Matters of Substance.

AUGUST 2012 | Volume 22 Issue No.3 | www.drugfoundation.org.nz

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

Storm in a pee cup

Drug-related impairment in the workplace is undoubtedly a serious issue and a legitimate concern for employers. But do our current testing procedures sufficiently balance the need for accuracy, the rights of employees and the principles of natural justice? Or does New Zealand currently have a drug testing problem?

Storm in a pee cup

COVER: **More than a passing problem**
You've passed your urine, but will you pass your workplace drug test? What will the results say about your drug use and level of impairment?

FEATURES

REGULARS

Become a member

The NZ Drug Foundation has been at the heart of major alcohol and other drug policy debates for over 20 years. During that time, we have demonstrated a strong commitment to advocating policies and practices based on the best evidence available.

You can help us. A key strength of the NZ Drug Foundation lies in its diverse membership base. As a member of the NZ Drug Foundation, you will receive information about major alcohol and other drug policy challenges. You can also get involved in our work to find solutions to those challenges.

Our membership includes health promoters, primary health and community organisations, researchers, students, schools and boards of trustees, policy makers, and addiction treatment agencies and workers.

Membership and subscription enquiries
membership@drugfoundation.org.nz
or visit our website.

www.drugfoundation.org.nz

MATTERS OF SUBSTANCE
August 2012
Vol 22 No 3
ISSN 1177-200X

MATTERS OF SUBSTANCE invites feedback and contributions. If you're interested in contributing a guest editorial or article, please contact us:
editor@drugfoundation.org.nz
p +64 4 801 6303

Brand development/ graphic design
Insight +64 4 801 6644
talktous@designedbyinsight.com
www.designedbyinsight.com

NZ Drug Foundation
3rd Floor, 111 Dixon Street
PO Box 3082, Wellington,
New Zealand
p +64 4 801 6303

THE DIRECTOR'S CUT

I have to admit I feel absolute despair every time a young New Zealander dies trying to get high on solvents and gases.

New Zealand has a tragic history of volatile substance abuse (VSA) deaths – 60 in the past decade. It's one of the most difficult areas of drug harm reduction work.

ROSS BELL
Executive Director

The people using these products are often very young and simply experimenting, yet they can die with their first high. It's almost impossible to control supply of the products as most are common and have legitimate household uses. We have few tools up our sleeve to try to prevent or reduce use and harm.

There is no easy answer but, frustratingly, every time there's a high-profile case, people who should know better go looking for one.

12-year-old Darius Claxton died in a Christchurch car park in May using butane. Jamie Jury (18) and Brendon McLeod (17) remain in hospital with serious burns after an explosion when they were using LPG last month.

Prompted by these cases, the Chief Coroner has announced he'll conduct an urgent inquiry into 'huffing'. His won't be the first.

I have a word of caution for the Chief Coroner: The inquiry itself isn't a silly idea but, from past experience, all these reviews accomplish is to remind us what a bloody difficult issue VSA is and that intuitions about solutions aren't always grounded in evidence.

This was starkly illustrated by a 2005 inquiry by the Wellington Coroner who examined six VSA deaths. Ignoring advice received from the Ministries of Health and Youth Development, he recommended a public awareness campaign. Child Youth Mortality Review Committee Chairman Dr Nick Baker recently reminded us the evidence says that's exactly the last thing we should pursue.

But evidence also shows we shouldn't wring our hands. Sellers of these products can be shown better ways to manage sales, and we've had some successes recently with retailers. Services that work with young people can be better informed.

The media have an important role – they can also get it very wrong. Coverage of recent cases has been clumsy and dangerous, showing specific brands, where to buy them and even how to inhale. Guidelines for reporting on VSA are clearly needed.

The Chief Coroner will undoubtedly look again at ways to control supply and availability, and we should keep an open mind about that. After all, the R18 restriction placed on spray paint as part of an anti-graffiti law has gone some way to reduce illicit use of those products. But considering we're still left with a supermarket full of alternatives, our attention should switch to renewing efforts on health promotion and harm reduction. ■

SOCIAL

@GNAT The Health Promotion Board needs a "range of views". Would be bias if all were in favour of promoting health. 28 JUNE

@VAUGHNDAVIS Accidently poured a @CokeZero into a glass that I'd spilt some espresso into. OMFG, as the young people say. I can see the music. 2 JULY

@PETERDUNNEMP If Labour's minimum alcohol price amendment depends on my vote, it is doomed. 4 JULY

@KEVINHAGUE Extraordinary behaviour from @winstonpeters in select committee on tobacco excise bill. Appears to believe no adverse health impacts! 17 JULY

NZ HERALD ONLINE "Mr Bell, it is simple to divert people from the real issue by focussing on a minor point. Can you please direct us to the empirical and irrefutable evidence which proves that raising the price of alcohol will reduce binge drinking?" NZ HERALD READER COMMENT NZDRUG.ORG/NHdABT

KEY EVENTS & DATES

19–21 SEPTEMBER

From Genetics to Practice: National Cannabis Conference
Brisbane, Australia
A fresh look at the evidence base on cannabis and mental health, and treatment interventions.
www.ncpic.org.au

11–14 NOVEMBER

First International Conference on Law Enforcement and Public Health
Melbourne, Australia
Investigating the partnership between law enforcement and public health in addressing complex social problems.
www.policing-and-public-health.com

27 NOVEMBER

NZ Drug Foundation Annual General Meeting
Wellington
Stick this in your calendar now. Chocolate cake will be served as usual.
www.drugfoundation.org.nz

9-12 JUNE 2013

2013 International Harm Reduction Conference
Vilnius, Lithuania
This 23rd conference is a must-attend for harm reduction practitioners from around the world.
www.ihra.net/conference

Follow us
Join us online
drugfoundation.org.nz/connect

NZ.

01

DUNNE SLAYS PARTY PILL HYDRA

New regulations for synthetic drugs announced in early July by Associate Minister of Health Peter Dunne will help move New Zealand's obsolete drug law into the 21st century.

The new regulations will ensure the synthetic drug industry will have to prove a substance is safe before it can be sold in New Zealand.

