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AT THE HEART OF THE MATTER, NZ DRUG FOUNDATION.
Te Tūāpapa Tarukino o Aotearoa

New Zealand Drug Foundation submission on the Women's Health Strategy

Submitted to Manatū Hauora on 17 March 2023.

Tēnā koutou

The New Zealand Drug Foundation welcomes the development of the Women's Health Strategy. We recognise that women suffer inequalities in accessing healthcare, and that certain groups of women are further marginalised due to their ethnicity, sexual or gender identity, or disability. Of particular concern to our work is the severely underserved group of women who use drugs and experience drug-related harms.

Substance use is common in Aotearoa. While a higher proportion of men than women overall use alcohol, drugs and tobacco, substance-related harm among women is not uncommon. Furthermore, it is disproportionately shouldered by Māori women and those from deprived neighbourhoods. This is especially the case for methamphetamine harms, where data consistently show higher use among Māori women compared to other ethnic groups. We urge Manatū Hauora to implement policies across the health system that can help early in order to reduce later harms, such as addiction, financial and family distress, and imprisonment.

Very little is known about substance use and harms experienced by women belonging to other communities with underprivileged access to healthcare and possible greatest unmet needs. Women who use drugs who are also members of the rainbow community, disabled women, and pregnant women, for example, would benefit from better understanding of their specific needs, and how the health system can better meet them.

In our work, we see every day how women who use drugs carry the added burden of stigma. That stigma causes delays in seeking help and leads to discrimination when women do seek help. This can deter women who use drugs from accessing support until significant harm had already been caused. Such harms can be prevented effectively.

The Drug Foundation advocates for the inclusion of harm reduction principles throughout the Women's Health Strategy. These must be judgment-free, low-threshold, and person-centred. Appropriately delivered harm reduction empowers individuals to have a say in their health and treatment. Reducing barriers to care will lead to earlier interventions, and less harm to women who use drugs and their whānau.

We sincerely hope Manatū Hauora considers the points we make and engages in meaningful consultation both with the New Zealand Drug Foundation, and directly with women with lived and living experience of substance use.

Thank you for the opportunity to contribute to this important work, both now and in the future.

Sarah Helm

Executive Director

The Drug Foundation is a charitable trust. We have been at the forefront of major alcohol and other drug debates for over 30 years, promoting healthy approaches to alcohol and other drugs for all New Zealanders.

We support the focus on women in the Pae Ora strategies but encourage more consideration of harm reduction needs

1. The New Zealand Drug Foundation strongly supports the development of the range of Pae Ora Health Strategies to address the health and wellbeing of populations that have been long underserved by the health system.
2. The Drug Foundation is disappointed not to have been consulted directly on the development of these strategies so far. We have substantial, specific knowledge on the unmet needs of women who use drugs. We are keen to contribute to the development of equitable strategies that provide better access to health services for women who are affected by harms from substance use, and who must be included in the Strategy.
3. We urge Manatū Hauora to include harm reduction principles across the continuum of care and across the lifespan of tangata whai ora in all Pae Ora population health strategies.
4. We note that substance use is often only addressed in the health system at the extreme end of the spectrum of substance use, where it may have caused significant harm to someone's life and the lives of their whānau.
5. We encourage an approach where harm reduction principles are embedded into standard care. This can prevent addiction or serious harm. A harm reduction approach can also help dismantle stigma that stops tangata whai ora from accessing healthcare and disclosure of information about their substance use.
6. To achieve these goals, it is critical to meaningfully engage people with lived and living experiences. We encourage Manatū Hauora to undertake targeted consultation with people who use substances at various levels of use and harm. Many people who would benefit from targeted consultation and resulting appropriate strategies are unlikely to be engaged in addiction services, or self-identify hazardous substance use.
7. Furthermore, we note that due to the adulterated supply of illicit substances (including with highly potent substances, such as fentanyl), people at all levels of drug use are currently at risk of serious harm. These harms include the risk of accidental fatal overdose, even in infrequent substance users.

