46-47.

¹⁴⁰ NZLC IP 16, 2010, p. 49.

¹⁴¹ NZLC IP 16, 2010, p. 358.

¹⁴² NZLC IP 16, 2010, pp. 50-51.

and addiction and in the context of perceptions of the widespread rise of recreational drug use. The results of this review led to the development and passing of the Misuse of Drugs Act 1975.

The Misuse of Drugs Act 1975, which continues to be largely a punitive/criminal justice law, prohibits the use, possession, supply, manufacture or importation of all illegal (referred to as ‘controlled’ in the legislation) drugs, unless otherwise allowed for under the Act (such as for medical or scientific reasons). The Act also classifies drugs into classes A, B and C based on their relative potential to cause harm and sets out the penalties for possession, selling, supplying, importing and manufacturing illegal drugs. The Act remains as the basis of New Zealand’s drug law today, even as debate has moved toward considering a greater emphasis on treating addiction as a health issue and the impossibility of preventing recreational use of various kinds of plant and chemical-based substances. That debate has become more focused with the difficulties of addressing use and distribution of synthetic drugs. Several recent amendments to the Act have attempted to respond to public and medical professional concerns in dealing with synthetic and medicinal cannabis issues. The Psychoactive Substances Act 2013 was also enacted in response to growing concerns about synthetic cannabis and other unregulated psychoactive substances (such as herbal highs and party/energy pills). The Act is further discussed in Chapter 3.

Alcohol and other drug addiction treatment services, 1910-2000

Prior to the 1970s, treatment in New Zealand for alcoholism and drug addiction, in particular, was limited. In 1910, the Salvation Army established the first residential treatment facility for alcoholics on Rotorua Island in the Hauraki Gulf. Under the Habitual Drunkards Act 1906, resident magistrates could compel alcoholics to undergo residential treatment there.¹⁴³ Non-government organisations such as the New Zealand Women’s Christian Temperance Union carried out national alcohol intervention campaigns in the 1930s.¹⁴⁴ But it was only from the 1950s that alcoholism began to be treated as a health problem rather than a ‘moral weakness’.¹⁴⁵

In the late 1960s, Queen Mary Hospital in Hanmer Springs began specialising in treating alcoholism. Prior to this it was military hospital treating returned soldiers suffering from shell shock and other psychiatric disorders. Queen Mary Hospital became one of the most well-known providers of treatment services for alcoholics in New Zealand, including a Māori support group in the early 1980s and the formal Taha Māori programme in 1990.¹⁴⁶ Non-government organisations, such as the Salvation Army, Alcoholics Anonymous (established in New Zealand in the late 1940s and early 1950s), and the New Zealand Society on Alcohol and Drug Dependence (NSAD) filled some of the void by providing and

¹⁴³ McEwan et al., p. 82.

¹⁴⁴ McEwan et al., p. 82.

¹⁴⁵ McEwan et al., p. 82.

¹⁴⁶ Cave et al., pp. 30, 48.

lobbying for treatment services.¹⁴⁷ The Alcoholism and Drug Addiction Act 1966, which was lobbied for by NSAD, marked the beginning of the government taking greater responsibility for alcoholism and drug addiction as a health issue.¹⁴⁸ The 1966 Act enabled funding for non-government organisations, such as NSAD, the Salvation Army and Presbyterian Support Service to provide alcohol and other drug addiction treatment services.¹⁴⁹

Prior to the 1970s, there were only a few Māori clients or Māori workers amongst alcohol and drug addiction treatment services in New Zealand.¹⁵⁰ A small number of Māori attended Alcoholics Anonymous, Narcotics Anonymous and Al Anon (for families and friends of alcoholics), but these numbers began to rise in the late 1970s and early 1980s.¹⁵¹

In the early 1970s, there were approximately 20 alcohol treatment services located around New Zealand. The first methadone programmes (also referred to as opioid substitution treatment, which aids opioid users to detox or reduce the harm associated with illegal opioid use) were also established in the 1970s.¹⁵² The 1974 Royal Commission on the Sale of Liquor recommended that the lack of treatment services be remedied, with ALAC to have a role in improving the situation. As noted earlier, ALAC was established in 1976 and began operating in 1978 as a national independent advisory body developing and coordinating alcohol policy advice, education, public health promotion and alcohol treatment services across New Zealand. Mason Durie was appointed to ALAC in 1978 and there appears to have been other Māori representatives on ALAC from 1978 until it was disestablished in 2012.¹⁵³

In the 1980s, a more collective and coordinated response to Māori experiencing addiction-related harm began to develop. In terms of community initiatives, Māori specific meetings of Alcoholics Anonymous, Al Anon, and Narcotics Anonymous began in Christchurch.¹⁵⁴ A number of kaupapa Māori residential treatment services were established in the early 1980s. The Māori Support Group was set up by Māori staff at Queen Mary Hospital in 1982 and was made official in 1988.¹⁵⁵

ALAC had an important role in assisting to develop the Māori AOD sector alongside other community-based and grassroots initiatives led by Māori.¹⁵⁶ In 1984, ALAC appointed a National Māori Coordinator and in 1988 a Māori Advisor to focus on and support a Māori response to alcohol-related harm.¹⁵⁷ Between the mid-1970s and mid-1980s ALAC worked to establish a network of alcohol

¹⁴⁷ McEwan et al., p. 83.

¹⁴⁸ McEwan et al., pp. 81, 83.

¹⁴⁹ McEwan et al., p. 83.

¹⁵⁰ Cave et al, pp. 22, 24.

¹⁵¹ Cave et al., pp. 22-23.

¹⁵² Cave et al., p. 24.

¹⁵³ Cave et al., p. 27.

¹⁵⁴ Cave et al. p. 35.

¹⁵⁵ Cave et al., pp. 28-29.

¹⁵⁶ Cave et al., p. 36.

¹⁵⁷ Cave et al., p. 34.

treatment facilities across New Zealand, increasing the number of services to 80.¹⁵⁸ By this time, many regional hospital boards were funding their own alcohol treatment services, so ALAC was mainly funding community-based providers, such as NSAD, the Salvation Army, and Presbyterian Support to deliver these services.¹⁵⁹

The first kaupapa Māori AOD service established under ALAC was Te Utuhina Manaakitanga in Rotorua.¹⁶⁰ In 1985, Māori alcohol and drug sector professionals came together for a national hui, after which a national network was established to present a Māori voice in the sector.¹⁶¹ In 1987, ALAC developed the ‘Kua Makona’ campaign and resources specifically targeting Māori. By 1989, ALAC was funding five Māori treatment service providers in Auckland, Wellington, Christchurch, Hamilton and Invercargill together with regional resource and training materials.¹⁶² In the early 1990s, funding for alcohol treatment was transferred from ALAC to Regional Health Authorities (the predecessors of DHBs). It has not been possible in the time available to identify any sources showing what success these providers have had in the provision of alcohol treatment services for Māori.

The 1990s saw an increase in the numbers of Māori accessing treatment, as well as an increase in Māori working in the sector. Non-Māori specialist services also began developing a Māori specific approach within mainstream services.¹⁶³ There was also an increase in Māori influence and presence in organisations in the sector.¹⁶⁴ The flourishing interest in the Māori AOD sector developed in the context of greater Māori activism for land rights, language, recognition of Treaty rights and recognition of Māori tino rangatiratanga over issues affecting Māori such as justice, social welfare and health.¹⁶⁵

New Zealand’s first National Drug Policy 1998-2003

In 1998 the government developed its first National Drug Policy (NDP), which was applied to the use of tobacco, alcohol and other drugs.¹⁶⁶ The policy explicitly set out the government’s commitment to minimising drug-related harm in New Zealand. Māori, along with young people, pregnant women and people with co-existing substance and mental health needs were identified as key groups most at risk of tobacco, alcohol and other drug-related harm.¹⁶⁷ The five national priorities of the policy were to:

1. enable New Zealanders to improve their health by limiting tobacco, alcohol and other drug-related harm;

¹⁵⁸ McEwan et al., p. 127.

¹⁵⁹ McEwan et al., p. 127.

¹⁶⁰ Cave et al., p. 39.

¹⁶¹ Cave et al., p. 40.

¹⁶² McEwan et al., p. 127.

¹⁶³ Cave et al., p. 61.

¹⁶⁴ Cave et al., p. 67.

¹⁶⁵ Cave et al., p. 16.

¹⁶⁶ NDP 1998, p. iii.

¹⁶⁷ NDP 1998, p. 2.

2. reduce the prevalence of tobacco smoking and second-hand smoke exposure;
3. reduce hazardous drinking and associated harm, such as injury, violence, road accidents and accidents in the workplace, at home and in and around other drinking environments;
4. reduce the rates of cannabis and other drug use; and
5. reduce the health risks, crime and social impacts associated with illicit drugs and other drugs used inappropriately.¹⁶⁸

The policy acknowledged the disproportionate harm suffered by Māori from the use of tobacco, alcohol and other drugs and that the Crown's strategies to reduce harm across the general New Zealand population had a limited effect on reducing harm amongst Māori. The policy also acknowledged the Crown's Treaty responsibility to ensure Māori enjoyed the same level of health as non-Māori. The policy specified a number of desired outcomes for Māori, including: a reduction in the Māori smoking prevalence and cannabis use rates; a reduction in the rate of hazardous and harmful drinking amongst Māori; and a reduction in the rate of death and injuries caused by alcohol-related motor vehicle accidents for Māori.¹⁶⁹

The policy set out to do this by reducing the supply of, and individual demand for, drugs through an intersectoral approach of governmental agencies such as the Ministries of Health, Corrections, Customs, Justice, Te Puni Kōkiri, Youth Affairs, Transport and Education, the Police, ALAC, and the Land Transport Safety Authority, as well as national and local community networks. Strategies included information, research and evaluation, health promotion, treatment services, assessment and advice, legislation and policy and law enforcement.¹⁷⁰

Within the policy the government also advocated for more Māori self determination to address tobacco, alcohol and other drug-related harm. The policy stated:

Problems in Māori communities may be addressed more effectively when targeted approaches are developed by and for Māori, because of the need for in-depth knowledge of the Māori community, and for acceptable and effective approaches to use when advocating changes in behaviour and lifestyle.¹⁷¹

The policy also stated the importance of 'Māori cultural components', tailoring services for Māori, increasing the knowledge, training and skills within the Māori AOD workforce and of local approaches that reflect the particular needs of local hapū and iwi.¹⁷² These issues capture ideas around cultural

¹⁶⁸ NDP 1998, p. 1.

¹⁶⁹ NDP 1998, p. 14, see also p. 38 in relation to other drugs.

¹⁷⁰ NDP 1998, pp. 11, 31-34.

¹⁷¹ NDP 1998, p. 14, see also p. 38 in relation to other drugs.

¹⁷² NDP 1998, pp. 17, 21.

responsiveness of services and support of the Māori addictions workforce, which continue to be priority areas for the delivery of addiction services to Māori today.

Of major significance is whether the government's goals and aspirations as expressed in the 1998 Drug policy have been realised for Māori in the two decades since it was released. This will be discussed in the next chapter of this report.

Summary

Between 1960 and 2000, the Crown progressively tightened tobacco control, using legislation and public health campaigns to restrict its supply and de-normalise tobacco smoking in New Zealand. The Smoke-free Environments Act 1990 and its later amendments have been most significant in achieving this goal. In the face of stagnant smoking rates amongst Māori in the 1990s, Māori called for greater support from the Crown for smoking cessation services and for support to develop solutions by Māori for Māori to address the disparities in smoking rates. In the context of rising Māori activism and more awareness of Treaty principles in the 1980s and 1990s, this approach was supported by the government in its 1998-2003 National Drug Policy. Tobacco control initiatives targeting Māori smoking rates were rolled out in 1999, with some signs of success in reducing smoking rates, but the disparity between Māori and non-Māori remained stubbornly high.

For the first 100 years from 1840 to 1940, the Crown's methods of controlling alcohol included provisions specifically targeting Māori as well as wider provisions. These were a response partly to pressure from Pākehā communities, but also from Māori determined to control harm in their communities, especially as alcohol abuse was linked with land loss and demoralisation following the wars. The focus of targeted provisions for Māori also tended to be more prohibitionist than for the community in general, although these targeted provisions were only poorly enforced. The presence of such regulation, nevertheless, meant some Māori communities also faced problems arising from prohibition and were therefore involved more keenly in debates around the merits of control and prohibition. The desire to restrict alcohol-related harm in Māori communities occurred at a time when Māori were still grappling with the impacts of warfare, land loss and Pākehā settlement. However, after the Second World War, there were changes in attitudes in New Zealand society about how Māori should be treated, and in 1948 the Crown began removing all racially-based liquor legislation targeting Māori. Such a move was debated within Māori communities, being largely supported by returned Māori servicemen, but not by all Māori, particularly those concerned with the wider health impacts.

The Crown's regulation of other drugs and psychoactive substances has only really been of significance for Māori since the 1970s, when Māori first started coming into contact with drugs like cannabis. In the 1970s, New Zealand's harmful drinking culture came under the spotlight, and ALAC was established

as an independent Crown entity to provide advice, monitoring and establish a network of alcohol treatment services across the country. ALAC also worked with Māori to establish a network of kaupapa Māori services in the main centres by the late 1980s. Around this time, Māori were continuing to do the ground work to establish the beginnings of a Māori AOD sector across the country. The further liberalisation of alcohol laws in 1989 and the 1990s saw the growth in demand for Māori AOD treatment services and workers leading into the year 2000.

3 – Current context: tobacco, alcohol, and other substance abuse legislation, policy and Māori response, 2000 to the present

Introduction

This chapter builds on the earlier history from Chapter 2. It discusses the last two decades of legislative and policy developments relevant to the government's control of tobacco, alcohol and other substances as well as interventions to prevent or minimise related harms, especially for Māori. Addiction services are also covered, with a focus on the continuing role of the Māori alcohol and other drug treatment sector and the role of national agencies tasked with addressing tobacco, alcohol and other substance issues and related harm.

The discussion begins with tobacco and an outline of key legislation, policy, and research developments related to tobacco control, including efforts to discourage or stop tobacco smoking from 2000 to the present day. Some of the issues considered most pertinent for Māori today are discussed, including the continuing high tobacco smoking rates amongst Māori women and pregnant Māori women, current debates surrounding vaping as a way for Māori to become smoke-free and current research concerning the Smokefree 2025 goal for Māori.

The second part of this chapter is concerned with key developments, legislation and policy related to alcohol and other drug treatment services with a focus on the Māori sector. The recent major government reviews of alcohol and drug laws are noted and recent legislative reforms, including the Sale and Supply of Alcohol Act 2012, the Psychoactive Substances Act 2013 and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 are discussed. Major reviews of national drug policies are also noted. The discussion briefly covers responses to the practical impacts of this legislation, including criticism of whether the government's legislative reforms and associated policies are proving sufficient to minimise or prevent alcohol and drug-related harm.

The general context

Over the last two decades there have been significant changes to address the continuing disparities in health outcomes between Māori and non-Māori in tobacco, alcohol and other drug-related harm. Changes include new legislation, policy initiatives and Māori alcohol and other drug sector initiatives. A key theme that emerges is the persistence of significant disparities for Māori. This is despite these disparities being recognised as early as the 1970s and despite a range of greater legislative and policy initiatives to attempt to significantly reduce or remove such disparities.

The statistics that measure tobacco, alcohol and other drug use and related-harm indicate that the disparity – that is, the gap between Māori and non-Māori – has not only persisted but continues to remain significant. For example, the most recent figures for the Māori rates of smoking are still more than double that of non-Māori. The Māori smoking rates recorded by the New Zealand Health Survey 2017/18 show that 31 per cent of Māori adults (aged 15+ years) still smoke, although that is down from 39 per cent in 2006/7. In comparison, 13 per cent of New Zealand adults still smoked in 2017/18, and that is down from 18 per cent in 2006/7.¹⁷³ Recent lung cancer registration and mortality statistics also show that stark disparities between Māori and non-Māori have continued since 2000.¹⁷⁴ In relation to alcohol, Māori men and Māori women are more likely to drink hazardously than non-Māori men and women.¹⁷⁵ The death rate from drinking alcohol is also higher for Māori in comparison to non-Māori (34 deaths per 100,000 for Māori in comparison to 14 deaths per 100,000 for non-Māori).¹⁷⁶ In relation to other substances, Māori are also more likely to have used cannabis and amphetamines, and be convicted of low-level drug charges than non-Māori.¹⁷⁷ Information provided by the Chief Coroner has also revealed similarly concerning data that 42 of the approximately 70-75 people who have died from using synthetic cannabis since 1 June 2017 were Māori, or around 58 per cent of deaths.¹⁷⁸ What this seems to indicate is that while there has been some success in gradually reducing rates for both Māori and non-Māori, the gaps between them have not reduced significantly.

In the last two decades, the government has responded to these continuing trends with more targeted policies and provisions to address the disparities for Māori. These include broader legislation and policies, such as the New Zealand Public Health and Disability Act 2000 and the Māori Health Strategy ‘He Korowai Oranga’, as well as more specific legislation and policies that address tobacco, alcohol and other drug control. These specific laws and policies are briefly discussed in this chapter.

The New Zealand Public Health and Disability Act 2000 provides the overall framework for the structure, manner of operation and funding for New Zealand’s current healthcare system. This includes healthcare provisions that address health impacts arising from tobacco, alcohol and other substance abuse. One of the Health and Disability Act’s key purposes is ‘to reduce health disparities by improving

¹⁷³ Smoking rates for Māori vary slightly across different sources, however these figures are published by the Health Promotion Agency on the Smokefree.org.nz website, ‘Facts and figures’ <https://www.smokefree.org.nz/smoking-its-effects/facts-figures>, last updated 5 Nov 2019. The Smokefree website also states the higher figure of 34 per cent for the Māori adult smoking rate. It is not clear what the difference between these two rates are.

¹⁷⁴ Population-standardised rates of lung cancer registrations and mortality by Ethnicity (Source: Ministry of Health), see Tobacco Control Data Repository, HPA, https://tcddata.org.nz/Cancer%20data/Cancer_00.html

¹⁷⁵ ‘Key facts about drinking in New Zealand: Hazardous drinking in New Zealand’, HPA <https://www.alcohol.org.nz/sites/default/files/documents/Key-facts-about-drinking-in-New-Zealand.PDF>

¹⁷⁶ ‘Key facts about drinking in New Zealand: Hazardous drinking in New Zealand’, HPA <https://www.alcohol.org.nz/sites/default/files/documents/Key-facts-about-drinking-in-New-Zealand.PDF>

¹⁷⁷ New Zealand Drug Foundation, ‘State of the Nation 2019’, November 2019, p. 4, <https://www.drugfoundation.org.nz/policy-and-advocacy/state-of-the-nation-2019>

¹⁷⁸ Information Advisor, Coronial Services to the Author, 15 November 2019. Coronial services were unable to provide an exact number as some of the cases are still active.

the health outcomes of Māori and other population groups'.¹⁷⁹ In order to 'recognise and respect the principles of the Treaty of Waitangi', the Act provides 'mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services'.¹⁸⁰ In addition, the Act sets out the provision of healthcare through District Health Boards (DHBs), including: establishing and maintaining 'processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement', continuing 'to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori' and to provide Māori with information relating to these two functions.¹⁸¹ The Crown's commitment to reducing inequalities and improving Māori health are also set out in the Māori Health Strategy 'He Korowai Oranga', first developed in 2002 and updated in 2014. With the ultimate goal of whānau ora, the strategy espouses support for Māori aspirations of rangatiratanga over their health.¹⁸² However, there has been considerable discussion about problems with the effectiveness of this legislative health framework for Māori. This discussion includes the Stage 1 Waitangi Tribunal report for this inquiry.¹⁸³

Tobacco control, 2000 to present

Since 2000, the New Zealand government has increasingly adopted policies which confirm that smoking is a significant health issue and that minimising smoking is a major health goal. To that end, in 2003 the New Zealand government signed the World Health Organisation Framework Convention on Tobacco Control (FCTC), an international public health treaty that provides countries with tools to develop comprehensive tobacco control legislation. In 2010, the Māori Affairs Select Committee ('the select committee') reported to Parliament on its inquiry into the tobacco industry in Aotearoa, driven by concerns about the impacts of tobacco use for Māori.¹⁸⁴ The following year, in response to that report, the government agreed to support the select committee's overall recommendation to make New Zealand smokefree by 2025. More recently, there have been widespread concerns that with current smoking trends, that goal is unlikely to be met for Māori, or for non-Māori. This is despite government and non-government agencies and health researchers producing a substantial amount of policy, plans, research, reports and advice aimed at significantly decreasing smoking rates, especially the persistently higher Māori smoking rates.

¹⁷⁹ New Zealand Public Health and Disability Act 2000 (2000 No 91) s 3 (1) (b)

¹⁸⁰ New Zealand Public Health and Disability Act 2000 (2000 No 91) s 4

¹⁸¹ New Zealand Public Health and Disability Act 2000 (2000 No 91) s 23 (d) (e) (f)

¹⁸² Ministry of Health, 'He Korowai Oranga: Māori Health Strategy', 2002, p. 7.

¹⁸³ Waitangi Tribunal, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*, Wellington, 2019, p. 97; 'He Korowai Oranga: Māori Health Strategy', 2002, p. 2.

¹⁸⁴ Māori Affairs Committee Report, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori', November 2010.

The Smoke-free Environments Act 1990 and amendments

As discussed in the previous chapter, the key current legislation governing tobacco control in New Zealand is the Smoke-free Environments Act 1990 along with the Smoke-free Environments Regulations 2007.¹⁸⁵ The 1990 Act, and its subsequent amendments and regulations (updated in 2017), have focused on making indoor workplaces and a large range of public areas smoke-free. Workplaces include offices, factories, warehouses and canteens. Public areas include all schools and early childhood centres; licensed premises such as bars, restaurants, cafes and sports clubs, casinos, as well as public transport areas. The legislation also places restrictions on the promotion, sale and advertising of tobacco and tobacco products, including vaping.¹⁸⁶ For example, tobacco products can only be sold or supplied to those 18 years of age or over. The Regulations include requirements for the packaging as well as placement, wording and size of health warnings. The Regulations also set out requirements for tobacco companies to provide annual testing and returns on the harmful constituents in different types of tobacco products. Further details of changes to the legislation are discussed in more detail below.¹⁸⁷

World Health Organization Framework Convention on Tobacco Control, 2003

In May 2003, New Zealand signed the World Health Organization Framework Convention on Tobacco Control (Framework Convention). The Framework Convention is an international public health treaty that provides countries with the tools to develop comprehensive tobacco control legislation.¹⁸⁸ The New Zealand government has been progressively rolling out tobacco control reforms in line with the Framework Convention guidelines, including increasing the price and tax on tobacco and introducing plain cigarette packaging. The objective of the Convention is to ‘protect present and future generations from the devastating health, social, environmental and economic consequences’ of tobacco use and exposure to tobacco smoke.¹⁸⁹ Signatories are also required to consider the need ‘to promote the participation of indigenous individuals and communities in the development, implementation and evaluation of tobacco control programmes that are socially and culturally appropriate to their needs and perspectives’.¹⁹⁰

In 2004, New Zealand ratified the Framework Convention ‘making the conventions and protocols outlined in the document legally binding’. The Ministry of Health reported in September 2004 that New

¹⁸⁵ For a full list of current amendments see <http://www.legislation.govt.nz/act/public/1990/0108/latest/LMS22417.html>

¹⁸⁶ Smoke-free Environments Act 1990, available from New Zealand Legislation website

<http://www.legislation.govt.nz/act/public/1990/0108/latest/whole.html#DLM223191>

¹⁸⁷ Smoke-free Environments Regulations 2007, available from New Zealand Legislation website

<http://www.legislation.govt.nz/regulation/public/2007/0039/latest/DLM427193.html>

¹⁸⁸ 4, WHO Framework Convention on Tobacco Control, 21 May 2003, United Nations Treaty Collection, Chapter IX, Health, Registration 27 February 2005, No. 41032, status as at: 18 Nov 2018, p 3

¹⁸⁹ World Health Organisation, *WHO Framework Convention on Tobacco Control*, World Health Organisation: Geneva, 2003, Article 3, p 5

¹⁹⁰ World Health Organisation, *WHO Framework Convention on Tobacco Control*, World Health Organisation: Geneva, 2003, p 6

Zealand was complying with all the mandatory requirements of the Convention apart from the ‘requirement to have health warnings on tobacco packaging of at least 30 percent of the principal areas.’ These were, however, subsequently introduced in the 2007 Regulations so that 30 per cent of the front and 90 per cent of the back of tobacco packages are to comprise health warnings.¹⁹¹

In 2016, the Smoke-free Environments Act 1990 was amended to require standardised tobacco packaging to reduce the ‘social and cultural acceptance and approval of smoking and tobacco products’, particularly for young people.¹⁹² The Act specifically notes that these changes give ‘effect to certain obligations and commitments’ that New Zealand had agreed to when it signed the Convention 13 years earlier. The amended Act, described as ‘a long overdue move which has been discussed for over 30 years’ by ASH Programme Manager Boyd Broughton, came into force in March 2018.¹⁹³ **Figure 3** shows an example of how standardised packaging now looks.



Figure 3: One of 14 graphic tobacco packet warnings that came into force in New Zealand in March 2018

(Source: Ministry of Health <https://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/tobacco-standardised-packaging/tobacco-packaging-warnings>)

Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)

In September 2004, the Ministry of Health published *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)*. The plan noted New Zealand’s legal requirement to comply with all the mandatory aspects of the Framework Convention and that it addressed the key threads of ‘He

¹⁹¹ Ministry of Health, *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)*, Wellington: Ministry of Health, Sept 2004, p 9; Smokefree NZ, History of Tobacco Control, <https://www.smokefree.org.nz/smokefree-resources/interactive-tools/history-of-tobacco-control>; accessed 21 November 2019

¹⁹² Smoke-free Environments (Tobacco Standardised Packaging) Amendment Act 2016, s 5-6

¹⁹³ ‘Tobacco plain packaging takes effect today’, *New Zealand Herald*, 14 Mar 2018, https://www.nzherald.co.nz/business/news/article.cfm?c_id=3&objectid=12012441 (Accessed on 25 Feb 2019. Screenshot available)

Korowai Oranga’ (the Māori Health Strategy) ‘in relation to the impact that tobacco has on Māori’. The plan included four goals: achieving a marked reduction in tobacco consumption levels and the prevalence of smoking; reducing health outcome inequalities; reducing exposure to second-hand smoke; and reducing Māori smoking prevalence ‘to at least the same level as among non-Māori’.¹⁹⁴ Targets were given with respect to reducing the smoking prevalence of Māori adults (aged 15 and over) from 49 per cent to at least 40 per cent by 2009; Māori females aged 14-15 from 34.3 per cent to at least 30 per cent by 2009; and Māori females aged 15-24 from 57.5 per cent to at least 50 per cent by 2009.¹⁹⁵ The plan also set out five objectives: preventing smoking initiation; promoting smoking cessation; preventing harm to non-smokers from second-hand smoke; improving ‘monitoring, surveillance and evaluation’ support; and improving ‘infrastructural support and co-ordination for tobacco control activities’.¹⁹⁶

Actions, including those specific to Māori were provided in the plan for each of the five objectives. For example, ‘special emphasis’ was needed for ‘Māori youth, especially young Māori women’ in respect to any mass media campaign the Ministry of Health might consider; ‘greater information about Māori prevalence’ would help monitor smoking among Māori and pregnant women; and that ‘Māori, particularly young Māori women’ should be considered a target group when improving the targeting of tobacco control funding. It was also noted that ‘culturally appropriate Māori smoking cessation services’ such as the Aukati Kai Paipa programme had been developed and that there were Māori quit advisors on Quitline but that there was ‘scope to make more progress’. The Aukati Kai Paipa programme had been evaluated, the plan said, and ‘found to be effective for Māori who prefer face-to-face quit advice’ (both programmes are discussed in more detail below).¹⁹⁷

Despite calls to do so from anti-smoking advocates and the Māori Affairs Select Committee, this Ministry of Health plan and its relatively modest goals developed in 2004 (for 2004 to 2009) were not ever replaced or updated in subsequent years. In comments to the author, Ministry of Health representatives have now stated that ‘the Ministry’s work program[me] has been designed to achieve the Smokefree by 2025 goal’ and that the government is currently developing its Action Plan.¹⁹⁸

¹⁹⁴ Ministry of Health, *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)*, Wellington: Ministry of Health, Sept 2004, p. iv, 12

¹⁹⁵ Ministry of Health, *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)*, Wellington: Ministry of Health, Sept 2004, p 2

¹⁹⁶ Ministry of Health, *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)*, Wellington: Ministry of Health, Sept 2004, p. v, 9

¹⁹⁷ Ministry of Health, *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004-2009)*, Wellington: Ministry of Health, Sept 2004, pp. 18, 23, 32, 33

¹⁹⁸ Ministry of Health feedback on 29 November 2019 draft of this report.