"The new law means the game of 'catch up' with the legal highs industry will be over once and for all," said Mr Dunne.

Distributors and producers will have to pay for the cost of proving that a product is safe through clinical trials and submitting the reports to an expert advisory committee.

Ross Bell, New Zealand Drug Foundation's Executive Director, said the new regulations are long overdue and are very welcome.

"We have seen time and time again that, when one substance gets banned, another similar substance (or substances) pops up in its place. This will help stop that," said Mr Bell.

Any substance already on the market for at least six months could stay on the market as long as there is an application pending for it with the new regulator. However, the regulator would have the power to recall any product of concern within the transition period.

RESOURCES

Read the government's policy advice:
nzdrug.org/MxvN2j

02 World drug report

THE 2012 United Nations World Drug Report released in late June showed New Zealand has the fifth highest prevalence of reported cannabis use in the world. The report estimated 14.6 percent of New Zealanders had used cannabis in 2010.

The report also estimated that ecstasy use had fallen but ecstasy substitutes had increased and seizures of cocaine had increased by 0.6 percent. It focused on the good work New Zealand had done preventing the spread of HIV through drug abuse.

Many mainstream media outlets reporting on the UN World Drug Report got mildly confused because the Oceania region contained four out of the top five countries for annual prevalence.

03 $300 for a smoke?

CORRECTIONS Chief Executive Ray Smith is heralding the smokefree prisons policy as the single most important health initiative the Department could have done.

"There has been a drop in asthma and other respiratory symptoms and smoking-related illnesses in prisoners since the ban."

From 1 November 2011 to 22 May 2012, of the 5,661 newly received prisoners who identified as tobacco smokers, 4,177 elected to take NRT using either patches and/or lozenges.

Smith said there had also been 72 percent fewer fires and a 57 percent improvement in air quality.

However, tobacco is still in our prisons and the price has skyrocketed. According to some prisoners *Matters of Substance* talked to, the price of tobacco can reach up to $300 for one pouch, which retails for $50 outside the fence.

04 Corrections changes

33,100 PEOPLE in prison are set to receive an expanded drug and alcohol treatment programme because of changes in the government's budget. The changes reprioritise $65 million of the Corrections Department budget with the aim of reducing reoffending 25 percent by 2017.

Corrections Minister Anne Tolley said it was time to get serious about breaking the cycle of reoffending.

"We know that two-thirds of prisoners have addiction problems and that up to 90 percent can't read or write well," said Tolley.

"By seriously addressing these major contributors to crime, alongside increased employment opportunities, we can reduce the likelihood of reoffending."

Associate Corrections Minister Dr Pita Sharples said the increase in funding represents a significant shift towards rehabilitation and restoration of prisoners to their whānau and communities.

"This is a more humane response to offending, and it is cheaper and more effective," said Dr Sharples.

The funding will also address rehabilitation services for community offenders, increase education and employment training and put prisoners into post-prison community reintegration programmes.

05 23 sober drivers are killed every year by drunk/drugged drivers

REPEAT DRINK DRIVING OFFENDERS are at an eight year high. While drink driving figures for 2011 were the lowest for four years, people with eight or more drink driving convictions rose 22 percent. The Ministry of Justice estimates that, for every 100 drunk/drugged drivers, 54 passengers are killed and 23 sober road users are killed. *One News* reported that the person with the worst drink driving record was convicted for the 19th time last year. A person *One News* spoke to has been convicted five times for drink driving and has never been referred to treatment by the Court.

06

TWO AUCKLAND bars lost their liquor licences in early June after they hid dangerously intoxicated women in a back room to avoid police. One of the women was unconscious.

The karaoke bars were snapped when a police officer saw the woman being carried into a back room during the Rugby World Cup in October 2011. The Liquor Licensing Authority report says the police officer followed them into the back room and said they were "too drunk to answer questions".

The licenses were only suspended for 42 days despite the Licensing Authority saying the actions were "reprehensible" and placed "the young women at even greater risk of danger".

08 Alcohol-related harm

AUCKLAND emergency rooms are being inundated with people suffering from alcohol-related harm. Of the 292,000 presentations to emergency rooms in Auckland during 2010–2011, 3,600 were alcohol related. Auckland Council has endorsed an alcohol harm reduction strategy but it has not been properly implemented yet due to the slow passage of the government's Alcohol Reform Bill.

09 Synthetic drugs

"When you're dealing with synthetic drugs, no one really knows what the composition of that particular tablet or pill is."

The seizure of drugs by Customs has been clouded by the increasing popularity of synthetic compounds that are not fully covered by existing law, Customs Manager Mark Day said.

He said much of what Customs were intercepting was fake ecstasy where the ingredients were cheap but unknown, which leads to complications when people overdose.

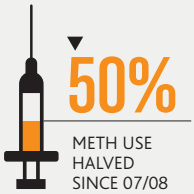
10 Tobacco excise

TREASURY may have underestimated the impact the government's latest tobacco excise tax increase would have on the number of smokers choosing to quit or smoke less. Dr Murray Laugesen predicted tobacco excise would only increase by $139 million over four years, not the $528 million calculated by the Treasury.

This claim comes after Treasury reported that the revenue gathered from tobacco excise is more than the health-related costs of smoking. Tobacco excise will raise an estimated $1.3 billion this year.

07 UPDATE

P use down



THE LATEST RESULTS from a Ministry of Health survey show methamphetamine use in New Zealand has halved since 2007–2008.

$90 ▶ $120M FUNDING FOR ADDICTION TREATMENT

THE *TACKLING METHAMPHETAMINE:* *Indicators and Progress Report*, which comes out of the Prime Minister's Methamphetamine Action Plan, shows that, last year, use decreased from 2.1 percent to 1 percent, while funding for addiction treatment had increased from $90 million to $120 million. The report also says the price of P in Christchurch has significantly increased due to the earthquake disruptions, going from $750 per gram in 2010 to $967 in 2011.

$P IN CHCH

$750 IN 2010

$967 IN 2011

World.

$25m

AVAILABLE THROUGH A REPLACEMENT GOVERNMENT FUND

01 Sports clubs ban alcohol sponsorship

LEADING Australian sports organisations have agreed to end all existing and future sponsorship from alcohol companies.

