Te Hiringa Mahara | Mental Health and Wellbeing Commission

Evidence brief: Alcohol and Other Drug harm reduction approaches

Published August 2026

This evidence brief summarises the evidence for a range of approaches to reduce alcohol and other drug harm, assessing the strength of evidence for effectiveness, cost-effectiveness, and relevance to Aotearoa New Zealand.

Why this is important

1.2 million adults in Aotearoa New Zealand are estimated to be at higher risk of problematic substance use, including higher rates among 15–24 year olds.[1] Harms from alcohol and/or other drugs affect not only individuals but their whānau and community, with impacts including illness, injury, anxiety, depression, substance use disorders, suicide, and death.

These harms also cost the country $9.1 billion per year (for alcohol)[2] and $1.9 billion per year (for other drugs).[3] Addressing alcohol and other drug (AOD) harms is a current government priority alongside prevention and early intervention. This summary provides evidence about "what works" to reduce AOD harm.

Note: This evidence brief is not monitoring of current services or service performance. It is a synthesis of evidence of effectiveness in the literature with regard to substance harm reduction.

In this document:

Part 1 includes a section that provides contextual understanding of AOD harm in Aotearoa New Zealand and knowledge on harm reduction development, principles, and practice.

Part 2 reviews current evidence for what works to reduce AOD harm. It summarises evidence in terms of impact, cost effectiveness, and strength of evidence for effectiveness.

What this review adds

This evidence brief summarises the evidence for a range of approaches to reduce alcohol and other drug harm, assessing the strength of evidence for effectiveness, cost-effectiveness, and relevance to Aotearoa New Zealand. It is derived from our published Alcohol and Other Drug Harm Reduction Literature Review,[4] and summarises the evidence presented in that work.

This evidence brief shows that a variety of harm reduction approaches are effective and cost-effective, especially when accessible, culturally appropriate, and inclusive of lived experience. Peer support and flexible, co-designed outcomes are key features of successful programmes.

The findings also show that of the public funding which has a clear objective to reduce prohibited drug use or problems, only 2% is spent on harm reduction. There is public support for this proportion to increase.[5] International evidence also supports adoption of additional harm reduction interventions, however adaptation to our local context is necessary to be fully effective.

Three key local adaptations would support effective AOD harm reduction: addressing legal barriers to implementation, contextualising approaches to our unique drug landscape, and using te ao Māori-centred and qualitative evaluation frameworks that acknowledge broader wellbeing outcomes.

Introduction

Drug use is relatively common, with around 75% of adults consuming alcohol and nearly 20% using illegal drugs annually.[6] While not all use is harmful, drug-related harm can affect individuals, families, communities, and society through health complications, psychological impacts, strained relationships, crime, and economic costs.

Increasingly, drug harm is recognised as not solely attributable to individual choice but as the result of interactions between the drug, the person, and their environment. Structural factors such as social conditions and public policy play a major role in shaping both drug use and harm. Therefore, to address AOD harm an evidence-based public health approach is needed, that moves beyond purely individual responses and recognises social and structural determinants of harm.

Regulation, treatment, and harm reduction should work together in a public health approach.[7] Key to this is understanding how evidence supports various approaches. This review summarises the evidence and provides key takeaway messages for each approach and for our Aotearoa New Zealand context.

Context and scope

Alcohol and Other Drug Harm Reduction Literature Review

This evidence brief brings together key findings from our Alcohol and Other Drug Harm Reduction Literature Review. The larger literature review examined international and Aotearoa New Zealand academic and grey literature, with a focus on post-2010 unless a study had specific relevance. 274 studies were included, of which 39 focus on Indigenous approaches. The focus of assessment was on the highest level of evidence, where possible using systematic reviews and meta-analyses.

Approaches outlined in the literature were appraised for effectiveness, cost effectiveness, and relevance to Aotearoa New Zealand. Not all studies could be included, so a diversity of evidence was used to illustrate key topics with a focus on providing the highest level of evidence where possible. Exclusion from the review does not imply that a study or programme is not valuable.

Research questions:

- What are the known harms, and drivers of harms, associated with alcohol and other drugs in Aotearoa New Zealand?
- What legislative, policy, and practical approaches (nationally and internationally) are shown by evidence to be effective for reducing alcohol and other drug harm?
- What approaches and interventions could reduce harm from alcohol and other drugs in Aotearoa New Zealand?

Out of scope:

- **Regulatory supply reduction for any drugs other than alcohol,** as alcohol is the only drug within scope that is legally regulated in a for-profit model.
- **Cigarettes, vapes, and tobacco products** were excluded to manage scope.
- **Uptake prevention approaches, including education** were excluded because our focus is on reducing harm for people with lived experience, who by definition are already using drugs.
- **Any intervention that involves force or coercion,** in line with our focus on moving towards a system that upholds human rights-based practices.[8]
- **Assessment of services or service performance.**

Assessing evidence of effectiveness

The GRADE tool was used to appraise literature and certainty of evidence. GRADE is a systematic approach to evaluating literature certainty and is commonly used for healthcare evidence. In this case, GRADE was used to apply a rating to each study, which could then be up- or down-graded according to set criteria. These criteria are weighted towards quantitative and controlled studies, which limits its applicability to qualitative or community engagement studies.

A low GRADE rating should not be taken to mean that an approach does not work, rather that the certainty is lower. Many interventions for Indigenous harm reduction and community-based harm reduction never have the opportunity to be evaluated or published – this does not make them invalid or their knowledge less relevant.

GRADE was not applied to the Indigenous harm reduction studies to avoid applying a Western tool which is strongly embedded in quantitative and health system standards of evidence, to Indigenous knowledge.

Limitations of the review

- This is a summary of evidence, not a systematic review.
- The GRADE evaluation tool has inherent limitations when used with multiple study types and methods.
- There is a reliance on peer-reviewed, English-language articles in the review of Indigenous approaches.
- Evidence gaps exist for approaches that have not yet been extensively evaluated.
- Narrative assessment from the study team was integrated to balance the limitations.

Part 1: Understanding drug harm and its sources is critical for reducing impact on individuals, families and community

Key facts

Of all people in Aotearoa New Zealand aged 15 or over:

74.9%
have used alcohol in the past year.

22.2%
of these report a hazardous drinking pattern.

Men, Māori, disabled people, and those experiencing economic deprivation
are more likely to report hazardous drinking.

14.1%
report past year illicit drug use.

1.2m
people are estimated to be at moderate to high risk of problematic substance use (including alcohol).

Sources: Ministry of Health. (2025b). *New Zealand Health Survey. Annual Data Explorer (Data File).* Ministry of Health | Manatū Hauora, New Zealand Drug Foundation. 2024. A health-based approach to drug harm in Aotearoa. Report: Wellington.

Humans have a very long history of altering their consciousness, and a fundamental principle of harm reduction is recognising that drug use has always been, and will remain, part of human society.[9] Motivations for using drugs are diverse and highly contextual. They can include both enhancing positive feelings and suppressing negative ones. While people may choose not to use or to stop using drugs, a harm reduction perspective accepts that drug use cannot be eliminated from society.

Drug harm is the negative consequences of drug use, which can impact individuals, their whānau, and community. There is no universally accepted definition or measure for drug harm, and people may conceptualise and experience harm in different ways. This makes harm challenging to measure.

Drug use is sometimes used as a proxy measure for harm, however this is a flawed approach as not everyone who uses drugs is harmed by them. Drug use as a proxy for harm can have unintended harmful consequences by focusing any efforts at harm minimisation solely towards reducing drug use which can in turn increase drug-related stigma.[10] Stigma both creates and perpetuates harm by pushing people who use drugs into secrecy and reducing help-seeking as well as contributing to marginalisation.[11]

Harm is influenced by the type of drug, how it is consumed, use patterns, individual factors, and social and environmental context. Data is not available to measure all types of harm, therefore other methods must be used to understand it. Widely used frameworks for assessing harm focus on analysis using expert judgment, and consensus on types of harm to self and harm to others associated with different drugs.