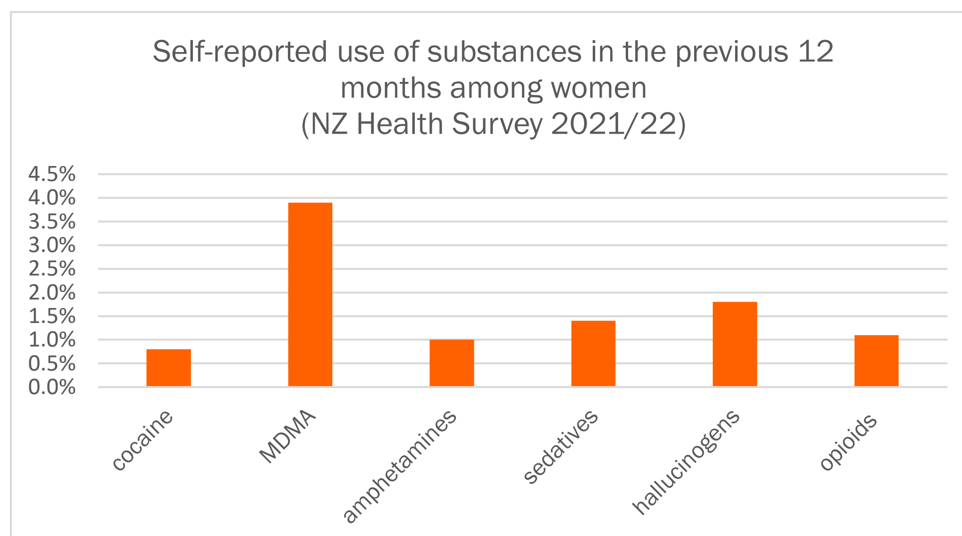
Substance use and harm is common among women in Aotearoa

8. Alcohol is the most commonly used substance in Aotearoa, and it causes the most harm. According to New Zealand Health Survey 2021/22 (1), 12.5% women drink hazardously (in a way that is likely to cause harm to their health or social functioning; AUDIT score ≥ 8). Hazardous drinking is especially common among young women, at a staggering 27.1% among 18-24 year-olds. Among all age groups, hazardous drinking figures are substantially higher for Māori women (23.7%) than for European women (13.6%).
9. Overall, 7.3% women smoke daily and these rates are much higher among Māori (18.2%) and Pacific (19.2%) women (1). Disabled women report daily

smoking at a higher rate as well (13.3% vs 6.7% among non-disabled women), which contributes to inequitable outcomes. Concerningly, women who live in the most deprived neighbourhood quintiles smoke much more often than women in the least deprived neighbourhoods (15.7% vs estimated 5.4%).

10. While use of cannabis is less common among women than men in Aotearoa, 3.2% women report at least weekly use of cannabis (1). Again, this rate is much higher among wahine Māori (8.3%) compared to European women (3.7%). Among disabled women 7.7% smoke cannabis at least weekly, which may indicate use for therapeutic use (self-medicating). However, data on those who use cannabis legally via a medical system is scarce. Overall, we know that most people who are using cannabis for therapeutic reasons are not using medical pathways to access it (2).

11. While self-reported use of other substances is less common among women, a substantial proportion of women had used other substances in the previous 12 months. Sedatives (or sleeping pills) are the only substances used by women at a higher rate than among men (1).



12. Despite large year-to-year variation in prevalence of use data in the NZ Health Survey, Māori women consistently report higher frequency of illicit stimulant use, primarily methamphetamine (1). This group of women is consistently neglected by the healthcare system, and at the same time, disproportionately criminalised. In fact, Māori women constitute more than 60% of the women's prison population, despite comprising only 15% of the female population (3), and we know that methamphetamine harms contribute substantially to this outcome. This inequity has been in place for years (4). Far too often, it is the criminal justice system which is the first to be involved in the lives of women who use drugs, rather than the healthcare system. A punitive approach, which continues to criminalise women for their substance use, only exacerbates the harms they experience. Early, targeted, health-based approaches, on the other hand, can prevent those serious harms and criminal engagement.