$25 million has been made available to soccer, basketball, netball, swimming, cycling, hockey and other sports organisations through a replacement government fund.

However, the three biggest sporting codes in Australia – AFL, NRL, and Cricket Australia – have so far refused to sign on for funding.

Co-chair of the National Alliance for Action on Alcohol Professor Mike Daube said these codes should start discussions with the government so "they, too, can move away from their present role in exposing children to alcohol promotion".

The 'Be the Influence' fund is supported by revenue from Australia's new alcopop tax.

02 HUMAN RIGHTS + DRUG ENFORCEMENT

"There are no safeguards – when the UN acts as a conduit for these funds, a further layer of bureaucracy separates the money from the abuses."

International aid money for drug enforcement may be funding human rights abuses, says a new report.

Deputy Director of Harm Reduction International and co-author of the *Partners in Crime* report Damon Barrett said that, in some cases, donor states effectively paid for the capture and killing of their own citizens.

"There are no safeguards – when the UN acts as a conduit for these funds, a further layer of bureaucracy separates the money from the abuses," said Mr Barrett.

"Instead of the UN being a guardian of human rights, it becomes more like a laundry mechanism, washing the funds of any form of accountability."

One of the examples cited in *Partners in Crime* shows that $US3.4 million for a UNODC border control project in Iran led to a dramatic increase in drug-related arrests and more than three times as many executions.

READ THE REPORT: **www.nzdrug.org/NxCaV0**

03 Highless cannabis

ISRAELI medicinal cannabis grower Tikun Olam has developed a strain of cannabis containing less than 1 percent THC and more than 15 percent cannabidiol. Researchers claim it is a "highless" alternative for medicinal marijuana.

"The cannabis plant, enriched with CBD, can be used for treating diseases like rheumatoid arthritis, colitis, liver inflammation, heart disease and diabetes," said Professor Ruth Gallily of the Hebrew University.

Clinical trials of the low THC strain, known as Avidekel, are due to start by the end of the year.

04 Singapore to (almost) end drug death penalty

SINGAPORE is proposing changes to its mandatory death penalty for some drug offences.

Courts will have discretion to either sentence offenders to death or life imprisonment with caning, when two conditions are met. The offender must only be a courier and not involved in the supply or distribution of drugs and must co-operate with authorities.

However, the mandatory death penalty will continue to apply in most cases, particularly for those who manufacture or traffic in drugs and those who fund, organise or abet drug trafficking. There are currently 35 prisoners awaiting execution – 28 for drug offences and seven for murder.

1 IN 4 ADULT PALAUANS USING CANNABIS

10 Palau and pot smoking

THE TINY pacific nation of Palau was named the world's cannabis capital in the recent United Nations 2012 World Drug Report.

However, the figure of 24.2 percent of adult Palauans using cannabis comes from a survey taken at the one state-run high school in the small archipelago.

The UN extrapolated the figures to estimate what usage would be for the entire country.

Palau's director for the Ministry of Education Emery Wenty said he did not believe the UN figures.

"You sort of know just about everybody. It's inconceivable that a quarter of the population uses cannabis."

The UN statistician who worked on the drug report accepted some of the criticism but insisted there is a relatively high prevalence of drug use across the Pacific.

05

CONSUMPTION ROOMS

The Danish Parliament has passed a law that will make consumption rooms legal. The law allows for "safe drug consumption rooms" where users can inject, snort or smoke small quantities of drugs. It also explicitly says police cannot search, seize and prosecute users in possession of personal use quantities. Denmark joins Australia, Canada, Germany, the Netherlands, Spain and Switzerland in allowing injection sites as a harm reduction measure.

06

ALCOHOL BAN FOR MPS STAFF, NOT FOR MPS

The UK Parliament is revamping its alcohol policies after incidents involving intoxicated Members of Parliament assaulting their colleagues. However, the policy, which will stop people from drinking on parliamentary grounds, will not cover the MPs or their staff, only parliamentary employees. Speaker of the House of Commons John Bercow said a growing number of MPs and staff were seeking help for problem drinking.

07

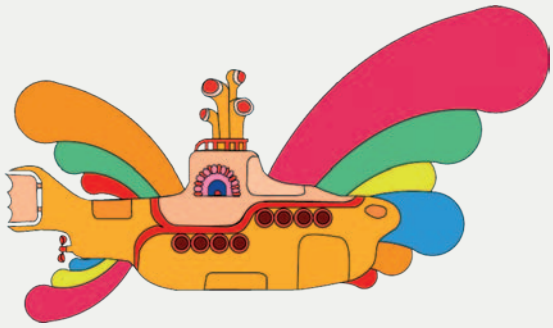
IRAN SENTENCES DEATH FOR ALCOHOL.

Two Iranian citizens were sentenced to execution for continuing to drink alcohol. The pair, who have been convicted twice before and were given 160 lashes the second time, were sentenced to death by the Iranian Supreme Court in late June. Under Sharia law, consuming alcohol is a crime, and sentencing is not at the discretion of a judge.

08

URUGUAY TO LEGALISE CANNABIS

A report by the Uruguay Government suggested it might legalise and control the sale of cannabis in the South American country. About 5.6 percent of Uruguayans between 15–64 smoke cannabis, and the industry is estimated to be worth US$35–75 million. This move comes after Guatemala, Costa Rica and Colombia have called for a debate about legalising cocaine and Brazil and Argentina have referenda coming up on whether to decriminalise personal use of all drugs.



09 Russia's top drug official blames The Beatles for kicking off Russia's drug problem

"After The Beatles went to expand their consciousness in India's ashrams, they introduced that idea – the changing of one's psychic state of mind using drugs – to the population."

Russia's top narcotics official Yevgeny Bryun recently blamed The Beatles for the global drug problem, saying that businesses are now capitalising on the image of pleasure.

Mr Bryun said tough measures were needed to combat mass culture and advertising that promoted drug use.

Storm in a pee cup

Standing next to a row of toilet cubicles in a Wellington drug testing agency, Sarah's nervousness gave way to panic. The shy 20-something office worker did her best to contain herself in front of the agency's manager and his assistant, but she was fraught with worry.