A 2023 Aotearoa New Zealand drug harm ranking study[12] included 17 criteria for harm, ranging from obvious harms such as drug-specific mortality, dependence, and crime to less tangible harms such as impairment of mental functioning, family adversities, and non-physical/spiritual damage. The study then ranked drugs in order of harm, showing harm to self in blue, and harm to others in orange:

Harm to self and others in overall population

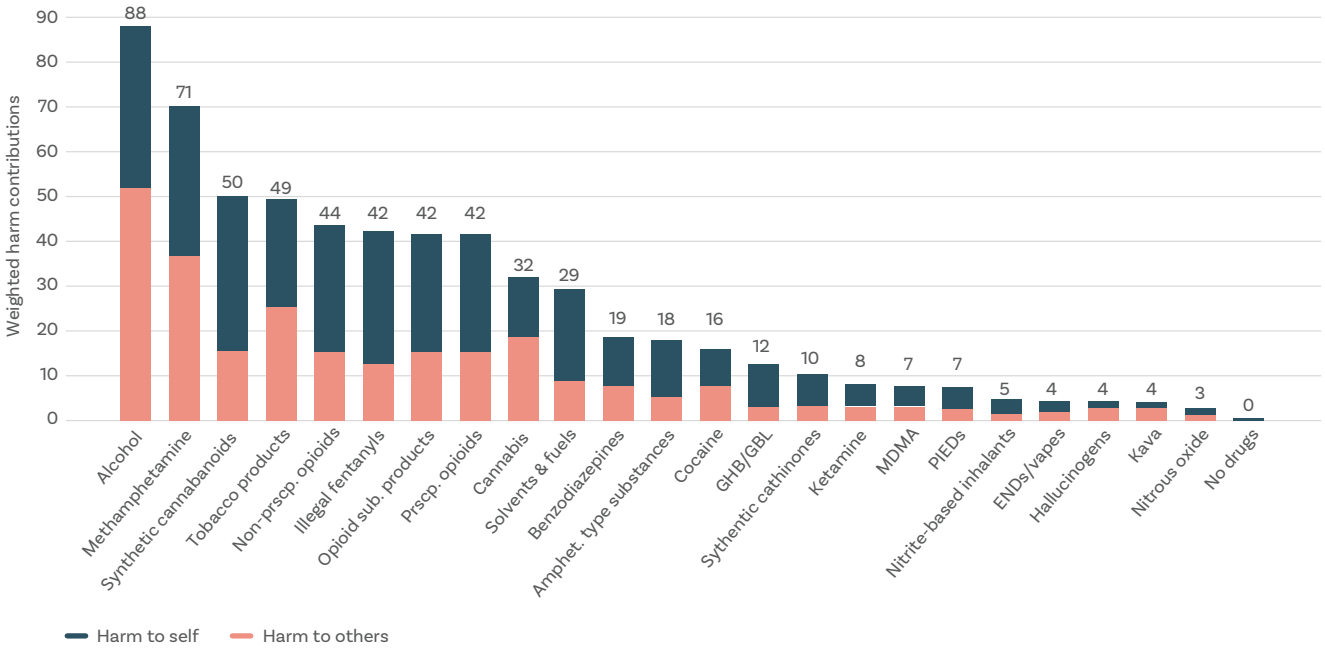

Figure 1 – Drug harm study findings for total NZ population (graph amended from Crossin et al., 2023).

Some drugs such as alcohol were associated with a diverse range of harms, whereas for others the harms were quite specific, for example opioids were dominated by drug-related mortality, loss of tangibles, loss of relationships, and family adversities.[12]

Contemporary harm reduction services primarily aim to target drug related mortality (fatal overdose, death due to blood-borne virus) and drug related damage (non-fatal overdose, harm from blood-borne virus). These are shown below in order of their ranking in the harm study.

Highest ranked for drug-related mortality	Highest ranked for drug-related damage
Alcohol	Alcohol
Illegal fentanyls	Synthetic cannabinoids
Non-prescription opioids	Methamphetamine
Synthetic cannabinoids	Illegal fentanyls
Prescription opioids	Non-prescription opioids
Opioid substitution products	Prescription opioids
Methamphetamine	Opioid substitution products

Sources of drug harm are complex and driven by individual, social and structural factors

Our understanding of what causes drug harm has evolved over several decades. While the potential for the direct physical and mental effects of drug use to cause harm is obvious, the sources of harm are more nuanced and complex. We now know that drug harm arises from multiple interconnected sources, including individual and social factors.

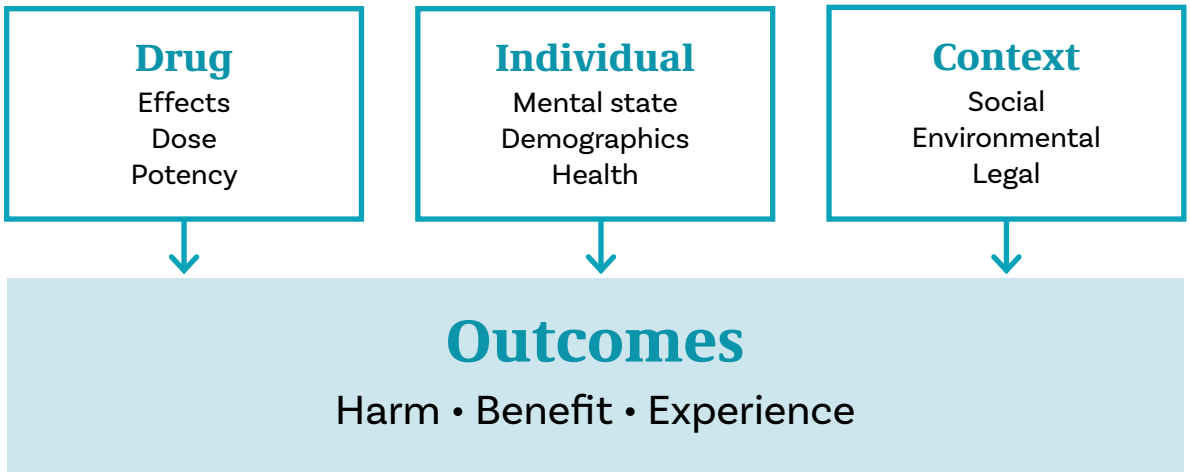

Figure 2 – Contributors to drug outcomes (Te Hiringa Mahara, 2026).

These factors interact, meaning the same drug use can lead to very different harms depending on who is using the drug and in what context. For example, the risks arising from injecting a drug may become more severe in an environment of strict prohibition where greater barriers to support exist.

Drug harms can also be intersectional, with outcomes influenced by the interaction of factors such as gender, ethnicity, whether someone is a member of an indigenous group (indigeneity), housing status, and gender identity.[13,14] Research on this highlights inequitable outcomes and emphasises the need for responses tailored to the needs of specific groups, and that include consideration of (for example) how stigma intersects with both drug use and indigeneity.

Ideas about social harm are now being integrated into drug policy.[15] In parallel, a "public health" approach to drug use is being explored, which acknowledges that individual harm does not take place in a vacuum and that responses must recognise social and structural determinants of harm. The public health approach to drugs has increasingly focused on harm reduction, and harm reduction principles are evident in a conceptual framework recently published in international public health journal BMC Public Health shown in Figure 3:[16]

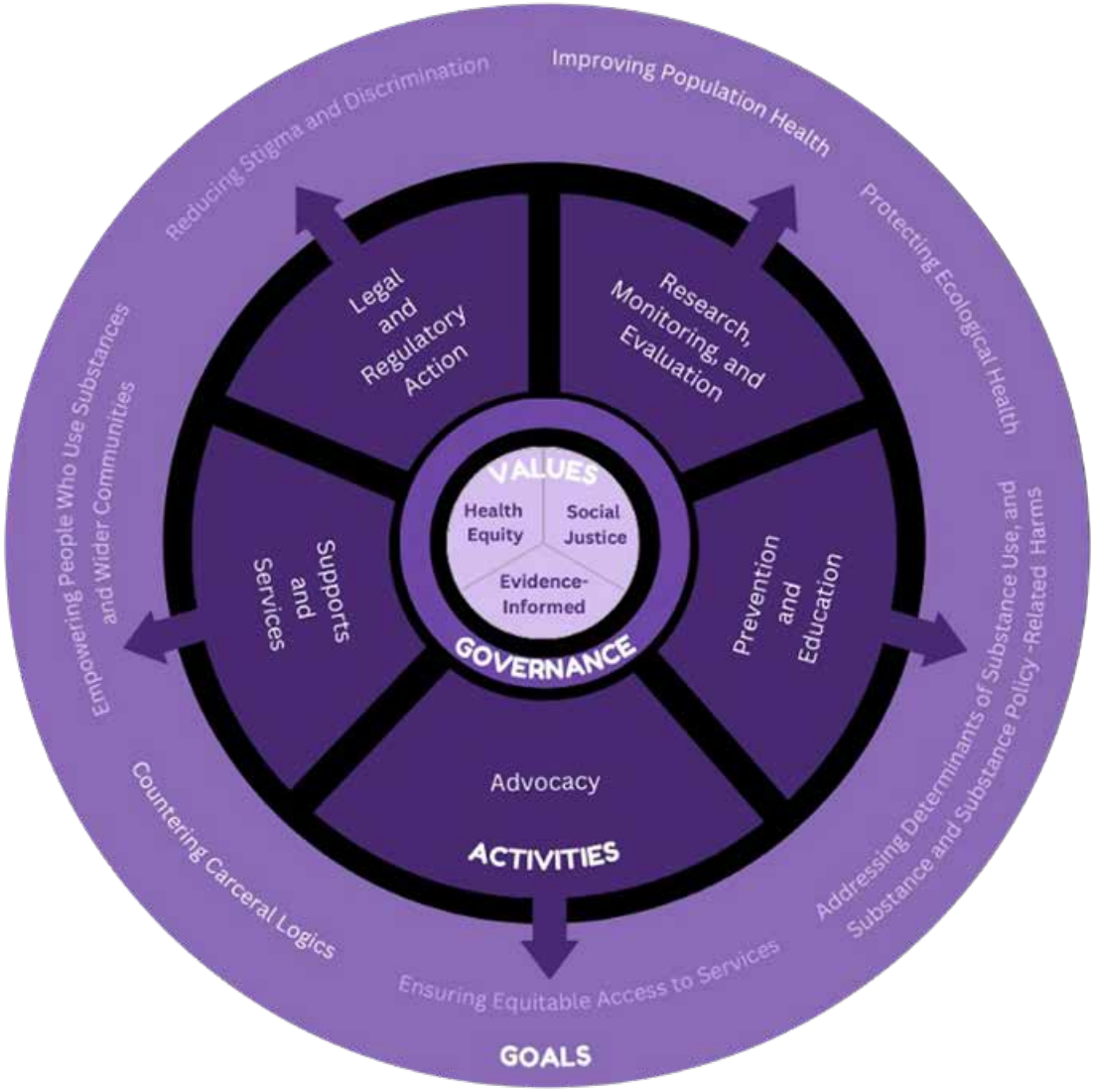

Figure 3 - Conceptual framework for a public health approach to substances (from Mathias et al., 2025).