13. A cause for concern is that MDMA use is relatively common among young women (13.5% among women aged 15-24) and among Māori women overall (8.8%) (1). MDMA is considered a lower risk substance, but the criminalisation

of its use can exacerbate harm at any level of consumption. Criminalisation pushes users to illicit markets which expose them to the highly toxic substances that recreational drugs are often adulterated with. At the same time, possession for personal use puts individuals at risk of criminalisation, and discourages disclosure in health settings.

14. Despite generally lower population rates of substance use in women, they continue to experience significant harms. In 2019, 97 women died of drug-related causes (5). These deaths were preventable.
15. While little current data is available, the 2018 Counting Ourselves report found that recreational drug use is much more common among trans and non-binary people, including trans women (6). This applies to all substances where data was available (cannabis, hallucinogens, opioids, MDMA, stimulants, sedatives, amphetamines, cocaine, and others). The discrepancies were several-fold.
16. New Zealand data for cisgender non-heterosexual women is not available. However, we know that gay and bisexual men consume illicit substances at much higher rates than their heterosexual counterparts in Aotearoa (7) and international evidence (8,9) suggests this may be the case for non-heterosexual women as well. The scarcity of evidence further prevents the health system from accurately responding to the unique needs of women belonging to sexual and gender minorities who use drugs.

Drug-related stigma causes harm and prevents from accessing appropriate healthcare, especially among people with childbearing potential

17. Drug use continues to be criminalised and stigmatised, which creates barriers for disclosure. It has been suggested that women who use drugs are more likely than men to experience stigma, possibly because of attributed gender norms of motherhood and traditional women's role in childcare (10). These barriers to disclosure and seeking healthcare are especially pronounced for pregnant people (11) who use substances, and especially those who use methamphetamine in pregnancy, which carries extreme stigma.
18. Stigma may delay or entirely prevent pregnant people who use drugs from accessing antenatal care due to shame or fear of legal or social repercussions (12). Sensationalised reporting about 'meth babies' often compounds this stigma, leading to an experience of anticipated stigma even before engaging with the healthcare provider.
19. The true prevalence of substance use during pregnancy and breastfeeding is difficult to estimate. While maternal drug use may cause pronounced harms to the foetus, a proportion of pregnant and breastfeeding people will not be able to maintain abstinence. However, they are likely to benefit significantly from interventions that reduce harm during pregnancy and lactation (10). It is therefore essential to ensure that barriers to continuous and appropriate antenatal care are removed, especially in complex cases with substance use disorder during pregnancy.

20. At the same time, people who use substances must have access to appropriate family planning advice and interventions. These will include a range of contraceptive interventions which can reduce the risk of substance-exposed pregnancies and improve autonomy over a person's health and wellbeing.
21. We have recently heard a story of a woman living with chronic pain, who was denied access to a medically indicated hysterectomy due to an expressed lack of trust in her decision-making around potential reproductive health because of her history of drug use. Situations like these are not uncommon, and we expect that Women's Health Strategy addresses inequities experienced by some women when seeking reproductive and sexual health services that must be underpinned by respect for patient autonomy.

Principles of harm reduction and intersectional needs must be an important part of all women's health strategies

22. Substance use and related harm are common among women of all ethnicities, sexualities, disability status, and across the lifespan. Encouraging disclosure through frank conversations, and removing stigma related to substance use is important to provide through mainstream health services and public health interventions.
23. It is also apparent that intersectional discrimination and stigmas create environments where drug harms are exacerbated for Māori women, disabled women, and women belonging to rainbow communities. These populations require targeted interventions that are designed with their meaningful involvement to best meet their needs as tangata whai ora.
24. Destigmatising drug use is necessary in healthcare to give way to disclosure that enables frank discussions between providers and tangata whai ora. This must ensure that women who access family planning, antenatal, and postnatal care are empowered to share information about substance use to access harm reduction or, when appropriate, addiction treatment to prevent ongoing harms to female parents and children.

Summary of recommendations

I. The Drug Foundation welcomes the Women's Health Strategy. We believe that women who use drugs will benefit from changes to the health system which are women-focused.

II. Women who use drugs face persistent barriers to health services. They are often stigmatised for drug use which hinders their ability to access healthcare. This can be compounded if they are also members of the rainbow community, disabled, parents, wahine Māori or Pacific.