A few minutes earlier, the assistant had studiously patted her down before sending her into the toilet. To ensure someone else's urine wasn't being substituted, the assistant stood with her ear by the cubicle door while Sarah awkwardly pissed in the cup.

It only took a quick shake of the urine canister and a short moment for the assistant to tell her she'd failed her workplace drug test. **By Sean Gillespie**

Since Air New Zealand won the right to test workers in the Employment Court in 2004, workplace testing has become a boom industry.

SEAN GILLESPIE

THE agency's manager came in and confirmed. With her mind spinning and the sense that she was being eyed suspiciously, Sarah didn't initially understand how this could have happened. Having come out of hospital only a few days earlier, she was feeling drowsy and was worried they would just see an addled junkie.

Eventually it occurred to her that her course of codeine painkillers could have been the cause.

The manager sent her on her way saying he needed to see the prescription. She raced home and desperately searched for the script. Fortunately, she hadn't thrown it out.

The agency gave her a tentative reprieve but said the lab would take a few days to do further tests and confirm. In the end, she passed but was left with a negative feeling towards her employer and resented what she saw as a pointless exercise in bureaucratic box ticking.

Sarah, not her real name, is one of the many people who've been innocently caught up in the burgeoning drug testing net. But not everyone is innocent – there's no doubt New Zealand has a drug problem.

According to ACC, more than half of New Zealanders are binge drinkers, one in seven smokes cannabis and eight percent have used three or more illegal drugs in the last year. With statistics like that, impairment of staff is a valid concern in safety-sensitive industries like aviation and forestry.

And since Air New Zealand won the right in the Employment Court in 2004 to test workers, workplace testing has become a boom industry. One private testing company boasts a 400 percent increase in the number of tests it conducted between 2009 and 2011, with about one in 10 tests returning positive results.

"Substances as innocuous as poppy seeds and painkillers containing codeine have been known to cause positive tests for opium."

So it would seem we also have a drug testing problem. How do we balance civil liberties, such as right to privacy, with the need for workplace safety? Are drug tests the best answer for this societal problem? And do tests actually address the issue?

Not so much, according to Victoria University's Julian Buchanan. The Associate Professor and Programme Director for the university's Criminology School has worked in substance abuse management for three decades, and he doubts the benefits of workplace drug testing.

"Whenever you've got any testing in a laboratory, you end up with false positives and false negatives," he says. "It's always a contested result."

Aside from human error, results can be skewed in other ways. Substances as innocuous as poppy seeds and painkillers containing codeine have been known to cause positive tests for opium.

But Buchanan says concerns about the validity of drug tests are much broader, as current techniques only indicate a drug's presence – not whether the person tested is actually impaired.

"Someone might have used cannabis on a Saturday and test positive on Wednesday, but they're not intoxicated," he says.

"It's a bit like me being tested for alcohol. I had a glass of red wine last night. If I test positive for alcohol today but I'm not intoxicated, should I lose my job? It doesn't make sense; it's a breach of civil liberties."

But those concerns haven't stopped the rapid growth of the drug testing industry, and Buchanan is troubled by the transparency of some of the companies within it.

"There's lots of glossy brochures and promotion, but we're only getting a one-sided argument on drug testing," he says.

"The question is: knowing the severe limitations of drug testing, who, if anybody, should it be applicable to? It has been rolled out across the board and is being used arbitrarily with some quite worrying consequences."

The law

No single law addresses workplace drug testing. Instead, it is regulated by a combination of case law and five Acts. These include the Crimes Act, which addresses whether forced drug tests could amount to assault, while the Employment Relations Act requires good faith consultation in the development of a workplace drug testing policy. The umbrella Bill of Rights Act outlines the rights to refuse medical treatment, be secure from unreasonable search and seizure and not suffer arbitrary arrest or detention.

Employment law specialist Peter Cullen, a partner at Cullen – The Employment Law Firm in Wellington, says this combination ensures a fair balance between workplace safety and personal right to privacy. He says the 2004 Employment Court case between six unions and Air New Zealand set the scene for workplace drug testing in New Zealand.

"It's an obvious area where you'd expect a line to be drawn because of the need to protect the public in terms of safety on the one hand and to see the reach of the law doesn't go beyond what's reasonably necessary on the other," he explains.

Air New Zealand won the case, with the court allowing drug testing in safety-sensitive areas.

While Cullen says case law and legislation strike a balance between individual rights and workplace safety, there can still be issues around consultation.

"If a workplace is not sure it's a safety-sensitive area and they bring in a drug testing policy, employees may not be aware it's not something the employer can actually do," he says. "That's potentially an area of dispute."

Employers aren't legally required to offer support, but some large companies have chosen to write it into their drug testing policy. Air New Zealand is one of those companies.

"It's always had an element in its policy of giving people who have infringed the opportunity to engage in a recovery process," Cullen explains.

"It's not a black and white policy with them. If people want to change, they'll often give them another chance. They'll be strict about it and make sure they do what they said they'll do."

Education and rehabilitation programmes are both part of Air New Zealand's testing policy. Although testing positive could result in "disciplinary action", it is more likely to lead to a referral to one of the available assistance and rehabilitation programmes.

It's a strategy that academic studies have found effective. One published in the United States by Health Sciences Research found lower levels of worker drug use in companies with drug education and

> **It's an obvious area where you'd expect a line to be drawn because of the need to protect the public in terms of safety on the one hand and to see the reach of the law doesn't go beyond what's reasonably necessary on the other.**
>
> Peter Cullen

> **We've got a bit of a challenging environment where employers want to put something good in place but because it's drugs, they're scared. It kind of freaks them out.**
>
> Ross Bell

employees assistance programmes.

Nobody from Air New Zealand was available to discuss drug testing policy for this story, but a lawyer for the Engineering, Printing and Manufacturing Union (EPMU), Greg Lloyd, says it's a step in the right direction.

"They have a comprehensive policy and on paper it looks great, but like anything, something's only as good as its application," he adds.

He says to help ensure good workplace culture, company drug policies should also exclude random testing, have a greater emphasis on rehabilitation over punishment and provide for consultation and representation. But even so, these policies don't necessarily protect employees.