Drug harm in Aotearoa New Zealand is diverse with inequities in people's experience and outcomes

The section below brings together three stories from people with lived experience of drug use and harm, and from academic literature as context for data presented. The aim is to integrate different types of AOD harm and how they might be experienced, with data and known contributors to harm from Aotearoa New Zealand. These are not intended to represent all types of harm but are rather intended to illustrate different types of harm, inequities in harm, and sources of harm.

All people in the stories are fictional.

Note: the stories used in this section are not intended to stereotype individuals or demographic groups, or to imply that the demographics described are the only groups at risk of drug harm. They aim to demonstrate the complexity of drug use, how harms can arise from societal context and structural determinants, and the influence of intersectionality. The concepts could be applied to different populations – for example the central nervous system (CNS) depressant example could be considered for isolated rural communities or for people recently released from prison.

Story 1: Central Nervous System Depressant overdose

L (they/them) grew up with parents who weren't really approachable. They went to a good school and were expected to get high grades and perform well in sports. They broke their leg when they were 17 during a rugby game; it was a bad break, requiring surgery. They were prescribed opioids for pain relief post-surgery and really liked the way it made them feel.

After school they enrolled at University, but found the pressure was intense, increasing their anxiety and disturbing their sleep. They went to their GP repeatedly and were eventually prescribed a short course of benzodiazepines, which helped a lot. But when they went back to their GP and asked for a repeat, the GP was reluctant and would not agree to a new script. However, they did prescribe pregabalin for ongoing pain issues following the leg injury, and this helped L a bit and incidentally also helped them sleep if they took it at night.

Many months down the track, L was really struggling. Anxiety, chronic pain, and insomnia were starting to impact their grades. They knew they needed help, but didn't want to appear weak in front of their parents and didn't want to go back to their GP because they'd already asked for a prescription and been told no.

They eventually found someone through friends of their flatmate who could get benzodiazepines, and their flatmate also gave them some leftover tramadol that they had not thrown out from years ago. L was a little worried about the benzodiazepines because they never actually saw the box, and did consider going to a drug checking service. But the nearest service that offered it was several hours drive away and they figured that because it was in a tablet form and was a pharmaceutical drug it would be ok.

One Friday night, L was drinking at home and started to feel really low and depressed. They told their flatmate that they had had enough and were going to bed. L tried to sleep but was feeling awful, so even though they had already taken their prescribed pregabalin that day, they took another one. 30 mins later they were still awake, with their leg hurting. They were desperate for sleep and for the pain to stop, so they took some of the benzodiazepine and tramadol tablets too.

Their flatmate looked into the room after they'd walked past L's door and heard them snoring loudly. They saw L in their bed on their back, snoring and occasionally making a gurgling noise. They were a bit worried and contemplated trying to wake L up, but then they saw the packet of tramadol they'd given L on the bedside table. They tiptoed in, took back the pack of tramadol and flushed the rest down the toilet. They didn't look too closely at L, but figured that they were probably just a bit drunk and would sleep it off, so closed the door again and hoped for the best.

Key facts for Aotearoa New Zealand:

The drug overdose reports produced by the NZ Drug Foundation[17] state the following:

In 2024:

148 people

died of an unintentional drug overdose.

The **three most common drugs** detected in unintentional overdose deaths between 2016 and 2024 were;

opioids, alcohol, and benzodiazepines.

The risk of overdose increases when multiple depressant drugs are taken at once, and

93% of deaths

involving opioids also included at least **one other depressant drug**.

Key contributors to harm in this example:

- Unmet healthcare needs, including pain and sleep issues.
- Co-occurring mental health issues.
- Medical stigma and concern about help-seeking.
- Unavailability of drug-checking.
- Misconceptions about safety of pharmaceutical drugs.
- Unregulated supply of drugs leads to unknown strength and purity.
- Lack of knowledge regarding effects of multiple depressant drugs.
- Lack of bystander knowledge on signs of an overdose and recognition when it has occurred.
- Lack of legal protections, creating a barrier to seeking medical help for potential drug-related harm.[i]

[i] Noting that this is a rapidly evolving situation, with legislation passing its first reading in the NZ parliament on 29 April 2026.

Story 2: Methamphetamine harm

M (she/they) grew up with parents who fought often, frequently neglecting M's nutrition and school attendance. M was eventually uplifted into state care. Changing homes several times was stressful, particularly as none of them supported M's identification as a queer person. They struggled daily; with their identity, difficulty making friendships, mental focus and chronic exhaustion throughout schooling, and were often excluded from class. They decided to move out of care just before they were due to 'age out' anyway, and found they were more readily accepted by street communities.

They were first offered a puff of methamphetamine by an acquaintance, who said it helped to stay vigilant and in better spirits. They found that the euphoria provided relief from regular overwhelming feelings of shame and suicidality. They didn't like the idea of injecting, but transitioned when their local dairy selling 'flower stem' (a.k.a. 'oil burner') pipes was shut down.

Injecting didn't cause the frequent burns, cuts or awful cough they used to get from smoking, but could produce fevers, abscesses, visible bruising and scars on their arms, hands and feet. They could never anticipate how strong '*a dose*' was until it took effect, often ending up taking too much, or getting no high at all. People they know were falling unconscious after some doses, and nobody could tell them why or how to avoid it.

M has no stable housing, but guys on dating apps eagerly offer them a place to stay and show up at M's usual spots offering drugs if they'll get in a vehicle. Sometimes they're offered the drug repeatedly if they'll stay longer than a night. They know it's best not to use methamphetamine several days in a row, but when they're too tired to find a new place, it helps – especially to not think so much about the things strangers make them do in exchange. Sometimes they go 3 or 4 days without eating much or sleeping at all, which causes them worsened feelings of depression on the comedown, hallucinations that make it difficult to see or tell what's real, and horrific voices that encourage physical self-harm.

Even when they try their best (and manage) to only use once in a few days, they've been taken to ED for "dirty hits"[ii] wound care, and bouts of psychosis more times than they can count. They recently learned about hepatitis and got tested, but the hospital staff never found a way to get back in touch and haven't brought it up again. M has heard of human immunodeficiency virus (HIV) but never realised they're at-risk. They peeked at their hospital chart once; the first page just said "IV drug user" with no other notes. Every healthcare worker treats them with suspicion, even though they've never asked for drugs.

The only time M has seen more than a few hundred dollars at once is when a dealer fronts them (provides in advance, expecting repayment for) a larger quantity of methamphetamine, on the promise they'll on-sell the extra to clear their debt. At first, this seemed better than other forms of payment but the threats and violence they experienced turned out even worse, and lots of their friends have been arrested for dealing lately. They don't know of any way to change their life.

[ii] Bacteraemia; germs getting into their bloodstream.

Key facts for Aotearoa New Zealand:

An estimated

56,000 people

aged 15+ (1.3%) reported past-year amphetamine-type stimulant use in 2023/24;

29% of past-six-month methamphetamine users reported daily or near-daily use (up from 19% in 2022/23),[18] with social harm conservatively estimated at ~$1.5B in 2024.[19]

More than

90% of people

surveyed who inject drugs in New Zealand have experienced **injecting-related injuries or diseases** (40% reporting >10);

63% have never sought medical attention for these, including 32% of those experiencing severe injuries.[20]

Methamphetamine was ranked the second most harmful drug in New Zealand (after alcohol) in a 2023 multi-criteria decision analysis,[21] with harm over-represented in areas of socio-economic deprivation and among Māori.[22]

Key contributors to harm in this example:

- Childhood adversity and state care: family disruption, state care, and other adverse childhood experiences predict alcohol and other drug harm.[23,24]
- Disproportionate violence toward takatāpui whānau: Gender-diverse people in Aotearoa New Zealand more often report psychological distress and greater odds of substance use compared with cisgender peers.[25]
- Gender: international evidence links methamphetamine to gendered risks when obtaining drugs and intimate-partner violence.[26]
- Unaccommodated neurodiversity: Autism spectrum and Attention Deficit Hyperactivity Disorders are strongly linked both to drug-taking as self-medication, and in the form of substance use disorders.[27]
- Stigma across healthcare, policing, housing and employment: Most New Zealand people who inject drugs (PWID) do not seek medical attention for injecting-related injuries; anticipating stigma and mistreatment, often leading to delayed care.[28] People who use drugs (PWUD) leaving prison face stigma and significant financial and social barriers to employment[29] and housing – as few as half of people leaving prison in Aotearoa New Zealand settle into long-term accommodation.[30] Māori are disproportionately charged for drug offences in Aotearoa New Zealand.[31]