‘Tobacco Free New Zealand/Tupeka Kore Aotearoa 2020: Achieving the Vision’ report, 2009

The Smokefree Coalition, a tobacco control advocacy group established in 1995 which included health professionals and anti-smoking groups, released ‘Tobacco Free New Zealand 2020/Tupeka Kore Aotearoa 2020: Achieving the Vision’ in 2009. In this report the coalition argued that smoking rates were declining too slowly with current trends suggesting that it would take ‘around 70 years to reduce adult smoking rates to close to zero, and 100 years to do the same for young adults.’ One of the rationales given in the report for a tobacco-free New Zealand was to ‘reduce inequalities in mortality for Māori and Pacific peoples.’ The report also emphasised the need to reduce smoking amongst young adults (those aged between 20 and 24) particularly Māori whose smoking rate was 57 per cent.¹⁹⁹ The coalition accepted that significant progress has been made in some areas of tobacco control, including the Smoke-free Environments Act, 1990 and its amendment in 2003; the development of the Auahi Kore Smokefree brand; an end to tobacco sponsorship; ‘large’ tax increases on tobacco products; the launch of Quitline and Aukati Kai Paipa (the aforementioned Māori smoking cessation programme); and the introduction of graphic health warnings on tobacco and cigarette packets. Nevertheless, the coalition asserted that in order to significantly reduce poor health outcomes from smoking ‘a new vision and radical new approaches’ were required that went beyond those prescribed by the Framework Convention.²⁰⁰

The coalition’s recommendations centred around three areas: protecting children from exposure to tobacco; reducing the demand and supply of tobacco products and increasing the rates of successful quitting. The recommendations that focused specifically on reducing Māori smoking rates included using additional revenue from an increase in the price of tobacco products for ‘targeted smoking cessation support programmes for Māori’; ‘greater efforts’ to increase Māori quit rates and research into the drivers of smoking for Māori and into what is required to support Māori to quit. A shortlist of priorities was also provided in the report. Those relating specifically to Māori included an ‘increase in targeted cessation support services to pregnant women, especially Māori women’ and the development of a media strategy to ‘promote parental influence over youth smoking, including targeted messages to Māori women, especially pregnant women’. The coalition recommended that these be instigated in 2010.²⁰¹

The New Zealand Medical Association in its position statement on tobacco in 2010, endorsed several smoking control measures including ‘the Smokefree Coalition’s vision of a smokefree New Zealand by 2020’.²⁰²

¹⁹⁹ Smokefree Coalition, Tobacco Free New Zealand 2020: Achieving the Vision, 21 Dec. 2009, pp 2, 5, 7

²⁰⁰ Smokefree Coalition, Tobacco Free New Zealand 2020: Achieving the Vision, 21 Dec. 2009, p 7

²⁰¹ Smokefree Coalition, Tobacco Free New Zealand 2020: Achieving the Vision, 21 Dec. 2009, pp 8, 34, 38 41-42

²⁰² New Zealand Medical Association, Position Statement – Smokefree New Zealand, approved July 2010, p 20

Māori Affairs Select Committee inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, 2010

As noted, in 2010 the Māori Affairs Select Committee presented a report to Parliament from its inquiry into the tobacco industry and the consequences of tobacco use for Māori. The report included 42 recommendations on how to reduce Māori smoking rates and smoking-related harm.²⁰³ The Select Committee report sought to promote an effective approach to decreasing not only Māori smoking rates, but also the prevalence of smoking in the general population of New Zealand with the goal of reducing tobacco consumption and the prevalence of smoking by half for all demographic groups by 2015 and making New Zealand smoke-free by 2025. The Select Committee indicated, however, that the smoke-free target represented an aspirational goal rather than a commitment to completely ban smoking by 2025.²⁰⁴

The Select Committee report highlighted three areas requiring particular attention: preventing children from becoming addicted to smoking; assisting smokers to break their addiction; and holding tobacco companies that benefitted financially from smokers' addictions accountable. The report recognised that the most effective way of reducing the impact of tobacco on New Zealand society was preventing people taking up smoking. It also highlighted the need for a dual approach to combatting the tobacco issue combining legislative measures with communities actively 'reinforcing the unacceptability and illegality' of supplying young people with tobacco. The inquiry noted the 'social' supply of tobacco to young people by friends and family was a major tobacco control issue that significantly impacted on Māori and Māori health. In order to ameliorate the impact of the social supply of tobacco, the report sought the help of te iwi Māori in discouraging the social supply of tobacco products to Māori youth.²⁰⁵

While recognising that anti-smoking media campaigns could exert a positive influence on public attitudes towards smoking, the report indicated that the onus was ultimately on communities to champion the smoke-free message among Māori youth. With this in mind, the report recommended the government increase support to communities and iwi in promoting smoke-free activities and events, enlarging smoke-free areas and encouraging Māori youth to remain smoke-free.²⁰⁶

The report also recommended that the Mate Pungarehu Tobacco claim (Wai 844) before the Waitangi Tribunal be progressed 'as soon as practicable'. That claim, which was registered in 2000, asserts that

²⁰³ Māori Affairs Committee, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee, 2010, (I. 10A)

²⁰⁴ Māori Affairs Committee, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee, 2010, (I. 10A), p 10

²⁰⁵ Māori Affairs Committee, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee, 2010, (I. 10A), pp 12-19

²⁰⁶ Māori Affairs Committee, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee, 2010, (I. 10A), p 19

Māori have been prejudicially affected by the Crown's failure to 'provide equitably for Māori health in the elimination or reduction of Māori smoking'.²⁰⁷

Considering the role of kaupapa Māori in reducing tobacco use, the report recommended that the government involve Māori in policy development and planning tobacco control.²⁰⁸ It also advocated the adoption of a kaupapa tupeka kore (tobacco free) approach, in which tikanga and kawa were used to positively influence Māori social and cultural behaviour regarding tobacco use, and bring about change 'in the use of tobacco within Māori environments'.²⁰⁹

The report recommended that the government recognise the effectiveness of smoke-free campaigns and continue targeting groups with a high prevalence of smoking, particularly Māori, and Māori women who were pregnant. Noting that the age at which Māori began smoking was lower than that of the general population, the Select Committee further recommended that the government continue research to ensure that smoke-free campaigns were reaching the appropriate demographic group.²¹⁰ The Select Committee also recommended that the government consider a funding formula that provided 'equitable funding to Māori specific programmes and campaigns'; extend both the reach and range of smoking cessation services for 'priority populations' particularly for Māori women; and advocated for the establishment of 'proactive cessation programmes' in all prisons. The report also advised the government to establish a tobacco action plan and control strategy that emphasised Māori-focused results.²¹¹

Soon after the Select Committee reported in 2010, the then Associate Minister of Health, Dame Tariana Turia, announced the removal of tobacco displays and a tightening of tobacco controls. In a November 2010 press release, Mrs Turia noted that tobacco cast 'a long shadow of death and disease' that had affected almost all New Zealand households.²¹²

In early February 2011, the government published an interim response to the Select Committee recommendations, noting that a more detailed response would be made to Parliament the following month. The government noted that since the Select Committee had completed its inquiry, action had already been taken to address six of the report recommendations. The government reiterated that policy settings reflected 'the objectives, principles and key elements' of the Framework Convention and

²⁰⁷ Māori Affairs Committee, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee, 2010, (I. 10A), p 19; Wai 844, #1.1

²⁰⁸ Māori Affairs Committee, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee, 2010, (I. 10A), p 22

²⁰⁹ Māori Affairs Committee, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee, 2010, (I. 10A), p 22

²¹⁰ Māori Affairs Committee, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee, 2010, (I. 10A), p 28

²¹¹ Māori Affairs Committee, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee, 2010, (I. 10A), pp 32, 33, 37

²¹² Associate Health Minister Tariana Turia, 'Tobacco controls tightened up', parliamentary press release, 5 Nov 2010, <https://www.beehive.govt.nz/release/tobacco-controls-tightened> (Accessed 23 Nov 2018. Screenshot available).

described New Zealand's tobacco control programme as 'rightly recognised as being at the forefront of global tobacco control efforts'. It also listed the six key components of current tobacco control policy:

1. tobacco price increases through increases in excise tax;
2. adopting 'Better Help for Smokers to Quit' as a health sector priority target;
3. significant government-funded smoking cessation services;
4. a combination of media campaigns, health education and promotion aimed at encouraging smokers to quit (with a particular focus on 'priority population groups' including Māori and pregnant women), and stopping young people from taking up smoking;
5. legislative protection from second-hand smoke and controls on tobacco through the Smoke-free Environments Act 1990; and
6. the introduction of the December 2010 Smoke-free Environments (Controls and Enforcement) Amendment Bill.

The government stressed that all measures within its tobacco control programme recognised 'Māori as a priority target group, supported by specific measures targeting Māori'.²¹³

Reiterating the earlier comments of Associate Minister Turia, the government confirmed that it was monitoring progress on Australian proposals to introduce legislation requiring plain packaging of tobacco products, and the New Zealand government was contemplating similar legislation. The government had also agreed to implement the recommendation that all retail displays of tobacco products be banned, noting that this would be provided in the Smoke-free Environments (Controls and Enforcement) Amendment Bill, which was then before Parliament, and which prohibited such displays.²¹⁴

In March 2011, the government presented its final response to the Select Committee. It agreed to support the aspirational goal to make New Zealand smokefree by 2025 by setting mid-term tobacco consumption and smoking rate targets to 'ensure meaningful progress towards the longer term goal of making New Zealand essentially a smoke-free nation by 2025'.²¹⁵ These targets were set in 2015 and included reducing daily smoking prevalence to 10 per cent by 2018 and halving the Māori and Pacific daily smoking rates from their 2011 levels of 38.4 per cent and 23.1 per cent, respectively.²¹⁶

²¹³ New Zealand Parliament, Government Response to the Report of the Māori Affairs Committee on its *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, Interim Response, 1 Feb 2011, J1, pp 3- 4

²¹⁴ New Zealand Parliament, Government Response to the Report of the Māori Affairs Committee on its *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, Interim Response, 1 Feb 2011, J1, pp 4-5

²¹⁵ 'Government response to the report of the Māori Affairs Committee on its inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori' (Final Response), J1, undated, p 4, https://www.parliament.nz/resource/en-NZ/49DBHOH_PAP21175_1/9f015010d386fe11050cddfb468c2a3f5b0cb89

²¹⁶ Ministry of Health, 'Statement of Intent 2015-2019', presented to the House of Representatives pursuant to section 39 of the Public Finance Act 1989, E.10, p. 23,

<https://www.health.govt.nz/system/files/documents/publications/ministry-of-health-soi-2015-to-2019-aug15-v2.pdf>, accessed 12 Dec 2019. The Ministry of Health's New Zealand Health Survey defines 'daily smokers' as 'has smoked more than 100 cigarettes in lifetime and currently smokes at least once a day', see <https://minhealthnz.shinyapps.io/nz-health-survey-2018-19-annual-data-explorer/> w e96acea4/ w e21fca72/#/explore-topics , accessed 18 Dec 2019.

Subsequent to the government's 2011 response, it appears that the tobacco control sector and the government have developed a different understanding of the meaning of the smokefree goal. The smokefree 2025 goal (as understood by the tobacco control sector) was that by 2025, less than five per cent of New Zealand's population would be smokers (this five per cent figure is discussed in research studies below). However, in feedback on the draft of this report, Ministry of Health officials stated that the government never specified the 5 per cent figure and that 'this has been a common misunderstanding of the sector but never agreed to by Government'.²¹⁷ Reference to the five per cent figure as a recommendation was not found in the Select Committee's report, nor the government's March 2011 response. This suggests that the five per cent may have been a figure adopted by the tobacco control sector independently of the government.

Along with the smoke-free 2025 goal, the government also agreed to:

- consider amending the Smoke-free Environments Act to further regulate tobacco packaging and display;
- review the regulations around what tobacco companies have to disclose about their products and additives;
- investigate what regulatory powers exist for the government to reduce the use of additives and amount of nicotine in tobacco products; and
- investigate what the government can do to further restrict the supply and availability of tobacco further down the track.²¹⁸

The government indicated that within its tobacco control programme 'all measures recognise Māori as a priority target group, supported by specific measures targeted for Māori'.²¹⁹ The government noted that it had already made, and would continue to make, decisions regarding funding in a manner that provided equitable funding for programmes and campaigns aimed at reducing the harm Māori experience due to smoking.²²⁰ This, the government indicated, applied to programmes that had a specific Māori focus as well as 'mainstream' programmes that provided Māori with services as a 'priority population'. The government also agreed to continue to engage with and involve Māori

²¹⁷ Ministry of Health feedback on 29 November 2019 draft of this report.

²¹⁸ 'Government response to the report of the Māori Affairs Committee on its inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori', J1, undated, https://www.parliament.nz/resource/en-NZ/49DBHOH_PAP21175_1/9f015010d386fe11050cddfbb468c2a3f5b0cb89; see also press release by Tariana Turia, 'Government response to tobacco enquiry tabled', 15 March 2011, <https://www.beehive.govt.nz/release/government-response-tobacco-enquiry-tabled>

²¹⁹ New Zealand Parliament, Government Response to the Report of the Māori Affairs Committee on its *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, Final Response, 14 Mar 2011, J1, p 4

²²⁰ New Zealand Parliament, Government Response to the Report of the Māori Affairs Committee on its *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, Final Response, 14 Mar 2011, J1, p 19

through consultation as well as relevant planning and policy development groups and to consider a kaupapa tupeka kore approach as a Māori framework for tobacco control.²²¹

Responding to the recommendation of the Select Committee regarding tobacco industry funding of cessation services, the government expressed support for the widespread provision of pharmaceuticals and nicotine replacement therapy (NRT) as cheaply as possible to assist smokers wishing to quit. The government also indicated it would consider whether additional measures, including the Select Committee proposal that the cost of smoking cessation pharmaceuticals should be borne by tobacco companies, were ‘necessary or desirable’, but noted that the tobacco industry would inevitably pass on additional costs by raising the price of tobacco products.²²²

The government rejected the Select Committee recommendation that legislation was required to prohibit cigarette vending machines. The government maintained that the prohibition of tobacco advertising on vending machines, combined with existing vending machine restrictions, was sufficient to prevent vending machines from being a significant factor in promoting tobacco consumption or preventing the decline in smoking rates.²²³ It also rejected the recommendation regarding the establishment of a Tobacco Control Authority on the grounds it was unnecessary and would not be cost effective.²²⁴

In response to the recommendation that the government respond favourably to the proposal to provide more funding for Māori smoking control initiatives (the subject of the Mate Pungarehu Tobacco Claim, Wai 844) the government indicated that it already funded Māori health initiatives aimed at reducing or eliminating smoking among Māori, and this financial support would continue.²²⁵

In 2019, Ministry of Health officials indicated that the Framework Convention and the government’s responses to the 2010 Select Committee report recommendations provide the basis for government action aimed at achieving the Smokefree 2025 objective.²²⁶ As discussed later, however, recent research completed by Professor Chris Cunningham of Massey University’s Research Centre for Māori Health and Development indicates that the Smokefree 2025 goal is ‘unlikely to be met’.²²⁷

²²¹ New Zealand Parliament, Government Response to the Report of the Māori Affairs Committee on its *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, Final Response, 14 Mar 2011, J1, p 19

²²² New Zealand Parliament, Government Response to the Report of the Māori Affairs Committee on its *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, Final Response, 14 Mar 2011, J1, p 5

²²³ New Zealand Parliament, Government Response to the Report of the Māori Affairs Committee on its *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, Final Response, 14 Mar 2011, J1, p 12

²²⁴ New Zealand Parliament, Government Response to the Report of the Māori Affairs Committee on its *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, Final Response, 14 Mar 2011, J1, p 18

²²⁵ New Zealand Parliament, Government Response to the Report of the Māori Affairs Committee on its *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, Final Response, 14 Mar 2011, J1, p 15

²²⁶ Interview with Brendon Baker, Senior Advisor, Tobacco Control Programme, Ministry of Health, 25 Feb 2019

²²⁷ Email communication from Chris Cunningham, Professor of Research Centre for Māori Health and Development, 2 Apr 2019

Marewa Glover & Anette Kira: ‘Why Māori women continue to smoke while pregnant’, 2011

Research into the reasons Māori women smoked while pregnant was completed in 2011 by researcher’s Dr Marewa Glover and Dr Anette Kira. They reported that in 2007 the number of pregnant Māori women who indicated they were smokers when they registered with a midwife was substantially higher than the figure for all pregnant women in New Zealand. The researchers attributed this concerning disparity to the prevalence of smoking being highest among the most disadvantaged groups, and Māori women being ‘one of the most socially deprived groups in New Zealand’.²²⁸

Glover and Kira found that Māori also suffered disproportionately from the harmful consequences of tobacco use and identified social influences including significant numbers of pregnant Māori women who smoked and took part in the research socialising with smokers and living with a partner who also smoked. Of the women who participated in their research, 33 per cent believed that due to their exposure to second-hand smoke they may as well continue smoking.²²⁹ Glover and Kira found that the pregnant Māori women who took part in their study were healthy but lived in environments where they were exposed to smoke; used smoking as a way of coping with stress; and did not fully understand the dangers of smoking while pregnant. The researchers’ findings suggested that strategies used to inform Māori about the inherent risks of tobacco use during pregnancy were either ineffective or were not effectively reaching Māori women.²³⁰

SHORE and Whariki Research Centre Review of Tobacco Control Services, 2014

In 2014 the SHORE (Social and Health Outcomes Research And Evaluation) and Whariki Research Centre at the Massey University College of Health published a Ministry of Health-funded review of tobacco control services. According to Ministry of Health officials, this later helped to inform parts of the Ministry’s 2015 ‘realignment’ of tobacco control services (discussed further below).²³¹

Smoking cessation programmes were included in the review including Aukati Kai Paipa, Quitline, pregnancy services and Pacific providers. The review described Aukati Kai Paipa as ‘a network of services that provides intensive face-to-face support for Māori smokers and whānau who wish to quit’ offering ‘evidence based counselling and provision of Nicotine replacement therapy (NRT) to clients’. The service was aimed at Māori smokers but could be ‘accessed by anyone’. The programme, comprising 32 service providers across New Zealand, was funded by the Ministry at a cost of \$5.8 million in 2013/2014. Enrolments for the previous financial year varied between 90 and 560 people.

²²⁸ Marewa Glover & Anette Kira, ‘Why Māori women continue to smoke while pregnant’, *New Zealand Medical Journal*, vol 124, no 1338 (29 Jul 2011), p 22

²²⁹ Marewa Glover & Anette Kira, ‘Why Māori women continue to smoke while pregnant’, *New Zealand Medical Journal*, vol 124, no 1338 (29 Jul 2011), p 26

²³⁰ Marewa Glover & Anette Kira, ‘Why Māori women continue to smoke while pregnant’, *New Zealand Medical Journal*, vol 124, no 1338 (29 Jul 2011), pp. 28-29

²³¹ Email communication from Tony Brown, Portfolio Manager, Ministry of Health, 5 Apr 2019

The review found that there was a ‘variation of effectiveness of AKP [Aukati Kai Paipa] providers with validated abstinence rates at three months ranging from 4% to 71%’ and that while it had ‘success in reaching Māori populations and those who live in deprived areas ... evidence regarding its effect on sustained abstinence is not clear’. The review noted that place of residence influenced the ability of Aukati Kai Paipa to provide a uniform level of service with larger providers in urban areas able to provide a more consistent service while smaller providers with fewer staff could face difficulties in recruitment and staff retention.²³²

The review also discussed Quitline, the primary national provider of smoking cessation services which received \$9.4 million in Ministry of Health funding for the 2013/14 financial year and supported 50,297 quit attempts in 2012/13. The review noted that Quitline reported a 24.2 per cent self-reported quit rate after three months and 20.9 per cent at 12 months. The figure for Māori was lower, however, at 16.4 per cent after 12 months.²³³

The review also recorded that the Ministry of Health funded several other organisations in 2013/14 that focussed on reducing the prevalence of smoking. These included Action on Smoking and Health (ASH) (\$578,000 for Smokefree Information Services and \$468,000 for an Innovations Fund project); the National Heart Foundation (\$248,000 for an Innovation Fund project and \$577,000 for services targeting Pacific people); Smokefree Coalition Trust (\$167,000 for tobacco control); and Hāpai Te Hauora Tapui Ltd (\$587,000 for national Māori tobacco control and public health leadership).²³⁴

A variety of other groups also received Ministry funding totalling \$3,822,500 for the 2013/14 financial year for ‘training or sectoral development’ aimed at reducing the prevalence of smoking. The work of some of these organisations, like Auckland Uniservices that reportedly received \$20,000 for smoking cessation innovations for ‘hard to reach pregnant women’, may have benefitted Māori.²³⁵

While the review found that many of the tobacco control measures funded by the Ministry of Health were to some degree effective, it was noted that inequalities remained, with Māori continuing to be disproportionately represented in smoking prevalence data. The review also noted the belief amongst the various groups consulted with that ‘the Smokefree 2025 goal had fallen off the national radar’. The target would not be achieved if reductions in smoking prevalence continued at 2014 rates. The review

²³² SHORE & Whariki Research Centre, *Review of Tobacco Control Services*, Auckland: SHORE & Whariki Research Centre, July 2014, p 14, 56, 85

²³³ SHORE & Whariki Research Centre, *Review of Tobacco Control Services*, Auckland: SHORE & Whariki Research Centre, July 2014, pp 9, 13, 80, 83

²³⁴ SHORE & Whariki Research Centre, *Review of Tobacco Control Services*, Auckland: SHORE & Whariki Research Centre, July 2014, p 80

²³⁵ SHORE & Whariki Research Centre, *Review of Tobacco Control Services*, Auckland: SHORE & Whariki Research Centre, July 2014, p 80

recommendations included that the Ministry of Health increase awareness of and support for the Smokefree 2025 objective by:

- clarifying with contracted non-government organisation providers the need to increase media advocacy specifically around the Smokefree 2025 goal;
- working with the Health Promotion Agency (HPA) to ensure adequate promotion of the Smokefree 2025 goal; and
- developing an action plan including a logic model(s) in consultation with the tobacco control sector and informed by the recommendations included in the 2014 review.

The SHORE and Whariki Research Centre researchers stressed the need to develop ‘cross-sectoral activity’ to achieve the Smokefree 2025 goal and recommended the Ministry of Health attempt to form a committee consisting of government ministries and agencies that could focus on attaining the Smokefree 2025 goal.²³⁶ No evidence was found in the sources consulted for this report that such an initiative was developed.

Richard Edwards, Janet Hoek and Frederieke van der Deen, ‘Smokefree 2025 – use of mass media in New Zealand lacks alignment with evidence and needs’, (2014)

Further research was completed in 2014 that focused on trends in tobacco control funding. University of Otago researchers Richard Edwards, Janet Hoek and Frederieke van der Deen found that the total government expenditure on mass media advertising undertaken by The Quit Group and the Health Sponsorship Council (the two main national bodies utilising national mass media tobacco control campaigns) fell by 43.8 per cent during the 2008-2013 period. The researchers noted that despite a Ministry of Health report indicating that ‘intensification of tobacco tax, mass media and cessation support’ would see the prevalence of smoking fall to 8-9 per cent by 2025 if accompanied by a twofold increase from pre-2009 levels in television mass marketing, funding for these initiatives had in fact decreased. While accepting that increased expenditure on tobacco control mass media campaigns alone would not ensure that the Smokefree 2025 target would be achieved, the researchers recommended ‘substantial and sustained’ increases in funding of such campaigns in conjunction with other tobacco control measures.²³⁷

²³⁶ SHORE & Whariki Research Centre, *Review of Tobacco Control Services*, Auckland: SHORE & Whariki Research Centre, July 2014, p 191

²³⁷ Richard Edwards, Janet Hoek and Frederieke van der Deen, ‘Smokefree 2025 – use of mass media in New Zealand lacks alignment with evidence and needs’, *Australian and New Zealand Journal of Public Health* (2014), doi:10.1111/1753-6405.12246, pp 1-2. The researchers noted that figures for the 2012-2013 period were forecasts.

Government ‘realignment’ of tobacco control services, 2015

In early 2015, the Ministry of Health announced a ‘realignment’ aimed at improving government purchasing of tobacco control services following concerns that too few people were quitting smoking compared to the amount of government expenditure spent on the services.²³⁸ The object of the realignment was to reassess all government-funded face-to-face smoking cessation services and tobacco control national health promotion and advocacy services ‘to improve outcomes, quality and value for money’. The new tobacco control services were to ‘build on’ the findings of the 2014 review of tobacco control services and the opportunities it identified, improve the implementation of ‘the expectations outlined in the 2014 *New Zealand Guidelines for Helping People to Stop Smoking* 2014’, provide ‘the most up-to-date models of service delivery practice’, maintain good business practice, and improve value for money.²³⁹

In an advance notice to interested parties, the Ministry stated that the realignment was an attempt to guarantee that resources were more effectively focused on ‘high needs populations in key geographic areas’ and would involve three phases taking place over a 15-month period between April 2015 and June 2016:

1. market engagement in which interested parties were invited to attend open forum meetings where they could express their views;
2. the procurement process where all interested parties would have a chance to comment on the Ministry’s open tender for the required smoking control services; and
3. the transition phase with the provision of new services being introduced from 1 July 2016.²⁴⁰

The Ministry also stated that a 2013 Ministry-commissioned review had found that a continuation of ‘a business as usual approach’ was unlikely to achieve Smokefree Aotearoa 2025. To address this, the Ministry believed the realignment of smoking cessation services was required. While acknowledging the role of legislation in advancing the Smokefree 2025 objective, the Ministry also indicated the importance of smoking cessation and advocacy services in achieving the smokefree target.²⁴¹

The Ministry announced its intention to terminate all existing smoking control contracts on 30 June 2015, and re-tender smoking control services. Discussing the implications of the realignment for groups most in need of tobacco control services, the Ministry indicated that the realignment process would

²³⁸ Interview with Brendon Baker, Ministry of Health, 25 Feb 2019

²³⁹ Email communication from Tony Brown, Portfolio Manager, Ministry of Health, 9 Apr 2019

²⁴⁰ Ministry of Health, ‘Realignment of tobacco control services – Advance notice, Overview, n.d.’; Ministry of Health, ‘Ministry of Health response to Smokefree Aotearoa 2025 goal: Questions and Answers – 20 March 2015 announcement meeting’, n.d.

²⁴¹ Ministry of Health, ‘Realignment of tobacco control services – Advance notice, Overview, n.d.’

result in ‘a stronger focus’ on their needs and ‘should’ result in improved outcomes for Māori, Pacific and pregnant women.²⁴²

As a result of the realignment process, the Crown accepted the tender of Hāpai Te Hauora, a Māori health organisation which became the sole provider of smoking control advocacy services. ASH lost its government funding for its advocacy work, although the organisation continues to engage in smoking control advocacy, which ASH programme manager Boyd Broughton describes as ‘a challenge’. ASH also continues to receive Ministry of Health funding to conduct its Year 10 Smoking Survey examining the smoking behaviour and attitudes of Year 10 students (discussed below).²⁴³

Ministry funding for Aukati Kaipaipa programmes was discontinued.²⁴⁴ As well, the Quit Group Trust ceased to be the Quitline provider from November 2015 after Homecare Medical Limited successfully tendered for the Ministry of Health’s National Telehealth Service and Homecare Medical Limited took over the operation of Quitline.²⁴⁵ This was despite Quitline organising in 2015 what the organisation said was one its most successful anti-smoking media campaigns, ‘Crayons Phase One’. Quitline indicates that the programme, which focussed on the impact of smoking on children in high deprivation areas, was responsible for a 35 per cent increase in Māori clients.²⁴⁶

Although the Ministry of Health monitors a range of tobacco control measures on an on-going basis, it has not conducted research comparing the results of tobacco control bodies before and after the 2015 realignment took place.²⁴⁷ It does, however, currently collect data on quit rates for Māori and these are discussed in Chapter 4 of this report.

Richard Edwards et al, ‘Realignment of tobacco control services – will it be sufficient to achieve the nation’s Smokefree 2025 goal?’ 1 May 2015

Shortly after the Ministry announced the realignment, tobacco control researcher Richard Edwards and others expressed their belief that the realignment failed to address a number of key factors. the foremost of which they identified as the need to formulate and adopt a strategic plan that would result in the Smokefree 2025 target being reached. The researchers believed that media reports created the false impression that instead of making a positive contribution to achieving the Smokefree 2025 objective,

²⁴² Ministry of Health, ‘Realignment of tobacco control services – Advance notice, Overview, n.d.

²⁴³ Email communication from Boyd Broughton, ASH Programme Manager, 19 Feb 2019

²⁴⁴ Interview with Brendon Baker, Senior Advisor, Ministry of Health, 25 Feb 2019

²⁴⁵ Auahi Kore, Aotearoa New Zealand 2025, ‘Celebrating 16 Years of Quitline’, [p 5], <https://quit.org.nz/en/about-us/about-the-quit-group> (Accessed on 1 April 2019, Screenshot available)

²⁴⁶ Quitline, ‘Crayons’, <https://quit.org.nz/media/crayons> (accessed on 1 Apr 2019, Screenshot available); Auahi Kore, Aotearoa New Zealand 2025, ‘Celebrating 16 Years of Quitline’, [p 5], <https://quit.org.nz/en/about-us/about-the-quit-group> (Accessed on 1 April 2019, Screenshot available)

²⁴⁷ Email communication from Tony Brown, Portfolio Manager, Ministry of Health, 9 Apr 2019

smoking cessation providers and tobacco control advocacy groups were instead impeding progress toward the smokefree goal.²⁴⁸

In the researchers' opinion, the most significant obstacle facing the successful implementation of Smokefree 2025 was 'insufficient central government planning and action at a national population level'.²⁴⁹ Perceived shortcomings included the lack of a strategic plan of action, the failure to introduce adequate legislative and policy measures, and insufficient funding for mass media campaigns despite evidence of the effectiveness of these measures in reducing the prevalence of smoking. Studies carried out in Australia have shown that there is an association between increased potential exposure to antismoking campaign material on television and improved smoking-related attitudes, behaviour and beliefs among youth.²⁵⁰ Television antismoking campaign material was also found to increase calls to smoking quit-lines, increase 'quit behaviours' among adults and reduce the prevalence of adult smoking.²⁵¹

Commenting on the realignment of tobacco services, researchers stressed the importance not only of effective cessation programmes that provided support and encouragement to individuals wishing to quit smoking, but also creating an environment that reduced the number of people taking up smoking.²⁵² In particular, the researchers highlighted the need for a multifaceted approach that involved a combination of measures already proven to be effective. This included policy implementation resulting in improved regulation of tobacco marketing and promotion; additional increases in tobacco prices; further limitations on areas where smoking could occur; reductions in the availability of tobacco products; and the use of mass-media campaigns to promote smoking cessation. The researchers noted that these measures could be implemented at both the local and national level through a combination of local body by-laws and national legislation.²⁵³

²⁴⁸ Richard Edwards et al, Realignment of tobacco control services – will it be sufficient to achieve the nation's Smokefree 2025 goal?, *New Zealand Medical Health Journal*, 1 May 2015, vol 128 no 1413 (2015), pp. 84-87.

²⁴⁹ Richard Edwards et al, Realignment of tobacco control services – will it be sufficient to achieve the nation's Smokefree 2025 goal?, *New Zealand Medical Health Journal*, 1 May 2015, vol 128 no 1413 (2015), p. 84.