"There's certainly examples of employers who implement these policies," he says.

"They have provision for rehabilitation, but whether it's a local manager or HR manager, they take the view that 'you tested positive, we have the right to sack you, so we're going to do it'."

Even with a supportive policy in place, drug testing can contribute to negative company culture. A study by Professor Debra Comer for Pittsburgh State University's *Journal of Managerial Issues* showed that, while employees found drug testing non-invasive, it created negative attitudes towards employers from staff because they felt the tests failed to detect impairment and enhance safety.

New Zealand Drug Foundation Executive Director Ross Bell says, even with staff consultation, companies' good intentions don't always carry through. Even if organisations develop good policies offering support, he says, echoing Lloyd, a failed drug test can quickly trump agreed processes.

"We've got a bit of a challenging environment where employers want to put something good in place, but because it's drugs, they're scared. It kind of freaks them out."

> **It seems to us that, because it's drugs, all kinds of natural justice principles can be thrown out the window.**
>
> Ross Bell

"And then," Bell adds, "there are these snake oil salesmen that come to them with the perfect solution saying: 'Here's this complex issue of alcohol and drugs in the workplace, and you have to manage your hazards, and the best way to do it is to get your employees to pee in a cup'."

Bell says many employers mistakenly see drug testing as the perfect deterrent, despite the tests being expensive and too often inaccurate.

"Not only is the science still a bit 'iffy', but asking staff to pee in a cup is a degrading approach. Fundamentally, it

11 people died in a hot-air balloon accident in Carterton. The pilot had tested positive for cannabis – the cause of the crash has yet to be determined.

strikes me as an awful way to develop workplace culture."

Like Buchanan and Lloyd, Bell is concerned about the tests' failure to measure actual impairment. He says, although the mandate is to ensure workplace safety, drug testing companies ignore that their tests don't pick up whether someone is hung-over or impaired from fatigue but will test positive to someone who has drugs in their system but is in no way impaired.

The unnecessary and negative fallout from a 'positive' drug test result is perhaps best illustrated by the aftermath from a hot-air balloon crash in Carterton earlier this year that resulted in the deaths of all 11 occupants.

After the accident, a government agency investigating the crash informed media that cannabis was found in the pilot's system. The bold newspaper headlines and court of public opinion weren't going to wait to hear that the ambiguous reference to drugs simply meant he had consumed cannabis sometime in the last month.

Bell says, despite there being no evidence the pilot was impaired at the time of the crash, his name was besmirched, the families of the victims caused further grief and New Zealand's international reputation as a safe tourist destination damaged.

"It's irresponsible and sadly consistent with a lot of public coverage you get of any drug topic, whether the drugs are a cause

Cannabis impairment

CANNABIS is New Zealand's favourite illegal drug. Almost half the population aged between 16 and 64 admit to having tried it, and each year, more than one in 10 adults say they use it.

There is no data on rates of cannabis use in New Zealand workplaces, but it accounts for more than two out of three positive results from workplace drug tests.

As an indication of how many Kiwis might be stoned on the job, statistics from across the Tasman show 2.5 percent of Australians turn up to work under the influence of an illicit drug.

Impairment from cannabis in safety-sensitive work environments is a risk that needs to be taken seriously, especially if the job requires a person to operate heavy machinery or drive a vehicle.

GETTING HIGH CAN CAUSE:

- impaired thinking and memory
- problems with balance and co-ordination
- poor concentration
- distorted sensory perception – visual, auditory and tactile
- reduced ability to perform complex tasks
- decreased alertness
- slowed reaction times.

These effects last from two to six hours depending on the user, how much they used, how the drug was taken and the environment in which they were using it. Cannabis impairment in the workplace therefore threatens the safety of the user and the people working around them.

In New Zealand, it is not clear what percentage of workplace injuries can be attributed to cannabis or other drug impairment. However, up to a quarter of workplace injuries and 20 percent of workplace fatalities in Australia have been linked to alcohol and other drug use.

If the rates of impairment-related workplace deaths are similar in New Zealand, then around 17 people were killed in workplace accidents in the past year where drug impairment was a factor. ■

Impairment of staff is a valid concern in safety-sensitive industries like forestry.
SNPA / Pam Johnson

> **“A good workplace culture that invites trust and openness between staff and management would be more valuable.”**
>
> Julian Buchanan

or not,” Bell says.

“It seems to us that, because it’s drugs, all kinds of natural justice principles can be thrown out the window.”

Moreover, Bell says more harm can be caused by drugs that are less detectable. When blood testing is used, such as after the balloon crash, traces of cannabis can be found a month after use. With urine tests – the usual method for workplace drug testing in New Zealand – it’s a week after use. However, methamphetamine can clear a person’s system in about 24 hours.

“You could get workers switching from a relatively less harmful drug like cannabis to a more harmful drug like meth. It’s an absolutely bizarre unintended consequence that the drug testing industry seems to ignore,” Bell says.

Other answers

A United Kingdom inquiry between 2002–2004 by the Joseph Rowntree Foundation into workplace drug testing concludes that there is “no justification for drug testing in the workplace as a means of policing the private behaviour of employees or of improving performance and productivity”.

The foundation, a social policy and research development charity founded in 1904, found drug testing has a role to play, particularly where safety is a concern, but investing in management training and systems is likely to have a more positive impact and would be less costly, divisive and invasive.

But what are the alternatives in the New Zealand context?

Back at Victoria University, Associate Professor Buchanan thinks drug testing has the potential to be developed into something workable, but it’d be a difficult and lengthy process.

He says the current legal levels for driver alcohol breath testing took a lot of testing and time to develop, and it would be significantly more difficult to define impairment test levels for multiple drugs.