- Follow-up for unhoused PWUD: Contact between PWUD and health services is often fragmented, and routine follow-up (e.g. bloodborne virus testing) commonly fails.[32] Chronic poverty, deprivation, crimes committed to obtain money: methamphetamine use is concentrated in Aotearoa New Zealand's most-deprived neighbourhoods; women living in the most-deprived areas are >10-times as likely to report past-year amphetamine use than those in the least-deprived.[33]
- The 'user-supplier' spectrum: Supplying substances to others – whether 'socially' or more 'professionally', can blur the distinction between 'user' and 'dealer'. In particular, debt-bondage and coerced on-selling contribute to increased risks of violence, interactions with law enforcement, and coercive/forced punishments.[34,35]
- Chronic use: Weekly methamphetamine use increases likelihood of involvement in violence (as victim or perpetrator).[36] Sleep deprivation across multi-day binges is also a key driver of methamphetamine-induced psychosis.
- 'Smoking' risks – especially from makeshift pipes: Cuts, burns, coughing up blood, blood borne viruses from sharing. 82% of the UK Safe Inhalation Pipe Provision (SIPP) cohort reported symptoms attributable to crack cocaine[iii] use, with rates of each harm disproportionately affecting women.[37]
- Injecting risks: More than 90% of people surveyed who inject drugs experience injecting-related injuries or diseases; 40% had experienced more than 10 of these, and 63% had never sought medical attention – including 32% who had experienced a severe injecting related harm.[38]
- Unregulated drug supply: Real and perceived[iv] experiences of inconsistency (potency) and adulteration (e.g. corrosive chemical) lead to injury, and normalisation of expectations of harm taking drugs – much of which could be mitigated by safer information and services.

Additional populations – there are intersecting harms between drug use and those already experiencing inequitable health outcomes, which magnify risks and negative impacts. For example:

- Māori and Pasifika: Tāne and wāhine Māori are 2.16-times and 2.86-times (respectively) more likely to report past-year amphetamine use than non-Māori men and women.[39] Māori bear disproportionate methamphetamine-related harm including premature death, criminal-justice penalties and intergenerational/whānau harm – disparities that are strongly influenced and perpetuated by systematic deprivation and structural racism.[40] Pasifika peoples also experience higher unmet treatment need and substance-related harm.[41]
- Prisoners: People who have been incarcerated have some of the highest reported lifetime methamphetamine use (56%),[42] substance use disorder or drug dependence (91%, up to 87-times the rate of the general population).[43] Ex-prisoners in Aotearoa New Zealand are particularly vulnerable to death (by suicide) following release.[44]

[iii] Noting that crack cocaine is often inhaled, similar to methamphetamine, so the harms associated with this route of administration are comparable between the two drugs.

[iv] Perceptions include community beliefs around 'sleepy meth' (where people taking methamphetamine feel very tired and lethargic), and this is particularly speculative around whether this is caused by adulteration of methamphetamine. NZ drug checking data have not yet corroborated e.g. fentanyl in methamphetamine, and stimulant adulteration with depressants remains generally isolated and speculative – described in a 2023 article by Aotearoa drug checking providers KnowYourStuffNZ, and New Zealand Needle Exchange Programme. 2023. **What's going on with our methamphetamine?** **knowyourstuff.nz/whats-going-on-with-our-methamphetamine**.

Story 3: Alcohol harm

N (she/her) lives in a rural region where vineyards and wine making are key attractions. N didn't consider herself a big drinker, in her younger years she would mostly drink socially with friends and there was the odd occasion where she would drink to the point of blacking out, although this was rare.

After having children, N's opportunities for social drinking decreased. She found she had less spare time for herself, and having a few glasses of wine in the evening felt like the only way to carve out some 'me time' while also carrying out the bulk of the care for her family. N has been drinking this way for 10+ years and often finds herself thinking about a wine after work.

Two years ago, N had a breast cancer scare. Thankfully, scans and further testing have shown she does not have breast cancer, but the experience prompted N to consider reducing her alcohol consumption. N struggles with feeling that alcohol consumption is her personal responsibility, while also noticing that alcohol is everywhere in her community. Being surrounded by vineyards means that alcohol is a common gift, it is always a prize in the school raffle or fundraisers, and social engagements seem to always involve drinking.

While some of N's friends have been supportive of her reducing drinking, others question why N is worried, given the negative result of her tests. As a result, N sometimes feels uncomfortable at social events where her friends are drinking, as she worries about drinking to fit in with her peers. N hasn't found a solution to the centrality of alcohol in her social life, missing social events to avoid pressure to drink is socially isolating and negatively impacts her mental health, but so too does attending social events and fending off questions or expectations about her drinking.

N thought she would feel more control over drinking in her private home life and decided to try not having alcohol in her home to curb the routine of an evening glass or two of wine. She has since realised just how easy it is for her to access alcohol. She often stops by the supermarket on her way home from work to pick up something for dinner, and walking past the illuminated alcohol aisle at the front of the store makes it easy to say "oh I'll just grab a bottle while I'm here, or while my favourite brand is on sale". As well as the supermarket selling alcohol, there are three liquor stores within a 10-minute drive of N's home. N also knows that food delivery apps recently started delivering alcohol, so she doesn't even need to leave the house to get it.

N also worries about her son's access to alcohol, having recently turned 18. He used to drink underage occasionally with friends, whose older siblings supplied them with alcohol. Now, he can drink in the local pubs which are often open late and have deals on shots. He sometimes tells N about himself or friends injuring themselves after leaving the pub intoxicated. She worries that he might be engaging in other antisocial behaviour he doesn't want to tell her about.

Key facts for Aotearoa New Zealand:

74.9% people

aged 15+ in New Zealand had an alcohol drink in the past 12 months. As defined by an AUDIT score of 8 or higher;

22.2% of these people had a hazardous drinking pattern; and

23.5% drink 6 or more alcoholic drinks on one occasion at least monthly.[45]

Taking into account physical, psychological, social, and economic harms,

alcohol is New Zealand's most harmful drug[46]

Alcohol harms are disproportionately experienced;

Māori are twice as likely to die from an alcohol related cause as non-Māori[47]

2018 data identify alcohol as a cause in over:

900 deaths

1,250 cancers

29,282 hospitalisations[46]

(NB. even though data from 2018, likely to still be relevant)

Key contributors to harm in this example:

- Easy access to alcohol (retail outlets, trading hours, cost, food delivery apps).
- Increased outlet density in lower socioeconomic status (SES) areas.
- Focus on personal responsibility for drinking when we live in alcohol saturated environments.
- Power of the alcohol industry in influencing policy outcomes, relatively low power of communities in comparison.
- Push back against local alcohol policies (LAPs).
- Alcohol marketing and promotion.
- Social narratives of 'mummy's little helper' / normalising alcohol to deal with motherhood.

Takeaway messages – drug harm

- Drug use is relatively common in Aotearoa New Zealand.
- Types of drug harm are diverse and can impact a person who uses drugs as well as others.
- Drug policy can be a source of drug harm and/or worsen drug harm.
- Harm is not experienced by all people equally, and intersectionality can lead to inequities in harm.
- A public health approach to drugs incorporates treatment, harm reduction and drug policy.

Harm reduction is an effective, lived experience centred to minimising harm from drug use

Harm reduction is a practical approach that focuses on making risky but ongoing activities safer—similar to using seatbelts, sunscreen, or condoms. Applied to drugs, it involves approaches, policies and services that reduce health, social, and legal harms without requiring people to stop using substances.

As an approach to drugs, contemporary harm reduction emerged from lived experience and evolved as a community-led, pragmatic response to drug harms arising within the framework of prohibition. Harm reduction often took place in contrast to dominant punitive approaches and developed within the communities bearing the brunt of the harms with little or no government support.[48]

Traditional approaches to drug harm and treatment have often operated within hierarchical, paternalistic structures that reinforce stigma and limit autonomy[49,50] while prohibition-influenced settings frame help-seeking as shameful or punitive and define success narrowly as sustained abstinence.

In contrast, harm reduction approaches arose out of lived experience which centres people's lived realities and supports safer choices without judgment, often making it more acceptable to people who use drugs. While there is no definitive list of harm reduction principles, harm reduction approaches tend to have these things in common:[51]

- Pragmatic, person-centred care: Accepts that drug use may continue, focuses on reducing harm without requiring abstinence, and values incremental change ("any positive change").
- Autonomy, empathy, and destigmatisation: Prioritises dignity, respect, non-judgement, and shifts control toward people who use drugs through safe, supportive engagement.
- Community leadership and lived experience: Centres peer involvement, mutual aid, and culturally safe, relationship-based approaches grounded in lived expertise.
- Equity and social justice: Addresses structural discrimination, supports self-determination, and promotes culturally appropriate care for marginalised, Indigenous, and neurodivergent populations.

Note: Harm reduction principles and AOD treatment do not sit in opposition to each other. Abstinence can be a goal of treatment while integrating harm reduction principles – as long as the person being treated has real agency in the choice of goals and the journey towards them.

Indigenous harm reduction approaches that work are underpinned by connections to culture, history and land

While harm reduction has achieved important successes, it is often criticised for failing to meet the needs of indigenous people. Mainstream approaches can lack cultural safety and be shaped by systemic racism, limiting access, trust, and quality of care for Indigenous peoples.[52,53,54] They also tend to focus on individual behaviour change and "value-neutral" practices, overlooking the broader social, historical, and political factors affecting Indigenous wellbeing.[55]

Indigenous perspectives emphasise that harm must be understood holistically, including connections to land, culture, spirituality, history, and community.[56]

Notably, colonisation is identified as a key driver of inequities, including trauma, poverty, incarceration, and drug-related harm.[57] Prohibition-based drug policies are seen by some scholars as an extension of colonial control that disproportionately harms Indigenous communities.