²⁵⁰ Sally Dunlop et al, 'Televised Antismoking Advertising: Effects of Level and Duration of Exposure', *American Journal of Public Health*, vol 103, no 8 (2013), p e67

²⁵¹ Sally Dunlop et al, 'Televised Antismoking Advertising: Effects of Level and Duration of Exposure', *American Journal of Public Health*, vol 103, no 8 (2013), p e67

²⁵² Richard Edwards et al, Realignment of tobacco control services – will it be sufficient to achieve the nation's Smokefree 2025 Goal?, *New Zealand Medical Health Journal*, 1 May 2015, vol 128 no 1413 (2015), p 85

²⁵³ Richard Edwards et al, Realignment of tobacco control services – will it be sufficient to achieve the nation's Smokefree 2025 Goal?, *New Zealand Medical Health Journal*, 1 May 2015, vol 128 no 1413 (2015), p 85

Jude Ball et al, 'Is the New Zealand government responding adequately to the Māori Affairs Select Committee's 2010 recommendations on tobacco control?' January 2016

In 2016, Jude Ball and other health researchers examined the government's response to the 2010 recommendations of the Māori Affairs Select Committee.²⁵⁴ The researchers assessed the Ministry of Health's progress report of the previous year which claimed that the government had either completed or 'largely' completed eight of the 42 Select Committee recommendations, that 18 were 'in progress or ongoing', 11 were reported as being a low priority and six had not been progressed at all because they were not considered government policy. The authors found that the Ministry of Health had completed (or largely completed) the following five recommendations: the adoption of the Smokefree 2025 goal and the setting of mid-term targets; the prohibition of point of sale tobacco displays; increased penalties for selling tobacco to minors; annual increases in tobacco taxation; and reductions in duty-free tobacco allowances.²⁵⁵

Significantly, the researchers stated that progress toward the Smokefree 2025 goal was being hampered by the government's failure to make adequate progress with the remaining 34 recommendations, 'particularly for Māori'. The areas where the researchers believed inadequate progress had been made included the government's implementation of a comprehensive Smokefree 2025 strategy and action plan that would create a 'monitoring and accountability framework'; a reduction in tobacco supply and availability; the introduction of standardised tobacco product packaging; increased disclosure of tobacco additives and the regulation of additives and nicotine; comprehensive and effective use of mass media, with a particular focus on Māori and pregnant women; and the expansion of smokefree environments.²⁵⁶

The researchers noted that if adequately supported, regional and local initiatives like the 'Tobacco-free Retailers Toolkit' developed in Northland could be implemented nationally.²⁵⁷ Echoing the concerns of Edwards, Hoek and van der Deen, the authors also noted the 2014 National Smokefree Working Group report that found that despite the Select Committee recommending increased use of smokefree campaigns and mass media, a steady decline in national tobacco control mass media spending had taken

²⁵⁴ Jude Ball, Richard Edwards, Andrew Waa, Shane Kawenata Bradbrook, Heather Gifford, Chris Cunningham, Janet Hoek, Toney Blakely, Nick Wilson, George Thomson, Sue Taylor, 'Is the NZ Government responding adequately to the Māori Affairs Select Committee's 2010 recommendations on tobacco control? A brief review', *New Zealand Medical Journal*, vol 129, no 1428 (8 Jan 2016), pp 93-97

²⁵⁵ Jude Ball et al, 'Is the NZ Government responding adequately to the Māori Affairs Select Committee's 2010 recommendations on tobacco control? A brief review', *New Zealand Medical Journal*, vol 129, no 1428 (8 Jan 2016), pp 93-94

²⁵⁶ Jude Ball et al, 'Is the NZ Government responding adequately to the Māori Affairs Select Committee's 2010 recommendations on tobacco control? A brief review', *New Zealand Medical Journal*, vol 129, no 1428 (8 Jan 2016), p 94

²⁵⁷ Jude Ball et al, 'Is the NZ Government responding adequately to the Māori Affairs Select Committee's 2010 recommendations on tobacco control? A brief review', *New Zealand Medical Journal*, vol 129, no 1428 (8 Jan 2016), p 94

place between 2008 and 2013 while the government's use of mass media 'did not align with best practice'.²⁵⁸

In conclusion, the researchers suggested the Select Committee should:

... consult widely, particularly with Māori groups and stakeholders, on the current status of the Smokefree 2025 goal and should hold the Government to account on its original response to the Committee's recommendations and demand that its action plan to achieve the Smokefree 2025 goal includes credible strategies to reduce disparities and protect Māori from tobacco-related harm, and ensure full Māori participation in that process.²⁵⁹

Office of the Associate Minister of Health, 'Report back on New Zealand's Tobacco Control Programme', 2016

In 2016, a cabinet paper cited evidence that the tangible costs of smoking to New Zealand, including lost production in the work-force, lost resources due to addictive consumption, and the enormous costs associated with smoking-related diseases, were estimated to total \$2.5 billion.²⁶⁰ This figure also appeared in the appendix to a Ministry of Health report of the same year on New Zealand's tobacco control programme which included a graph illustrating the division of government expenditure on its tobacco control programme for 2014/15 (see **Figure 4**). It also noted that the government 'currently' received approximately \$1.5 billion per year in tobacco excise tax, which represented slightly less than two percent of consolidated government revenue.²⁶¹

The cabinet paper indicated that in 2014/15 \$61.7 million was spent on the national tobacco control programme, which included a range of interventions designed to stop people from starting smoking and get current smokers to quit. An \$8.49 million Ministry of Health budget provided for 42 community-based smoking cessation services, which included 32 Aukati Kai Paipa, four Pacific and six pregnancy-focused services. During the 2014/15 financial year \$3.87 million was spent on tobacco control mass media campaigns targeting youth. As the report noted, international research showed the effectiveness

²⁵⁸ Jude Ball et al, 'Is the NZ Government responding adequately to the Māori Affairs Select Committee's 2010 recommendations on tobacco control? A brief review', *New Zealand Medical Journal*, vol 129, no 1428 (8 Jan 2016), p 95, Richard Edwards, Janet Hoek & Frederieke van der Deen, 'Smokefree 2025 – use of mass media in New Zealand lacks alignment with evidence and needs', *Australia and New Zealand Journal of Public Health*, vol 38, no 4 (August 2014), p 395. The Māori Affairs Committee recommendation did not use the term 'mass media', instead referring to 'educational media campaigns' and 'smoke-free campaigns using newer forms of marketing, such as social media'. (see Māori Affairs Committee, 'Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori, Report of the Māori Affairs Committee, 2010, pp 9, 25)

²⁵⁹ Jude Ball et al, 'Is the NZ Government responding adequately to the Māori Affairs Select Committee's 2010 recommendations on tobacco control? A brief review', *New Zealand Medical Journal*, vol 129, no 1428 (8 Jan 2016), p. 96

²⁶⁰ Office of the Associate Minister of Health, 'Report back on New Zealand's Tobacco Control Programme', 8 Apr 2016, p 2

²⁶¹ Ministry of Health, 'Appendix, Background Information: New Zealand's Tobacco Control Programme', April 2016, p 9

of mass media campaigns in dissuading youth from taking up smoking and encouraging young smokers to quit.²⁶²

The cabinet paper cited researchers' findings that mass media campaigns aimed at reducing the prevalence of smoking were both cost effective and value for money.²⁶³ During the 2014/15 period, the combined cost of the 2014/15 Stop Before You Start, Quitline and Smokefree Cars and Homes mass media campaigns was \$3.87 million compared to the campaigns' 'combined value' of \$8.76 million - a saving achieved through the government's use of the all of overnment scheme to purchase mass media coverage at lower than usual rates.²⁶⁴

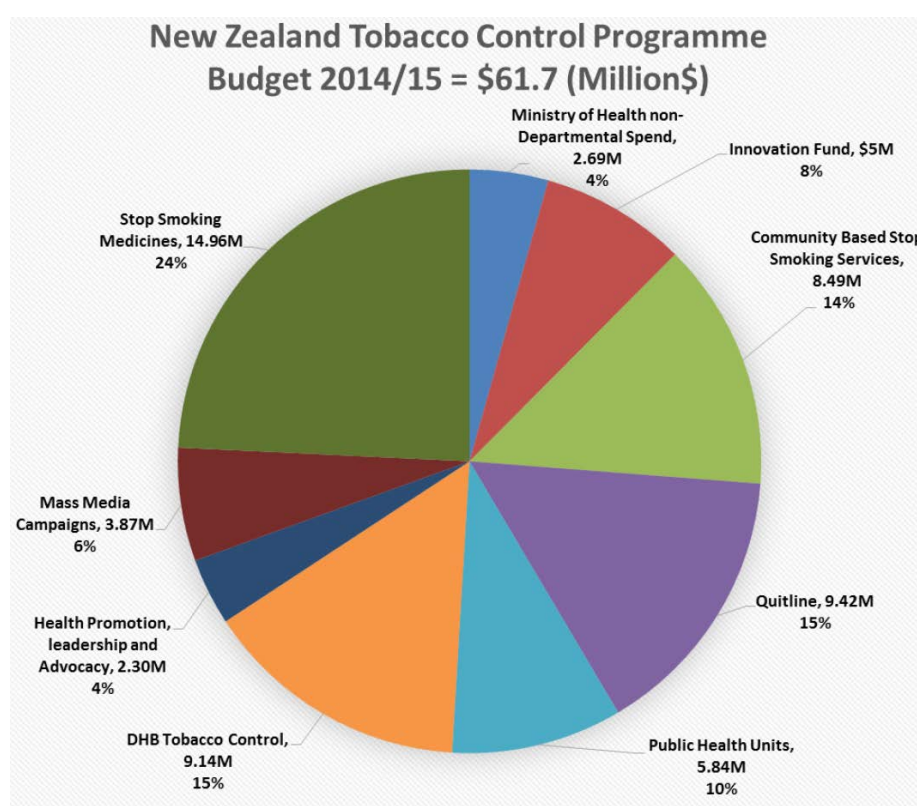


Figure 4: New Zealand tobacco control programme budget for 2014/15²⁶⁵

²⁶² Office of the Associate Minister of Health, 'Report back on New Zealand's Tobacco Control Programme', 8 Apr 2016, pp 7, 9, 12

²⁶³ Office of the Associate Minister of Health, 'Report back on New Zealand's Tobacco Control Programme', 8 Apr 2016, p 9

²⁶⁴ Office of the Associate Minister of Health, 'Report back on New Zealand's Tobacco Control Programme', 8 Apr 2016, p 10

²⁶⁵ Ministry of Health, Appendix, Background Information: New Zealand's Tobacco Control Programme, Wellington: Ministry of Health, April 2016 p 8. The Ministry of Health pie graph excludes Ministry of Health and Health Promotion Agency staffing costs, and DHB and PHO-funded activities 'within their general allocation to improve performance or achieve targets relating to this area'.

Achieving Smokefree Aotearoa by 2025 Plan (ASAP), 2017

In August 2017, the Achieving Smokefree Aotearoa by 2025 Plan ('Smokefree Aotearoa Plan') was launched in Wellington. It was commissioned by the Quit Group Trust and led by researchers from ASPIRE 2025 based at the University of Otago to review the status of the 2025 smokefree goal and provide a plan to achieve it.²⁶⁶ The plan was developed through consultation with key experts in tobacco control and practitioners including Māori and Pacific community leaders. The foreword supporting the report was written by Hon Dame Tariana Turia.²⁶⁷ The Smokefree Aotearoa Plan was a response to concerns regarding what advocates saw as inadequate progress and insufficient 'political priority' given to reaching the Smokefree 2025 objective.²⁶⁸ While acknowledging that 'some important progress' had been made since the adoption of the Smokefree 2025 goal in areas such as increased tobacco taxation, smokefree prisons and removing point-of-sale tobacco displays from stores, the report highlighted the 'urgent' need for an action plan and noted that many Select Committee recommendations had not been implemented.²⁶⁹

These included limiting retail tobacco sales, the introduction of modifications to reduce tobacco's appeal and addictiveness, and more effective use of mass media. The authors emphasised their belief that Smokefree 2025 was achievable but noted that to do so 'a major increase in the intensity and scope of interventions' was needed and that these interventions needed to be far more effective for Māori and Pacific people. The authors also drew attention to pronounced disparities in smoking statistics and identified reducing smoking and its harmful effects among Māori as a 'top priority' if Smokefree 2025 was to be achieved.²⁷⁰

The Smokefree Aotearoa Plan included recommendations for the implementation of a number of measures that the plan's authors believed, if adopted in the five years following the plan release, would reduce tobacco use. The importance of politicians and decision makers in the Plan's successful adoption was also highlighted. The authors noted that based on prevalence trends and modelling estimates the Smokefree 2025 goal would not be achieved by the deadline with the government policies then in place. In particular, the authors indicated there were substantial ethnic disparities in smoking statistics and believed it was unlikely Māori would reach the five per cent smoking prevalence threshold until 2060 or later unless changes were instituted.²⁷¹

²⁶⁶ Aspire 2025, *Report: Achieving Smokefree Aotearoa by 2025*, n.d., <https://aspire2025.org.nz/hot-topics/smokefree-action-plan/> (accessed on 14 Jan 2019); Email communication from Chris Cunningham, Professor of Research Centre for Māori Health and Development, 2 Apr 2019

²⁶⁷ Thornley L et al, *Achieving Smokefree Aotearoa by 2025 (ASAP)*. Wellington: ASPIRE 2025, 2 Aug 2017, pp 2-5, 11

²⁶⁸ Thornley L et al, *Achieving Smokefree Aotearoa by 2025 (ASAP)*. Wellington: ASPIRE 2025, 2 Aug 2017, p 4

²⁶⁹ Thornley L et al, *Achieving Smokefree Aotearoa by 2025 (ASAP)*. Wellington: ASPIRE 2025, 2 Aug 2017, p 12

²⁷⁰ Thornley L et al, *Achieving Smokefree Aotearoa by 2025 (ASAP)*. Wellington: ASPIRE 2025, 2 Aug 2017, p 16

²⁷¹ Thornley L et al, *Achieving Smokefree Aotearoa by 2025 (ASAP)*. Wellington: ASPIRE 2025, 2 Aug 2017, pp 5, 7, 12, 16

To achieve the Smokefree 2025 goal, the Smokefree Aotearoa Plan recommended implementing three objectives and seven actions in conjunction with existing smoking control measures.²⁷² The objectives were to reduce the affordability and availability of tobacco products, while also making tobacco products less appealing and less addictive. To make tobacco less affordable the plan included recommendations for an annual 20 per cent increase in tobacco excise in 2019, 2020 and 2021 combined with the establishment of a minimum tobacco retail price effective from late 2020. To limit access to tobacco, the authors recommended requiring that retailers transition out of tobacco sales by late 2021 and that tobacco only be available from a small number of tobacco retailers by 2022. Finally, to reduce both the appeal of tobacco and its addictiveness, the authors recommended the removal of all tobacco ‘additives and innovations’ by December 2020, and the introduction of a nicotine-reduction policy that would ensure that only tobacco products with very low nicotine levels were sold from late 2022.²⁷³

The Smokefree Aotearoa Plan proposal to increase the excise tax on tobacco did not meet with universal support. Dr Marewa Glover claimed that a key issue was the disproportionate amount of tobacco tax Māori are paying and the detrimental financial effect on them. She stated that ‘financial stress is preventing them from buying healthier food, it’s preventing them from [paying] their bills...all of that stress drives smoking.’²⁷⁴ As discussed in the vaping section below, Glover is the director of the Centre of Research Excellence: Indigenous Sovereignty and Smoking, which in 2018 was funded by the Foundation for a Smokefree World, an organisation funded by one of the world’s largest tobacco companies, Philip Morris International.²⁷⁵

The importance of eliminating tobacco smoking for Māori and Pacific people, who are ‘disproportionately affected’ by tobacco use, was highlighted in the Smokefree Aotearoa Plan, with the authors claiming that eliminating smoking ‘would address the requirements of Te Tiriti o Waitangi for the protection of Māori health’.²⁷⁶

Professor Cunningham of the Research Centre for Māori Health and Development notes that both the Smokefree Aotearoa Plan approach and that of the Select Committee were ‘reasonably in sync’ but

²⁷² Thornley L et al, *Achieving Smokefree Aotearoa by 2025 (ASAP)*. Wellington: ASPIRE 2025, 2 Aug 2017, p 5

²⁷³ Thornley L et al, *Achieving Smokefree Aotearoa by 2025 (ASAP)*. Wellington: ASPIRE 2025, 2 Aug 2017, p 6

²⁷⁴ Leigh-Marama McLachlan, ‘A Tobacco-free Māori nation is important’, Radio New Zealand, <https://www.radionz.co.nz/news/national/380097/a-tobacco-free-maori-nation-is-important>, (accessed 19 Jan 2019)

²⁷⁵ Keira Stephenson, ‘Proceeds of tobacco pay for research into indigenous smoking cessation’, *New Zealand Doctor*, 21 Aug 2018, <https://webcache.googleusercontent.com/search?q=cache:FHQtn6MOCyYJ:https://www.nzdoctor.co.nz/article/news/proceeds-tobacco-pay-research-indigenous-smoking-cessation+&cd=1&hl=en&ct=clnk&gl=nz>, accessed 18 Jan 2019; The Foundation for a Smoke-free World website states the following: ‘The Foundation has received a pledge of \$80 million USD annually for 12 years, beginning in 2018 from Philip Morris International (PMI)’ (see Foundation for a Smoke-free World, <https://www.smokefreeworld.org/our-vision/funding>, accessed 18 Jan 2019).

²⁷⁶ Thornley L et al, *Achieving Smokefree Aotearoa by 2025 (ASAP)*. Wellington: ASPIRE 2025, 2 Aug 2017, pp 10, 12

indicates that evidence suggested that the aspirational Smokefree 2025 goal was unachievable given the state of tobacco control measures at the time.²⁷⁷

Esther Lim et al, ‘Young Māori women who smoke: technical report’, 2017

Further research was produced in 2017 that focused on young Māori women who smoked. One of the key findings of a 2017 report by Esther Lim et al and commissioned by the Ministry of Health is that the biggest change in their smoking status occurred ‘at a fairly young age particularly between the ages of 15 and 24 years’. It was noted that at 18 years of age, two out of three Māori women had never smoked but by the age of 24 years old, just one in three Māori women had never smoked. It was also found that smoking was ‘more common among young women who were not employed’ (53 per cent of young Māori women who received the unemployment benefit were regular smokers); that there was a ‘clear pattern seen between level of secondary school qualification and smoking status’ (61 per cent of young Māori women who lacked a secondary school qualification were regular smokers); that smoking was ‘more commonly associated with ... requiring income assistance (57 per cent of young Māori women who received the domestic purposes benefit were regular smokers); and that there was a relationship between smoking and receipt of the sickness benefit (more than half) and those who attended the emergency department and were admitted to hospital in the previous 12 months (47 per cent and 46 per cent).²⁷⁸

ASH Year 10 Snapshot, April 2018

Every year the Ministry of Health funds Action on Smoking and Health (ASH), an incorporated society set up in 1983 to ‘eliminate the death and harm caused by tobacco’, to survey 20,000 to 30,000 year 10 students on their smoking behaviours and attitudes. Their most recent research is from 2018. While the 2018 ASH Year 10 Survey reveal promising trends in tobacco use among the general Year 10 student population, the survey noted that daily smoking among Māori and Pacific students remained ‘markedly higher than for other ethnicities’.²⁷⁹ The daily smoking figure for all survey participants was 1.9 per cent compared to 5.2 per cent for Māori students. The percentage of Year 10 students who had never smoked was 81.1 per cent compared to 63.3 per cent for Māori students. Commenting on the survey results, Associate Health Minister Salesa stated that further work was needed to ‘achieve equity amongst all New Zealand teenagers’ and noted that although the rate of daily smoking among Māori girls who participated in the survey had fallen to 5.8 per cent it remained higher than the overall daily

²⁷⁷ Email communication from Chris Cunningham, Professor of Research Centre for Māori Health and Development, 2 Apr 2019

²⁷⁸ Esther Lim et al, *Young Māori women who smoke: technical report*, Wellington: Ministry of Health, June 2017, vii, pp 24-28

²⁷⁹ ASH, 2018 ASH Year 10 Snapshot; Topline Results, https://www.ash.org.nz/ash_year_10 (Accessed on 5 Apr 2019. Screenshot available)

smoking rate among Year 10 students of 1.9 per cent. The Minister said that the disparity in smoking prevalence between Māori and non-Māori ‘needs to change and the gaps need to close’²⁸⁰

Hāpai Te Hauora, ‘Smokefree future out of reach for Māori’, July 2018

In July 2018, Hāpai Te Hauora, who hold the national service contract for tobacco control advocacy, claimed that the New Zealand Smokefree 2025 target appeared to be ‘increasingly unachievable’. In their statement entitled ‘Smokefree future out of reach for Māori’, Hāpai Te Hauora noted that the Ministry of Health’s annual Health and Independence Report found that while smoking rates in the general population were roughly on track, Māori smoking rates had fallen by 17 per cent to 32.5 per cent – ‘a significant disappointment’ as the goal had been a 50 per cent reduction in Māori smoking rates by 2018. Hāpai Te Hauora advocated an increased focus on reducing smoking inequities and recommended a reduction in tobacco supply combined with ensuring that culturally appropriate smoking cessation ‘services and tools’ were easily accessible. It further noted that a University of Otago and Cancer Society briefing paper on tobacco retail availability indicated that there was a greater concentration of tobacco retailers in areas that had higher deprivation indices scores, and that Māori were more likely to reside in these areas. Lance Norman, the Hāpai Te Hauora chief executive, considered the link between Māori smoking rates and the disproportionate availability of tobacco in high deprivation areas was irrefutable.²⁸¹

Government evaluation of the impact of tobacco excise increases, November 2018

In 2018, Ernst and Young was commissioned by the Ministry of Health to evaluate the impact of tobacco excise increases as a contributor to the Smokefree 2025 goal. Ernst and Young indicated that one of the purposes of its report was to ‘explicitly consider’ the impact of tobacco excise increases for Māori, Pacific people, low-income populations and young people.²⁸² It found that despite progress being made in decreasing the prevalence of smoking, ‘significant inequities’ remained for Māori and noted that addressing these inequities required a ‘targeted approach’. Māori households were found to be less likely to quit smoking due to tobacco tax increases and more likely to search for more affordable brands, find alternative tobacco vendors or smoke roll-your-own cigarettes in response to tobacco tax hikes.²⁸³ Māori households were also found to be twice as likely as ‘European/other’ households to go without a necessity item in response to tobacco tax increases.

Many of the stakeholders consulted by Ernst and Young expressed concern about ‘the perceived imbalance’ between the amount of revenue generated by increases in tobacco excise and the level of

²⁸⁰ Television New Zealand, ‘Teen smoking at record low in New Zealand, new research finds’, <https://www.tvnz.co.nz/one-news/new-zealand/teen-smoking-record-low-in-new-zealand-research-finds> (Accessed on 5 Apr 2019. Screenshot available)

²⁸¹ ‘Smokefree future out of reach for Māori’, Hāpai Te Hauora, 20 July 2018, <http://Hāpai.co.nz/content/smokefree-future-out-reach-maori> (accessed on 7 Jan 2019)

²⁸² Ministry of Health, Evaluation of the tobacco excise increases as a contributor to Smokefree 2025, 27 Nov 2018, p 10

²⁸³ Ministry of Health, Evaluation of the tobacco excise increases as a contributor to Smokefree 2025, 27 Nov 2018, p 13

resourcing for tobacco control initiatives. Māori women were also found to bear a ‘significant burden’ with 36 per cent of Māori women still smoking daily compared to 29 per cent of Māori men and 13 per cent of women overall.²⁸⁴

The report’s authors noted that tobacco excise was usually considered ‘regressive’ as low-income groups tended to have a higher smoking prevalence.²⁸⁵ However, research also found that lower income groups had a stronger response to tobacco taxation, benefitted most from the savings and costs that were avoided through either quitting or not taking up smoking, and reaped health benefits stemming from tobacco excise increases.²⁸⁶ Focus groups consulted during research for the report considered that tobacco excise impacted unfairly on people from lower socio-economic backgrounds and was a form of racial discrimination affecting minority groups more than their more affluent counterparts. Despite these views, the authors noted that stakeholders were ‘generally supportive’ of the excise providing that it was accompanied by adequate support measures.²⁸⁷ In the report’s conclusions, the authors indicated that ‘the weight of evidence’ showed that further increases in the price of tobacco remained the most effective means of reducing the prevalence of tobacco use.²⁸⁸

In January 2019 Richard Edwards, Janet Hoek and Anaru Waa of ASPIRE 2025, a collaboration of health researchers committed to supporting the achievement of the Smokefree 2025 objective, commented on the Ernst and Young tobacco report. They noted that the report’s recommendations, which included conditional tobacco excise increases and the implementation of ‘comprehensive and multi-faceted complementary measures’ as a strategy for reaching the Smokefree 2025 objective, were ‘highly consistent’ with recommendations made by the New Zealand tobacco control sector in the Smokefree Aotearoa Plan.²⁸⁹

Nick Wilson et al, ‘Modelling the number of quitters needed to achieve New Zealand’s Smokefree 2025 goal for Māori and non-Māori’, December 2018

Further research produced towards the end of 2018 indicates that the smokefree 2025 target is looking increasingly more difficult to achieve. Nick Wilson et al in a *New Zealand Medical Journal* article modelled the number of people required to quit smoking if the government was to meet the target and again found that based on future smoking prevalence projections, current government policies and

²⁸⁴ Ministry of Health, Evaluation of the tobacco excise increases as a contributor to Smokefree 2025, 27 Nov 2018, p 163

²⁸⁵ Ministry of Health, Evaluation of the tobacco excise increases as a contributor to Smokefree 2025, 27 Nov 2018, p 50. The report defines a regressive tax as ‘A tax applied uniformly, taking a larger percentage of income from low-income earners than from high-income earners’.

²⁸⁶ Ministry of Health, Evaluation of the tobacco excise increases as a contributor to Smokefree 2025, 27 Nov 2018, p 165

²⁸⁷ Ministry of Health, Evaluation of the tobacco excise increases as a contributor to Smokefree 2025, 27 Nov 2018, pp 157, 166

²⁸⁸ Ministry of Health, Evaluation of the tobacco excise increases as a contributor to Smokefree 2025, 27 Nov 2018, p 173

²⁸⁹ Richard Edwards, Janet Hoek and Anaru Waa, ‘What does the EY Tobacco Excise Tax Evaluation Report mean for reaching the Smokefree 2025 Goal?’, University of Otago, <https://blogs.otago.ac.nz/pubhealthexpert/2019/01/24/what-does-the-ey-tobacco-excise-tax-evaluation-report-mean-for-reaching-the-smokefree-2025-goal/> (accessed on 7 February 2019, last updated 24 January 2019)

services would not be enough to achieve the 2025 goal. They noted that their modelling suggested that not only would non-Māori fail to achieve the goal of adult daily smoking prevalence being below 5 per cent, but Māori would also miss this target ‘by a very wide margin’.²⁹⁰ Highlighting the need for urgent progress, the article also noted that while Associate Minister of Health Salesa had in 2018 committed to developing an action plan to achieve the Smokefree 2025 target, no plan indicating how this goal would be achieved had been published by a New Zealand government.²⁹¹

The authors predicted that if current annual trends in smoking uptake and cessation continued, the projected prevalence of smoking would be 17.4 per cent for Māori and 7.2 per cent for non-Māori in 2025. These projected figures equated to approximately 90,000 Māori and 220,000 non-Māori still smoking in 2025. While the estimate for non-Māori smoking prevalence is comparatively close to the Smokefree 2025 target of below 5 per cent, the projected figure for Māori falls well short of this goal. In order to achieve this objective, the authors calculated that a yearly average of an additional 8,400 Māori and 8,800 non-Māori would need to quit smoking.²⁹²

They conceded, however, that in formulating their projections they may have overestimated the difficulties involved in achieving the Smokefree 2025 target, and had not fully considered the impact of e-cigarettes and plain cigarette packaging on smoking cessation.²⁹³ They also indicated they may have ‘slightly overestimated’ the positive effect of increases in tobacco tax, overestimated the long-term smoking cessation rates achieved as a result of Quitline,²⁹⁴ and underestimated smoker numbers and the number of people stopping smoking.²⁹⁵

Despite these limitations, the authors doubted that these factors would have a major impact on their finding that to meet the Smokefree 2025 smoking cessation target an ‘unrealistically large increase’ in people using smoking cessation services would be required. To achieve the 2025 target, the article proposed two options: a substantial increase in funding to support the establishment of tobacco control measures; and the addition of ‘substantive novel interventions into the tobacco control intervention mix’. The authors indicated that the first option would involve a combination of ‘massively increased’ investment in smoking cessation services like Quitline and other mass media cessation campaigns. Despite tobacco control programmes like ‘Its About Whānau’ achieving positive results for Māori, they

²⁹⁰ Nick Wilson et al, ‘Modelling the number of quitters needed to achieve New Zealand’s Smokefree 2025 goal for Māori and non-Māori’, *New Zealand Medical Journal*, vol 131, no 1487 (14 Dec 2018), pp 30- 31

²⁹¹ Rachel Thomas, ‘No room for complacency if we are to kick smoking by 2025, Helen Clark says’, Stuff, 27 Mar 2018, <https://i.stuff.co.nz/national/102608415/no-room-for-complacency-if-were-to-reach-kick-smoking-by-2025-helen-clark-says> (accessed on 14 Dec 2018); Nick Wilson et al, ‘Modelling the number of quitters needed to achieve New Zealand’s Smokefree 2025 goal for Māori and non-Māori’, *New Zealand Medical Journal*, vol 131, no 1487 (14 Dec 2018), p 30

²⁹² Nick Wilson et al, ‘Modelling the number of quitters needed to achieve New Zealand’s Smokefree 2025 goal for Māori and non-Māori’, *New Zealand Medical Journal*, vol 131, no 1487 (14 Dec 2018), pp 30-31

²⁹³ Nick Wilson et al, ‘Modelling the number of quitters needed to achieve New Zealand’s Smokefree 2025 goal for Māori and non-Māori’, *New Zealand Medical Journal*, vol 131, no 1487 (14 Dec 2018), p 32

²⁹⁴ Ministry of Health, *The Quit Book: Beat the Smoking Addiction*, Revised Sept 2014

²⁹⁵ Nick Wilson et al, ‘Modelling the number of quitters needed to achieve New Zealand’s Smokefree 2025 goal for Māori and non-Māori’, *New Zealand Medical Journal*, vol 131, no 1487 (14 Dec 2018), p 34

found New Zealand seemed to have ‘under-invested in mass media campaigns historically’. Continuing to increase tobacco taxation and using a portion of the revenue generated to assist those wishing to quit smoking was another element of this option.²⁹⁶

With respect to the second option, it was suggested the government adopt ‘one or more novel endgame strategies’ including reducing tobacco supply, significantly reducing tobacco retail outlets, a government ‘tobacco-free generation’ policy, and/or only permitting the sale of low nicotine tobacco products. Apart from the proposed reduction in tobacco supply, the authors noted that all of these interventions were included in the action plans of New Zealand health sector groups like Aspire2025, Quitline and Hāpai Te Hauora.²⁹⁷

Joint briefing to the government on progress towards the smokefree 2025 goal, December 2018

In December 2018, the Health Committee and the Māori Affairs Committee provided a joint briefing on the government’s progress towards the smokefree 2025 goal. The committees also provided an update on the government’s progress towards the other recommendations from the 2010 MASC inquiry it agreed to adopt. The briefing noted that the government had taken action on 11 of 42 of MASC’s recommendations. However, according to projections, the Smoke-free goal of 5 per cent would not be met in 2025, particularly for Māori.