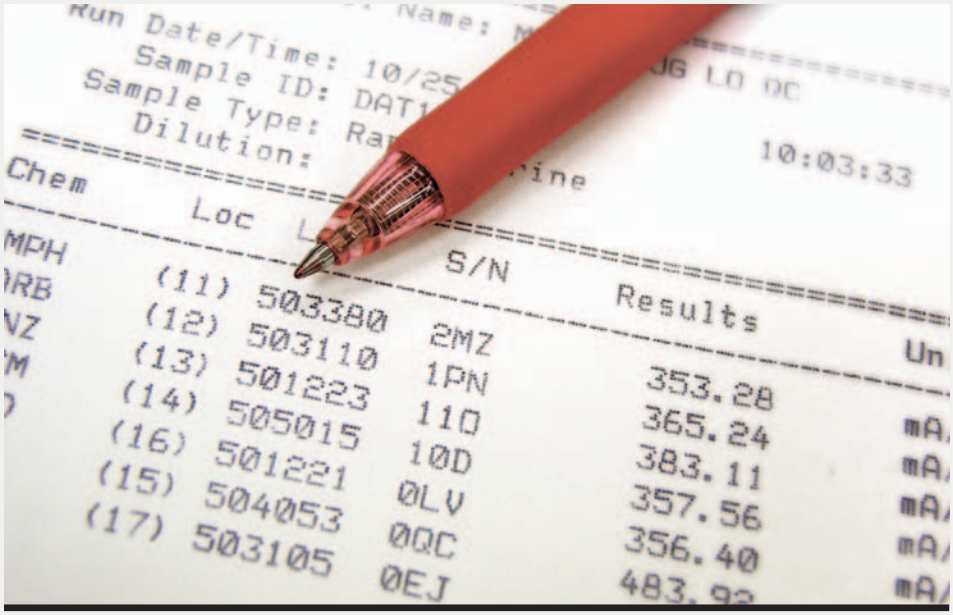
He argues it would make more sense for workplaces to design behavioural cognitive tests indicating impairment relative to tasks performed by staff members. These sorts of tests would also capture people who were fatigued or hung-over to the point of being a risk to safety.

Buchanan also says a good workplace culture that invites trust and openness between staff and management would be more valuable.

“If we’re worried about people who are impaired or have got drug and alcohol problems, the best way is to talk to them rather than police them.

“If you have a child and they have problems or issues, the best way to deal with those issues is to have a relationship with open communication.

“If you start drug testing your children, once you go down that route of distrust and policing, you might improve your stats, but you’re not necessarily improving the situation. Because all you have is a



STANDARD DRUGS TESTED FOR	URINE TEST TIMES (NZ WORKPLACES' USUAL TEST METHOD)
Cannabinoids (marijuana, hashish, hash oil)	Occasional users: 3–4 days Heavy users: 10 days Chronic users/high body fat: 30+ days
Opiates (heroin, morphine, codeine)	1–2 days
Cocaine	2–5 days
Amphetamines	1–7 days
Ecstasy	20–24 hours
Speed	1–3 days
Methamphetamine (P)	1–3 days
Benzodiazepines (tranquillisers, sedatives, antidepressants)	Up to 7 days Chronic users: 4–6 weeks

**There are many variables affecting drug detection times, including body weight, metabolism, form of drug intake, strength of drug and frequency of drug use.*

hiding culture, a deceitful culture."

And there are other alternatives that have proved successful in the workplace.

About six years ago, the EPMU developed a peer intervention and support programme called 'Not on the Job Mate', where workers looked out for workmates. It was based on a similar workers' support initiative created by the Australian Builders Union, which gained official recognition from the United Nations International Labour Organization as being the ideal form of drug management programme.

Although it fell off the radar with the growing prevalence of drug testing in New Zealand, the EPMU is looking at reimplementing it.

At the Drug Foundation, Bell agrees with the need to focus on developing positive workplace culture.

"Employers have to put a bit of effort into their workplace culture rather than taking an enforcement or punitive approach.

"Bosses have two choices: they can either build a workplace culture that has high trust and collaboration between workers and bosses or they can create a culture that creates an 'us and them' barrier, which can't be good for workplace productivity." ■

Sean Gillespie is a Wellington-based writer.

Do you need a policy for managing alcohol and drugs in your workplace?
nzdrug.org/Ms3SSu

Bizarre behaviour

Bath salts. Police and media keep blaming them for bizarre behaviour. But, as **Russell Brown** writes, perhaps they need also to have a look at their own bizarre actions.

RUSSELL BROWN

WE live in an age of novel psychoactive substances. They're hard to escape – because even if they're not in our bodies, they're in our heads, thanks to the news media. And nowhere has that been better demonstrated than in the case of bath salts.

Methylenedioxypyrovalerone (MDPV) is a psychoactive stimulant related to – but considerably stronger than – Ritalin. It was first synthesised in 1969 and has been in recreational use since around 2004. In recent years, it has been marketed in the US as 'bath salts' in the same way that smoking products sprayed with novel cannabinoids are sometimes sold as 'incense' – as a cute, fooling-no-one means to suggest it is not being purchased and ingested for recreational purposes.

But in 2010, something else began to happen. 'Bath salts' became a meme. A stream of news stories attributing bizarre behaviour to ingestion of bath salts began – and continued after the US Drug Enforcement Agency instituted an emergency one-year ban on MDPV on November 2011. People were trashing hotel rooms, screaming, attacking priests and policemen. And then things got really weird.

Bath salts got tied up with a light-hearted popular culture meme around zombies. When Rudy Eugene was partially captured on video in a mystifying attack on a poor homeless man – chewing off most of the victim's face – the place of bath salts in the pantheon of horror was confirmed. Three languishing Senate bills were swiftly mashed together into one aimed at banning the bath salts plague permanently.

There were a couple of problems here. Firstly, no one really knows exactly what's in a packet labelled 'bath salts'. It might be MDPV or the related (and more widely used) drug mephedrone – or it might be one of the 2C class of psychoactives or methylone, which have wholly different effects. Hell, it might be actual bath salts.

Secondly, and more seriously, a toxicology report eventually found Eugene had nothing stronger in his blood than marijuana at the time he was shot by a policeman. Compiling actual incidences of MDPV psychosis into a convenient narrative would be misleading enough. Simply assuming that bizarre behaviour that could be a consequence of anything from methamphetamine abuse to mental illness must be down to the panic drug du jour was disastrous.

Someone should perhaps have told that to the New Zealand police, who recently announced – via an unnamed "police source" speaking to a *New Zealand Herald* reporter – that a disturbed man apprehended in Greenhithe recently had been on 'bath salts'.