Ultimately, achieving equitable outcomes requires transforming legal, health, and social systems, and upholding Indigenous rights, sovereignty, and justice frameworks (including Te Tiriti o Waitangi in Aotearoa New Zealand).

Indigenous harm reduction

- Grounded in Indigenous worldviews and knowledge.
- Community-led and relational.
- Supported by strong Indigenous leadership in services.
- Prioritises decolonisation of drug policy and services.
- Addresses structural inequities and systemic racism.
- Moves beyond narrow, individual-focused interventions to broader social change.

Decolonisation in harm reduction means ensuring indigenous voices, knowledge systems, and community priorities shape programme design and delivery. This includes expanding support beyond clinical therapy, embedding indigenous perspectives, and co-designing services with indigenous people who use drugs. More broadly, it involves strengthening community and iwi leadership, supporting the continued growth of Māori harm reduction practitioners, and further developing kaupapa Māori evaluation tools, reflecting a shift from externally imposed models towards indigenous definitions of wellbeing and hauora.

Types of harm reduction approaches

As the landscapes of risk and harm from alcohol and other drugs have evolved, various types of harm reduction services have been developed to meet new challenges. Frequently beginning as unauthorised community activities, many have grown to receive formal acceptance and funding by governments, particularly where programmes have become supported by medicalisation and the involvement of clinicians.[58] In this review, harm reduction activities are broadly categorised into the following six branches, each examined in detail in the associated Literature Review.[59]

Examples of harm reduction approaches

1. **Safer supply:** Agonist therapies (e.g. methadone) and safe(r) supply. By providing pharmaceutical or quality-assured alternatives to illicit substances, these interventions reduce exposure to a contaminated or unpredictable supply for people who are dependent or at high-risk.
2. **Prevent infection and injury:** Sterile needle and syringe provision (NSP) and safer smoking kit provision. These programmes aim to reduce blood-borne virus (BBV) transmission, injection site injuries and infections associated with shared or re-used equipment, while also increasing contact with community and referral to support services.
3. **Reverse overdose:** Naloxone (and similar reversal agents). Community and clinical distribution of opioid antagonists enables first-responder and bystander-led reversal of overdose, restoring breathing long enough for further care.
4. **Know what you're taking:** Drug checking services and early warning systems. Chemical analysis of obtained substances informs decision-making by the person using them and can support timely public alerts about unexpectedly harmful substances in circulation.
5. **Don't use alone:** Supervised consumption and overdose prevention sites. Witnessed consumption – whether at a dedicated site or via phone-based services – ensures that a trained responder is present or available to respond in the event of overdose.
6. **Provide amnesty or remove criminal penalties:** Good Samaritan laws and supportive housing that does not require abstinence. These legal and structural protections reduce the fear of prosecution (for bystanders) or of eviction (for tenants) that can otherwise deter people from seeking help or stable accommodation. Decriminalisation removes criminal penalties for personal possession or use.

Challenges to harm reduction approaches remain despite evidence of effectiveness

- Conceptual critiques such as "encouraging drug use" or "delaying recovery" – not supported by evidence but still carry political and moral weight.[60]
- Tension between traditional clinical approaches/ cultural values around abstinence, and the centring of lived/living experience within harm reduction.[61]
- When community-driven approaches become accepted, they can be sanitised in favour of risk management or institutional priorities, and lose what made them effective.[62]
- Peer-led services can be complex, as workers often draw on lived experiences of trauma, grief, and systemic harm. Adequate training, supervision, fair pay, and clinical support are essential but frequently underfunded, creating challenges in valuing and sustaining the peer workforce.[63]
- Difficult to evaluate – accepted gold standards for evidence can be impossible to meet even where benefits are obvious (e.g. supervised consumption sites).[64]
- Constrained by prohibition framework, or conversely by (with alcohol) a for-profit model.

Takeaway messages: harm reduction

- Harm reduction principles and programmes are intended to reduce the potential harms of drug use, without requiring abstinence.
- Harm reduction has primarily arisen as a response to drug prohibition, and is led from the affected community.
- Harm reduction emphasises the value of lived experience and upholds respect and care for people who use drugs.
- Indigenous harm reduction recognises that colonisation and racism are drivers of drug harm, and creates a focus on community-led solutions.

Part 2: There are clear evidence based solutions to reducing harm from drugs

This section summarises the results of the review of evidence. The results of the literature review are consistent with a public health approach to drugs, which includes regulation and treatment, as well as harm reduction. Of the drugs within scope only alcohol is currently legally regulated in a for-profit model in Aotearoa New Zealand, therefore this is the only drug discussed in that section. As harm reduction approaches can be standalone or incorporated into treatment, both contexts were examined. The sections are:

- Regulating alcohol supply.
- Harm reduction:
  - As integrated into treatment.
  - Different types of intervention.
  - Legal models to support harm reduction.
  - Indigenous harm reduction.

Results are presented in tables with one table for each section. In this summary, the GRADE score and narrative assessment have been analysed in combination to provide an overall rating for strength of evidence of high, moderate, or low. For further details of evidence strength, see Appendix A. It is recommended that these tables be viewed alongside the full report for comprehensive discussion of the evidence for each approach. Below each table is a summary of key takeaways for each approach from the narrative section of the review.

Evidence – regulating the supply of alcohol[v]

Approach	Impact	Evidence strength
Minimum unit pricing based on standard drink	Reductions in consumption, violence in night-time precincts, alcohol related morbidity/mortality, alcohol related hospitalisations Consumption among those who buy cheap alcohol	Moderate to high
Minimum purchasing age	Reductions in consumption, frequency of drinking among young people, weekend assaults resulting in hospitalisation	Moderate
Reduction of trading hours	Direct effect on prevention of injuries, alcohol related hospitalisations, homicides and crime Reduced prevalence of assault and vehicle mortality Slight reduction in availability of alcohol in city centres	Moderate
Reduced outlet density	Reduced crime and violence, police-attended events, child and adolescent harms	Moderate to high

Takeaway messages from the narrative review: alcohol regulation

- The alcohol environment strongly shapes consumption and harm across the population.
- WHO recommends reducing availability, increasing price, and restricting marketing.
- Effective, evidence-based measures exist for Aotearoa New Zealand but remain largely unimplemented.

[v] Alcohol regulation approaches were not assessed for cost effectiveness, however the approaches above are drawn from WHO's five most cost-effective interventions to reduce alcohol harm: **www.who.int/initiatives/SAFER/alcohol-availability**

Evidence – Drug treatment approaches

Approach	Impact	Cost effectiveness	Evidence strength
Treatment – psychosocial or pharmacological approaches	**Psychosocial:** improving engagement and mental health outcomes, variable across substances **Pharmacological:** effective for reducing relapse, improving retention, and reducing illicit use (opioids and cannabis), weak impact for other drugs **Combined:** Best evidence for efficacy, improved treatment completion, reduction in substance use, abstinence at follow-up. Especially for alcohol and opioids	Mixed and uncertain due to inconsistent efficacy and limited long-term evidence	Moderate
Integrating harm reduction within healthcare settings including treatment	Improved access and engagement, greater retention in treatment, more equitable care and improved trust, reduced stigma, safer service environments, broader and more meaningful outcomes	Promising but not well quantified	Conceptually high, empirically low
Supporting recovery capital (factors which help a person in their recovery e.g. housing, social networks)	When barriers are addressed early: Better engagement, more sustainable recovery, improved wellbeing outcomes	Plausibly strong but not well measured	Low to moderate

Takeaway messages from the narrative review: drug treatment approaches

- Treatment must be adapted to the Aotearoa New Zealand context and be accessible and acceptable.
- Harm reduction can be integrated when outcomes are collaboratively defined.
- Well-integrated services increase access to both treatment and harm reduction.
- Peer support helps build recovery capital.
- Key knowledge gaps remain on best-practice integration in Aotearoa New Zealand.