The briefing noted that as of December 2018, lung cancer remained the leading cause of death for Māori women and the second leading cause of death for Māori men. Daily smoking rates for Māori in 2016/17 were 33 per cent, down from around 38 per cent in 2011. However, it was also noted that the rate should have dropped to around 19 per cent in order to meet the smokefree 2025 target, and that there needed to be more than a five-fold increase in the numbers of Māori quitting smoking to reach the target.²⁹⁸

The briefing made the following six recommendations for the government to progress its commitment to the smokefree 2025 goal and implement the recommendations of the 2010 MASC inquiry:

- that ethnicity data be collected on smoking-related deaths, in order to find out how many Māori are dying each year from smoking;
- that legislation be enacted to regulate vaping and e-cigarettes as a way to help smokers quit and progress towards the smokefree 2025 goal;
- that the government ensure better targeting of stop smoking services and evaluate their effectiveness by reviewing stop smoking services in prisons;

²⁹⁶ Nick Wilson et al, ‘Modelling the number of quitters needed to achieve New Zealand’s Smokefree 2025 goal for Māori and non-Māori’, *New Zealand Medical Journal*, vol 131, no 1487 (14 Dec 2018), p[34-35

²⁹⁷ Nick Wilson et al, ‘Modelling the number of quitters needed to achieve New Zealand’s Smokefree 2025 goal for Māori and non-Māori’, *New Zealand Medical Journal*, vol 131, no 1487 (14 Dec 2018), pp 35, 37

²⁹⁸ ‘Briefing on achieving the Smokefree 2025 goal for New Zealand’, report of the Health Committee and the Māori Affairs Committee’, December 2018, p. 27.

- that the government investigate expanding the subsidies on nicotine replacement therapy products;
- that the government investigate how to reduce smoking in cars carrying children; and
- that the uncompleted recommendations from the 2010 MASC inquiry be re-examined and re-prioritised by the government to better realign with achieving the smokefree 2025 goal.²⁹⁹

An appendix to the committees' report noted that of the 42 recommendations made by MASC in 2010, 11 had been completed, 13 were ongoing, 1 was in progress, 9 were considered low priority and 8 were not government policy.³⁰⁰ The recommendations that the government found to be outside of current policy included:

- requiring tobacco companies to finance all smoking cessation pharmaceuticals;
- embedding in legislation and policy FCTC guidelines intended to limit tobacco industry influence on public policy;
- removing a section of the Smoke-free Environments Act 1990 to allow tobacco companies to offer discounts or rebates;
- requiring individuals selling tobacco to be older than 18 years of age;
- amending legislation to prohibit vending machines;
- investigating extending legislation to prohibit smoking in vehicles carrying children and public places;
- requiring that nicotine replacement therapies be available wherever tobacco is sold; and
- investigating options for achieving an optimal tobacco control governance and management structure.³⁰¹

Government update on achieving the Smokefree 2025 goal, March 2019

In March 2019, the government published its response to the December 2018 report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 target. The government acknowledged that the committees' report represented 'a significant contribution to the development of policy towards achieving Smokefree 2025' and indicated it was either taking or would act 'to meet the Committees' recommendations'.³⁰²

²⁹⁹ Briefing Dec 2018, p. 26.

³⁰⁰ Health Committee and Māori Affairs Committee, *Briefing on achieving the Smokefree 2025 goal for New Zealand*, Dec 2018, p 36

³⁰¹ Health Committee and Māori Affairs Committee, *Briefing on achieving the Smokefree 2025 goal for New Zealand*, Dec 2018, pp 36-37, 39-43, 45

³⁰² New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, p 2

The government said it supported ‘the intent’ of the recommendation that the Ministry of Health collect data on smoking-related deaths by ethnicity and acknowledged there was a need for this information. It also indicated it would ‘explore the feasibility of improving estimates of the number of smoking-related deaths by ethnicity’.³⁰³ It noted, however, that applying analytical techniques to existing data to arrive at an approximate number of smoking-related deaths by ethnicity as opposed to changing the data collected was ‘not straight-forward’.³⁰⁴ The government stated that it was impossible to directly collect data on smoking-related deaths because in cases such as people dying of lung cancer, smoking may have increased a person’s chances of contracting the disease, but it was not the identifiable cause. In other cases, smoking may have been a contributing factor in a person’s death but other factors such as obesity or heart disease may also have played a part.³⁰⁵

The government noted that the Ministry of Health applied epidemiological models to the data it collected when it estimated the number of annual smoking-related deaths in New Zealand at 4500 to 5000. It added, however, that those estimates had not been ‘disaggregated by ethnicity’ because the modelling methods used to reach those figures may have inaccurately inflated the number of Māori who die from tobacco-related conditions. Further, it noted that ‘The number of Māori who die each year is small, so the epidemiological models don’t have enough data for the estimates to be accurate.’³⁰⁶ The government stated that in 2019/20 the Ministry of Health would ‘explore the feasibility of undertaking such analysis again, including whether it will be possible to produce accurate estimates for Māori’.³⁰⁷

In response to the joint committees’ second recommendation, the government indicated it supported the recognition and regulation of vaping and e-cigarettes as a means of assisting smokers who wished to quit, and said it expected a Smoke-free Environments Amendment Bill that improved ‘the regulatory framework for vaping products to be introduced’ in Parliament in mid-2019. Significantly, it also noted that the HPA was developing a campaign that was to be implemented in stages beginning in April 2019 and was ‘being co-designed with young Māori women’ (who it identified as a priority group) aimed at providing support to smokers switching to vaping.³⁰⁸

Responding to the joint committees’ third recommendation that the Ministry of Health ‘explore the expansion of subsidised nicotine replacement therapy products based on evidence’, the government

³⁰³ New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, p 2

³⁰⁴ New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, p 2

³⁰⁵ New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, pp 2-3

³⁰⁶ New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, p 3

³⁰⁷ New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, p 3

³⁰⁸ New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, p 3

indicated that it considered the processes utilised by PHARMAC when making decisions about NRT-product funding were adequate.³⁰⁹

The government supported the committees' fourth recommendation that it review smoking cessation programmes in prisons to gauge their effectiveness. It indicated that the Department of Corrections and the Ministry of Health would conduct a joint review of the effectiveness of these programmes.

In response to the committees' recommendation that it explore the most effective ways of reducing smoking in vehicles carrying children, the government again supported the recommendation and noted that a Smoke-free Environments Amendment Bill prohibiting smoking in vehicles carrying children under the age of 18 was expected to be introduced to Parliament early in 2019.³¹⁰ This issue is discussed further below.

The government also supported the committees' final recommendation that 'as part of its action plan to achieve the Smokefree 2025 target' the government re-examine and prioritise the remaining uncompleted 2010 MASC inquiry recommendations and prioritise the implementation of those recommendations that would be most effective in achieving the Smokefree 2025 target.³¹¹ The committees' sixth recommendation appeared to presuppose that the government already had an official action plan whereas in fact it does not, as the government made clear in its response when it stated that 'the Ministry of Health will review the uncompleted recommendations of the 2010 MASC as part of developing an action plan for Smokefree 2025'.³¹²

Following publication of the government's 2019 response, health researcher Richard Edwards was critical of what he considered the government's lack of action regarding the Select Committee's 2010 recommendations:

It is extremely regrettable that following its adoption of the Smokefree Aotearoa goal the Government did not follow through on some of its key commitments made in its 2011 response – such as to investigate options to reduce supply and to modify the product (remove additives and nicotine), and to develop a comprehensive smoke-free public education and marketing strategy. These are the major interventions that could have made a real difference but were not progressed from 2011 to 2017. This represents a failure to fulfil the Government's promises,

³⁰⁹ New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, p 3

³¹⁰ New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, p 4

³¹¹ New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, p 4

³¹² New Zealand Parliament, *Government response to report of the Māori Affairs Committee and the Health Committee on achieving the Smokefree 2025 goal for New Zealand*, 28 Mar 2019, p 5

and arguably to meet its Treaty commitments to protect Māori, given the exceptionally high level of smoking and smoking related disease among Māori.³¹³

Smoking in vehicles

The aforementioned 2019 commitment by the government to amend legislation to prohibit smoking in vehicles carrying children comes eight years after it acknowledged, in its March 2011 response to the Māori Affairs Select Committee report, the potentially-harmful effects of second-hand smoke on non-smokers. The government also indicated its willingness to consider options ‘with an emphasis on non-legislative options’ that would expand areas where smoking restrictions applied, including in vehicles.³¹⁴

Others also advocated to prohibit smoking in cars. In 2015, the Health Committee considered a petition presented by Patu Puaauhi Tai Tokerau/Smokefree Northland seeking the introduction of legislation or other measures prohibiting smoking in cars carrying children under the age of 18.³¹⁵ In response, the government stated that ‘present initiatives are sufficient’ to deter the practice.³¹⁶ Two years later tobacco control experts noted that evidence showed 20 per cent of children were exposed to second-hand smoke with the number increasing in 2015.³¹⁷

In a Cabinet paper discussing the proposed 2019 amendment, Associate Minister Salesa noted that ‘Māori children and those living in the most deprived areas are more likely to be exposed to second-hand smoke in vehicles’.³¹⁸ The proposed ban would include vaping and apply to all vehicles whether stationary or moving. While welcoming the announcement, Boyd Broughton (ASH Programme Manager) noted that the amended legislation would require effective support coupled with a robust public campaign to prevent it further harming New Zealand’s ‘high smoking community, who are predominantly lower socioeconomic, Māori and Pacific Islanders’.³¹⁹

Chris Cahill, the head of the Police Association, described the proposed legislation as ‘a little bit short sighted’ and questioned the practicality of enforcing a law which he saw as a ‘health and education

³¹³ Email communication from Richard Edwards, 8 Apr 2019

³¹⁴ New Zealand Parliament, Government Response to the Report of the Māori Affairs Committee on its *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, Final Response, 14 Mar 2011, J1, p 14

³¹⁵ Associate Minister of Health Honorable Jenny Salesa, Cabinet paper, ‘Prohibiting smoking in motor vehicles carry children under 18 years of age’, dated 8 Feb 2019, p 3

³¹⁶ Associate Minister of Health Honorable Jenny Salesa, Cabinet paper, ‘Prohibiting smoking in motor vehicles carry children under 18 years of age’, dated 8 Feb 2019, p 3

³¹⁷ Richard Edwards, ‘Thousands of NZ children continue to be exposed to second-hand smoke in cars’, University of Otago, 7 July 2017, <https://www.otago.ac.nz/news/news/otago655444.html> (Accessed 5 Mar 2019. Screenshot available)

³¹⁸ Associate Minister of Health Honorable Jenny Salesa, Cabinet paper, ‘Prohibiting smoking in motor vehicles carry children under 18 years of age’, dated 8 Feb 2019, p 1

³¹⁹ *New Zealand Herald*, ‘Smoking to be banned in cars when children under 18 are present, Govt announces’, 10 Feb 2019, https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12202406 (Accessed on 11 Feb 2019. Screenshots available)

issue'. Cahill expressed concern that the majority of those who received fines for smoking in vehicles would 'to a large degree' be those with limited financial resources.³²⁰

Vaping

Vaping is commonly considered to refer to the use of electronic cigarettes such as vapes (vaporisers), vape pens and other electronic nicotine delivery systems that heat a liquid into vapour which users inhale to mimic smoking.³²¹ In New Zealand, the liquids usually contain propylene glycol, vegetable glycerine, flavouring and nicotine – although nicotine is optional.³²² The Vaping Facts website, launched in June 2019, advises that vaping is not harmless, but acknowledges that it is much less harmful than smoking.³²³

The rates of vaping have risen sharply in New Zealand over the last three years, with 171,000 New Zealanders (4.3 per cent of the population) using vaping products in 2018, compared to 66,000 in 2016.³²⁴ The Ministry of Health and the Health Promotion Agency currently support vaping as a way for people to quit smoking, particularly Māori women and pregnant Māori women.³²⁵ Given the recent development of vaping technology and the rapid uptake of vaping in the population, it is not yet possible to determine trends or impacts of these products. Likewise, health practitioners, researchers and policy advisors have not yet had the opportunity to collect definitive evidence, or to develop a position on the impacts of vaping.

Tobacco giant Philip Morris International's targeting of its products to Māori and funding Māori smoking cessation research has recently come under criticism. The company made headlines in June 2019 when company representatives began targeting their new e-cigarettes and vaping products to Māori by visiting marae and sports clubs and offering promotions on e-cigarette devices.³²⁶ As mentioned, Māori smokefree advocate and academic Marewa Glover also recently faced criticism from public health academics for receiving research funding from Philip Morris via 'The Foundation for a Smoke-Free World'. Glover is a strong advocate for vaping as a way for Māori to quit smoking.³²⁷

³²⁰ Brittany Keogh, 'Ban on smoking in cars with children short sighted, says head of police union', Stuff, 12 Feb 2019, <https://i.stuff.co.nz/national/health/110513025/ban-of-smoking-in-cars-with-children-short-sighted-says-head-of-police-union?cid=neighbourly.post> (Accessed on 25 Feb 2019. Screenshots available)

³²¹ United States Centers for Disease Control and Prevention, 'Outbreak of Lung Injury Associated with E-Cigarette Use, or Vaping', https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html, accessed 26 September 2019.

³²² 'What is Vaping', Vaping Facts Website, Ministry of Health and Health Promotion Agency <https://www.vapingfacts.health.nz/the-facts-of-vaping/what-is-vaping/>

³²³ <https://quit.org.nz/en/help-to-quit/vaping>

³²⁴ Kupe Data Explorer 'Indicator: Current vaping product users in the population' (source is the 2018 Health and Lifestyles Survey) <https://kupe.hpa.org.nz/#!/tobacco/vaping-e-cigarettes/current-vaping-product-users-in-the-population>

³²⁵ 'Vaping to quit Smoking', Vaping Facts Website, <https://vapingfacts.health.nz/vaping-to-quit-smoking/>, accessed 25 Nov 2019; HPA 'Māori women's perspectives and experiences with smoking and vaping', May 2019, <https://www.hpa.org.nz/sites/default/files/M%C4%81ori%20Woman%20and%20Vaping.pdf>

³²⁶ Newsroom, 'Big Tobacco targeting Māori with e-cigarettes', 11 Jul 2019, <https://www.newsroom.co.nz/2019/07/11/677880/big-tobacco-targeting-maori-with-e-cigarettes#>, accessed 25 Nov 2019.

³²⁷ Stuff, 'Māori smoking researcher Marewa Glover shunned over Philip Morris funding'

Hāpai Te Hauora, the sole national tobacco control advocacy provider, also support vaping as a way for Māori, particularly wāhine Māori to quit smoking, but have stated that they have had to cut ties with Glover because of her involvement with Philip Morris.³²⁸ In August 2019, the Ministry of Health strongly discouraged DHBs and PHOs from engaging with Philip Morris International or any representatives of the company in relation to its smokeless tobacco products. It also strongly discouraged DHBs from engaging with Glover's research foundation because it was funded by Philip Morris.³²⁹

There are currently no safety standards in New Zealand for vaping devices or vaping liquids.³³⁰ Further, vaping in public places, vaping devices and vaping liquids do not yet fall under the Smoke-free Environments Act 1990, although the sale of vaping liquids containing nicotine is restricted to people aged 18 years or over.³³¹ In the US, vaping liquids can also contain tetrahydrocannabinol (THC) and cannabinoid (CBD) oils. However, with the exception of CBD, which is available on prescription in New Zealand, these oils are not available for sale in New Zealand.

Recently, international concerns have surfaced about the health risks associated with vaping. In September 2019, 530 cases of lung injury and 7 deaths associated with vaping had occurred in the United States, although the outbreak seemed to be related more to users vaping TCH and CBD.³³² In Australia, it is illegal to sell or buy e-cigarettes or vaping liquids containing nicotine without a prescription from a medical doctor. The Australian government has taken the stance that there is not sufficient evidence to show that vaping does help people quit smoking or that it is safe.³³³

In June 2019, the New Zealand government announced that it planned to roll out a campaign targeted at Māori women to quit smoking by vaping.³³⁴ However, this campaign has been put on hold until the Smoke-free Environments (Vaping) Amendment Bill is passed. In a similar way to its approach to tobacco, the government has stated that the Bill will regulate vaping and smokeless tobacco products

³²⁸ Hāpai Te Hauora, 'National Tobacco Control Advocacy Service responds to media stories on vaping', 25 Jul 2019, <https://www.hapai.co.nz/content/national-tobacco-control-advocacy-service-responds-media-stories-vaping>, accessed 25 No 2019. The four key objectives of Hāpai te Hauora national tobacco control advocacy are reducing rates of smoking initiation, increasing the number of smokers quitting, reducing the social, economic and health impact of tobacco and reducing inequalities, see Hāpai te Hauora, National Tobacco Control Advocacy, <http://Hapai.co.nz/national-tobacco-control-advocacy>, accessed on 11 Apr 2019.

³²⁹ Ashley Bloomfield, Director-General of Health, to District Health Board Chief Executives and PHO Executives, August 2019, <https://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/who-framework-convention-tobacco-control> accessed 25 Nov 2019.

³³⁰ 'What vape liquid should I get', <https://www.vapingfacts.health.nz/vaping-to-quit-smoking/what-vape-should-i-get/what-vape-liquid-should-i-get.html>

³³¹ 'Law and Regulations', <https://www.vapingfacts.health.nz/the-facts-of-vaping/vaping-law-and-policy/>; 26 sept accessed

³³² United States Centers for Disease Control and Prevention, 'Outbreak of Lung Injury Associated with E-Cigarette Use, or Vaping', https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html, page posted 19 September 2019, accessed 26 September 2019.

³³³ 'About e-cigarettes', Australian Government Department of Health, page last updated 8 April 2019, accessed 26 September 2019 <https://www.health.gov.au/health-topics/smoking-and-tobacco/about-smoking-and-tobacco/about-e-cigarettes>

³³⁴ Hon Jenny Salea, 'New vaping to quit smoking website launches', 9 June 2019, accessed 26 Sep 2019, <https://www.beehive.govt.nz/release/new-vaping-quit-smoking-website-launches>

and protect children and young people from the associated risks by banning vaping in bars, restaurants and workplaces, and place restrictions on the retail and advertising of vaping products.³³⁵

As recently as 26 November 2019, it was reported that ‘more than 60 health, community and school organisations’ had written an open letter outlining concerns about vaping. The group called on Associate Minister of Health Jenny Salesa to ‘fast-track legislation’ that will regulate vaping in a similar way to tobacco and protect young people who are becoming addicted.³³⁶

Alcohol control, 2000 to present

In 1998, the first National Drug Policy addressing tobacco, alcohol and other drug issues was developed. The policy explicitly set out the government’s intersectoral approach and commitment to minimising drug-related harm, particularly for Māori, young people, pregnant women and people with co-existing substance and mental health needs.³³⁷

Since 2000, the government has made several changes to alcohol legislation and policy, including developing a National Alcohol Strategy in 2001 and updating the National Drug Policy in 2007 and 2015. In 2016, the government also recognised the importance of addressing fetal alcohol spectrum disorder as an issue and released its action plan ‘Taking Action on Fetal Alcohol Spectrum Disorder: 2016-2019’.³³⁸ However, public health professionals and academics argue that the government has not done enough to strengthen alcohol control and reduce alcohol-related harm, particularly amongst Māori.³³⁹

National Alcohol Strategy 2000-2003

The government’s most recent National Alcohol Strategy 2000-2003 was developed by ALAC and the Ministry of Health in 2001. In line with the three main strategies of the 1998-2003 National Drug Policy, the National Alcohol Strategy specified alcohol initiatives in the three areas of supply control (such as legislation governing the sale and supply of alcohol), problem minimisation (e.g. treatment services, liquor bans and drink driving rules), and thirdly, demand reduction (e.g. health promotion, increases in prices, education, social media campaigns and health warnings). The National Alcohol Strategy, like other policies of its time, recognised the Crown’s obligations to protect the health of Māori under the Treaty of Waitangi and identified seven principles that underpinned the strategy and reflected the

³³⁵ Jenny Salesa, ‘Vaping and smokeless tobacco products to be regulated’, Press Release, 24 Nov 2018, <https://www.beehive.govt.nz/release/vaping-and-smokeless-tobacco-products-be-regulated> accessed 25 Nov 2019.

³³⁶ <https://www.rnz.co.nz/news/national/404191/schools-vaping-industry-want-govt-regulations-as-students-addicted>; accessed 27 November 2019.

³³⁷ NDP 1998, p. 2.

³³⁸ FASD working group, ‘Taking Action on Fetal Alcohol Spectrum Disorder: 2016-2019’, Wellington, Ministry of Health, 2016, <https://www.health.govt.nz/system/files/documents/publications/taking-action-on-fetal-alcohol-spectrum-disorder-2016-to-2019.pdf>, accessed 12 Dec 2019.

³³⁹ McEwan et al, pp. 107-109; Alcohol Healthwatch, ‘Submission to the Māori Affairs Select Committee on the Inquiry into health inequities for Māori’, 13 Sep 2019.

Crown's Treaty obligations. These were appropriateness, effectiveness, efficiency, empowerment, equity, innovation, and working together.³⁴⁰ It also set out eight demand reduction strategies to reduce alcohol-related harm for Māori. These were:

1. 'Resource Māori community development initiatives as a way of reducing alcohol-related harm.'
2. 'Foster the development of kaupapa Māori alcohol and drug services, especially in those Māori communities that do not have such services.'
3. 'Support the further development and delivery of Maanaki Tangata and other health promotion programmes designed by Māori for Māori.'
4. 'Support the development of appropriate advertising and other marketing strategies for Māori to promote both moderation in the use of alcohol and the non-use option.'
5. 'Ensure all initiatives for age-related alcohol health promotion, especially those targeting youth and older people, also address the needs of Māori.'
6. 'Support the work of Māori wardens in the reduction of risky drinking practices by Māori.'
7. 'Ensure Māori communities are involved fully in developing policies on alcohol, including control/ regulation, education, treatment and research.'
8. 'Improve linkages between Māori communities and statutory agencies to ensure co-ordinated and integrated planning, and to avoid the separation of alcohol-related initiatives from other social and health-related initiatives.'

It is not clear the extent to which progress was made on achieving these objectives for Māori between 2000 to 2003, but a 2007 independent review of the National Alcohol Strategy noted that:

concerns were raised in relation to the effectiveness of the implementation of the NAS and the lack of monitoring and accountability to ensure that the NAS was implemented. A strong need for better leadership, clear responsibilities, and accountability was identified, as well as better and more extensive communication.³⁴¹

The independent review of the National Alcohol Strategy in 2007 did not make any mention of Māori and does not appear to have consulted with Māori stakeholders in its review of the strategy, but did consult with other stakeholders such as the Ministry of Pacific Island Affairs, and Ministry of Youth Development.³⁴²

In 2008, the Ministry of Health began a process of consultation with key stakeholders to develop a new National Alcohol Action Plan, but this was halted in 2010 while new alcohol legislation was being

³⁴⁰ 'National Alcohol Strategy 2000-2003', Ministry of Health and ALAC, March 2001, p. 22.

³⁴¹ Allen and Clarke, 'Review of the National Alcohol Strategy 2000-2003', 12 Sep 2007, Wellington, p. vii.

³⁴² Appendix D Stakeholders contributing to this review, p. 85,

developed. Nothing further, however, has been progressed.³⁴³ The lack of government direction in terms of addressing alcohol-related harm, is an issue of concern for Māori, given that Māori have experienced, and continue to experience alcohol-related harm disproportionately to non-Māori.

In their September 2019 submission to the Māori Affairs Select Committee inquiry into health inequities for Māori, Alcohol Healthwatch (an independent charitable trust contracted by the Ministry of Health to provide alcohol-related national and regional health promotion services) highlighted the government's lack of national strategy or action plan to reduce alcohol-related harm in New Zealand over the past 15 years is despite 'the high levels of harm' that existed 'from our most widely-used recreational drug'.³⁴⁴

The Sale and Supply of Alcohol Act 2012

From 2008 to 2010, the New Zealand Law Commission conducted a review of The Sale of Liquor Act 1989. It released its recommendations in 2010.³⁴⁵ As a result, the government repealed the 1989 Act and passed the Sale and Supply of Alcohol Act 2012. The main features of the 2012 Act are that it:

- restricts the sale of alcohol to people aged 18 years or over³⁴⁶;
- allows local councils to develop local alcohol policies (LAPs) in consultation with the community to further restrict the sale and supply of alcohol;
- controls or restricts the promotion, display and advertising of alcohol;
- restricts where alcohol can be sold;
- sets out how alcohol licenses are issued and their conditions;
- restricts trading hours of on-license (where alcohol is consumed on site such as bars and restaurants) and off-license (such as liquor store and supermarkets) premises; and
- sets out rules around license fees, infringement fees and penalties for alcohol licensees.

The Ministry of Justice administers the 2012 Act and advises the government on relevant alcohol-related offending and crime prevention policies. The Health Promotion Agency, established in 2012, has an alcohol-specific statutory role and this work is funded by a levy on alcohol. The Health Promotion Agency carries out national marketing campaigns, develops resources and tools, advises the

³⁴³ Alcohol Healthwatch, 'Submission to the Māori Affairs Select Committee on the Inquiry into health inequities for Māori', 13 Sep 2019, p. 7.

³⁴⁴ Alcohol Healthwatch, 'Submission to the Māori Affairs Select Committee on the Inquiry into health inequities for Māori', 13 Sep 2019, p. 7.

³⁴⁵ New Zealand Law Commission, *Alcohol in our lives: Curbing the harm, A report on the review of the regulatory framework for the sale and supply of liquor*, Wellington, 2010.

³⁴⁶ Minors (people under 18 years of age) can be supplied with alcohol by their parent or guardian (or by someone who has the consent of the minor's parent or legal guardian) if the alcohol is supplied responsibly, which means that the person under 18 is supervised, provided with food and a choice of low and non-alcoholic drinks, as well as transport. See HPA website [alcohol.org.nz 'The law about supply to young people', https://www.alcohol.org.nz/help-advice/advice-on-alcohol/for-parents/the-law-about-supply-to-young-people](https://www.alcohol.org.nz/help-advice/advice-on-alcohol/for-parents/the-law-about-supply-to-young-people)

government, non-government organisations, health professionals and communities about alcohol related matters, and conducts research on alcohol use and misuse in New Zealand.³⁴⁷

The 2012 Act addresses 130 of the 153 recommendations made by the Law Commission and – in comparison to the 1989 Act – tightens rules governing the availability, promotion and pricing of alcohol. Changes include restricting the ability of dairies and convenience stores to sell alcohol and allowing communities to have a say in limiting the location, maximum trading hours and density of alcohol licenses in their neighbourhoods through the introduction of Local Alcohol Policies.³⁴⁸

Although the government and the alcohol industry expressed satisfaction with the Act, many health and social service professionals were critical of it. They expressed disappointment that the changes did not go far enough to have sufficient effect on reducing alcohol-related harm. In particular, the government's alcohol legislation and policy were criticised for failing to implement population-based strategies advocated for by health experts and community groups.³⁴⁹ These strategies include:

- raising the legal age to purchase alcohol;
- increasing the price of alcohol through excise tax or minimum pricing;
- reducing the blood alcohol content levels for drinking and driving;
- limiting the alcohol content of ready to drink (RTD) beverages; and
- restricting alcohol sponsorship and advertising.³⁵⁰

Alcohol Healthwatch have suggested that for Māori, the following three evidence-based methods (also advocated for by the World Health Organisation) would be most effective at reducing alcohol related-harm:

1. increasing the price of alcohol (by increasing excise tax or having a minimum price);
2. decreasing the availability of alcohol and alcohol outlet density – particularly in Māori and lower income communities; and
3. restricting alcohol advertising and sponsorship.³⁵¹

Further criticism of the Act has been expressed in recent research, which concludes that the Act had 'little impact on the alcohol environment between 2013 and 2015, other than a small reduction in on-

³⁴⁷ 'About us', <https://www.alcohol.org.nz/about-us>

³⁴⁸ McEwan et al, pp. 107-108.

³⁴⁹ McEwan et al, pp. 107-110.

³⁵⁰ McEwan et al, pp. 107-108; Alcohol Healthwatch, 'Submission to the Māori Affairs Select Committee on the Inquiry into health inequities for Māori', 13 Sep 2019.

³⁵¹ Alcohol Healthwatch, 'Submission to the Māori Affairs Select Committee on the Inquiry into health inequities for Māori', 13 Sep 2019, p. 7; WHO, 'Discussion Paper: Implementation of the WHO global strategy to reduce the harmful use of alcohol since its endorsement, and the way forward', DRAFT, 21 Oct 2010 https://www.who.int/docs/default-source/alcohol/2010-strategy/discussion-paper.pdf?sfvrsn=a171471c_2, accessed 12 Dec 2019.

licence trading hours in urban centres.’³⁵² The same research also found that the Local Alcohol Policies provided for by the Act are ineffective because of the ability of the alcohol industry to appeal the policies, stating that the impact of these ‘was delayed and muted by litigation, particularly from alcohol suppliers’. The study’s authors reiterated the relevance of national population strategies (such as increasing the tax on alcohol, increasing the legal purchase age and restricting advertising), as originally recommended by the Law Commission’s 2010 report and the health and community advocates noted above.³⁵³ The current price of alcohol in relation to income means it is now more affordable than it was in the 1980s.³⁵⁴

A study published in 2019 examined whether Māori are being consulted by local governments in developing Local Alcohol Policies. It concludes that local governments do not have the ‘inclination or capacity’ to consult meaningfully with Māori in developing them and the current legislation – the Sale and Supply of Alcohol Act 2012 – risked ‘widening existing health inequalities between Māori and non-Māori’ because of its failure to ‘compel and resource local government to give regard to treaty obligations’.³⁵⁵ Because Local Alcohol Policies are one of the very few ways in which hapū and iwi can have a say or input into controlling alcohol, this is an area of concern for Māori. Under sections 179 and 192 of the Sale and Supply of Alcohol Act 2012 there is no provision for Māori representation on the Alcohol Regulatory Licensing Authority and District Licensing Committees, which make decisions on alcohol licenses. In addition, when granting a license under section 105 of the 2012 Act, the licensing committee or authority does not have to have regard to the impact on Māori.

