The New Zealand Illicit Drug Harms Index: how can it inform a health-based approach to drug use?

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Psychoactive drugs are widely available in Aotearoa New Zealand, and their use, has potential to cause harm; either to the person using the drug, or to others. Drug harm is multi-factorial, and forms a complex health, equity, and public health issue. The New Zealand Drug Harms Index was first published in 2008 and revised in 2016 to guide drug policy and resource allocation. An updated report, renamed the New Zealand Illicit Drug Harm Index (NZIDHI; referred to as the ‘Index’), was released in February 2022. The updated Index incorporates a number of improved data sources (ie national wastewater estimates, coronial services, hospital admissions), and provides an updated cost estimate of drug harm to New Zealanders of $1,904 million per year; differentiated into personal harm ($813 million) and community harm ($1,091 million). In this editorial we discuss the scope and methodology of the Index, and relate these to the utility of the Index for informing health-based drug policy.

The first key consideration is that the Index’s scope is limited to illegal (‘illicit’) drugs, thus excluding alcohol and tobacco, two widely used substances with substantial health and social harms. For example, the most recent estimate of the cost of alcohol-related harm in New Zealand is $7 billion per annum; more than triple of all illegal drugs included in the Index. This scope reflects the historic purpose and origins of the Index, which was predominantly law enforcement focused. However, drug harm ranking studies using multi-criteria decision analysis in the United Kingdom, Europe, and Australia have identified alcohol and tobacco among the most harmful drugs (including overall harm and prevalence-weighted harm). By only quantifying harms from illegal drugs, the Index perpetuates the misconception that only illegal drugs are harmful.

A second important issue is that the stated aim of the Index is to evaluate the “costs of harmful illicit drug use”. However, “harmfulness” is not a fixed property of a drug, and can be mitigated or compounded by the social and policy context in which drug-use occurs. In this Index, a significant proportion of community harm is attributed to either reinvestment of drug trafficking profits into other crime ($61 million 6% of community harm) or foregone tax revenue ($240 million, 24% of community harm). Therefore, 30% of the community harm estimates were not attributable to the harmful use of drugs, but rather to the current prohibition framework in which drug use has occurred. This is also likely to be a substantial underestimate, as there are other types of drug-related harm arising from illegality (eg loss of employment, loss of reputation). The inclusion of foregone tax revenue as a harm creates a counterfactual state of affairs that is policy-dependent. In the Practical Guideline accompanying the Index, an example is provided on reduction of harm based on the seizure of X kg of a drug, multiplied by harm per kg. However, if reductions in community harms are calculated for drug seizures, foregone tax revenue cannot be included as avoided harm. Any tax that could have been collected was foregone whether the drugs were seized or not, because they cannot be sold legally. We are not advocating that these estimates of harm be removed; in fact, we think their inclusion in the updated Index is a strength, and reflects the impacts of current drug policy. However, the Index would benefit from clearly separating drug harms from drug policy harms.

The most important consideration is how the updated Index will inform policy evaluation and resource allocation. The NZ Drug Strategy (2015–2020) (yet to be updated) has an overarching goal of “reducing drug-related harm”. Given that drug-use remains relatively high despite prohibition, we argue that legislation should move more towards a harm reduction and health-based approach. It is important to acknowledge that not all drug use is associated with harm, and there is a broad spectrum of use patterns from sporadic or casual, through to dependent and problematic.
use. In contrast with the 2016 edition, the current Index does not enable differentiation by use patterns, effectively attributing harm equally across those who use a drug. In reality however, there are a large proportion of individuals experiencing no, or very little, harm from their drug use, alongside a smaller proportion of individuals and their significant others experiencing substantial harm. This distribution of harm will differ by drug type. The current Index does not provide a cost estimate per “dependent user”, unlike the 2016 iteration. Considering the results of the Index from a resource allocation perspective (consistent with a harm reduction goal) would prioritise resourcing interventions such as needle exchanges, naloxone access and drug checking, as well as drug treatment services. By targeting efforts more directly on reducing drug-related harm, rather than drug-use, we can move closer to a health-based approach to drugs in New Zealand, and focus resources toward those experiencing harm.

A health-based approach must also address the established health and social inequities for drug harm in New Zealand. The Wai 2575 claim reinforces that substantial health inequities exist for drug harms and treatment for Māori. A prohibition-focused drug policy reinforces stigma, creates barriers to help-seeking, and can directly contribute to harm through biased policing and prosecution. The Index does not attempt to quantify harms to Māori relative to the total population; however, we know from current evidence of inequity that this will be greater than would be attributable simply by population proportion. Future iterations of the Index should consider how drug harms are spread across population groups.

The updated Index presents an opportunity to evaluate New Zealand’s current drug policy and how effective it has been in reducing drug-related harm. Drug use can be associated with harm, but equating use with harm misrepresents this relationship, and may lead to poor policy-making. We see this conflation between use and harm within the Misuse of Drugs Act 1975, whereby any possession or use is considered misuse—the current Act fully conflates use with harm. Independent reviews have highlighted that our current drug policy approach requires reform, and the Misuse of Drugs Act, at 47 years old, is beyond the point where it can be coherently amended. We argue that drug policy should reflect the relative harmfulness of drug types, and current classifications need evidence-based revision. We maintain that drug policy should be coherent and proportionate, and that would include considering the harmfulness of alcohol and tobacco alongside currently illegal drugs.

New legislation that genuinely enshrines a harm reduction and health-based approach to all drugs (regardless of legal status) is required. Such legislation could then be supported by a re-designed “Substance Harms Index” with a broader scope and definition of harm, and which differentiates harm associated with drug use from harm associated with drug policy. Like any analysis, the accuracy of the Index is reflective of the quality of available data. The authors of the Index highlight, and we concur, that there are methodological constraints and limitations attributable to issues with New Zealand data quality. Therefore, an investment in improved data is also required. After more than 50 years of a prohibition approach during which drug supply and use has increased globally, it is time for our legislation in Aotearoa New Zealand to be reformed, centered on human rights, equity, and health.
**COMPETING INTERESTS**
Nil.

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**REFERENCES**