Evidence – Harm reduction approaches

Approach	Impact	Cost effectiveness	Evidence strength
Sterile needle and syringe provision for people who inject drugs	Reduced transmission of blood-borne viruses, especially HIV and hepatitis B/C Most effective when coverage is high, access is widespread, and combined with opioid substitution treatment and broader harm reduction programmes	$6.79 for every $1 invested	High
Naloxone (opioid overdose reversal medication) provision	Effective overdose reversal, reduced overdose mortality, increased community response capacity, no evidence of increased risky drug use	Up to $3219 per $1 spent, cost per quality-adjusted life year represents value for money	Moderate
Provision of non-injecting drug use equipment (smoking, snorting, measuring) to support less harmful routes of administration	Reduced injecting behaviour, reduced equipment sharing, reduced physical injury and respiratory harm, lower overdose risk (indirectly), increased engagement with services, high acceptability	Indirect efficiency benefits suggest potential value but no formal evaluations done	Consistent positive findings but empirically low
Drug checking to provide information about content and purity of substances	Behaviour changes, safer consumption decisions, improved risk management, increased service engagement and trust, potential upstream market impacts, population-level risk monitoring	Not consistently cost-effective in low-risk settings, however likely benefit-cost ratio of 14:1 in high-risk drug markets	Moderate
Safer supply – safe provision of substances of known content and potency	Retention in care, reduced illicit use, reduced overdose risk, reduced healthcare burden. Improved social and wellbeing benefits (e.g. housing, social connection)	Moderate value for money (1:1.5 through modelling). High upfront costs, downstream savings	Moderate but highly variable by intervention type

Approach	Impact	Cost effectiveness	Evidence strength
Don't use alone – overdose prevention by witnessed consumption either physical or virtual	Preventing overdose deaths, safer use behaviours, service engagement, community safety	$1.90-$2.70 per $1 invested. Also prevention of high-cost events. Greater value in high risk environments	Moderate
Managed alcohol programmes – providing set amounts of alcohol in a controlled environment e.g. a "wet house"	Stabilised alcohol use, reduced acute health and social harms such as injury and intoxication in unsafe settings, improved service engagement, improved social stability – particularly for highly vulnerable populations	$1.09-$1.21 per $1 invested, plus reliably consistent reductions in service use costs (healthcare, social services, justice system)	Moderate confidence in benefit, low certainty of effects

Takeaway messages from the narrative review: harm reduction approaches

- Evidence generally shows harm reduction is effective and cost-effective, though its strength varies.
- The evidence base is complex and diverse and uses varied outcome measures, making interpretation difficult.
- Interventions need to be locally adapted and community-led, not directly transferred from overseas.
- Legal barriers can limit implementation despite good evidence.
- There is a significant gap in Māori-focused evidence and evaluation.

Evidence – Legal models to support harm reduction

Approach	Impact	Cost effectiveness	Evidence strength
Alternatives to justice/criminal responses. Includes decriminalisation, police discretion, health-based responses	Reduced convictions and reoffending Lower burden on justice system, improved wellbeing, increasing service engagement. Inequities and implementation challenges	Potential cost savings and system efficiencies, limited formal economic evaluation	Low to moderate

Takeaway messages from the narrative review: legal models to support harm reduction

- Drug law and how the law is enforced can be a source of drug harm and exacerbate harm or perpetuate inequities.
- While there have been some efforts made in Aotearoa New Zealand to enable a health-based approach to drugs, these are either not widely available, or rely on 'discretion' that may be inequitably applied.
- There are opportunities for Aotearoa New Zealand to reform its laws to enact a health-based approach to drugs, which would strengthen harm reduction.

Evidence – Indigenous approaches to harm reduction

Global Indigenous approaches are characterised by – Indigenous-led and community-controlled delivery, "culture as care", holistic, blended Indigenous/western models, relational approaches, decolonisation, context-specific, flexible delivery.

Māori approaches are characterised by – emphasising whānau-centred, culturally grounded, and decolonising practices, combining Māori knowledge systems with adapted clinical tools to support holistic wellbeing and self-determined pathways.

> *"There is an underlying tension between Indigenous and Western evidence. While Indigenous harm reduction principles or values often mention evidence-based practice, they also discuss decolonisation, which could include change to the evidence-based practice system itself."*

Approach	Impact	Cost effectiveness	Evidence strength
Global Indigenous approaches (international literature)	Improved holistic wellbeing, cultural connection, service engagement, reduced substance use and related harms, empowerment and self-determination	Likely cost effective at a system level, reduced cost of harms, broader social/equity impacts. Largely absent of formal economic evaluation	Moderate-high conceptually, low in empirical evidence
Kaupapa Māori approaches	Improved holistic and whānau wellbeing, cultural connection, self-determination, reduced substance-related harm, improved engagement with services, increased mana/reduced stigma	Likely high value and cost effective at a system level, reducing high-cost harms and improving wellbeing. Formal economic evidence is limited	High conceptually, low in empirical evidence

Takeaway messages from the narrative review: Indigenous approaches to harm reduction

- Indigenous harm reduction incorporates principles of decolonisation, indigenisation, holistic wellbeing, inclusivity, and innovation.
- To address persistent inequities in wellbeing for Māori, harm reduction strategies cannot sit as 'one-size-fit-all' models.
- Many successful Indigenous initiatives are likely not documented formally due to resource constraints and the true scale of Indigenous-led approaches and their success is likely underappreciated.
- Evidence suggests that the most promising pathways toward health equity lie in shifting power and resources away from punitive individual and state-based systems alone, towards Indigenous-led, holistic, relational and decolonial frameworks and practices.

Key messages for Aotearoa New Zealand

A public health approach to reducing drug harm is essential

The review supports shifting NZ drug policy toward a public health approach, where drug harm is treated as a health and social issue rather than a criminal one. This involves coordinated use of treatment, regulation, and harm reduction. Moving away from a criminal justice focus is seen as essential to reducing harm and improving wellbeing outcomes in Aotearoa.

Harm reduction is effective, evidence based and underutilised

Evidence shows harm reduction is effective and cost-effective for reducing AOD harm. In Aotearoa New Zealand, existing services such as needle and syringe programmes, opioid substitution treatment, and drug checking are effective and aligned with international evidence. However, coverage remains limited, and additional evidence-based interventions (e.g. supervised consumption services) are not yet implemented.

Potential additional harm reduction approaches for Aotearoa New Zealand

Stronger regulation of alcohol – international evidence for reduced hours, minimum unit pricing, higher drinking age, and lower outlet density is strong but Aotearoa New Zealand has not implemented these.

Regulated safer supply (outside of methadone and buprenorphine maintenance). Aotearoa New Zealand has neither implemented the regulated-supply interventions for which the evidence is strongest, nor invested in performing the harm-reduction-aligned trials that the amphetamine type stimulant evidence-base most needs.

Non-injecting equipment provision – Existing Aotearoa New Zealand infrastructure provides a plausible delivery vehicle for this approach. However, most utensils distributed with knowledge or intent to consume a (non-alcoholic) substance qualify as paraphernalia and are unlawful to supply.

Supervised consumption sites (SCS) – None exist here despite the evidence for their efficacy. This is partly due to the dominance of opioids in the evidence for SCS, however there is evidence to support uptake of SCS for injecting stimulants, and Aotearoa New Zealand lends itself well geographically to virtual overdose monitoring.

More widely available needle and syringe programmes (NSPs) – NSPs are not currently available in prisons, despite high rates of substance use disorders among incarcerated people.

Naloxone nasal spray is currently unavailable in Aotearoa New Zealand due to lack of funding. Injectable naloxone is available through NSPs.

Integration of harm reduction in treatment – this happens to varying degrees already but principles for integrated approaches were developed in the US and would benefit from NZ-specific guidelines co-designed with Māori and lived experience communities.

Managed alcohol programmes (MAPS) – there is a programme in Wellington (Te Pā Maru) but it is only available for men, despite evidence showing women with Alcohol Use Disorders are particularly benefited by MAPS.

Legal models – While there have been some efforts made in Aotearoa New Zealand to enable a health-based approach to drugs, these are either not widely available, or rely on 'discretion' that may be inequitably applied. The Overdose Assistance Bill currently before the Select Committee is an example of a legal model that removes discretion and enables a health-based approach. For some harm reduction programmes, law change is required to facilitate implementation.

Embedding te ao Māori is critical for equitable outcomes

Effective responses in Aotearoa must centre te ao Māori perspectives. Indigenous harm reduction recognises the impacts of colonisation and emphasises holistic wellbeing, including cultural, spiritual, and community dimensions. Māori leadership and culturally grounded approaches are critical for building trust and achieving equitable health outcomes.

Treatment is most effective when accessible, flexible, and person-centred

Barriers to harm reduction and treatment remain for many populations, including Māori, young people, and notably prisoners – who are excluded from key harm reduction services despite high levels of need. Programmes show better outcomes when they are culturally appropriate, integrated with harm reduction approaches, grounded in lived experience, and allow for multiple definitions of success (not just abstinence).

Policy and funding are misaligned with evidence

Despite strong evidence and public support, harm reduction receives less than 2% of drug policy funding in Aotearoa New Zealand. Legislative barriers also limit the ability to implement effective interventions. This gap between evidence and policy highlights an opportunity for reform to better support public health outcomes.

Community and Māori knowledge must be better recognised

Māori and community-led initiatives are often underrepresented in formal research due to structural inequities and funding constraints. This means effective local approaches may be overlooked in policy decisions. Greater recognition of practice-based evidence and culturally appropriate evaluation methods is needed in Aotearoa New Zealand, as well as engaging directly with communities to identify "what works" from their perspective.

Appendix A – Evidence strength

This section provides more detail about the strength of evidence ratings for each harm reduction approach that was assessed.

1. **Regulating the supply of alcohol**

   Min unit pricing – moderate to high: multiple systematic reviews and real-world evaluations demonstrating consistent reductions in alcohol consumption and related harms, with relatively few methodological limitations compared to other population-level interventions.

   Min purchasing age – moderate: natural experiment studies showing consistent increases in alcohol consumption and harm following the lowering of the minimum purchase age, but limited by observational design, subgroup uncertainty, and context specificity.

   Trading hours – moderate: consistent international findings showing reductions in alcohol-related harms, but limited by observational study designs, variability in implementation, and weaker, less conclusive evidence in the Aotearoa New Zealand context.