Although the Sale and Supply of Alcohol Act 2012 has now been enacted for seven years, the government currently does not have in place a national alcohol policy aimed at specifically reducing alcohol-related harm across New Zealand. Public health academics have also recently criticised New Zealand’s current alcohol policy as being ‘in crisis’.³⁵⁶ They argue that this is in part a result of the dissolution of the Alcohol Advisory Council (ALAC) in 2012, and its replacement with the Health Promotion Agency, which has less autonomy and a wider remit than ALAC.³⁵⁷ ALAC was an autonomous Crown Entity funded by a levy on alcohol and was the government’s lead agency on

³⁵² Stephen Randerson, Sally Casswell, Taisia Huckle, ‘Changes in New Zealand’s alcohol environment following implementation of the Sale and Supply of Alcohol Act (2012)’, NZMJ 8 June 2018, Vol 131 No 1476, p. 21.

³⁵³ Stephen Randerson, Sally Casswell, Taisia Huckle, ‘Changes in New Zealand’s alcohol environment following implementation of the Sale and Supply of Alcohol Act (2012)’, NZMJ 8 June 2018, Vol 131 No 1476, p. 21.

³⁵⁴ New Zealand Drug Foundation, ‘State of the Nation 2019’ November 2019, p. 8, citing Health Promotion Agency (2018). Trends in affordability of alcohol in New Zealand. Health Promotion Agency, Wellington.

³⁵⁵ Kypros Kypri, Brett Maclellan, Shawnee Brausch, Emma Wyeth, and Jennie Connor, ‘Did New Zealand’s new alcohol legislation achieve its objectives of facilitating public input? Qualitative study of Māori communities’, *Drug and Alcohol Review*, 38, pp. 331-338.

³⁵⁶ Kypros Kypri, Jennie Connor, Doug Sellman, ‘The dissolution of the Alcohol Advisory Council: a blow for public health’, NZMJ 20 Feb 2015, vol 128, no 1409, p. 58.

³⁵⁷ Kypros Kypri, Jennie Connor, Doug Sellman, ‘The dissolution of the Alcohol Advisory Council: a blow for public health’, NZMJ 20 Feb 2015, vol 128, no 1409, p. 56.

providing policy advice, research, health promotion and treatment in relation to alcohol-related harm in New Zealand.

Fetal alcohol spectrum disorder and hazardous drinking among Māori women

One area of concern the government has attempted to address in recent years is the issue of fetal alcohol spectrum disorder caused by women consuming alcohol during pregnancy. Broadly, fetal alcohol spectrum disorder is the term applied to a range of ‘physical and neurodevelopmental impairments’ that can result when a fetus is exposed to alcohol, such as miscarriage, still or premature birth and physical or mental abnormalities.³⁵⁸ International studies show the disorder is likely to be ‘New Zealand’s leading preventable cause of non-genetic intellectual disability’.³⁵⁹ One of the indicators of success set by the government’s 2016-2019 action plan on fetal alcohol spectrum disorder is a decrease in the 2012/2013 rates of drinking during pregnancy, particularly among Māori women, by 1 July 2019.³⁶⁰ Research conducted for this report was unable to locate statistics on the rates of drinking during pregnancy. However, the latest hazardous drinking statistics show that hazardous drinking among Māori women – particularly young Māori women – is increasing, and the disparities between Māori women and non-Māori women are very high.³⁶¹ Hazardous drinking is defined by the New Zealand Health Survey ‘as a score of 8 points or more on the Alcohol Use Disorders Identification Trust’ and is a way to measure drinking that carries high risks for developing physical or mental health issues in the future.³⁶² The Health Promotion Agency states that in relation to its alcohol work one of its priority populations is ‘young women who are drinking moderately to dangerously who are at risk of unplanned pregnancy, with a focus on Māori’.³⁶³ In September 2018, it also launched a campaign encouraging women to stop drinking if there is a chance they might be pregnant.³⁶⁴ Whether and how the effectiveness of this campaign and the Health Promotion Agency’s alcohol work among Māori is evaluated is not known.

National Drug Policy 2015-2020

The absence of focus on improving alcohol (and drug) related harm for Māori is evident in the government’s latest National Drug Policy 2015-2020. The policy excludes tobacco. In comparison to

³⁵⁸ FASD working group, ‘Taking Action on Fetal Alcohol Spectrum Disorder: 2016-2019’, Wellington, Ministry of Health, 2016, p. 1, <https://www.health.govt.nz/system/files/documents/publications/taking-action-on-fetal-alcohol-spectrum-disorder-2016-to-2019.pdf>, accessed 12 Dec 2019.

³⁵⁹ FASD working group, p. 1.

³⁶⁰ FASD working group, p. 4.

³⁶¹ HPA, ‘Hazardous drinking rates are high in Maori men and women of all ages’, August 2019, <https://www.hpa.org.nz/sites/default/files/Hazardous-drinking-Maori-non-Maori-factsheet.pdf>, accessed 19 Sep 2019; Alcohol Healthwatch, ‘Factsheet: hazardous drinking: New Zealand Health Survey 2018/19’, December 2019, http://www.ahw.org.nz/Portals/5/Resources/Fact%20Sheet/2019/AHW%20Factsheet%20-%20NZHS%202018_19_Hazardous%20drinking.pdf

³⁶² Māori health trends 1990-2015 project: Risks and protective factors module appendices, Wai 2575, #B20, pp 8, 47.

³⁶³ HPA, ‘Alcohol’, <https://hpa.org.nz/programme/alcohol> accessed 13 Dec 2019.

³⁶⁴ HPA, ‘Don’t know? Don’t drink – Digital toolkit’, <https://www.alcohol.org.nz/digital-toolkit-dont-know-dont-drink>, accessed 13 Dec 2019.

the two previous National Drug Policies, the 2015-2020 policy sets out specific, measurable government actions (many of which it appears the government has progressed) with associated timeframes in line with the three strategies of ‘problem limitation’, ‘demand reduction’ and ‘supply control’.³⁶⁵ Where the policy falls short of previous policies is that it does not explicitly mention or acknowledge the disparities in drug-related harm experienced by Māori. Neither does it set any goals or strategies to specifically address the disparity. Yet the introduction mentions that government agencies will collaborate, support and partner with others to achieve ‘common goals’, and that in particular:

the principles of partnership, participation and protection will continue to underpin the relationship between government and Māori to achieve pae ora and health equity by supporting the health and wellbeing aspirations of Māori.³⁶⁶

Such a statement raises issues of how the government plans to reconcile its current drug policy with responding to Māori needs when Māori make up a large proportion of drug treatment service users (as discussed in Chapter 4), up to half of those convicted or imprisoned for low-level drug offences, and are dying from alcohol-related deaths at a rate two-and-a-half times that of non-Māori. The current lack of a strong evidence-based national alcohol policy, strategy and action plan that prioritises the reduction of alcohol-related harm for Māori is therefore a key area of concern for Māori.

The control of other drugs, 2000 to present

Around the time that alcohol laws were being reviewed, the Law Commission was also appraising New Zealand’s drug laws. In 2007, the New Zealand Law Commission began its review of the Misuse of Drugs Act 1975, and in 2009 also began reviewing the Alcoholism and Drug Addiction Act 1966 (discussed in Chapter 3). The review of the 1966 Act was given priority and in 2010 the Law Commission recommended that the government replace the Alcoholism and Drug Addiction Act 1966 with legislation that was easier to navigate and provided greater safeguards for people undergoing compulsory treatment under the Act. In 2017, the Act was repealed and The Substance Addiction (Compulsory Assessment and Treatment) Act passed.

The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 provides for the compulsory treatment of people with severe substance abuse addiction, which includes alcohol and other drugs, whose capacity to make decisions about getting treatment for their addiction is severely impaired. Section 3(d), which sets out the purpose of the Act, refers to the notion of enabling compulsory treatment to protect and enhance the mana and dignity of persons receiving compulsory treatment for their addiction. The 2017 annual report of the Office of the Director of Mental Health and

³⁶⁵ NDP 2015-2020, p. 6.

³⁶⁶ NDP 2015-2020, p. 3.

Addiction Services notes that the inclusion of the concept of mana enhancement for both the person receiving treatment as well as their whānau is significant and that the reference to mana enhancement will have ‘service implications for the entire health sector in delivering mana-enhancing health services’.³⁶⁷ How this will be implemented in practice in the long term remains to be seen.

In relation to the Misuse of Drugs Act 1975, the Law Commission recommended to the government in 2011 that a new legislative regime was required to respond to the constantly evolving market in drugs (such as legal highs, party pills, and synthetic cannabis) and align New Zealand’s drug laws with the 2007-2012 National Drug Policy. Like its 1998 predecessor, the updated 2007-2012 National Drug Policy was focused on an intersectoral/whole of government approach to reducing the health, social, and economic harms associated with tobacco, alcohol and drug use.³⁶⁸ It also highlighted the health inequalities and disproportionate drug-related harm experienced by Māori. In response to the Law Commission’s recommendations, the government stated in 2011 that it would overhaul the Misuse of Drugs Act 1975.³⁶⁹ As of December 2019, The Misuse of Drugs Act 1975 is yet to be overhauled but has been amended recently.³⁷⁰

The recommendations of the Law Commission in 2011 aimed to treat drug use as a health – as well as – criminal policy matter. The commission found that the 1975 Act did not deal appropriately with the health and addiction issues that underpin illegal drug use and recommended more flexibility around small-scale dealing, possession and drug use when these were associated with addiction.³⁷¹ A recent amendment to the Act in August 2019 has enabled the beginnings of a shift to a health focus by affirming existing Police discretion to prosecute and specifying that ‘when determining whether a prosecution is required in the public interest for personal drug possession and use, consideration should be given to whether a health approach is more beneficial’.³⁷² Given that between 2012 and 2016 Māori have made up, on average, 42 per cent of all people convicted of offences for possession and/or use of an illicit drug or drug utensil and 51 per cent of all people imprisoned for the same offences, the expectation is that the amendment will result in fewer Māori with addiction issues being convicted for low-level drug offences.³⁷³ However, both the Law Commission in its 2011 report, and the New Zealand Drug Foundation in its submission on the amendment, state that Police discretion to prosecute is a double-edged sword for Māori as it provides an opportunity for discrimination (and what could be

³⁶⁷ P. 5, ‘Office of the Director of Mental Health and Addiction Services Annual Report 2017’, February 2019.

³⁶⁸ National Drug Policy 2007-2012, p. 4.

³⁶⁹ Peter Dunne ‘Next Government will overhaul Misuse of Drugs Act’, 8 Sep 2011 <https://www.beehive.govt.nz/release/next-government-will-overhaul-misuse-drugs-act>

³⁷⁰ An amendment to the Act in 2018 enabled terminally-ill or those in palliative care to use cannabis without being prosecuted under the Act.

³⁷¹ For the issues paper, report to government, as well as other associated documents see ‘Misuse of Drugs Act 1975’, <https://www.lawcom.govt.nz/our-projects/misuse-drugs-act-1975>

³⁷² Ministry of Health, ‘Changes to the Misuse of Drugs Act’, updated 16 August 2019, accessed 20 Nov 2019, <https://www.health.govt.nz/our-work/mental-health-and-addictions/alcohol-and-other-drug-policy/changes-misuse-drugs-act>

³⁷³ Ministry of Justice OIA response Sep 2017, available from NZ Drug Foundation ‘Drug Use and Criminal Justice’ website <https://www.drugfoundation.org.nz/policy-and-advocacy/drug-use-and-criminal-justice/>, accessed 20 Nov 2019

considered institutionalised racism) against Māori, who have not benefitted historically from police discretion and are over-represented in conviction and imprisonment rates for low level drug offences.³⁷⁴

Cannabis law reform and the 2020 referendum

Health Not Handcuffs, a collective of seven health and social justice organisations including Hāpai Te Hauora, Te Rau Ora, and the New Zealand Drug Foundation, are campaigning for drug law reform that ensures ‘Māori voices, and solutions, are at the forefront of conversations about drug law reform’.³⁷⁵ They also signal the increasing importance of a Māori voice in the lead up to the 2020 cannabis referendum on whether to legalise the personal use of cannabis. The legalisation and regulation of cannabis has the potential, according to the Health Not Handcuffs campaigners and the New Zealand Drug Foundation in particular, to lead to better health and justice outcomes for Māori by reducing the number of Māori convicted of cannabis offences by as many as 1,279 per year.³⁷⁶ In its September 2019 proposed model for cannabis law reform in New Zealand, the Foundation stated:

Voting yes to legalisation would improve health outcomes for Māori by bringing in tax dollars that the Government has promised to spend on drug-related education, treatment and prevention programmes. It would also reduce and eventually eliminate the stigma associated with cannabis dependency, meaning more Māori actively seeking help when they find themselves using too often or too heavily.

The foundation also emphasised the importance of having a clear plan for how the government will meet its Treaty obligations to Māori in designing a proposed regulatory model for cannabis:

The Government acknowledges that Māori are disproportionately harmed by prohibition and that we need to protect Māori rights and interests if cannabis becomes legal. This is a good first step, but we need to ensure the Government has a clear plan in place for how they will meet their fundamental obligations under te Tiriti o Waitangi as they design the model.³⁷⁷

One of the Foundation’s recommendations was to set aside a percentage of funding for kaupapa Māori treatment, education and harm reduction in recognition of the disproportionate Māori cannabis use and

³⁷⁴ ‘New Zealand Drug Foundation submission on the Misuse of Drugs Amendment Bill’, 11 April 2019, p. 11, <https://www.drugfoundation.org.nz/assets/uploads/2019-uploads/Drug-Foundation-submission-2019-MoDA-Amendment-bill.pdf>

³⁷⁵ ‘Why is this an issue for Māori?’, Health Not Handcuffs website, no date, accessed 20 Nov 2011, https://www.healthnothandcuffs.nz/why_is_this_an_issue_for_maori

³⁷⁶ New Zealand Drug Foundation, ‘Taking control of cannabis: a model for responsible legislation’, September 2019, p. 6, <https://www.drugfoundation.org.nz/policy-and-advocacy/drug-law-reform/taking-control-of-cannabis/>

³⁷⁷ New Zealand Drug Foundation, ‘Taking control of cannabis: a model for responsible legislation’, September 2019, p. 6, <https://www.drugfoundation.org.nz/policy-and-advocacy/drug-law-reform/taking-control-of-cannabis/>

harm rates.³⁷⁸ A clear plan of action with measurable outcomes to address disparities in drug-related harm for Māori has been missing from the government's national drug policies to date.

Māori deaths from synthetic cannabis since 1 June 2017

The legalisation of cannabis may have the potential to reduce some of the harms currently experienced by Māori because of the current synthetic cannabis crisis. Synthetic cannabis is made by combining smokable plant material with laboratory manufactured synthetic cannabinoids that are supposed to mimic the natural high of cannabis.³⁷⁹ The products were launched in the early 2000s and were widely available with some being sold in dairies and liquor stores.³⁸⁰ In 2013, in response to growing concern around the use of unregulated psychoactive substances such as synthetic cannabis, herbal highs, and party/energy pills, the government passed The Psychoactive Substances Act. Prior to the 2013 Act, these products existed in a 'grey area' as they were not considered illegal under the Misuse of Drugs Act 1975 or the Medicines Act 1981 and so were easily accessible.

The 2013 Act was originally intended to enable approved low-harm psychoactive substances to be sold legally in a regulated market, thereby making all unapproved psychoactive substances illegal. Some hoped that having approved low-harm psychoactive substances available would help divert people from using more harmful illegal drugs. However, to date, no psychoactive substances have been approved for sale in New Zealand so the 2013 Act has had the unintended effect of driving all psychoactive substances underground to the black market.³⁸¹ This is because the framework set up under the legislation for approving psychoactive substances was apparently rendered unworkable when the Act was amended in May 2014 to prohibit testing of psychoactive substances on animals.³⁸²

Despite being banned by the Psychoactive Substances Act 2013, demand for synthetic cannabis is well established in New Zealand. As stated at the beginning of this chapter, 42 of the approximately 70-75 people who died from using synthetic cannabis in New Zealand since 1 June 2017 were Māori, equating to around 58 per cent.³⁸³ These figures suggest that the harm experienced by Māori as a result of synthetic cannabis is currently a major issue of concern. Hundreds of people have also been hospitalised

³⁷⁸ New Zealand Drug Foundation, 'Taking control of cannabis: a model for responsible legislation', September 2019, p. 7.

³⁷⁹ 'Synthetic Cannabis', Ministry of Health Website, <https://www.health.govt.nz/our-work/regulation-health-and-disability-system/psychoactive-substances-regulation/synthetic-cannabis>, updated 20 Aug 2019, accessed 20 Nov 2019.

³⁸⁰ See Ministry of Health, 'Review of the Psychoactive Substances Act 2013', 6 Dec 2018, appendix one 'A history of the Psychoactive Substances Act and the Environment', p. 8.

³⁸¹ See Ministry of Health, 'Review of the Psychoactive Substances Act 2013', 6 Dec 2018, appendix one 'A history of the Psychoactive Substances Act and the Environment', pp. 8-10. <https://www.health.govt.nz/publication/review-psychoactive-substances-act-2013>

³⁸² For further details on the Act see Ministry of Health, 'Review of the Psychoactive Substances Act 2013', 6 Dec 2018, <https://www.health.govt.nz/publication/review-psychoactive-substances-act-2013>

³⁸³ Information Advisor, Coronial Services to the Author, 15 November 2019. Similar percentage is also noted in 'Synthetic Drugs Response', Cabinet Paper, 7 March 2019, para 14, p. 3. <https://www.health.govt.nz/system/files/documents/information-release/cabinet-paper-synthetic-drugs-response-redacted-version-6mar2019.pdf>

in connection with using synthetic cannabis.³⁸⁴ Information collected by the New Zealand Drug Foundation from two Māori AOD treatment providers reflects the magnitude of the issue for Māori, with one provider in Porirua noting that synthetic cannabis is a ‘big issue’ and that people are not aware of and not seeking treatment services. Another in the South Island stated that ‘synthetics are a constant factor in screening and treating Māori for alcohol and other drug issues from across the South Island’.³⁸⁵ Research on the synthetics crisis undertaken by the New Zealand Drug Foundation for the Ministry of Health in 2018 found that:

people who use synthetic substances heavily are some of New Zealand’s most vulnerable people. Most demonstrated a need for intensive support in many areas of their lives. Many were homeless and most were unemployed. They struggled to regulate their use of these substances and continued to use them despite knowing that they risked serious injury or death from doing so.³⁸⁶

To address the concerns around synthetic cannabis, the government has recently attempted to tighten the supply side of the equation. An August 2019 amendment to the Misuse of Drugs Act 1975 classified the synthetic cannabinoids AMB-FUBINACA and 5F-ADB as class A drugs. The amendment also enabled temporary class drug orders to be made by the Minister of Health, which would effectively mean the substances are treated as Class C drugs under the 1975 Act. This is so that the government can enforce harsher penalties for manufacture, supply, possession and use of these substances than under the Psychoactive Substances Act 2013 which they fall under by default.³⁸⁷ According to the Ministry of Health, the combined moves would increase ‘opportunities for health and social services to be provided to users, and focus enforcement efforts on suppliers’.³⁸⁸

Developments in alcohol and other drug addiction treatment services since 2000

Chapter 2 of this report outlined the beginnings and development of the mainstream and Māori Alcohol and Other Drug (AOD) treatment sector from the 1970s to 2000. This section provides an overview of some of the key policy developments that have occurred in the sector since 2000, including the

³⁸⁴ ‘New Zealand Drug Foundation submission on the Misuse of Drugs Amendment Bill’, 11 April 2019, p. 3, <https://www.drugfoundation.org.nz/assets/uploads/2019-uploads/Drug-Foundation-submission-2019-MoDA-Amendment-bill.pdf>, citing NZ Herald on 1 March 2019: www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12208448

³⁸⁵ Appendix One, Raw data collected from meetings with organisations by NZ Drug Foundation, in ‘Synthetic Drugs Response’, Cabinet Paper, 7 March 2019, para 14, p. 3. <https://www.health.govt.nz/system/files/documents/information-release/cabinet-paper-synthetic-drugs-response-redacted-version-6mar2019.pdf>

³⁸⁶ ‘New Zealand Drug Foundation submission on the Misuse of Drugs Amendment Bill’, 11 April 2019, p. 4, <https://www.drugfoundation.org.nz/assets/uploads/2019-uploads/Drug-Foundation-submission-2019-MoDA-Amendment-bill.pdf>

³⁸⁷ ‘Synthetic Drugs Response’, Cabinet Paper, 7 March 2019, p. 5.

³⁸⁸ ‘Changes to the Misuse of Drugs Act’, Ministry of Health website, updated 16 Aug 2019, accessed 19 Nov 2019.

development of a National Strategic Framework for Alcohol and Drug Services in 2001 and the challenges as well as growth in Māori treatment service providers.

The Māori Alcohol and Other Drug treatment sector has continued to grow since 2000. Exact figures are not known, but sources indicate that in 1994 there were around 15 dedicated Māori service providers.³⁸⁹ In 1999, this figure was around 13.³⁹⁰ In 2006, the number of service providers more than tripled to around 43.³⁹¹ In 2012, there were 41.³⁹² Information provided by the Ministry of Health in 2019, states that there are currently approximately 42 kaupapa Māori Alcohol and Other Drug treatment service providers across the country meaning numbers have remained relatively stable over the past 13 years.³⁹³ The current state of mainstream and kaupapa Māori Alcohol and Other Drug treatment services is discussed further in Chapter 4 of this report.

The growth in Māori service providers in this sector appears to be the result of a commitment by the government to prioritise the provision of such kaupapa Māori services from the early 2000s. Shortly after the public health reforms brought about by the New Zealand Public Health and Disability Act 2000, the Ministry of Health developed a National Strategic Framework for Alcohol and Drug Services in 2001. The Framework ranked the development of Māori-responsive alcohol and drug treatment services, particularly kaupapa Māori services, as being the major priority of the strategy.³⁹⁴

Further support for kaupapa Māori Alcohol and Other Drug treatment services was expressed in the updated National Drug Policy 2007-2012 which recognised, like its 1998 predecessor, that Māori were a priority group because of the disproportionate amount of drug-related harm Māori experience in comparison to non-Māori. However, the 2007-2012 policy went a step further than the 1998 policy by explicitly recognising the potential of Māori self-determination to address the issue:

The National Drug Policy recognises that drug problems in Maori communities may be addressed more effectively when targeted approaches are developed by and for Māori. This has implications for the way services are provided for Māori to minimise the drug-related harm they experience.³⁹⁵

The policy also provided some suggestions as to how current drug treatment services could be better organised to meet Māori needs. It stated that Māori should have access to the full range of mainstream drug treatment services and should not be limited by socioeconomic factors or geographical location or

³⁸⁹ Cave et al, pp. 188-189.

³⁹⁰ Cave et al, pp. 188-189.

³⁹¹ Cave et al, pp. 190-191.

³⁹² No author, 'Māori and addiction treatment services: A paper prepared for the National Committee for Addiction Treatment', August 2012, p. 6.

³⁹³ Email correspondence from Manager, Addictions, Ministry of Health, 26 Sep 2019.

³⁹⁴ Ministry of Health, 'A National Strategic Framework for Alcohol and Drug Services',

³⁹⁵ National Drug Policy 2007-2012, p. 20.

isolation, and that the entire spectrum of mainstream services should also be appropriate for Māori, from health promotion to early intervention and treatment. The policy also noted the existence of kaupapa Māori services and encouraged Māori advocacy and peer support workers.³⁹⁶

The most recent vision for the addictions sector was set out in ‘Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017’.³⁹⁷ The plan, like the National Drug Policy 2015-2020, did not mention the Crown’s Treaty obligations to Māori, which were a feature of earlier policies. However, it noted several priority actions ‘to make better use of current resources for Māori’. In relation to addiction services, the plan stated that the Ministry of Health would evaluate pilot kaupapa Māori programmes for substance misuse prevention in at-risk 10 to 13-year olds; that DHBs and NGOs would actively involve Māori in service planning and would work together to identify and address disparities for Māori and would commit to measuring the impact over time of decisions addressing disparities.³⁹⁸

In terms of effectiveness of Alcohol and Other Drug treatment services, the Ministry of Health and DHBs were together tasked with evaluating service effectiveness in terms of access and outcomes for Māori in both mainstream and kaupapa Māori services. The Ministry and DHBs were also instructed to use any information on effectiveness to inform future funding service development decisions.³⁹⁹ The plan also sets a commitment for DHBs to provide kaupapa Māori services within regions where ‘the number of Māori who need a service is sufficiently high and Māori are not achieving equitable outcomes relative to other populations from mainstream service use’. It also instructs DHBs to ‘evaluate whether these services are more effective than mainstream services in addressing disparities in outcomes’.⁴⁰⁰ It is unclear the extent to which these priorities and actions have been implemented by the Ministry of Health, DHBs and NGOs and how outcomes are measured and accountabilities monitored. In his February 2018 report the Mental Health Commissioner also notes a ‘failure to track tangible progress against the 2012-2017 plan *Rising to the Challenge*, and to develop a plan to succeed it’.⁴⁰¹

Despite the period of growth since 2000 in the numbers of Māori Alcohol and Other Drug service providers, they have faced challenges in the period. In their detailed history of the Māori Alcohol and Other Drug treatment sector from 1980-2008, Cave, Robertson, Pitama and Huriwai discuss the closure of kaupapa Māori service providers across the country. For example, Queen Mary at Hamner was closed in 2003 after reviews by the Ministry of Health and funding cuts lead the company running the hospital

³⁹⁶ National Drug Policy 2007-2012, p. 20.

³⁹⁷ Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 <https://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017>

³⁹⁸ Rising to the challenge, pp. 34-35.

³⁹⁹ Rising to the challenge, pp. 34-35.

⁴⁰⁰ Rising to the challenge, p. 35.

⁴⁰¹ Health and Disability Commission, ‘New Zealand’s mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner, February 2018, p. 6.

into liquidation, which put an end to the Taha Māori programme that had been operating there since the early 1980s.⁴⁰² In 2005, The Kahunui Trust in the Eastern Bay of Plenty and Te Huarahi ki te Oranga Pai in Invercargill were closed. Te Rito Arahi in Christchurch closed in 2007. Cave et al state that these closures were the result of audits and contracts being withdrawn by DHBs for a range of reasons, including ‘a decrease in referrals, failing confidence in the programme and perceived management and governance issues’, ‘falling confidence’ in the structure and delivery of services and ‘poor management and governance practice’.⁴⁰³ However, at the same time as these audits, closures and reviews, new Māori AOD services and networks of Māori AOD providers were being established. These were still driven largely by NGOs and included new services located in Hamilton, Invercargill, Christchurch, Hawkes Bay and Auckland, some being within the hospital service provider arm (as opposed to NGOs based in the community).⁴⁰⁴ It remains to be seen how successfully they can overcome the challenges faced by their predecessors.

Summary

In considering the last two decades of tobacco, alcohol and other substance legislation, policy and provision of services to prevent or minimise addiction-related harm, several themes emerge. These include government recognition of persistent disparities (gaps) between Māori and non-Māori in the statistics that measure tobacco, alcohol and other drug use and related health outcomes. Throughout the period Māori have also made continued efforts to participate in policy development and the provision of tobacco, alcohol and other drug treatment services. These efforts have been met with challenges, such as the 2015 realignment of tobacco control services and changes to funding arrangements in the alcohol and other drug sector. There have also been more recent attempts by the government to deal with new types of harmful substances, such as synthetic cannabis.

Tobacco

While legislative measures have resulted in a decrease in smoking prevalence among Māori (albeit a comparatively small reduction), the number of Māori smoking remains disproportionately higher than that of non-Māori. Although key tobacco legislation like the 1990 Smoke-free Environments Act predated the 2010 Māori Affairs Select Committee inquiry, the Committee’s recommendations (informed by the submissions it received) provided the impetus for the government’s adoption of the Smokefree 2025 target. The recommendations also influenced changes in policy such as the plain packaging legislation.

⁴⁰² Cave et al, p. 52.

⁴⁰³ Cave et al, pp. 72-73.

⁴⁰⁴ Cave et al, p. 74.

While the government has implemented some of the recommendations of the 2010 Select Committee inquiry into the tobacco industry, some were classified as in progress while others were deemed to be beyond current government policy. It took almost a decade from the 2010 Māori Affairs Select Committee report for the government to take steps towards implementing the ban on smoking in cars carrying children. In this case, the government announced that it intends to amend the 1990 Smoke-free Environments Act by the end of 2019 to include a ban on smoking in cars carrying children under the age of 18. The new amendment will also address regulation of vaping and vaping products.

For Māori, government measures taken to achieve the Smokefree 2025 goal have so far failed to achieve the desired results. A number of tobacco control experts and health organisations have indicated their belief that unless a multifaceted approach to tobacco control (supported by significantly increased funding) is adopted Māori will fall well short of the Smoke-free 2025 target. Despite repeated calls from tobacco control experts for the government to develop an action plan for achieving the Smoke-free 2025 goal, and assurances from Associate Health Minister Peter Dunne in 2015 and Associate Health Minister Jenny Salesa in 2018 and 2019 that such a plan would be developed, an action plan is yet to be completed. Nonetheless, tobacco researcher Richard Edwards considers Minister Salesa's commitment to developing a strategy for achieving Smoke-free 2025 by the end of 2019 a positive (if long overdue) move. Further, questions remain about whether the Crown is doing enough to bring down the Māori smoking rate amongst Māori women, Māori youth, and pregnant Māori women.

Alcohol and other drugs

The disproportionate statistics for drug-related harm for Māori are stark, and have proved difficult to improve, especially in the absence of concrete and measurable action plans that target Māori. For alcohol, which is the most widely used drug in New Zealand society and amongst Māori, critics suggest that the Crown has not taken strong enough measures to increase controls and regulations, despite the prevalence of alcohol-related harm. Currently, Māori hardly feature in the government's consideration of alcohol control.