The Herald's reporter rose to the bait, reporting injuries suffered by two Toronto policemen apprehending a "raging" man suspected to have taken bath salts. But the original report, in Canada's *National Post*, also noted that no toxicology tests had been conducted and the police spokesperson could only offer that the man's behaviour "was consistent with someone who could be [on drugs]" – or possibly, the spokesperson acknowledged, just mentally ill.

"Simply assuming that bizarre behaviour that could be a consequence of anything from methamphetamine abuse to mental illness must be down to the panic drug du jour was disastrous."

The Herald's story also reported the case of another man who "skinned himself alive while on the drug", for which I can find no original report other than an unsourced line in a feature in the July issue of *Spin* magazine. The line has since been recycled, often verbatim, by news services all over the internet.

"In 2010," *Spin* reported, "304 calls were made to poison control centers nationwide regarding bath salts. A year later, the calls skyrocketed to 6,138."

But which came first? Widespread use of the drug and consequent problems? Or the reflexive attribution of any bizarre behaviour to bath salts? We really do not know.

But here's one thing you can say: MDPV is a very poor candidate for a legal high. It raises blood pressure and heart rate and can trigger severe anxiety attacks. Compulsive re-dosing seems to be a common issue. The MDPV 'experience vault' at erowid.org contains far more than the usual proportion of bad experiences – and some of them are very bad. One is titled 'I Went to Hell and I Saw the Abyss'. Another, headed 'Terrible Stuff', recounts "the worst withdrawal that I've ever experienced from any stimulant".

So why would anyone take this stuff? The same reason people usually take psychoactive substances: they want to get high. Also, for years, MDPV was legal. Even where it wasn't, it was easier to obtain (usually from places where it remains legal) or synthesise than better-known but more thoroughly prohibited recreational drugs. Toss in uncertain provenance and potency and potential impurities, and it's pretty much a poster child for the flaws in the progressive-prohibition model of drug enforcement. You ban one drug and a nastier one comes along. You have no control over the situation at all.

Perhaps the new regulatory regime for psychoactive substances will break New Zealand out of this vicious cycle. But for that to happen, everyone will need to keep their heads. And by that I don't just mean the drug users. ■

Russell Brown blogs at publicaddress.net and hosts *Media3*.

In 1914, a clever scientist working for the German pharmaceutical company Merck created and patented the MDMA molecule. He obviously had no idea what he had created because the first recorded human ingestion of MDMA wasn't until the 1970s when it was rediscovered by Dr Alexander Shulgin.

3,4-methylenedioxymethamphetamine

3

TOTAL NUMBER OF DEATHS RELATED TO MDMA IN NEW ZEALAND

4–6

NUMBER OF HOURS MDMA REMAINS ACTIVE IN A HUMAN BODY

14

MAXIMUM NUMBER OF YEARS IN PRISON FOR IMPORTING, MANUFACTURING OR SUPPLYING ECSTASY IN NEW ZEALAND

$43

MEDIAN PRICE FOR ONE ECSTASY PILL IN NZ DURING 2010. AUCKLAND $41, WELLINGTON $56 AND CHRISTCHURCH $54

180,800

NUMBER OF NEW ZEALANDERS AGED 16–64 WHO HAVE USED ECSTASY

Psychiatrists heralded MDMA as "penicillin for the soul" and a "low calorie martini". They sought to use it to reduce the psychological defences of patients, making them easier to treat. What these pioneering psychiatrists didn't tell their patients was that it hadn't actually been clinically tested or approved for human use. Whoops.

Michael Clegg, a Catholic priest, coined the term "ecstasy" for MDMA because he felt it put him in touch with God. Clegg created a flood of ecstasy of biblical proportions in Texas by distributing around about 500,000 pills in a single month in Dallas. Incidentally, he became a millionaire in the process. By the mid-80s, MDMA had become known as ecstasy and had entrenched itself as the drug of choice for people going to nightclubs and listening to S'Express.

Despite little evidence of MDMA-related harm, the substance was banned by the US Drug Enforcement Agency in 1985,

> **"I remove the 3D glasses, lay back and close my eyes. Everyone else is a few feet away, licking grape and lime popsicles off each other. I remember thinking about how fun that looked, but I knew I had even better in store for myself."**
>
> A person describing their experience on MDMA.

and New Zealand followed suit in 1987. Evidence shows MDMA is only mildly addictive and well below drugs like alcohol and cocaine on the harm scale, and to date, there have been only three MDMA-related deaths in New Zealand.

After cannabis, MDMA is the second most used illegal drug in New Zealand and Australia. Of cause for concern is that pills sold as MDMA in New Zealand can contain a cocktail of other substances such as mephedrone, BZP, ketamine and DXM.

According to the New Zealand National Household Drug Survey, people who regularly took ecstasy felt the presence of MDMA had been trending downward, possibly due to a shrinking supply and increased demand. There have only been one or two examples of laboratories producing MDMA in New Zealand, although police believe a number of pill presses are currently in operation.

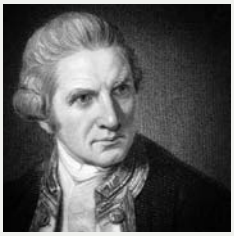
There has also been a shortage of MDMA over the past few years due to the Cambodian government cracking down on illegal plantations of mreah prew phnom. The critically endangered plant, commonly known as selsian wood, is a source of sassafras oil – a key ingredient in MDMA. In 2009, the Australian police worked with Cambodia to track down and destroy more than 33 tonnes of sassafras oil, enough to manufacture 2.45 million ecstasy pills.

MDMA is not risk free. It can make you confused, raise your body temperature to dangerously high levels and cause depression and sleep problems. Chronic use can lead to memory loss and affect the body's ability to regulate serotonin production.

But MDMA is currently being tested as a treatment option for many afflictions. One group at the University of Western Australia has been trying to find a compound of MDMA that will help treat Parkinson's disease. Post-traumatic stress disorder is where MDMA is showing the most promise of being approved for widespread use as a treatment.