   Outlet density – moderate to high: consistent international and Aotearoa New Zealand findings linking higher density to increased crime and violence, though limited by observational designs and weaker evidence for some outcomes such as impacts on children and adolescents.

2. **Drug treatment approaches**

   Treatment – moderate: high-quality Cochrane reviews of RCTs but substantial variability and mixed findings, with strong and consistent evidence for some treatments (notably opioid substitution therapy and combined approaches) and weak or inconclusive evidence for others, limiting confidence in broad conclusions about treatment efficacy across all substances.

   Integrated care – conceptually high but empirically low: Strong conceptual frameworks and consistent case-study findings, but limited by a lack of rigorous quantitative evaluation, standardised outcome measures, and controlled studies—resulting in low certainty regarding effectiveness despite high plausibility and acceptability.

   Recovery capital – low to moderate: strong conceptual support and consistent qualitative findings on the importance of social and structural factors in recovery, but limited by a lack of robust quantitative studies and direct outcome measurement, resulting in moderate confidence in its relevance but low certainty in its measurable impact.

3. **Harm reduction approaches**

   Needle and syringe programmes – high: extensive and consistent findings across multiple systematic reviews demonstrating clear effectiveness in reducing HIV and hepatitis transmission and strong cost-effectiveness, despite methodological limitations inherent to observational study designs.

   Naloxone – moderate: very strong and consistent evidence of effectiveness and cost-effectiveness, but limited by observational study designs and ethical constraints on experimental research-resulting in high confidence in benefit, but moderate certainty in precise effect size. Evidence is stronger for intranasal and take-home naloxone programmes.

   Non-injecting equipment provision – consistent positive findings but empirically low: consistent positive findings and strong theoretical plausibility, but limited by observational study designs, indirectness to key settings, and major gaps in health, economic, and population-specific evidence-resulting in low certainty despite encouraging signals of effectiveness. Evidence development hindered by the legal framework.

Drug checking – moderate: strong and consistent findings that it influences behaviour and supports safer decision-making, but limited by observational designs, heterogeneous outcomes, and weak evidence for direct health and economic impacts-resulting in moderate confidence overall, with highest certainty in its behavioural effects.

Safer supply – moderate but highly variable by intervention type: strong randomised evidence for clinical heroin-assisted treatment and weaker, largely observational evidence for safer supply models; while findings are consistently positive across outcomes, certainty is limited by study design, heterogeneity, and major gaps—particularly for peer-led and stimulant-focused interventions and in the Aotearoa New Zealand context.

Don't use alone – moderate: very strong and consistent real-world evidence for preventing overdose deaths and reducing harm, but formally limited by reliance on observational designs and contextual variability; despite low GRADE ratings, confidence in the direction and magnitude of core effects—especially overdose prevention —is high.

Managed alcohol programmes – moderate in benefit, low certainty of effects: consistent positive findings across health, behavioural, and social outcomes, particularly for highly vulnerable populations, but limited by observational designs, heterogeneous outcomes, and a lack of long-term and NZ-specific evidence.

4. **Legal models – low to moderate:** moderate support for specific health centred interventions such as drug courts and diversion programmes, but weaker and less consistent evidence for broader drug law reform due to observational designs, limited NZ-specific evaluation, and complexity in attributing system-wide effects. Evaluations of broader outcomes including the cost-effectiveness of different legal models is scarce, and outcomes are often narrowly measured on prevalence of use, therefore the strength of evidence is constrained by the outcomes the policies are measured against.

5. **Indigenous approaches**

   Global Indigenous approaches – moderate-high conceptually, low empirically: characterised by strong conceptual frameworks and consistent qualitative and case-study findings, but limited by small-scale, non-experimental designs, lack of long-term and economic evaluation, and challenges in measuring culturally grounded outcomes—resulting in promising but not yet highly certain evidence of effectiveness.

   Kaupapa Māori approaches – high conceptually, low empirically: strong conceptual grounding and consistent qualitative and practice-based support for culturally grounded, whānau-centred harm reduction approaches, but limited by a lack of rigorous quantitative evaluation, standardised outcomes, and formal evidence across many services, resulting in moderate confidence in benefit but low certainty in measurable effects.

References

[1] New Zealand Drug Foundation. 2024. **A health-based approach to drug harm in Aotearoa. Report**: Wellington.

[2] NZIER. 2024. Costs of alcohol harms in New Zealand: Updating the evidence with recent research. A report for the Ministry of Health.

[3] National Drug Intelligence Bureau. 2024. **The New Zealand Illicit Drug Harm Index 2023: Research report.** Wellington: Ministry of Health.

[4] Te Hiringa Mahara: Mental Health and Wellbeing Commission. 2026. **Alcohol and Other Drug Harm Reduction Literature Review.** Wellington: Te Hiringa Mahara.

[5] Crossin, R. 2025. **New Zealand's choice: Funding our drug policy (A study on public perspectives and willingness to pay).** Helen Clark Foundation.

[6] Ministry of Health. 2025. **New Zealand Health Survey. Annual Data Explorer** (Data File). Ministry of Health | Manatū Hauora. Retrieved 2 March 2026 from **https://minhealthnz.shinyapps.io/nz-health-survey-2024-25-annual-data-explorer**

[7] Mathias, H., Gehring, N. D., Hammond, R. M., Navarrete, J., Crépault, J.-F., Emerson, B., Markov, A., Kosteniuk, B., Speed, K., & Candler, E. 2025. **Defining a public health approach to substance use: insights from a systematic scoping review and conceptual framework development approach.** BMC Public Health, 25(1), 4365.

[8] Te Hiringa Mahara. 2026. **Monitoring mental health and addiction system performance in Aotearoa New Zealand.** Wellington: Te Hiringa Mahara.

[9] National Harm Reduction Coalition. (n.d.-b). **Principles of Harm Reduction.** Retrieved 26 November 2025 from **https://harmreduction.org/about-us/principles-of-harm-reduction**

[10] Ahern, J., Stuber, J., & Galea, S. 2007. **Stigma, discrimination and the health of illicit drug users.** *Drug and Alcohol Dependence, 88*(2-3), 188-196.

[11] Lloyd, C. 2013. **The stigmatization of problem drug users: A narrative literature review.** Drugs: education, prevention and policy, 20(2), 85-95.

[12] Crossin, R., Cleland, L., Wilkins, C., Rychert, M., Adamson, S., Potiki, T., Pomerleau, A. C., MacDonald, B., Faletanoai, D., & Hutton, F. 2023. **The New Zealand drug harms ranking study: A multi-criteria decision analysis.** Journal of Psychopharmacology, 37(9), 891-903.

[13] Collins, A. B., Bardwell, G., McNeil, R., & Boyd, J. 2019. Gender and the overdose crisis in North America: Moving past gender-neutral approaches in the public health response. The International journal on drug policy, 69, 43.

[14] Patton, D., Best, D., & Brown, L. 2022. **Overcoming the pains of recovery: The management of negative recovery capital during addiction recovery pathways.** Addiction Research & Theory, 30(5), 340-350.

[15] Dertadian, G. C., & Askew, R. 2024. **Towards a social harm approach in drug policy.** International Journal of Drug Policy, 127, 104425.

[16] Mathias, H., Gehring, N. D., Hammond, R. M., Navarrete, J., Crépault, J.-F., Emerson, B., Markov, A., Kosteniuk, B., Speed, K., & Candler, E. 2025. **Defining a public health approach to substance use: insights from a systematic scoping review and conceptual framework development approach.** BMC Public Health, 25(1), 4365.

[17] New Zealand Drug Foundation. 2024. **Drug overdoses in Aotearoa**. Report. Wellington

[18] Ministry of Health. 2025a. **Annual Data Explorer 2024/25**. **https://minhealthnz.shinyapps.io/nz-health-survey-2024-25-annual-data-explorer/_w_8ea5dac0e40748009a95406e24da7a41/#!/explore-indicators**

[19] Ministry of Justice. 2025. **Action to address methamphetamine-related harm**. Wellington: Ministry of Justice.

[20] Potter, S., Noller, G., Pillay, L., & Crossin, R. 2025. **Injecting-related injuries experienced by people who inject drugs in New Zealand: impact, healthcare access and stigma.** The New Zealand Medical Journal (Online), 138(1611), 65-78.

[21] Crossin, R., Cleland, L., Wilkins, C., Rychert, M., Adamson, S., Potiki, T., Pomerleau, A. C., MacDonald, B., Faletanoai, D., & Hutton, F. 2023. **The New Zealand drug harms ranking study: A multi-criteria decision analysis.** Journal of Psychopharmacology, 37(9), 891-903.

[22] New Zealand Drug Foundation. 2025a. **Drug Use in Aotearoa 2023/24.** Wellington: NZ Drug Foundation.

[23] Bax, T. 2021. **The adverse childhood experiences of methamphetamine users in Aotearoa/New Zealand.** International Journal, 10, 1431.