Some recent changes have been made to the Misuse of Drugs Act 1975 to help shift the focus from drugs as a criminal offence to a health issue where appropriate. Advocacy groups are currently pushing for reform that will result in better outcomes for Māori. However, New Zealand's alcohol and drug laws and policies since 2000 have done little to address the disproportionate drug-related harm experienced by Māori.

The reasons why the government has not undertaken a more wide-ranging reform of New Zealand's drug law and has not yet repealed the Misuse of Drugs Act 1975 are not completely clear. It is possible that the current debates around the tensions between criminalising drug use and treating it as a health

issue has some role to play. The rise of synthetic drugs and associated harm prompted new legislation, the Psychoactive Substances Act 2013 and its amendments, but not a complete overhaul of the legislative regime. The upcoming issues with respect to legalising the personal use of cannabis, and how the Crown will deal with the synthetic cannabis crisis for Māori, may see more wide-scale changes on the horizon.

There has been two decades of government policy recognising the disproportionate tobacco, alcohol and drug related harm experienced by Māori and prioritising the reduction of these disparities. But how the prioritisation of Māori needs in strategies and frameworks has transpired into action is less clear and disparities in statistics for use and harmful outcomes remain.

4 – Current services, effectiveness, and barriers for Māori

Introduction

This chapter outlines the current provision of stop smoking services and alcohol and other drug treatment services in New Zealand. It discusses issues around the effectiveness and barriers to accessing these addiction treatment services for Māori. The chapter begins with the provision of stop smoking services, then moves on to an overview of existing alcohol and other drug treatment services.

Stop smoking services

A range of free stop smoking services are currently available throughout New Zealand. Nationally, stop smoking services are available through the Quitline's telephone, text and online service. Locally, services are available via community, Public Health Organisation and District Health Board-based face-to-face services created under the New Zealand Public Health and Disability Act 2000 (as described earlier). A significant proportion of the face-to-face services appear to be delivered by Māori organisations using a kaupapa Māori approach (discussed below). Smokers wanting to quit can access these services through referral from their general practitioner, nurse, midwife, pharmacist or other health professional, or through self-referral.

Quitline

As covered in previous chapters, Quitline was established in 1999 when the government first began funding stop smoking services in New Zealand. It was originally a joint initiative of the Health Sponsorship Council, Te Hotu Manawa and the Cancer Society (together forming the Quit Group charitable trust). Since November 2015, Quitline has been operated by Homecare Medical as part of the National Telehealth Service, which provides a range of telehealth lines including Healthline, Depression Helpline, Alcohol and Drug Helpline, and Poisons Advice. The combined National Telehealth Service is funded by the Ministry of Health, the Accident Compensation Corporation, the Health Promotion Agency, the Ministry of Social Development and the Department of Corrections.⁴⁰⁵

Quitline provides the following free services for people who smoke or are concerned about a third party who smokes:

- tailored quit plans/programmes;
- advice on and how to access stop smoking medications/nicotine replacement therapy, such as patches, gum, lozenges, inhalers and other medicines;

⁴⁰⁵ Homecare Medical, 'The National Telehealth Service Annual Plan 2017/18', p. 3.

- monitoring and follow up on quit progress; and
- triage and referral to kaupapa Māori, Pasifika, face-to-face and group-based service providers.⁴⁰⁶

For the 2016/2017 financial year, 36,581 people used Quitline.⁴⁰⁷ This represents around 7 per cent of the 529,000 estimated daily smokers for 2016/17.⁴⁰⁸ It is not known how many of these 36,581 people were Māori. Public health academics have noted that Quitline, in conjunction with Quitline's mass media promotion, provides good value for money in terms of cost saving to the New Zealand health system, and that the service has historically had a 'high reach', including to Māori smokers.⁴⁰⁹ The majority of users in 2016/17 accessed the service via a phone call (58 per cent), 21 per cent via the text message service, 10 per cent via the Quitline website, 2 per cent via email, and 9 per cent via referral.⁴¹⁰

Quarterly figures in 2019 reveal that despite being overrepresented in current smoking statistics, Māori do not seem to use Quitline at a higher rate than other ethnicities, which raises questions about its effectiveness for Māori. In the 12 months from September 2018 to September 2019, Māori made up only 15 per cent of all Quitline users, despite currently making up around a third of all smokers.⁴¹¹ In addition, the success rate for Māori quitting at 4 weeks using Quitline was also lower (28 per cent) than other non-Māori (32 per cent).⁴¹²

Face-to-face services

Since 1 July 2016, when the retendered services replacing Aukati Kai Paipa services were rolled out, Māori have made up approximately 45 per cent of all enrolled face-to-face stop smoking service users.⁴¹³ Face-to-face stop smoking services are located across New Zealand and are usually contracted by the Ministry of Health or DHBs. These local services assist smokers to quit by providing additional support including:

- one-on-one support from a trained professional such as 'Quit coaches';

⁴⁰⁶ Homecare Medical, 'The National Telehealth Service Annual Plan 2017/18', p. 32.

⁴⁰⁷ Homecare Medical, 'The National Telehealth Service Annual Plan 2017/18', pp. 19-20.

<https://www.health.govt.nz/system/files/documents/pages/national-telehealth-service-annual-plan-2017-18.pdf>

⁴⁰⁸ 2016-2017 number of daily smokers taken from Ministry of Health New Zealand Health Survey Annual Data Explorer, <https://minhealthnz.shinyapps.io/nz-health-survey-2018-19-annual-data-explorer/> w 6371f8bc/#!/home, accessed 26 Nov 2019.

⁴⁰⁹ Prof Nick Wilson, Dr Nhung Nghiem, Dr Cristina Cleghorn, Dr Frederieke Sanne van der Deen, Prof Tony Blakely, 'NZ's Quitline Service is value-for-money: But how does it compare with other tobacco control actions in a league table?', University of Otago Public Health Expert blog, <https://blogs.otago.ac.nz/pubhealthexpert/2017/08/21/nzs-quitline-service-is-value-for-money-but-how-does-it-compare-with-other-tobacco-control-actions-in-a-league-table/>, posted 21 Aug 2017, accessed 26 Nov 2019. Citing article

⁴¹⁰ Figures appear to be for the 2016/2017 year, 'Chart 3: Pathways for Quitline service users', Homecare Medical, 'The National Telehealth Service Annual Plan 2017/18', p. 33.

⁴¹¹ Homecare Medical, 'Quitline Quarterly Report: Q1 2020 July 2019 to September 2019', pp. 11-12; New Zealand Health Survey data explorer, 2018/19 results <https://minhealthnz.shinyapps.io/nz-health-survey-2018-19-annual-data-explorer/> w 17f36b81/#!/explore-indicators, accessed 28 Nov 2019.

⁴¹² Homecare Medical, 'Quitline Quarterly Report: Q1 2020 July 2019 to September 2019', pp. 11-12.

⁴¹³ Ministry of Health, Stop Smoking Service Data, Quarter 4, Year 3, April 2019 to June 2019 (3 Years YTD).

- free stop smoking medications/nicotine replacement therapy, as well as information and advice on using these medicines;
- home visits, community clinics and support in the workplace; and
- incentive programmes, such as vouchers for quitting smoking for pregnant mothers.⁴¹⁴

In terms of expenditure, the Ministry of Health spends \$10 million per year on community-based stop smoking services. For the 2016/17 year this made up the second largest item of expenditure within the tobacco control programme budget after the \$13 million spent on stop smoking medicines (see **Figure 5** below).

The Ministry of Health advised that apart from the amount spent on stop smoking medicines (which varies year-to-year based on demand), its budget for tobacco control has remained the same since 2016/17.⁴¹⁵

Item	\$
Ministry of Health non-departmental spend	\$1,682,973
Community-based stop smoking services	\$10,000,000
Public Health Units	\$5,264,611
DHB tobacco control	\$7,903,939
Health promotion, leadership and advocacy	\$737,182
Health Promotion Agency	\$3,980,000
Stop smoking medicines	\$13,671,361
TOTAL	\$43,240,066

Figure 5: Ministry of Health tobacco control programme expenditure 2016/17⁴¹⁶

The total in **Figure 5** above excludes expenditure on the Quitline smoking cessation programme, which the Ministry of Health indicates cannot be disaggregated from the wider telehealth service contract.⁴¹⁷

Prisons

Since July 2011, all prisons in New Zealand have been officially smoke-free. Stop smoking services, including access to nicotine replacement therapy from doctors, are available to prisoners. However, a 2018 pilot study found that a certain level of tobacco use was continuing in New Zealand prisons and that relapse after release from prison was common. The study recommended that New Zealand's

⁴¹⁴ Examples of face-to-face services offering voucher incentives for hapū māmā include Te Tairāwhiti area <https://www.tostopsmoking.nz/incentives-prizes>

⁴¹⁵ Email communication from Brendon Baker, Senior Advisor, Ministry of Health, 11 Nov 2019.

⁴¹⁶ Email communication from Brendon Baker, Senior Advisor, Ministry of Health, 27 Mar 2019.

⁴¹⁷ Email communication from Brendon Baker, Senior Advisor, Ministry of Health, 27 Mar 2019.

smokefree prison policy be reviewed and advised that greater access to stop smoking support and medication and assistance during imprisonment, as well as at discharge (such as being supplied with a 'discharge pack' containing local stop smoking service contact information and nicotine replacement therapy) could help decrease relapse rates.⁴¹⁸

Kaupapa Māori stop smoking services

At present, Māori organisations appear to have established a presence in the provision of face-to-face stop smoking services across New Zealand. As outlined in the previous chapter, following a review in 2014, the Ministry of Health realigned tobacco control services in 2015, with new and re-tendered smoking control services being introduced in July 2016. According to information provided by the Ministry of Health for this report, stop smoking services are currently provided by 16 lead providers that service all 20 of the DHB areas across the country. Over a third of these lead providers are Māori organisations, namely:

1. Takiri Mai Te Ata (servicing Hutt, Wairarapa, and Capital and Coast DHB areas)
2. Te Ohu Auahi Mutunga (MidCentral DHB)
3. Ngā Kete Matauranga Pounamu (Southern DHB)
4. Tui Ora (Taranaki DHB)
5. Toki Rau (Northland DHB)
6. Te Haa Matea (Hawkes Bay DHB)

Māori organisations also make up 55 of the 75 partner organisations that work with the 16 lead providers to deliver stop smoking services.⁴¹⁹

Because of the higher rates of smoking amongst Māori women, many of these face-to-face stop smoking services target Māori (as well as Pacific) women, particularly women who are pregnant and/or have children under five years of age. As part of this strategy, in recent years some stop smoking services have been offering shopping vouchers as financial incentives for pregnant women to quit, an approach that is supported by international research and appears to be successful.⁴²⁰ Sometimes the voucher system is extended to whānau members of pregnant women living in the same home, in order to encourage a smokefree environment for the baby.⁴²¹ Sometimes the vouchers are extended to all

⁴¹⁸ Sarah Logan, Sarah Twine, Georgie Bromiley, Holly Curtis, Jude Ball, and Richard Edwards 'Factors influencing the smoking status of ex-prisoners reintegrating into the community after release: a pilot study', *NZMJ*, 23 Feb 2018, vol 131, no 1470.

⁴¹⁹ Email from Senior Advisor, Tobacco Control, Ministry of Health, 8 March 2019.

⁴²⁰ Tappin David, Bauld Linda, Purves David, Boyd Kathleen, Sinclair Lesley, MacAskil Susan et al., 'Financial incentives for smoking cessation in pregnancy: randomised controlled trial', *BMJ*, 2015; 350 :h134. <https://www.bmj.com/content/350/bmj.h134>

⁴²¹ For example, 'Ready, Steady, Quit' in the Auckland and Waitematā DHB areas, offers up to \$350 in Countdown or The Warehouse shopping vouchers for pregnant women who successfully quit, as well as up to \$200 vouchers for whānau living in the same house as the expectant mother who also successfully quit. https://readysteadyquit.org.nz/s/Mum-to-be-flyer-A5-Final-HR-No-Bleed-No-Marks-21_02_18.pdf

smokers, or smokers who have had children admitted to hospital for certain illnesses such as a respiratory infection or glue ear.⁴²²

As mentioned above, there are currently six kaupapa Māori lead providers of stop smoking services across New Zealand. The way in which kaupapa Māori stop smoking services are contracted and subcontracted by the Ministry of Health, DHBs and PHOs is varied, and has had implications on service delivery for some stop smoking service providers.

Some kaupapa Māori stop smoking services are part of a larger collective of health and social service providers. For example, Tākiri Mai te Ata Regional Stop Smoking Service is part of a larger collective of seven Māori health, education, justice and social service providers in the Wellington region and is directly funded by the Ministry of Health. Takiri Mai te Ata is currently the sole Whānau Ora stop smoking service in New Zealand and subcontracts to Kokiri Marae Keriana Olsen Trust to provide stop smoking services covering Wellington, Kāpiti, Hutt Valley and Porirua. It also subcontracts to Whaiora to provide stop smoking services in the Wairarapa region.⁴²³ Ora Toa PHO, which is funded by the Capital and Coast DHB, runs the Hapū Ora smoking cessation programme for pregnant mothers and young mothers with children under five. Women who use Ora Toa receive smoking cessation advice but can also be referred to other Ora Toa health services that address the causes of their smoking.⁴²⁴

Issues have been raised by some kaupapa Māori stop smoking service providers that they are not receiving adequate funding to deliver services. Although further evidence would be needed to confirm this, subcontracting arrangements may play a part in the dissatisfaction expressed by some Māori stop smoking service providers. For example, Ngā Mataapuna Oranga Ltd in the Bay of Plenty is a Māori PHO which provides brief advice on smoking cessation and smoking prevention through its general practitioners and health and social services programmes. Ngā Mataapuna Oranga Ltd are subcontracted by the Eastern Bay Primary Health Alliance (also a PHO) to provide aspects of the Regional Hāpainga Stop Smoking Service. According to Ngā Mataapuna Oranga Ltd's PHO Clinical Performance Manager, the PHO receives minimal funding from the Bay of Plenty DHB for smoking cessation programmes and the funding it does receive is insufficient to adequately provide smoking cessation programmes for its high needs communities.⁴²⁵

The 2015 Ministry of Health realignment (described earlier) has also impacted on the ability of kaupapa Māori stop smoking service providers to deliver services to Māori in rural areas. According to the Practice Manager at Puhī Kaiti Community Health Centre in Gisborne, prior to the realignment, the

⁴²² For example the smokefree families incentive programme for Southern Stop Smoking service, see http://www.kaitahu.maori.nz/uploads/1/2/3/7/12374782/smokefree_dl_3.pdf

⁴²³ Email communication from Catherine Manning, Regional Manager, Tākiri Mai te Ata Regional Stop Smoking Service, 5 Mar 2019

⁴²⁴ Telephone interview with Puhī Miller, Ora Toa, 4 Mar 2019

⁴²⁵ Email communication from Carliza Patuawa, Clinical Performance Manager, Ngā Mataapuna Oranga Ltd, 5 Mar 2019

Ngāti Porou Hauora Charitable Trust (a Primary Health Organisation) provided an Aukati Kai Paipa smoking cessation service, but now Puhi Kaiti provides The Stop Smoking Programme funded by Pinnacle via Midlands Health Network, who service both the Waikato and Te Tairāwhiti regions.⁴²⁶ A Puhi Kaiti rural health nurse described the ‘reverberating effects’ of the realignment on the Centre’s ability to provide smoking cessation services to Māori in rural regions on the East Coast:⁴²⁷

Even though the smoking cessation contract was taken away from the organisation (with the [Ministry of Health] realignment), we continued to deliver this service (in part) to our whānau, complete with NRT [nicotine replacement therapy] and smoking cessation aids. With no funding to continue this important work, our referral numbers were right down, we no longer received the official support we were so used to and we didn't spend anymore time (as we previously did) out in the community promoting smoking cessation, local radio station interviews, education sessions, competitions and providing the support our whānau desperately needed, we even stopped recording the data in the reporting templates.⁴²⁸

It has not been possible to clearly establish how the funding arrangements for stop smoking services provided by Puhi Kaiti changed since the realignment and its new arrangement with Pinnacle. However, the comments above indicate that, in this case, the realignment caused some concerns about Puhi Kaiti’s continuing ability to deliver stop smoking services to East Coast Māori.

Effectiveness and barriers to accessing services

In terms of outcomes, data provided by the Ministry of Health suggests that stop smoking services over the 2018/2019 financial year are performing better than the previous Aukati Kai Paipa services that were operating in 2014-2015, prior to the realignment and retender in 2015-2016.⁴²⁹ The data shows increases in the total number of referrals, enrolments, quit dates, quit dates set by Māori, and carbon monoxide (CO)-validated 4-week quit rates for the 2018-2019 year, compared to the 2014-2015 year. Forty per cent of the 20,050 people who had successfully quit smoking between 1 July 2016 and 30 June 2019 were Māori. This suggests that stop smoking services are contributing to helping Māori smokers to quit. The success rate for all enrolled Māori patients was 32 per cent. The success rate for Māori who had set quit dates was 45 per cent. These figures indicate that face-to-face services appear more effective for Māori, particularly if they have set quit dates.⁴³⁰

The current level of provision of kaupapa Māori stop smoking services also indicates that there are a range of culturally responsive services for Māori. It must be noted, however, that there are some

⁴²⁶ Email communication from Lisette Hayes, Practice Manager at Puhi Kaiti Community Health Centre, 5 Mar 2019

⁴²⁷ Email communication from Lisette Hayes, Practice Manager at Puhi Kaiti Community Health Centre, 9 Apr 2019

⁴²⁸ Email communication from Lisette Hayes, Practice Manager at Puhi Kaiti Community Health Centre, 9 Apr 2019

⁴²⁹ Ministry of Health, Stop Smoking Service Data, Quarter 4, Year 3, April 2019 to June 2019 (3 Years YTD).

⁴³⁰ Ministry of Health, Stop Smoking Service Data, Quarter 4, Year 3, April 2019 to June 2019 (3 Years YTD).

limitations to the data provided by the Ministry of Health on the effectiveness of its current services in comparison to the Aukati Kai Paipa services. Ministry of Health stop smoking service data for previous quarters was not viewed. Also, it is not clear whether the increase in referrals, enrolments, quit dates and other measurements reflects changes in population between 2015 and 2019, or changes in data collection methods between the two periods. Neither does the data reveal anything about relapses in service users smoking after the 4-weeks.

Despite the extensive range of stop smoking services available, there are a number of barriers to Māori quitting smoking. Partly because of this, high smoking rates persist among young Māori, Māori women, and pregnant Māori women. In 2017, in recognition of these high smoking rates, the Ministry of Health began a project evaluating and addressing the barriers to young Māori women quitting smoking so that it could 'evaluate new services and approaches that directly relate to the lives and needs of those women, in supporting them to stop smoking'.⁴³¹ Phase one of the project, which was based on interviews with 37 young wāhine Māori, identified some of the barriers to accessing stop smoking services and quitting. These barriers included a lack of knowledge about face-to-face services other than Quitline, a lack of information and education about vaping as a way to quit smoking, patronising advice from health professionals and a lack of information about how to use nicotine replacement therapy medications.⁴³²

Phase one of the project also utilised information from Statistics New Zealand's Integrated Data Infrastructure, which showed that young wāhine Māori who smoke regularly were more likely to live with adult smokers, be unemployed, be without any secondary school qualifications, receive the domestic purposes benefit, to have attended the emergency department in the last 12 months, and to look after children (other than those that live in their household). On the other hand, young wāhine Māori were less likely to smoke if they had higher secondary school qualifications, access to the internet at home, and lived in higher socio-economic areas.⁴³³ These insights suggest that there are structural barriers or influences outside the health system, and outside the control of young wāhine Māori, that bear heavily on these smoking rates.

The second phase of the Ministry of Health's project in 2018 involved working with four kaupapa Māori health and social service providers (three of which were stop smoking service providers) to co-design, prototype and test a new approach to delivering stop smoking services for young wāhine Māori.⁴³⁴ In October 2019, the Ministry of Health published its new guidance document 'Ka Pū te Ruha, ka Hao te Rangatahi: Good practice guidance for stop smoking services to work in more responsive ways with

⁴³¹ Ministry of Health, 'Insights into Māori women smoking', page updated 19 Oct 2019, accessed 26 Nov 2019.

⁴³² Ministry of Health in collaboration with ThinkPlace, 'Exploring why young Māori women smoke', July 2017, pp. 8-11.

⁴³³ Ministry of Health and NOOS Consulting, 'Young Māori women who smoke: a journey of discovery through data', 2017.

⁴³⁴ Wehipeihana N, Were L, Goodwin D, and Pipi, K, 'Addressing the Challenges of Young Māori Women Who Smoke: A developmental evaluation of the phase two demonstration project. Evaluation report.', Ministry of Health, 2018, p. 5.

young wāhine Māori’.⁴³⁵ It is not clear how the new guidelines are going to be rolled out, implemented and evaluated by the Ministry of Health or DHBs, and whether new initiatives, additional funding or targets will be developed to help reduce the smoking rate amongst young wāhine Māori.

Alcohol and other drug treatment services

There are a wide variety of alcohol and other drug treatment services currently provided in New Zealand. Services range from online information and self-help websites, helplines and phone counselling, to face-to-face counselling, detox services, outpatient programmes, and residential live in programmes for those with more serious addiction needs. These services are provided by DHB community alcohol and drug services (CADS), or by NGOs or private organisations funded by the Ministry of Health or DHBs, including kaupapa Māori service providers and organisations. People are able to access these services, by self-referral, referral via calling the Alcohol and Drug Helpline (also run by the National Telehealth Service) or other medical professional such as a GP.

Outlined below is a basic summary of the different types of alcohol and other drug treatment services currently available:

- Online information and advice:
 - Drug Help and Pot Help online tools (developed by the New Zealand Drug Foundation and funded by the Ministry of Health⁴³⁶)
 - Alcohol advice and information, such as the website Alcohol.org.nz (developed by the Health Promotion Agency), and Living Sober (developed by the NZ Drug Foundation)⁴³⁷
- Counselling:
 - 0800 Meth Help Counselling Service via phone
 - group counselling or one-on-one sessions through local community alcohol and drug services
- Detox:
 - via specialist addiction services (can involve waiting times)
- Peer support:
 - Alcoholics or Narcotics Anonymous programmes run through non-government organisations
- Day/outpatient programmes:

⁴³⁵ Ministry of Health in collaboration with ThinkPlace, ‘Ka Pū te Ruha, ka Hao te Rangatahi: Good practice guidance for stop smoking services to work in more responsive ways with young wāhine Māori’, July 2019, <https://www.health.govt.nz/system/files/documents/publications/good-practice-guidance-for-stop-smoking-services-oct2019.pdf>

⁴³⁶ See Drughelp.org.nz; Pothelp.org.nz.

⁴³⁷ See livingsober.org.nz.

- via District Health Boards or non-government organisations
- Provide intensive support over a few months
- Can be referred by a GP
- can be waitlisted, which can take several months⁴³⁸
- Residential/live-in programmes:
 - for those struggling with addictions for a long period of time
 - provided by non-government organisations
 - can be referred through a GP or community alcohol and drug service
- Support/half-way house (non-government organisation)
- Opioid substitution treatment:
 - for addiction to morphine, codeine, tramadol, oxycodone and methadone
 - prescribed methadone or buprenorphine with naloxone to treat opioid dependence
 - can get treatment at community pharmacy
- Drink driving intervention programme (Alcohol and Other Drug Treatment Court)
 - group sessions for 6-8 weeks after a court conviction and being directed by a court judge or probation officer.⁴³⁹

In addition to these services is the Alcohol and Drug Helpline. The Helpline is part of the National Telehealth Service (which also delivers Quitline). The service is free and according to its website is delivered by trained counsellors who provide advice, harm reduction information and assistance for people concerned about their own or another person's alcohol or drug use.⁴⁴⁰ People can access the service via phone, text message, or webchat. Helpline services include:

- screening and assessment;
- short-term interventional counselling and primary counselling for people located in areas where other services are not available;
- call-back service; and
- referral to face-to-face local alcohol and drug services.⁴⁴¹

⁴³⁸ See <https://drughelp.org.nz/making-a-change/treatment-options/intensive-outpatient-programme>

⁴³⁹ 'Help with alcohol and drug problems', Ministry of Health website, <https://www.health.govt.nz/your-health/services-and-support/health-care-services/help-alcohol-and-drug-problems>; updated August 2018, accessed 11 Nov 2019.

⁴⁴⁰ Alcohol and Drug Helpline <https://alcoholdrughelp.org.nz/helpline/services/>, accessed 1 October 2019.

⁴⁴¹ Homecare Medical, 'The National Telehealth Service Annual Plan 2017/18', p. 29, <https://www.health.govt.nz/system/files/documents/pages/national-telehealth-service-annual-plan-2017-18.pdf>

The Alcohol and Drug Helpline also provides a specific Māori helpline, which the service states is ‘a culturally affirming service, utilising resources available specifically for Māori’.⁴⁴² The Alcohol and Drug Helpline can also refer people to kaupapa Māori treatment services.

The Alcohol and Drug Helpline contributes to the National Drug Policy 2015-2020 by removing barriers to accessing support for people with alcohol and drug use needs.⁴⁴³

Kaupapa Māori services

Information provided by the Ministry of Health states that 52,593 people accessed alcohol and drug services in New Zealand over the 2017/2018 financial year. For the same period, there were 113 service providers of alcohol and other drug services across New Zealand, 45 of which were kaupapa Māori service providers located in all DHB regions except for the Wairarapa and South Canterbury regions.⁴⁴⁴

Te Rau Matatini (now renamed Te Rau Ora), the National Centre for Māori Health, Māori Workforce Development and Excellence, explain that kaupapa Māori mental health and addiction services are indigenous solutions that provide treatment environments based on Māori ‘cultural values, processes, and beliefs’.⁴⁴⁵ According to Te Rau Matatini, kaupapa Māori mental health and addiction services are based on best practice methodologies using Māori models of health and wellbeing such as Mason Durie’s Te Whare Tapa Whā, which recognises the interrelated nature of physical, mental, spiritual and whānau health.⁴⁴⁶ In terms of funding services, the Ministry of Health defines kaupapa Māori specialist mental health and addiction services as ‘those services that have been specifically developed and are delivered by providers who identify as Māori’ and may be situated within a DHB Provider Arm, or a community or iwi organisation.⁴⁴⁷

Significantly, the Ministry of Health data indicates that almost half (47 per cent) of the 52,593 people who accessed alcohol and drug services were Māori. The majority (65 per cent) accessed general (non-kaupapa Māori), rather than kaupapa Māori alcohol and drug services.⁴⁴⁸ For Māori who engaged with

⁴⁴² ‘Helpline Services’, Alcohol and Drug Helpline <https://alcoholdrughelp.org.nz/helpline/services/>, accessed 1 October 2019.

⁴⁴³ Homecare Medical, ‘The National Telehealth Service Annual Plan 2017/18’, p. 30,

<https://www.health.govt.nz/system/files/documents/pages/national-telehealth-service-annual-plan-2017-18.pdf>

⁴⁴⁴ Information sourced from PRIMHD 23 Sep 2019 and provided by the Ministry of Health on 26 Sep 2019.

⁴⁴⁵ Te Rau Matatini, ‘kaupapa Māori Mental Health and Addiction Services: Best Practice Framework’, Wellington, 2015, p. 8.

⁴⁴⁶ Te Rau Matatini, ‘kaupapa Māori Mental Health and Addiction Services: Best Practice Framework’, Wellington, 2015, p. 8, citing Mason Durie, ‘A Māori perspective of health’, *Journal of Social Sciences and Medicine*, 20 (5), pp. 483-486.

⁴⁴⁷ ‘kaupapa Māori Mental Health and Addiction Services – Mental Health and Addiction Services Tier Two Service Specification’, p. 2. Nationwide Service Delivery Framework Library website, <https://nsfl.health.govt.nz/system/files/documents/specifications/kaupapamaorimentalhealthandaddictionservicesmhakt2april2017.docx>. Service specifications are developed by the Ministry of Health and DHBs and set out the minimum national service requirements (e.g. clarify services provided, reporting requirements, and quality and auditing requirements) when they are contracting or providing certain health services. See <https://nsfl.health.govt.nz/service-specifications/about-service-specifications>

⁴⁴⁸ Number of people accessing alcohol and drug services by ethnicity sourced from PRIMHD and provided by the Ministry of Health on 26 Sep 2019.

alcohol and drug services in 2018, two of the most common types of activity undertaken were individual treatment attendances (attending appointments or counselling sessions) and group programme session attendances.⁴⁴⁹

Ethnicity information of users of alcohol and drug services by DHB area reveals that Māori make up a much larger proportion of service users than they do of the population within the DHB areas they reside, and this trend is consistent across all regions. For example, Māori make up around 35 per cent of the DHB population in Lakes DHB, but account for 62 per cent of all alcohol and drug service users. Figures are similar for Tairāwhiti: Māori make up 50 per cent of the DHB population but account for 76 per cent of service users. In Northland, Māori comprise 34 per cent of the population but 60 per cent of service users. In South Canterbury, Māori make up only 9 per cent of the DHB population but account for 23 per cent of service users.⁴⁵⁰

In comparison to non-Māori, Māori use certain facilities at a higher rate than non-Māori, and some facilities at a lower rate than non-Māori. Services used at a higher rate include advocacy services, integrated Māori and clinical interventions, Māori-specific interventions, and residential overnight facilities (where a staff member is awake on night shift). Services used at a lower rate include: community residential overnight facilities, methadone treatment services, and substance use withdrawal management/detox overnight facilities.⁴⁵¹ Whether these differing rates reflect lower prevalence of certain addictions (such as to opioids, for example) amongst Māori, or barriers to accessing certain types of treatment, such as residential and detox facilities, is not clear.

Expenditure on alcohol and other drug treatment services

The Office of the Director of Mental Health Addiction Services notes in its 2017 annual report that while the majority of people access mental health and addiction services in the community, a small number access both community and inpatient services, and only a very small number of people access inpatient services.⁴⁵²

Expenditure for addiction services also reflects the majority of funding going to community-based services, as set out in **Figure 6** below, which shows expenditure for the 2017-2018 financial year. Of the \$161.4 million dollars spent on addiction services for 2017-2018, \$39 million went to kaupapa Māori services.⁴⁵³

⁴⁴⁹ Sourced from PRIMHD and provided by the Ministry of Health on 26 Sep 2019.

⁴⁵⁰ Alcohol and drug service users by ethnicity and DHB area source from PRIMHD and provided by the Ministry of Health on 25 Oct 2019.