III. Women suffer significant harm from drug use that could be avoided if the health system adopted a more harm reduction-centred approach. Treatment for substance use should be an especially low-threshold, stigma-free area of

healthcare. Making it easier for women to receive healthcare will prevent significant health harms later in life.

References

1. Ministry of Health. Annual Data Explorer 2021/22: New Zealand Health Survey [Data File] [Internet]. 2022 [cited 2023 Mar 13]. Available from: https://minhealthnz.shinyapps.io/nz-health-survey-2021-22-annual-data-explorer/

2. NZ Drug Foundation. State of the Nation 2022 [Internet]. 2022 [cited 2023 Mar 14]. Available from: https://www.drugfoundation.org.nz/assets/uploads/2022-uploads/State-of-the-Nation-2022/State-of-the-Nation-2022-web.pdf

3. Foulds JA, Nutt D. Principled sentencing for drug supply offences: Revised methamphetamine sentencing guidelines in New Zealand. https://doi.org/101177/2050324520942347 [Internet]. 2020 Jul 27 [cited 2023 Mar 15];6:205032452094234. Available from: https://journals.sagepub.com/doi/full/10.1177/2050324520942347

4. Beehive. Meth offences put more women behind bars [Internet]. 2009 [cited 2023 Mar 15]. Available from: https://www.beehive.govt.nz/release/meth-offences-put-more-women-behind-bars

5. National Coronial Information System. NCIS Fact Sheet. Drug-related deaths in New Zealand in 2019. [Internet]. 2022 [cited 2023 Mar 10]. Available from: https://www.ncis.org.au/wp-content/uploads/2022/06/2019-NZ-NCIS-fact-sheet-Mortality-data-series-Drugs.pdf

6. Veale J, Byrne J, Tan K, Guy S, Yee A, Nopera T, et al. Counting Ourselves: The health and wellbeing of trans and non-binary people in Aotearoa New Zealand [Internet]. Hamilton, NZ; 2019 [cited 2023 Mar 16]. Available from: https://countingourselves.nz/wp-content/uploads/2022/09/Counting-Ourselves_Report-Dec-19-Online.pdf

7. Saxton P, Newcombe D, Ahmed A, Dickson N, Hughes A. Illicit drug use among New Zealand gay and bisexual men: Prevalence and association with sexual health behaviours. Drug Alcohol Rev [Internet]. 2018 Feb 1 [cited 2023 Mar 10];37(2):180–7. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/dar.12536

8. Green KE, Feinstein BA. Substance Use in Lesbian, Gay, and Bisexual Populations: An Update on Empirical Research and Implications for Treatment. Psychology of Addictive Behaviors [Internet]. 2012 Jun [cited 2023 Mar 10];26(2):265. Available from: /pmc/articles/PMC3288601/

9. Hyde Z, Comfort J, McManus A, Brown G, Howat P. Alcohol, tobacco and illicit drug use amongst same-sex attracted women: Results from the Western Australian Lesbian and Bisexual Women's Health and Well-Being Survey. BMC Public Health [Internet]. 2009 Sep 2 [cited 2023 Mar 10];9(1):1–10. Available from: https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-9-317

10. Weber A, Miskle B, Lynch A, Arndt S, Acion L. Substance Use in Pregnancy: Identifying Stigma and Improving Care. Subst Abuse Rehabil. 2021;12:105–21.

11. Wu M, Lagasse LL, Wouldes TA, Arria AM, Wilcox T, Derauf C, et al. Predictors of Inadequate Prenatal Care in Methamphetamine-Using Mothers in New Zealand and the United States. Matern Child Health J [Internet]. 2013 Apr [cited 2023 Mar 10];17(3):566. Available from: /pmc/articles/PMC3717345/

12. Maessen S, Wouldes T. Parental alcohol, cannabis, methamphetamine, and opioid use during pregnancy. In: Cutfield W, Derraik J, Waetford C, Gillon G, Taylor B, editors. Brief Evidence Reviews for the Well Child Tamariki Ora Programme. Auckland: New Zealand; 2019. p. 120–40.