[24] Mongan, D., Millar, S. R., Brennan, M. M., Doyle, A., Galvin, B., & McCarthy, N. 2025. **Associations and mediating factors between adverse childhood experiences and substance use behaviours in early adulthood: A population-based longitudinal study.** Addictive Behaviors, 161, 108194. **https://doi.org/https://doi.org/10.1016/j.addbeh.2024.108194**

[25] Yee, A., Bentham, R., Byrne, J. L., Veale, J., Ker, A., Norris, M., Tan, K. K., Jones, H., Polkinghorne, T., & Gonzalez, S. 2025. **Counting ourselves: Findings from the 2022 Aotearoa New Zealand trans and non-binary health survey.** Report. Wellington

[26] Guggisberg, M. 2010. **An exploratory study of the association between intimate partner male-to-female violence, mental health problems and substance use among victimised women.** University of Western Australia.

[27] New Zealand Drug Foundation. 2024b. **Neurodivergence and substance use: Evidence, insights and recommendations.** Wellington: NZ Drug Foundation.

[28] Potter, S., Noller, G., Pillay, L., & Crossin, R. 2025. **Injecting-related injuries experienced by people who inject drugs in New Zealand: impact, healthcare access and stigma.** The New Zealand Medical Journal (Online), 138(1611), 65-78.

[29] Welwean, R., Chambers, L., Marshall, B., & Beaudoin, F. 2025. **Risk factors for experiencing substance use-related employment stigma among emergency department patients at high risk of opioid overdose.** Harm Reduct J, 22(1), 174. https://doi.org/10.1186/s12954-025-01289-7

[30] Low, G., Lindsay Latimer, C., & Mills, A. 2025. **Stable housing, 'home' and desistance: Views from Aotearoa New Zealand.** Criminology & Criminal Justice, 25(5), 1629-1649. https://doi.org/10.1177/17488958231210990

[31] Ministry of Justice. 2025. **Data tables: drug offences**. Retrieved March 2026 from https://www.justice.govt.nz/justice-sector-policy/research-data/justice-statistics/data-tables/#offence

[32] Potter, S., Noller, G., Pillay, L., & Crossin, R. 2025. **Injecting-related injuries experienced by people who inject drugs in New Zealand: impact, healthcare access and stigma.** The New Zealand Medical Journal (Online), 138(1611), 65-78.

[33] New Zealand Drug Foundation. 2025a. **Drug Use in Aotearoa 2023/24.** Wellington: NZ Drug Foundation.

[34] Coomber, R., & Moyle, L. 2014. **Beyond drug dealing: developing and extending the concept of 'social supply' of illicit drugs to 'minimally commercial supply'.** Drugs: education, prevention and policy, 21(2), 157-164.

[35] Foulds, J. A., & Nutt, D. 2020. **Principled sentencing for drug supply offences: revised methamphetamine sentencing guidelines in New Zealand.** Drug Science, Policy and Law, 6, 1-5.

[36] Foulds, J. A., Boden, J. M., McKetin, R., & Newton-Howes, G. 2020. **Methamphetamine use and violence: Findings from a longitudinal birth cohort.** Drug and Alcohol Dependence, 207, 107826.

[37] Harris, M. 2026. The Safe Inhalation Pipe Provision (SIPP) Study: Engaging with people who use crack cocaine in England. Pipes, Peers and Prevention: Webinar launch.

[38] Potter, S., Noller, G., Pillay, L., & Crossin, R. 2025. **Injecting-related injuries experienced by people who inject drugs in New Zealand: impact, healthcare access and stigma.** The New Zealand Medical Journal (Online), 138(1611), 65-78.

[39] New Zealand Drug Foundation. 2025a. **Drug Use in Aotearoa 2023/24.** Wellington: NZ Drug Foundation.

[40] Crossin, R., Cleland, L., Wilkins, C., Rychert, M., Adamson, S., Potiki, T., Pomerleau, A. C., MacDonald, B., Faletanoai, D., & Hutton, F. 2023. **The New Zealand drug harms ranking study: A multi-criteria decision analysis.** Journal of Psychopharmacology, 37(9), 891-903.

[41] Nosa, V., Palavi, L., & Heather, M. 2023. **A Pacific addictions perspective: a qualitative study exploring barriers and solutions for Pacific substance and behavioural addictions services in Aotearoa, New Zealand.** Drugs, Habits and Social Policy, 24(3), 191-204.

[42] Indig, D., Gear, C., & Wilhelm, K. 2017. **Impact of stimulant dependence on the mental health of New Zealand prisoners. In: Department of Corrections, Inter-agency Committee on Drugs. 2015.** National Drug Policy 2015 to 2020.

[43] Bowman, J. 2016. Comorbid substance use disorders and mental health disorders among New Zealand prisoners. Substance, 62, 91.

[44] Cunningham, R., King, P. T., Telfer, K., Crengle, S., Carr, J., Stanley, J., Gibb, S., & Robson, B. (2022). **Mortality after release from incarceration in New Zealand by gender: A national record linkage study.** SSM – Population Health, 20, 101274.

[45] Ministry of Health. 2025a. **Annual Data Explorer 2024/25.** https://minhealthnz.shinyapps.io/nz-health-survey-2024-25-annual-data-explorer/_w_8ea5dac0e40748009a95406e24da7a41/#!/explore-indicators

[46] Crossin, R., Cleland, L., Wilkins, C., Rychert, M., Adamson, S., Potiki, T., Pomerleau, A. C., MacDonald, B., Faletanoai, D., & Hutton, F. 2023. **The New Zealand drug harms ranking study: A multi-criteria decision analysis.** Journal of Psychopharmacology, 37(9), 891-903.

[47] Chambers, T., Mizdrak, A., Jones, A. C., Davies, A., & Sherk, A. 2024. **Estimated alcohol-attributable health burden in Aotearoa New Zealand.** Report.

[48] Harm Reduction International. 2024a. **The cost of complacency: a harm reduction funding crisis.** Report.

[49] Ahern, J., Stuber, J., & Galea, S. 2007. **Stigma, discrimination and the health of illicit drug users.** Drug and Alcohol Dependence, 88(2-3), 188-196.

[50] Lloyd, C. 2013. **The stigmatization of problem drug users: A narrative literature review.** Drugs: education, prevention and policy, 20(2), 85-95.

[51] Te Hiringa Mahara: Mental Health and Wellbeing Commission. 2026. **Alcohol and Other Drug Harm Reduction Literature Review.** Wellington: Te Hiringa Mahara.

[52] Godkhindi, P., Nussey, L., & O'Shea, T. 2022. **"They're causing more harm than good": a qualitative study exploring racism in harm reduction through the experiences of racialized people who use drugs.** Harm reduction journal, 19(1), 96.

[53] Lavalley, J., Kastor, S., Tourangeau, M., Society, W. A. H. R., Goodman, A., & Kerr, T. 2020. **You just have to have other models, our DNA is different: the experiences of indigenous people who use illicit drugs and/or alcohol accessing substance use treatment.** Harm reduction journal, 17(1), 19.

[54] Pegler, E., Garvey, G., Fitzgerald, L., Kvassay, A., Alexander, N., Davey, G., Rowling, D., & Smirnov, A. 2025. **The Unique Experience of Intersectional Stigma and Racism for Aboriginal and Torres Strait Islander People Who Inject Drugs, and Its Effect on Healthcare and Harm Reduction Service Access.** International Journal of Environmental Research and Public Health, 22(7).

[55] Canadian Aboriginal Aids Network, & Interagency Coalition on AIDS and Development. 2019. **Indigenous harm reduction = Reducing the harms of colonialism.** Canada: CAANIAD.

[56] McLachlan, A., & Waitoki, W. 2024. **Tawhiti: An Indigenous Trauma-Informed Harm Reduction Approach to Alcohol and Other Drug Use.** Journal of Indigenous Wellbeing, 7(1), 21-36.

[57] Harm Reduction International. 2024b. **Global State of Harm Reduction 2024.** Report. HRI.

[58] Jeziorska, I., Martinelli, T. F., & Kools, J.P. 2025. **50 years of harm reduction in Europe: high time for transformation.** Harm reduction journal, 22(1), 94.

[59] Te Hiringa Mahara: Mental Health and Wellbeing Commission. 2026. **Alcohol and Other Drug Harm Reduction Literature Review.** Wellington: Te Hiringa Mahara.

[60] Tse, W. C., Djordjevic, F., Borja, V., Picco, L., Lam, T., Olsen, A., Larney, S., Dietze, P., & Nielsen, S. 2022. **Does naloxone provision lead to increased substance use? A systematic review to assess if there is evidence of a 'moral hazard' associated with naloxone supply** (Review). International Journal of Drug Policy, 100(no pagination), Article 103513.

[61] Godkhindi, P., Nussey, L., & O'Shea, T. 2022. **"They're causing more harm than good": a qualitative study exploring racism in harm reduction through the experiences of racialized people who use drugs.** Harm reduction journal, 19(1), 96.

[62] Lasco, G. 2022. **Decolonizing harm reduction.** Harm reduction journal, 19(1), 8.

[63] Castedo de Martell, S., Wilkerson, J. M., Ranjit, N., Holleran Steiker, L., McCurdy, S. A., & Shelton Brown III, H. 2025. **What we know about the peer workforce and economic evaluation for peer recovery support services: a systematic review.** Substance use & addiction journal, 46(1), 90-102.

[64] Reddon, H., Kerr, T., & Milloy, M. J. 2020. **Ranking evidence in substance use and addiction.** Int J Drug Policy, 83, 102840.

Compiled by Te Hiringa Mahara – Mental Health and Wellbeing Commission. April 2026.
ISBN: 978-1-0671478-0-8 (online version and docx)