⁴⁵¹ Sourced from PRIMHD and provided by the Ministry of Health on 26 Sep 2019.

⁴⁵² p.6 'Office of the Director of Mental Health and Addiction Services Annual Report 2017', February 2019.

⁴⁵³ Figure for Kaupapa Māori AOD services expenditure provided by the Ministry of Health on 26 Sep 2019

<i>Service Type</i>	<i>Expenditure 2017/18 \$M</i>
Inpatient	6.9
Adult community	91.1
Adult residential	19.8
Child and youth community	19.7
Child and youth residential	1.3
Opioid Substitution Treatment	15.7
Other ⁴⁵⁴	6.9
Total	161.4

Figure 6: Expenditure for addiction services 2017/18

(Source: Table provided by the Ministry of Health, 25 Oct 2019)

Alcohol and Other Drug Treatment Court

Māori are overrepresented in comparison to non-Māori as users of alcohol and other drug treatment services within the justice system. For example, Māori make up 46 per cent of the people admitted to the Alcohol and Other Drug Treatment (AODT) Court.⁴⁵⁵ The AODT Court was established in 2012 and is targeted at ‘offenders who would otherwise be imprisoned, but whose offending is being fuelled by their unresolved “high-needs” issues of addiction or dependency’.⁴⁵⁶ The Court currently sits in the Auckland and Waitakere District Courts and up to 50 people at any one time can be involved in the programme at each Court. Up to 30 June 2018, 484 people had been admitted to the court since 2012 and over 200 participants had successfully completed the programme and moved on to a community-based monitored sentence. The programme involves case management, treatment, drug testing, monitoring and mentoring, with sentencing being deferred while participants are on the programme.⁴⁵⁷

Prison Drug Treatment Units

A 2016 study on the comorbidity (co-occurrence) of substance use disorders and mental health disorders among New Zealand prisoners found that approximately 48 per cent of Māori prisoners had substance use disorders in the last 12 months and around 95 per cent over their lifetime.⁴⁵⁸ Information provided by the Department of Corrections states that there are currently eleven drug treatment unit programmes delivered across nine prisons by experienced addiction counsellors. Of these eleven, five are kaupapa

⁴⁵⁴ ‘Other’ includes mental health establishment, flexifund, and service development.

⁴⁵⁵ Figure for up to 30 June 2018. Information provided by Ministry of Justice, 4 Nov 2019.

⁴⁵⁶ The District Court of New Zealand, ‘Alcohol and Other Drug Treatment Court’, Sep 2019, accessed 27 Nov 2019, <http://www.districtcourts.govt.nz/criminal-court/criminal-jurisdiction/specialist-criminal-courts/alcohol-and-other-drug-treatment-court/>

⁴⁵⁷ The District Court of New Zealand, ‘Alcohol and Other Drug Treatment Court’, Sep 2019, accessed 27 Nov 2019, <http://www.districtcourts.govt.nz/criminal-court/criminal-jurisdiction/specialist-criminal-courts/alcohol-and-other-drug-treatment-court/>

⁴⁵⁸ Devon Indig, Craig Gear and Kay Wilhelm, ‘Comorbid substance use disorders and mental health disorders among New Zealand prisoners’, Department of Corrections, June 2016, p. 27. <https://www.corrections.govt.nz/resources/research-and-statistics/comorbid-substance-use-disorders-and-mental-health-disorders-among-new-zealand-prisoners>

Māori mental health and addictions providers. These five services are delivered at Hawkes Bay Regional Prison, Rimutaka Prison, and Whanganui Prison. In 2018, Māori made up around 48 per cent (451) of all participants (947) in the Drug Treatment Unit programmes. Corrections also run several alcohol and other drug treatment programmes outside of the drug treatment units, including two kaupapa Māori pilot programmes launched in 2018 targeting women and young men.⁴⁵⁹

Effectiveness and barriers to accessing services

In terms of effectiveness, there is little specific data and research on the outcomes of drug and alcohol treatment services in New Zealand for Māori. Limited information is collected by the Ministry of Health about the outcomes of community-based alcohol and other drug treatment services. In 2015 the Ministry of Health mandated the Alcohol and other Drug Outcome Measure (ADOM) tool for all community-based adult outpatient alcohol and other drug services to collect information and report on outcomes for service users.⁴⁶⁰ Customised ADOM data on Māori obtained for the period July 2018 to March 2019 provides a number of insights, namely that:

- where ADOM information was captured at the beginning and three months into treatment, Māori experienced significant improvement in levels of substance use and wellbeing;
- treatment outcome satisfaction for Māori is comparable with non-Māori;
- Māori are more likely to be serviced by NGOs, rather than DHBs;
- Māori women presented at a higher rate than non-Māori women;
- alcohol is the primary substance of concern for Māori, as well as non-Māori; and
- Māori are more likely than non-Māori to state cannabis and amphetamines as their main substance of concern.⁴⁶¹

Consideration has to be given to the fact that the findings are based on relatively small numbers and cannot be interpreted at the whole population level for Māori.⁴⁶²

A number of barriers to accessing alcohol and other drug services have been identified that are specific to the context of addiction. Some, such as stigma and fear of incrimination, may weigh more heavily on Māori (discussed below). The National Committee for Addiction Treatment, which provides leadership and advice on the addiction treatment sector in New Zealand, notes that barriers to accessing addiction services include:

⁴⁵⁹ Information provided by Department of Corrections, 11 Nov 2019.

⁴⁶⁰ Information provided by Te Pou o Whakaaro Nui, 11 Nov 2019. Te Pou o Whakaaro nui are a mental health, addiction and disability sector workforce development organisation funded by the Ministry of Health. Te Pou notes that residential services, people under 18 years of age and prisoners' outcomes information is not captured by ADOM.

⁴⁶¹ Information provided by Te Pou o Whakaaro Nui, 11 Nov 2019.

⁴⁶² The information is based on 12,293 engagements for Māori with ADOM services, and 20,264 engagements with non-Māori over the period July 2018-June 2019. Information provided by Te Pou, 11 Nov 2019.

- stigma and discrimination;
- lack of awareness of available services;
- financial costs (such as for GP visits, travel and accommodation);
- waiting lists (such as long wait times or lack of available spaces);
- limited appropriate treatment options (such as a lack of continuing care options); and
- co-existing conditions (such as being treated for a mental health condition but not receiving treatment for an addiction).⁴⁶³

The New Zealand Drug Foundation note that New Zealand's current drug laws, which treat drug use primarily as a criminal rather than health issue, further stigmatise drug use and are a barrier for Māori seeking help. As outlined in the previous chapter, Māori are disproportionately represented in low-level drug conviction and imprisonment rates.⁴⁶⁴ The Drug Foundation also draw attention to how multiple barriers can compound for particularly vulnerable people wanting to access treatment for addiction. These barriers include poverty, a lack of transport (making it difficult for people to visit their GP or specialist), waiting lists (which can cause people to lose 'hard won' motivation to seek help), the requirement for referral from a GP (when people might not regularly access GP services), and punitive approaches to missing appointments (such as being stood down, leading to people falling through the cracks).⁴⁶⁵ As a solution, the Drug Foundation have called for greater government investment to provide:

- more on-call out of hours services;
- more integrated services where multiple government agencies address co-existing issues;
- more low threshold walk-in services;
- a greater range of treatment options to reflect a more consumer-centred and integrated approach; and
- greater prevention and education targeted at young people.⁴⁶⁶

A recurring theme in statements of claim submitted to the Health Outcomes Kaupapa Inquiry (Wai 2575) is the lack of provision of alcohol and other drug treatment services in the geographic locations where Māori reside. Research conducted for this report revealed that the Ministry of Health do not keep a list of all the alcohol and drug service providers and the programmes they deliver in New Zealand, as they do not fund them directly.⁴⁶⁷ The Ministry of Health suggested using the 'Healthpoint' online

⁴⁶³ National Committee for Addiction Treatment, 'Submission to the Mental Health and Addictions Inquiry Panel', 2019, pp. 6-7.

⁴⁶⁴ New Zealand Drug Foundation submission on the Mental Health and the Addiction Inquiry, 7 Jun 2019, p. 6.

⁴⁶⁵ New Zealand Drug Foundation submission on the Mental Health and the Addiction Inquiry, 7 Jun 2019, p. 13.

⁴⁶⁶ New Zealand Drug Foundation submission on the Mental Health and the Addiction Inquiry, 7 Jun 2019, pp. 13-17.

⁴⁶⁷ Ministry of Health email, 30 Sep 2019.

directory for the most up-to-date and comprehensive list of addiction service providers and programmes available.

Information on the location, types of AOD programmes offered by service providers and the area serviced was extracted from the 'Healthpoint' directory website.⁴⁶⁸ A table showing the areas serviced, tallies of the number of AOD programmes located in the area, the number of AOD programmes located outside the area (but providing service to residents in the area), and the total number of AOD programmes available is shown in the table in **Figure 1** below.⁴⁶⁹

The locations in the directory mostly correspond to DHB areas. The Healthpoint directory categorised AOD programmes into 13 different types, namely:

1. Helpline/self-help -addictions
2. Peer Support
3. Community/Social Support
4. Kaupapa Māori
5. Pacific Island People
6. Social detox
7. Community (medical detox)
8. Hospital (medical detox)
9. Opioid substitution treatment
10. Coexisting Problems- Mental and health addictions
11. Residential alcohol and other drug treatment
12. Advocacy/Group/Family Whanau Support
13. Training

⁴⁶⁸ The Healthpoint directory was filtered using the following to compile results by region: 'location' (which are mostly aligned to DHB areas), 'service' (mental health and addictions), 'programme area' (Addictions – drug & alcohol) and 'programme type' (13 different types listed in the text above).

⁴⁶⁹ The totals shown in this table will, in some instances, be smaller than the totals shown in Healthpoint directory search results. This is due to Healthpoint including non-AOD programmes within its total count (e.g. mental health and gambling programmes). These have been gone through manually and excluded when calculating totals for this report.

Area serviced	AOD programmes located physically in the area	AOD programmes located physically outside (but providing services to) the area	Total AOD programmes available
Northland DHB	41	48	89
North Auckland (Waitemata DHB)	25	76	101
West Auckland (Waitemata DHB)	48	54	102
Central Auckland (Auckland DHB)	43	56	99
East Auckland (Counties Manukau DHB)	9	93	102
South Auckland (Counties Manukau DHB)	41	65	106
Waikato DHB	54	49	103
Bay of Plenty DHB	98	44	142
Lakes DHB	23	44	67
Tairāwhiti DHB	15	46	61
Taranaki DHB	15	46	61
Hawkes Bay DHB	22	36	58
Whanganui DHB	31	44	75
MidCentral DHB	63	38	101
Wairarapa DHB	20	51	71
Hutt Valley DHB	24	50	74
Wellington (Capital & Coast DHB)	35	44	79
Nelson Marlborough DHB	28	37	65
West Coast DHB	18	40	58
Canterbury DHB	55	36	91
South Canterbury DHB	26	43	69
Waitaki (Southern DHB)	6	47	53
Dunedin- South Otago (Southern DHB)	19	43	62
Central Lakes (Southern DHB)	8	46	54
Southland (Southern DHB)	13	46	59

Figure 7: Table showing the number of AOD (alcohol and other drug) programmes offered by DHB area as of 6 December 2019.

(Source: Healthpoint services directory <https://www.healthpoint.co.nz/> accessed 6 December 2019)

A map showing the total number of AOD programmes offered by service providers within each DHB area, along with the proportion that Māori make up of the DHB population, is depicted in **Figure 8** below.⁴⁷⁰ To be expected, the map shows a greater number of AOD programmes available in the larger

⁴⁷⁰ The number of AOD programmes available to residents in the Southern DHB area has been calculated by combining the numbers for the Waitaki, Dunedin-South, Central Lakes and Southland districts (shown in the table in

Figure 7) with duplicate service programmes removed. The same method was applied to calculate the total for Waitemata DHB, which is made up of North and West Auckland districts, and Counties Manukau (which is made up of South and East Auckland districts).

city centres, such as Auckland, Wellington, Christchurch and Hamilton. Bay of Plenty DHB and MidCentral DHB also have a large number of AOD programmes on offer. It also shows a smaller number of services available in less-densely populated areas that have a higher proportion of Māori in the DHB population, such as Taranaki, Hawkes' Bay, Lakes, and Tairāwhiti DHB areas. However, the data is limited in that it does not provide the ability to assess how far Māori living in remote areas have to travel to access AOD programmes. It is also not known what the ideal number of AOD service programmes for each DHB area should be.

Data provided by the Ministry of Health indicates that DHB areas with the highest number of Māori accessing AOD services in 2018 were: Counties Manukau (2,907 Māori, who make up 41 per cent of clients seen), Waikato (2,423 Māori, who make up 46 per cent of clients), Northland (2,039 Māori who make up 60 per cent of clients) and Bay of Plenty (1,646 Māori, who make up 49 per cent of clients), Waitemata (1,642 Māori, who make up 27 per cent of clients) and Auckland (1,601 or 29 per cent of clients).⁴⁷¹

Whether the Ministry of Health and/or DHBs consider this data when planning the delivery of kaupapa Māori AOD services is not known. However, the Ministry of Health notes that each year DHBs develop planning documents that set out how they intend to address service gaps and access issues.⁴⁷² The Ministry also advise that 'within each of the four DHB regions (Northern, Midland, Central, and Southern) there has been work to plan, develop, and implement improved access to services. For example, in Midland, there have been several projects focusing on the Addictions sector over the last five years:

1. Midland Addiction Model of Care, 2016
2. Midland SACAT Model of Care, 2017
3. Midland Residential Review, 2016
4. Midland Qualifications Framework, 2015⁴⁷³

The question of whether there is a lack of alcohol and other drug treatment services where Māori live is complex and more detailed information is required to provide more in-depth analysis of this issue.

⁴⁷¹ Alcohol and drug service users by ethnicity and DHB area source from PRIMHD and provided by the Ministry of Health on 25 Oct 2019.

⁴⁷² Ministry of Health feedback on the 29 November 2019 draft of this report. These documents have not been viewed by or made available to the author.

⁴⁷³ Ministry of Health feedback on the 29 November 2019 draft of this report.

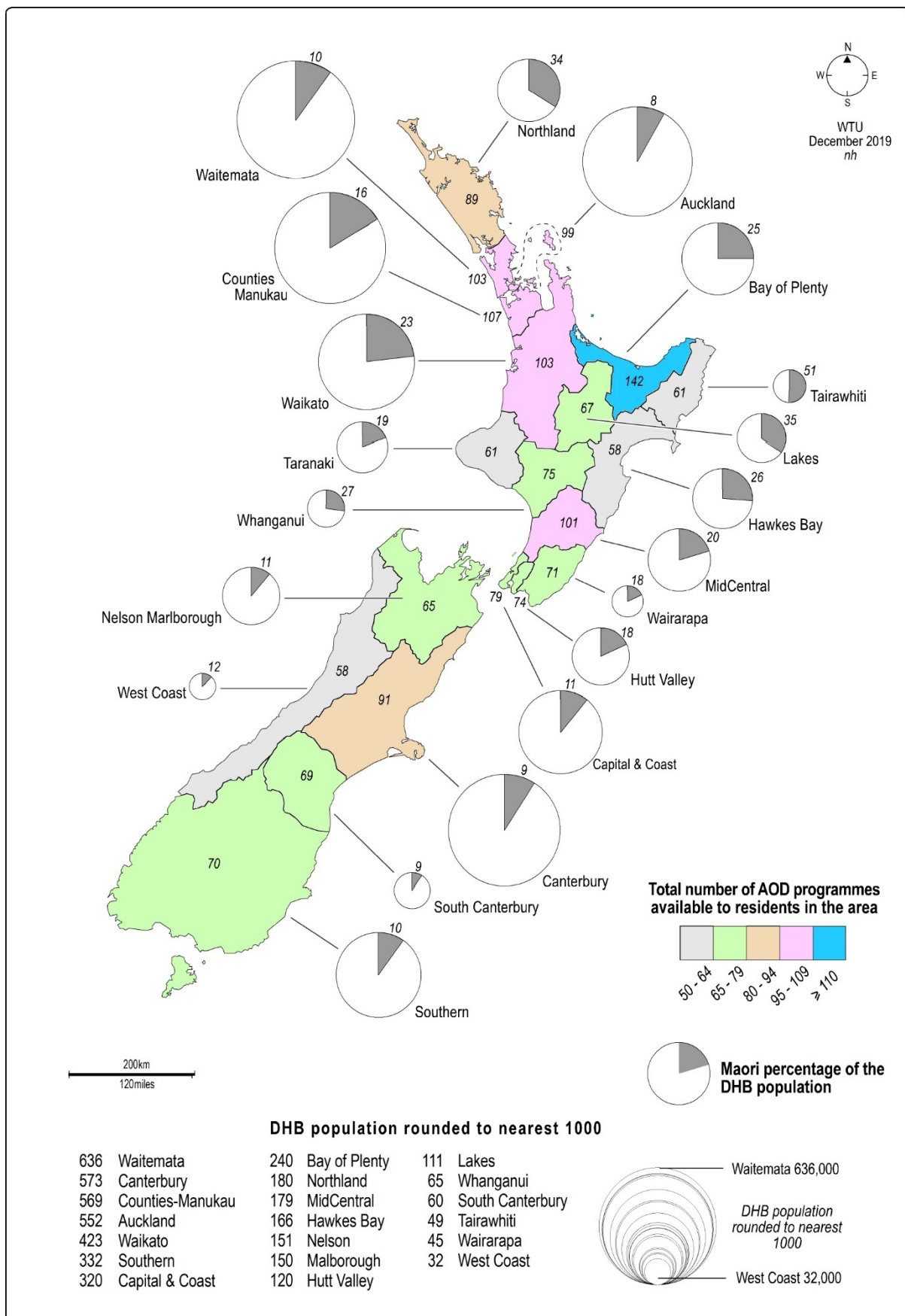


Figure 8: Map showing the number of alcohol and other drug (AOD) programmes available in DHB areas

Increased funding of mental health and addiction services, 2019

Following the report of the 2018 government inquiry into mental health and addiction, further calls were made for increased investment and funding in the mental health and addictions sector. In May 2019 the government announced its 'Wellbeing' Budget.⁴⁷⁴ The Budget provided for a number of initiatives aimed at increasing access to services and allowing for more choice of service types. The Ministry of Health announced that these initiatives include:

- expanded access and choice of primary mental health and addiction services rolled out over five years;
- expanding primary addiction services (such as counselling or group therapy) to approximately 5000 more people per year (with funding of \$14 million over four years);
- expanded support for pregnant women and parents of children under three years of age with alcohol and other drug issues (from four to six services around the country, enabling support for an extra 100 parents);
- more adequate funding (\$44 million over four years) for specialist alcohol and other drug services such as residential care, detox services and aftercare support for the approximately 2000 people per year accessing these services; and
- continued funding for Te Ara Oranga, a methamphetamine reduction programme in Northland that supports around 500 people in the Northland region.⁴⁷⁵

It appears that the Ministry of Health has recognised this is an ongoing issue and since May 2019, the Ministry has undertaken further work to progress these initiatives, including commissioning new kaupapa Māori alcohol and other drug addiction treatment services.⁴⁷⁶

Summary

A range of addiction treatment services are provided for or funded by the government and Māori continue to maintain a presence in delivering these services. However, issues remain in relation to the effectiveness of these services for Māori and the way in which these services are funded and administered, given the high proportion of Māori service users and the continuing disparities in tobacco, alcohol and other drug-related health outcomes for Māori. In order to provide an in-depth analysis, more

⁴⁷⁴ 'He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction', November 2018.

⁴⁷⁵ 'Budget 2019: Mental health, wellbeing and addiction initiatives', Ministry of Health website, updated 30 May 2019, accessed 21 Nov 2011, <https://www.health.govt.nz/our-work/mental-health-and-addictions/budget-2019-mental-health-wellbeing-and-addiction-initiatives#primarycare>

⁴⁷⁶ Compilation of powerpoint slides for regional workshops July 2019, 'Expanding primary mental health and addiction support', Ministry of Health website, https://www.health.govt.nz/system/files/documents/pages/mental-health-addiction-regional-workshops-july-2019_final2.pdf

detailed information on the issue of access to tobacco, alcohol and other drug services for Māori living in more remote areas is required. As is further information on how changes to the Ministry of Health's 2015 tobacco realignment have affected the ability of Māori stop smoking service providers to continue to deliver these services to Māori.

5 – Report conclusion

This report has provided an overview and brief outline of the key legislation, policies and practices of the current health system relevant to alcohol, tobacco and other substance abuse issues for Māori. It is not possible, with an outline of this nature, to be exhaustive or deal with contemporary issues in depth. However, the report has set out the relevant major legislation, policies and key issues for Māori in the areas of tobacco, alcohol and substance abuse and related health harms.

This report has focused on the contemporary health system but has provided brief historical context as required by the commissioning direction.⁴⁷⁷ As described, the overall framework for New Zealand's current health system was set up under the New Zealand Public Health and Disability Act 2000. The Act provides a system of healthcare delivered through District Health Boards, Primary Health Organisations, hospitals, and non-government organisations. A series of other legislation also currently governs each subject area of this report, including the Smoke-free Environments Act 1990 and its subsequent amendments, the Sale and Supply of Alcohol Act 2012, the Misuse of Drugs Act 1975, the Psychoactive Substances Act 2013 and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017. A wealth of government policy statements and responses addressing these issue areas have been produced, including the National Drug Policies of 1998, 2007-2012 and 2015-2020, the 'National Alcohol Strategy 2000-2003', 'Taking Action on Fetal Alcohol Spectrum Disorder: 2016-2019', 'Clearing the Smoke: A five-year plan for tobacco control in New Zealand, 2004-2009' and others.

As outlined, the Crown has at its disposal a range of interventions to control tobacco, alcohol and other harmful substances and minimise associated harms for Māori. These interventions have focused on reducing the supply of and demand for these substances and includes legislative measures, regulations, excise taxes, national health promotion and education, marketing campaigns and law enforcement. Other measures include health interventions, screening and treatment such as through community and specialist alcohol and drug treatment services, residential rehabilitation, helplines, websites and stop smoking services and medicines.

As noted in Chapter 2, historically it took time before the harmful health effects of smoking tobacco were well understood and accepted. But from the 1960s, in response to overwhelming evidence of the harmful health effects and associated costs of tobacco use, the government began implementing a comprehensive national tobacco control programme and applying aspects of all three interventions (supply control, demand control and problem limitation). Crown controls have been implemented in various ways, including through legislation and regulations, excise tax, national anti-smoking

⁴⁷⁷ Wai 2575, #2.3.2

campaigns, education, restrictions on advertising, product display and warnings on packaging of tobacco products. In the late 1990s, tobacco control initiatives targeting Māori smoking rates were rolled out with some signs of success in reducing smoking rates, but the disparity between Māori and non-Māori remained.

In the case of alcohol, as discussed in Chapters 2 and 3, the government's response has very much reflected public pressure. Government interventions have veered from relatively light to much stricter regulatory controls. At times, there has even been some provision for types of prohibition, especially for Māori. Governments have also been willing to provide separate stricter controls for Māori districts at the request of both Māori communities and concerned Pākehā, although practical implementation of these controls was often less strictly enforced. Following relatively strict controls in the first half of the twentieth century, in later decades the control of alcohol was liberalised in New Zealand, again in response to public demand. This was implemented through the Sale of Liquor Act 1989 and its subsequent amendments, which resulted in a large increase in the availability of alcohol in New Zealand amidst growing perceptions of major health-related harm and social impacts. The Sale and Supply of Alcohol Act 2012 was an attempt to re-tighten controls over alcohol and alcohol-related harm, although there has been criticism that the Act has not gone far enough to have sufficient effect on reducing harm.

At present, alcohol remains the main substance of concern for which Māori, as well as non-Māori seek treatment for. Apart from the National Drug Policy 2015-2020, there is little in the way of alcohol policy, action plans or strategies that directly target alcohol-related harm for Māori, which remains disproportionately higher for Māori than non-Māori. The Crown has not implemented some of the recommendations of the New Zealand Law Commission from 2010, which could minimise harm for Māori, including increasing the purchasing age of alcohol, further increasing the price of alcohol (which is now more affordable than in the 1980s), decreasing the availability of alcohol and alcohol outlet density, particularly in Māori and lower income communities, and further restricting alcohol advertising and sponsorship in New Zealand. The issue of Local Alcohol Policies being an ineffective means of consulting Māori on issues of local alcohol control is also an important area where the Crown could take action.

Other drugs, as discussed in Chapter 2, have long been the subject of control, with laws regulating opium from the 1860s, morphine in 1908 and other substances such as heroin, cocaine and cannabis in the 1920s. New Zealand followed the lead of international conventions on drugs and responded with further laws criminalising the use and distribution of these substances, the key legislation being the Misuse of Drugs Act 1975, which is still in effect today. The other main recent legislation enacted is the Psychoactive Substances Act 2013, which came about in response to growing concern around the use of unregulated psychoactive substances such as synthetic cannabis, herbal highs and party/energy pills. The Alcoholism and Drug Addiction Act 1966 provided for the compulsory treatment of

alcoholics from a health perspective, reflecting the change in recognising alcoholism as an addictive illness. Following a review of New Zealand's drug laws by the Law Commission in 2007, the Act was replaced by the Substance Addiction (Compulsory Assessment and Treatment Act) 2017, which was intended to be easier to navigate and provide greater safeguards for people undergoing compulsory treatment. These are discussed in Chapter 3.

For Māori, illegal drug use has been more of a recent issue from the 1970s. The Misuse of Drugs Act 1975 and its subsequent amendments still form the basis of New Zealand's drug legislation today. With respect to providing for Māori, a major issue is the criminalisation of Māori as a result of current laws which treat drug use as a criminal, rather than health issue. The failure of the Psychoactive Substances Act 2013 to regulate synthetic drugs resulted in substances being driven to the black market where the government has been unable to regulate the safety and potency of substances being sold. This has led to a number of synthetic cannabis-related deaths, over half of whom were Māori. The upcoming cannabis referendum, and possible reforms of New Zealand's drug law, present an opportunity for the Crown to consult with Māori so that subsequent reforms might work to reduce the number of Māori convicted and imprisoned for low-level drug offences. At present, the government's legislation and policies in relation to drug-related harm are not providing for Māori needs.

A key objective of the New Zealand Public Health and Disability Act 2000 is to reduce health disparities by improving the health outcomes of Māori and other population groups. The outline provided in this report indicates that the government is well aware of and has recognised for a long time (since the 1970s at least) the disparities between Māori and non-Māori. These disparities are evident in the statistics that measure the rates of use and health outcomes in relation to tobacco, alcohol and other drugs. For example, research in the early 1970s found that Māori women suffered the highest female rate of lung cancer in the world and a 1984 study found that the higher mortality rate for Māori in comparison to non-Māori was due to higher Māori smoking rates. Statistics for the period also show that Māori suffered disproportionately in comparison to non-Māori from alcohol and drug-related harm. These statistics are discussed in Chapter 2.

Government-led efforts and strategies have had an effect on reducing Māori smoking rates since 2000. For example, the Māori smoking rates recorded by the New Zealand Health Survey 2017/18 show that 31 per cent of Māori adults (aged 15+ years) still smoke, although that is down from 39 per cent in 2006/7. In comparison, 13 per cent of New Zealand adults still smoke in 2017/18, and that is down from 18 per cent in 2006/7. However, the disparities between Māori and non-Māori in tobacco use and related harm do not appear to be reducing, with the current adult Māori smoking rate more than twice that of non-Māori. There are also key populations for which smoking rates remain high, such as young Māori, young Māori women and pregnant Māori women. The Ministry of Health is conducting ongoing research and attempting to develop new initiatives to improve stop smoking services for these groups.

The issue of vaping and its use as a strategy to achieve the Smokefree 2025 goal, particularly for Māori, is still being debated. How these initiatives will be implemented, funded, delivered, and evaluated for effectiveness is still to be seen. The continuing role of kaupapa Māori organisations in the tobacco control sector and the implementation of new initiatives also remains to be seen.

Researchers and health professionals with knowledge in the field appear to believe that the Smokefree 2025 goal will not likely be achieved for Māori, nor the wider population. The absence of a government action plan to achieve the Smokefree 2025 goal, or whether the goal will likely be replaced by new targets, are key issues. By its nature, this report cannot be exhaustive and has provided only an outline, but the evidence suggests that there are issues with the lack of clear direction in the government's current policies about how it intends to specifically address not just current smoking rates for Māori, but the disparity or gap between Maori and non-Māori.

In relation to statistics measuring alcohol and other substance use and related health harms, disparities also remain between Māori and non-Māori. As outlined in Chapter 3, 2019 figures indicate that Māori men and Māori women are more likely to drink hazardously than non-Māori men and women. The death rate from drinking alcohol is also higher for Māori in comparison to non-Māori. In relation to other drugs, Māori are also more likely to have used cannabis and amphetamines and be convicted of low-level drug charges than non-Māori. In comparison to tobacco control, much less information on the effectiveness for Māori of government controls of alcohol was located, which likely reflects the relatively smaller amount of research and policy development in these areas. There appears to be even less on illegal drugs, their harmful health effects and the effectiveness of government controls, particularly for Māori, because of the difficulties in dealing with prohibited substances.

In terms of Māori-led and Māori-developed systems and methods of health care, The New Zealand Health and Disability Act 2000 provides for Māori to contribute to and participate in the decision making and delivery of health services and strategies for improving Māori health. As briefly outlined in Chapter 2, from an early period Māori have sought to exercise tino rangatiratanga over their health in relation to alcohol and later tobacco and other drugs. Māori have called for government support to develop initiatives to address addiction-related issues, such as the high Māori smoking rates and alcohol and other drug related harm in their communities. Over the last two decades, the Crown's response has been to continue to fund a range of tobacco, alcohol and other drug treatment services, including funding kaupapa Māori services. These services are outlined in Chapters 3 and 4. Through the provision of kaupapa Māori services the Crown has enabled the provision of culturally appropriate services for Māori. However, at present most Māori access general/mainstream non-kaupapa Māori alcohol and other drug treatment services. This raises issues about the level of cultural responsiveness of these mainstream services, and whether and how cultural responsiveness is measured and accounted for, particularly if, as the figures indicate, a large proportion of these service users are Māori.

Where the Crown's efforts fall short in relation to addressing tobacco, alcohol and other substance abuse issues for Māori, is in relation to preventing harm and involving and resourcing Māori to participate more at the point of control, rather than at the point of treatment. This is reflected in the National Drug Policy 2015-2020 which appears to provide little avenue or recognition for Māori participation in the process of controlling these substances. In recent decades there has also been a disconnect between the Crown's recognition of significant tobacco, alcohol and other drug issues for Māori (through research and statistics, for example) and its action plans, strategies, and national policies which seek to address issues such as substance-related harm. This raises the issue of whether there is a lack of coordinated monitoring and evaluation of the effectiveness of these Crown policies and initiatives for Māori in terms of minimising related harms. With the current National Drug Policy due to expire in 2020, the development of a new national drug policy may provide opportunities for the Crown to consult and work with Māori to minimise harm more at the control end, rather than at the treatment end. Similarly, the government's proposed action plan for achieving the Smokefree 2025 goal may also provide opportunities for the Crown to work with Māori to address smoking-related disparities for Māori.

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Appendix I – List of relevant claims⁴⁷⁸

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
58	Whangaroa Lands and Fisheries Claim	Patricia Jane Tauroa and the late Nuki Aldridge	Ngā Hapū o Whangaroa	<p>Deprivation and lack of opportunities in Whangaroa have contributed to men turning to alcohol and drugs</p> <p>Alcohol and drugs use is linked to violence against wāhine Māori</p> <p>Drug manufacturing is used to generate income when employment opportunities are low, which also has an impact on violence against wāhine Māori</p>
88/89	<p>88 Kapiti Island Claim</p> <p>89 Whitioreia Block Claim</p>	<p>88 Ani Parata, Darrin Parata and Damian Parata</p> <p>89 Ani Parata and Darrin Parata</p>	<p>88 Te Āti Awa Marae Committee, other whānau and hapu of Te Āti Awa/Ngāti Awa ki Waikanae, and descendants of Te Kakakura Wi Parata Waipunahau</p> <p>89 Te Āti Awa Marae Committee, other whānau and hapu of Te Āti Awa/Ngāti Awa ki Waikanae, and descendants of Te Kakakura Wi Parata Waipunahau</p>	<p>Mentions study findings in Te Tai Tokerau but notes these are factors that impact Māori across the country, including that: there are high smoking rates that will lead to high rates of premature death; there is a high hospitalisation rate for alcohol-related conditions; alcohol is the highest cause of motor vehicle accidents; a high number of young teenagers are drinking; cannabis is the main drug used after alcohol and tobacco; and cannabis is easy to access and its use has become the norm</p>
179	Māori Affairs Act and Burials and Cremations Act Claim	The late Colin Malcolm, Anne Davies, Huhana Seve and Louisa Te Matekino Collier	Themselves and their extended whānau	<p>Issues of concern include reducing the causes of Māori ill-health (including smoking) and the fact that there are very few addiction rehabilitation services for those suffering tobacco, alcohol and drug addictions</p>
558	Ngāti Ira O Waioeka Rohe Claim	The late John Kameta, Te Rua Rakuraku and John Terehita Pio	Ngāti Ira o Waioweka Rohe	<p>Māori drug dependency remains disproportionate to that of non-Māori</p>

⁴⁷⁸ This list is not exhaustive and is based on information and analysis undertaken by Waitangi Tribunal Unit staff.

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
762	Waimihia River Eel Fisheries (King Country) Claim	Evelyn Kereopa	Herself, her whānau of, and members of, Te Ihingarangi, a hapu of Maniapoto	<p>Māori have higher rates of smoking, cannabis use, amphetamine use and hazardous drinking than non-Māori and, in particular, there are high rates of hazardous drinking among Māori women</p> <p>Problems with excessive drinking have emerged due to urbanisation</p> <p>The Crown has failed to protect Māori adults from the health impacts of smoking</p> <p>The Crown has failed to adequately consult Māori on a new approach to tobacco cessation that is incompatible with Māori-run Aukati KaiPaipa cessation programmes</p> <p>Sexual violence is a leading cause of trauma for wāhine Māori and is strongly linked with substance abuse</p>
844	Mate Pungarehu/Tobacco Claim	Huhana Mihinui	Herself and supported by the New Zealand Māori Council	<p>The Crown has failed to provide equitably for Māori health in the elimination or reduction of Māori smoking</p> <p>Māori smoking, and the resultant deaths are disproportionate to that of the general population</p> <p>Funding for Māori smoking prevention is not reflected in the amount of tax taken from Māori smokers</p> <p>Tax revenue from Māori smokers is disproportionate to Crown expenditure on Māori smoking-related hospitalisation</p> <p>Tobacco education campaigns lack a sufficiently Māori focus despite the disproportionate impact of smoking on Māori</p> <p>The Crown has failed to give sufficient attention to Māori-managed, culturally-specific anti-smoking programmes</p> <p>Māori designed health programmes have been comparatively more successful for Māori</p>

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
				<p>Despite the Crown being aware of the impact of smoking on Māori, it has failed to give Māori concerns adequate attention</p> <p>Historically the Crown has contributed to smoking amongst Māori</p>
864	Moutohorā Quarry Claim	John Hata, Russell Hollis and John Brown	Moutohorā Quarry	<p>Māori drug dependency remains disproportionate to that of non-Māori</p> <p>There is a need for wairua and whānau driven treatment</p>
874	Mangatū Block Claim	Rawiri Brown	Ngariki Kaiputahi Tribal Authority	The Crown has failed to adequately address the health costs of smoking, drinking, drug abuse, and the health issues relating to dependency, which disproportionately impact Māori
884 1835 1460 1941 2179	<p>884 Te Pa O Tahuhu (Mt Richmond, Auckland)</p> <p>1835 Ngāti Paki and Ngāti Hinemaru (Winiata, Lomax, Cross and Teariki) Claim</p> <p>1460 Tauhinu Ki Mahurangi Claim</p> <p>1941 Kingi and Armstrong (Nga Puhi) Claim</p> <p>2179 Ngā Uri o Tama, Tauke Te Awa and Others Lands (Dargaville) Claim</p>	Rihari Dargaville, Joseph Kingi and Marama Stead (and others)	2179 Māori of Taitokerau	<p>Due to Crown acts and omissions, Māori have higher rates of consumption and abuse of alcohol and drugs than non-Māori</p> <p>The Taitokerau region is suffering from drug abuse and its associated health and social outcomes</p>

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
966	Ngāpuhi Ti Tiriti o Waitangi Claim	Gray Theodore, Pereme Porter and Rangimarie Maihi	Ngāpuhi	Mentions study findings in Te Tai Tokerau but notes these are factors that impact Māori across the country, including that: there are high smoking rates that will lead to high rates of premature death; there is a high hospitalisation rate for alcohol-related conditions; alcohol is the highest cause of motor vehicle accidents; a high number of young teenagers are drinking; cannabis is the main drug used after alcohol and tobacco; and cannabis is easy to access and its use has become the norm
996	Ngāti Rangitihi Inland and Coastal Land Blocks Claim	David Potter and Andre Paterson	Themselves, and the hapū of Ngāti Rangitihi and Cletus Maanu Paul	Issues of concern include reducing the causes of Māori ill-health (including smoking) and the fact that there are very few addiction rehabilitation services for those suffering tobacco, alcohol and drug addictions
1072	Ngāti Ruakopiri Waimarino Block Alienation Claim	Matiu Haitana	His whānau and Ngati Ruakopiri	Māori were targeted in the promotion of alcohol and cigarettes leading to poor health outcomes
1544	Descendants of Hairama Pita Kino Claim	George Davies and Huhana Lyndon	The descendants of Hairama Pita Kino	<p>Due to the Crown's failure to provide health care, substance abuse is prevalent and causes many social problems</p> <p>The Crown's current health policy does not do enough to prevent or reduce tobacco-related illness</p> <p>A greater focus on prevention is sought</p>
1677	Orokawa 3B Block Claim	Huhana Lyndon	Hairama Pita Kino	<p>Due to the Crown's failure to provide health care, substance abuse is prevalent and causes many social problems</p> <p>The Crown's current health policy does not do enough to prevent or reduce tobacco-related illness</p> <p>A greater focus on prevention is sought</p>
1712	Descendants of Toi Te Hua Tahi and Te Maawe Claim	Marino Mahanga	The claimants and the descendants of Hohepa	The claimants have suffered from the social effects of land loss including alcoholism

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
			Mahanga, Mohi Te Peke, Itikai Hoterene, and Raniera Kopa	
1781	Ngāi Tama Haua (Biddle) Claim	Tracy Hillier and Rita Wordsworth	Themselves and the hapū of Ngāi Tamahaua	<p>Smoking rates in the Eastern Bay of Plenty (including the Opotiki region) are slightly higher than national average, and are highest among the Māori population</p> <p>Teen smoking rates in Bay of Plenty are higher than national average</p> <p>There are also high rates of hazardous drinking in the Bay of Plenty, and is most prevalent among men and Māori men</p>
1837	Whānau and Hapū of Te Tai Tokerau Settlement Issues (Nehua) Claim	Deidre Nehua	The whānau, hapū and iwi of Te Tai Tokerau	Mentions study findings in Te Tai Tokerau but notes these are factors that impact Māori across the country, including that: there are high smoking rates that will lead to high rates of premature death; there is a high hospitalisation rate for alcohol-related conditions; alcohol is the highest cause of motor vehicle accidents; a high number of young teenagers are drinking; cannabis is the main drug used after alcohol and tobacco; and cannabis is easy to access and its use has become the norm
1957	Maunga Kawakawa Block Claim	William Reihana	Himself, his whānau and members of Ngati Tautahi ki Te Iringa	Contact with alcohol and drugs led to a rapid increase in mental disorders among Māori
2053	Muaūpoko Health (Kupa and Ferris) Claim	Mona Kupa and Hera Ferris	Muaūpoko	The inequalities experienced by Muaūpoko are linked to exposure to health risks, including addictive substances such as nicotine, alcohol and other drugs
2063	Ngāti Tai Lands (Cotter-Williams) Claim	Jasmine Cotter-Williams	Herself, her whānau and members of Ngāti Taimanawaiti	<p>Contact with alcohol and drugs has led to a rapid increase in mental disorders among Māori</p> <p>Māori are more likely than non-Māori to develop a substance disorder</p> <p>There are high rates of hazardous drinking among Māori women</p>

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
				There has been a lack of treatment for substance disorders and Māori find it difficult to access substance disorder rehabilitation services
2072	Te Ihutai Lands (Robinson and Others) Claim	Mereana Robinson (nee Witana), Margaret Tito (nee Witana), Lina Stockley (nee Witana) and Rachel Witana (also known as Rāhera)	Themselves, their whānau and their hapū Te Ihutai Ki Ōrirā	Claimant mentions the use of tobacco as payment in a pre-Treaty land transaction
2121	Ngāti Tahinga, Ngāti Maniapoto and Others Health Issues (McKinnon) Claim	Inuwai McKinnon	Ngati Tahinga and Ngati Maniapoto, including his whānau and his hapū	The inequalities experienced by the claimants are linked to exposure to health risks, including exposure to addictive substances such as nicotine and alcohol
2173	Muaūpoko Health (Murray) Claim	Carol Murray and Bruce Murray	Muaūpoko	The inequalities experienced by the claimants are linked to exposure to health risks, including addictive substances such as nicotine, alcohol and other drugs
2217	Children of Te Taitokerau (Broughton) Claim	Violet Nathan and Maringi Te Aroha Kalva Emily Pia Broughton	Themselves and their whānau	<p>Māori children, especially girls aged 12-15, start smoking and become committed smokers at higher rates than teenagers from other ethnic groups</p> <p>Māori children are more likely to die prematurely because of Sudden Infant Death Syndrome (in which second-hand tobacco smoke can be a factor)</p> <p>Māori women in the 20th century commonly suffered from the impacts of alcohol abuse</p>
2257	Te Whānau Āpanui Mana Wāhine (Stirling) Claim	Maruhaeremuri Stirling, Ruiha Edna Stirling, Parehuia Herewini and Haro McIlroy	Themselves and the whānau of the hapū Te Whānau a Apanui	Mentions study findings in Te Tai Tokerau but notes these are factors that impact Māori across the country, including that: there are high smoking rates that will lead to high rates of premature death; there is a high hospitalisation rate for alcohol-related conditions; alcohol is the highest cause of motor vehicle accidents; a high number of young teenagers are drinking; cannabis is the main drug used after alcohol and tobacco; and cannabis is easy to access and its use has become the norm

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
2494	Racism Against Māori Claim	Donna Awatere-Huata	Herself and all Māori	<p>Māori experience disproportionate rates of drug dependency</p> <p>The Crown has failed to provide ongoing drug and alcohol rehabilitation for Māori inmates</p>
2499	Māori Health Disparities (Jansen, Laking and Moke) Claim	David Jansen and others	Themselves as an individual Māori, Te Ohu Rata o Aotearoa, and on behalf of all Māori generally	<p>The Crown has failed to exert timely controls on access to harmful substances, including tobacco and alcohol</p> <p>The Crown has failed to deliver initiatives that would result in improvements to Māori health, including smoking cessation programmes and alcohol addiction prevention policies</p>
2510	Land Confiscation (Te Kahika) Claim	Wiremu Te Kahika and Joe Kahika	Te Whānau o Te Kahika, Kahika, Kahikatea, Kahikaroa and Wharekahika	Māori experience disproportionate rates of drug dependency
2623	New Zealand Māori Council Health Claim	Cletus Maanu Paul, Desma Kemp Ratima, Rihari Richard Takuira Dargaville, Titewhai Harawira and William Jackson	Themselves, Mataatua District Māori Council, Takitimu District Māori Council, Te Tai Tokerau District Māori Council, Tamaki Makaurau District Māori Council and Tamaki ki te Tonga District Māori Council	Issues of concern include reducing the causes of Māori ill-health (including smoking) and the fact that there are very few addiction rehabilitation services for those suffering tobacco, alcohol and drug addictions
2624	Alcohol Healthcare Claim	David Ratu		<p>Alcohol use is leading to health disparities between Māori and non-Māori</p> <p>Māori suffer more harm from alcohol than any other demographic group, including alcohol-attributable death, cardiovascular disease, breast cancer, criminal behaviour (including physical and sexual assault), and fetal alcohol syndrome</p> <p>The Sale and Supply of Alcohol Act 2012 fails to recognise the Treaty</p>

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
				<p>The Crown has failed to implement the recommendations made by the Law Commission in 2010</p> <p>Also highlights that other claimants have called for reducing the causes of Māori ill-health, including tobacco smoking</p>
2629	Synthetic Drugs Healthcare Claim	Hamuera Hodge, Tumahaurangi Māori Committee		Synthetic drugs pose danger to the Māori community
2634	Smoking Healthcare Claim	Maraea Katene	Herself and her whānau	<p>The claimants allege that due to Crown acts and omissions they have been and continue to be prejudicially affected due to their whānau suffering disproportionately from smoking</p> <p>Māori smoking rates are nearly three times that of non-Māori</p> <p>Thousands of Māori continue to die as a result of smoking, and many children become addicted to nicotine</p> <p>The Crown is not doing enough to address tobacco-related harm amongst Māori, including failing to progress key measures recommended by the Māori Affairs Select Committee in 2010</p> <p>Despite strong Māori support, key smoking-reduction opportunities have been missed, including reducing the availability and supply of tobacco, using mass media campaigns targeting Māori and pregnant women, disclosing product additives, and regulating nicotine and additives</p>
2635	Tairāwhiti Methamphetamine Claim	Mark West and Tuta Ngarimu	Themselves and Māori in the Tairāwhiti region	<p>The Crown has failed to adequately address the methamphetamine epidemic among Māori, e.g. there are no residential drug rehabilitation centres in Gisborne</p> <p>Māori are more likely to use amphetamines than non-Māori and are more likely to suffer the associated impacts like domestic violence and abuse, breakdowns of the family structure, ill-health, and economic deprivation</p>

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
				<p>There are geographical, social and economic barriers to accessing drug rehabilitation</p> <p>The Crown's methamphetamine action plan is not working as it does not adequately consider cultural competency, consultation, whānau, hapū, iwi or Treaty of Waitangi, and it does not address the lack of residential care and rehabilitation centres</p>
2639	Rangiteaorere Health Claim	Rangimatua Easthope	Himself and Ngati Rangiteaorere	The claimant's iwi has a need for facilities to treat drug and alcohol addictions
2641	Hastings Mongrel Mob Health Claim	Rex Timu	The Hastings Chapter of the Mongrel Mob	<p>There is a connection between colonisation and racial discrimination and health-risk behaviours such as smoking, drinking alcohol, and drug abuse</p> <p>The Crown is failing to adequately address the methamphetamine epidemic among Māori, who are overrepresented in numbers of amphetamine users</p> <p>The Crown's methamphetamine action plan is not working as it does not adequately consider cultural competency, consultation, whānau, hapu, iwi or the Treaty of Waitangi, and it does not involve working with the people most effected by methamphetamine</p>
2643	Mental Health, Addiction and Suicide Claim	Rosaria Hotere and Jane Hotere	Themselves and their whānau	The Crown has failed to provide healthcare and assistance for those affected by alcohol and drug addiction
2655	Nga Kairauhii Nannies against P Claim	Lovey Edwards and Anne Hakiwai		<p>The Crown has failed to prevent the use of methamphetamine, to address the underlying causes of addiction, to provide funding/treatment, to support the community in the face of the methamphetamine epidemic, to keep the community and whānau safe, to treat Māori communities fairly, to recognise tikanga, and to consult/include Māori in the provision of care for those suffering methamphetamine addictions</p> <p>Due to Crown actions and omissions, Māori within the claimant's rohe are more likely to use methamphetamines, communities have suffered, and whānau have been stigmatised</p>

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
2670	Treatment of Substance Abuse Issues Claim	Jack Rifle	Māori including his Ngāti Te Wehi whānau	<p>The Crown has failed to provide sufficient support for Māori with substance abuse issues</p> <p>The effects of substance abuse on families include mental health/psychiatric related admissions to hospital, whānau relationship problems, increased number of prison admissions, and employment issues</p>
2673	Sexual Abuse of Māori Wāhine and Tamariki Claim	Sheena Ross		Māori affected by sexual abuse are at a greater risk of developing alcohol and substance abuse problems
2682	Medical Practitioners Racial Prejudice Claim	Richard Takuira (also known as Ritchie Akapita)	Himself and on behalf of the Takuira – Akapita Whānau	Health claim but does not specifically mention alcohol/tobacco/substances
2684	Healthcare of Imprisoned Māori Claim	Dr Lynne Russell	Her whānau, her brother Phillip, and all those Māori suffering from mental health issues while in prison, on probation or on parole, or as a result of having been in prison, on probation or on parole	<p>A significant number of inmates with substance abuse or diagnosis are not getting the treatment they require</p> <p>A higher proportion of male sentenced prisoners receive treatment for alcohol and drug addictions but fewer prisoners in remand and fewer female prisoners receive treatment</p> <p>A high percentage of prisoners with a major mental disorder also have a substance abuse disorder</p> <p>Substance abuse disorders known to contribute to re-offending</p>
2688	Māori Health (Rawiri) Claim	Glennis Rawiri	Herself and her whānau	The Crown has failed to provide sufficient support for Māori with substance abuse issues
2697	Holistic Māori Health Approach Claim	Reverend Anthony Brooking		<p>There are high rates of alcohol and drug disorders among Māori</p> <p>There is a link between mental illness, alcohol abuse, and housing difficulties</p>

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
				The Crown needs to better support Māori transitioning from alcohol and drug rehabilitation programmes
2713	Māori Nurses Claim	Hineraumoa Te Apatu and Kerri Nuku	Te Rūnanga o Aotearoa Tōpūtanga Tapuhi Kaitiaki o Aotearoa	Claimants indicate that Tōpūtanga Tapuhi Kaitiaki o Aotearoa (NZ Nurses Organisation) affiliates with the Smokefree coalition
2718	Karepe Herekiuha Whānau Trust Claim	Christine Anne Karu, Caroline Ara Karu, Tamara Karu, Kerry Patricia Karu, Jocene Helen Karu, Russell Charles Karu and Martin Thomas Karu	Themselves, their children and the Karepe Wikiriwhi nee Karepe Herekiuha also known as the Karepe Herekiuha Whānau Trust	Māori have much higher rates of smoking, lung cancer and alcohol addiction than non-Māori
2719	Māori Maternal Health Services Claim	Beverly Te Huia		<p>Māori women have a higher prevalence of maternal risk factors as they are more likely to smoke during pregnancy</p> <p>Smoking rates among pregnant Māori women are three times higher than that of pregnant non-Māori women</p> <p>45 per cent of Māori women smoked during their pregnancy between 2004 and 2007</p> <p>Suggests delivering Kaupapa Māori smoking cessation support for pregnant women</p>
2720	Health Services Claim	John Tamihere	Himself, Te Whānau o Waipareira Trust, the Manukau Urban Māori Authority, the National Urban Māori Authority, Te Roopu Awhina ki Porirua, and the Kirikiriroa Marae	Issues of concern include reducing the causes of Māori ill-health (including smoking) and the fact that there are very few addiction rehabilitation services for those suffering tobacco, alcohol and drug addictions

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
2723	Mental Health (Baker) Claim	Maria Baker	All Māori	Substance disorders are becoming more prevalent within Māori communities Substance use is a risk factor for mental illness
2728	Mental Health Services (Campbell) Claim	Sharon Campbell	Herself and her whānau, and for the benefit of ngā uri whakaheke a Rangihuatake rāua ko Haami Parehe, Patehepa Tāpono, Tipene Te Peha Tutaki Tamatea, rāua ko Hana Konewa	The health system's reactive model of diagnosis leads to drug abuse and dependency The Crown has failed to prevent high rates of Māori mental illness and in some cases this results in drug abuse and addiction
2729	Mental Health Services (Taylor) Claim	Susan Taylor	The wāhine of the Taylor whānau as a member of Te Whakatohea	Māori are more likely to develop a substance abuse disorder than non-Māori Sexual violence can be correlated with substance abuse
2738	Mental Health and Addictions (Fergusson-Tibble) Claim	Kahurangi Fergusson-Tibble	Māori mental health and addiction workers	There is a need for more resourcing of the Alcohol and Other Drug Treatment Courts Māori struggling with drug addiction are criminalised rather than given treatment/support Incarcerated Māori do not get proper treatment for drug addictions
2829	Wāhine Addiction (Waihi) Claim	Roimata Waihi		Māori women are disproportionately impacted by smoking and alcohol addictions, for example, they have higher rates of smoking- and alcohol-attributable death and illness than non-Māori women Māori have the highest rates of certain recreational drug use and Māori women suffer disproportionate harm Alcohol is a leading driver of health and social inequalities for Māori women Māori women begin smoking and drinking at a younger age, leading to dependence and harm

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
				The Crown has a duty of active protection towards Māori women but it has failed to adequately respond
2836	Impacts of Alcohol on Wāhine (Hauwai) Claim	Atawhai Hauwai		<p>Māori women are disproportionately impacted by hazardous drinking and the Crown has failed to adequately respond</p> <p>Alcohol is a leading driver of health and social inequalities for Māori women</p> <p>Māori women begin drinking at a younger age, leading to dependence and alcohol-related harm</p> <p>Māori women have higher rates of alcohol-attributable death than non-Māori women (including breast cancer, motor vehicle accidents, heart disease, liver cirrhosis, and stroke), and alcohol-attributable hospitalisations have increased</p>
2848	Health Services and Outcomes (Paul) Claim	Pita Paul	Himself, his whānau, his hapū, and various marae throughout Aotearoa	Issues of concern include reducing the causes of Māori ill-health (including smoking) and the fact that there are very few addiction rehabilitation services for those suffering tobacco, alcohol and drug addictions
2849	Health Services and Outcomes (Lawrence) Claim	Awhirangi Panehina Lawrence	Herself, her whānau, and Ngā Uri o Ngata me Pomana Honetua	Issues of concern include reducing the causes of Māori ill-health (including smoking) and the fact that there are very few addiction rehabilitation services for those suffering tobacco, alcohol and drug addictions
2862	Mana Wāhine (Koha) Claim	Nancy Matekino Koha		<p>Māori women disproportionately bear and/or care for children with Fetal Alcohol Spectrum Disorder, and the Crown has failed to adequately respond</p> <p>There have been substantial increases in Māori women's drinking and Māori women begin drinking at a younger age, increasing the risk of Fetal Alcohol Spectrum Disorder</p> <p>Alcohol consumption during pregnancy can lead to lifelong disability for tamariki Māori</p>

Wai	Claim Name	Named Claimants	Claim for and on behalf of	Issues raised by claimants
2890	Ngāti Ueoneone and Ngāti Tautahi of Ngāpuhi Claim	Tasilofa Huirama	Zipporah Grace Huirama (deceased), her whānau who are of Ngāti Ueoneone and Ngāti Tautahi of Ngāpuhi	The claimant mentions the use of cannabis and datura by the child they were caring for and who had significant mental health issues and later committed suicide

Appendix II – Research commission

OFFICIAL

Wai 2575, #2.3.2

WAITANGI TRIBUNAL

Wai 2575

CONCERNING

the Treaty of Waitangi Act 1975

AND

the Health Services and
Outcomes Kaupapa Inquiry

DIRECTION COMMISSIONING RESEARCH

1. Pursuant to clause 5A of the second schedule of the Treaty of Waitangi Act 1975, the Tribunal commissions Barry Rigby to prepare a report on issues of alcohol, tobacco and substance abuse for Māori, for the Health Services and Outcomes Kaupapa Inquiry.
2. The researcher should focus on providing an outline of contemporary health services relevant to issues of alcohol, tobacco and substance abuse for Māori, how these are implemented, the impacts and outcomes for Māori, and Māori responses. Māori participation in legislation, governance and policy developments in respect to alcohol, tobacco and substance abuse health services should also be examined.
3. The researcher will provide a brief outline of significant historical developments relevant to the development of the current health system including Māori historical experiences of government health services in respect to alcohol, tobacco and substance abuse issues and how these may have contributed to any current barriers to service.
4. Utilising the four key topics identified in the pre-casebook discussion paper of disparities in outcomes for Māori with alcohol, tobacco and substance abuse issues; accessibility of health services for Māori with alcohol, tobacco and substance abuse issues; responsiveness of health services to Māori with alcohol, tobacco and substance abuse issues; and effectiveness of health services for Māori with alcohol, tobacco and substance abuse issues, where possible the overview will address:
 - (a) How does the contemporary health system, including legislation, policies and practices recognise and provide for the needs of Māori with alcohol, tobacco and substance abuse issues? To what extent, if any, does implementation and outcomes diverge from policy objectives?
 - (b) To what extent does health policy and practice provide culturally appropriate health services and treatment for those Māori with alcohol, tobacco and substance abuse issues, or provide for Māori led and developed systems and methods of health care/kaupapa Māori?
 - (c) To what extent have Crown acts or omissions, if any contributed to disparities in health services and outcomes between Māori and non-Māori with alcohol, tobacco and substance abuse issues and how are these recognised and addressed?

- (d) What barriers, if any, do Māori with alcohol, tobacco and substance abuse issues experience in accessing health services and what are existing Crown policies and practices for recognising and addressing any such barriers?
 - (e) How effective is current monitoring and data collection for identifying and addressing any disparities in health services and outcomes for Māori with alcohol, tobacco and substance abuse issues?
 - (f) To what extent have Māori had opportunities to contribute to relevant policy and legislative developments?
 - (g) What key historical developments have contributed to the current system of government health services for Māori with alcohol, tobacco and substance abuse issues and to Māori experiences and attitudes to health services?
5. The completed report draft will be made available to parties for feedback by 30 April 2019 to be followed by quality assurance and final revision with the final report filed by 28 June 2019. An electronic copy of the report and supporting documentation should be submitted to the Registrar in Word or PDF file format.
6. The report may be received as evidence and the author may be cross-examined on it.
7. The Registrar is to send copies of this direction to:
- Barry Rigby
 - Claimant counsel, Crown counsel and unrepresented claimants in the Health Services and Outcomes Kaupapa Inquiry
 - Chief Historian, Waitangi Tribunal Unit
 - Principal Research Analysts, Waitangi Tribunal Unit
 - Manager Research Services, Waitangi Tribunal Unit
 - Manager Inquiry Facilitation, Waitangi Tribunal Unit
 - Inquiry Facilitator, Waitangi Tribunal Unit
 - Solicitor General, Crown Law Office
 - Director, Office of Treaty Settlements
 - Chief Executive, Te Puni Kōkiri

DATED at Hamilton on this 24th day of September 2018



Judge S R Clark
Presiding Officer

WAITANGI TRIBUNAL

WAITANGI TRIBUNAL

Wai 2575

CONCERNING

the Treaty of Waitangi Act 1975

AND

the Health Services and
Outcomes Kaupapa Inquiry

**MEMORANDUM-DIRECTIONS CANCELLING AND RE-COMMISSIONING
RESEARCH**

1. On 24 September 2018, the Tribunal commissioned Dr Barry Rigby, a member of the Waitangi Tribunal Unit's staff to prepare a report on alcohol, tobacco and substance abuse for the Health Services and Outcomes Kaupapa Inquiry (Wai 2575, #2.3.2). The commission deadline was 28 June 2019, subsequently extended to 30 August 2019 (Wai 2575, #2.6.14).
2. I am advised that Dr Rigby is not able to complete this report. The commission is hereby cancelled.
3. Pursuant to clause 5A of the second schedule to the Treaty of Waitangi Act 1975, the Tribunal commissions Kesaia Walker, a member of the Waitangi Tribunal Unit staff, to complete the research specified in the original commission (Wai 2575, #2.3.2).
4. The commission ends on Friday 20 December 2019 at which time an electronic copy of the report must be submitted for filing, together with indexed electronic copies of any supporting documents. The report, accompanying supporting papers and any subsequent evidential material based on it, must be filed through the Registrar.
5. The Registrar is to send copies of this direction to:

Dr Barry Rigby;
Kesaia Walker;
Claimant counsel, Crown counsel and unrepresented claimants in the Health Services and Outcomes Kaupapa Inquiry;
Chief Historian, Waitangi Tribunal Unit;
Principal Research Analysts, Waitangi Tribunal Unit;
Manager Research Services, Waitangi Tribunal Unit;
Manager Inquiry Facilitation, Waitangi Tribunal Unit;
Principal Inquiry Facilitator, Waitangi Tribunal Unit;
Senior Inquiry Facilitator, Waitangi Tribunal Unit;
Solicitor General, Crown Law Office;
Chief Executive, Te Arawhiti;