> **"MDMA got you feelin' like a champion. The city never sleeps, better slip you an Ambien."**
>
> Jay Z, Empire State of Mind

Alcohol milestones in New Zealand



1770
Captain Cook brews beer, flavoured with rimu leaves and bark, while harboured at Ship Cove in Queen Charlotte Sound.

1835
First commercial brewery is established in Kororāreka/Russell.

1839
First alcohol tax by British Colonial Secretary Lord Normandy.
It excludes beer.

1863
First temperance movement meeting is held in the Bay of Islands.

1873
Licensing Act is passed, prohibiting the sale of liquor if two-thirds of residents petitioned against sale.

1884
King Country Te Rohe Pōtae is declared a special Māori 'no licence' district. Locals voted to restore licences in 1954.

1893
Alcoholic Liquors Sale Control Act is passed, making licensing areas consistent with electorates and allowed for licensing polls to be held every election.

1909
Masterton declares itself a dry zone and all pubs close. None reopen until 1946.

1911
Nationwide referendum is held on prohibition of alcohol. 56 percent vote in favour of prohibition, shy of the 60 percent needed for it to become law.

1917
A law forces pubs to close at 6pm as a temporary wartime measure. This remains for the next 50 years.

1918
240,000 signature petition calling for prohibition is presented to Parliament.

1919
Votes of 32,0000 New Zealand soldiers returning from WWI stop the passage of prohibition.

1958
Arnold Nordmeyer's 'Black Budget' increases tax on beer.

1947
Workers in Greymouth boycott local pubs for four and a half months after they raise the price of beer.

1961

Alcohol can be served with food in restaurants.

1967

Six o'clock swill ends with pubs opening until 10pm.

1969

Drink drive blood limit of 100mg per 100ml introduced (lowered to 80mg in 1978).

1989

A new Sale of Liquor Act liberalises liquor law. Supermarkets can sell wine. 24/7 trading allowed.

1989

Broadcasting Standards Authority established, with one role to review alcohol advertising.

1992

BSA allows alcohol ads after 9pm in exchange for free airtime for alcohol health promotion.

1995

Number of off-licences has almost doubled from 1989 levels.

1999

Alcohol purchase age lowered to 18 years. Supermarkets can sell beer.

2003

'Sherry tax' is introduced by Economic Development Minister Jim Anderton, almost doubling the price of cheap drinks with high alcohol content.

2007

Labour government asks the Law Commission to review liquor law.

2010

Law Commission tables 153 recommendations for Parliament to change alcohol law.

2012?

Government passes the Alcohol Reform Bill?

2011

Justice Minister Simon Power writes the Alcohol Reform Bill.

Electorally toxic

In a parliamentary democracy, are we able to have rational, evidence-based drug law? Former ACT Party leader **Rodney Hide** discusses Don Brash, Nándor Tánczos and the political conundrum that is drug policy.

RODNEY HIDE

I **HAVE** next to no knowledge about drugs, drug use and drug policy, and I think that's typical of the average parliamentarian.

That might explain why present drug policy is a chaotic failure, but I don't think it does. The problem runs a little deeper than that. After all, few MPs know much about monetary policy, but New Zealand's monetary policy is robust and working well.

We clearly – and fortunately – don't need policy whizzes as parliamentarians to ensure good policy.

What we do need is a good policy dynamic so politicians have every incentive to seek out policy that works and to follow good advice. And that's where our drug policy falls down. Politicians find it impossible to engage in any sensible debate about drugs and drug policy, which leaves us stuck with the occasional tweak of the status quo without regard for overall efficacy.

The political tweaks with alcohol are the purchase age and hours of purchase. With tobacco, it's packaging and where you can indulge. Cannabis is illegal, but its widespread availability and use appears of little concern to the authorities.

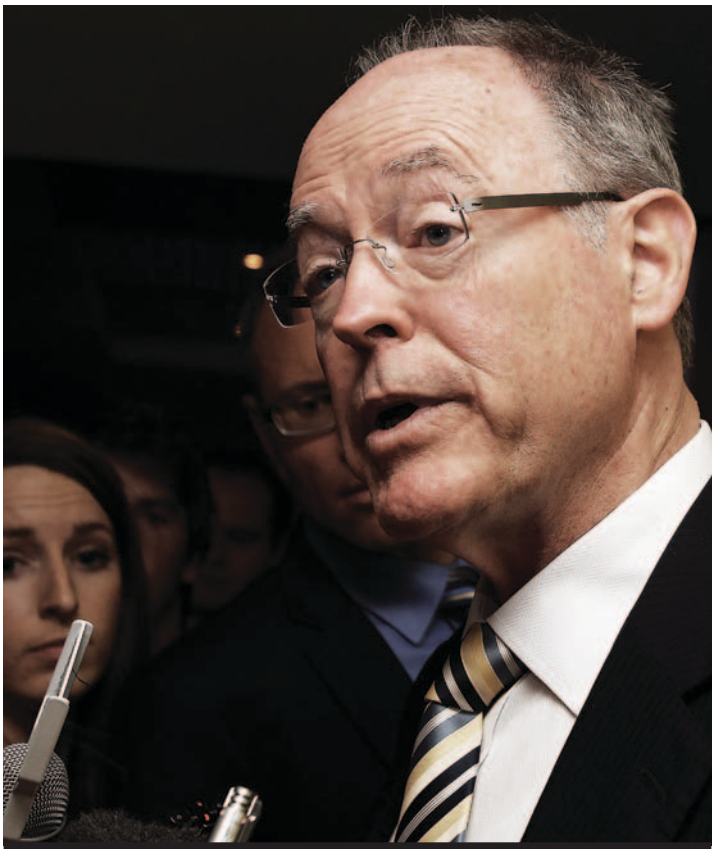
Nonetheless, Don Brash and Nándor Tánczos both proved that even discussing liberalisation is electorally toxic. The point is all the more dramatic because they come from opposite ends of the political spectrum and demographic.

Methamphetamine is demonized and no expense is spared trying to stamp it out. Politicians can trumpet a hard line to their electoral advantage but can't discuss the policy rationally or question whether it's working.

> **"It's the nature of drug policy that people's views on drugs vary widely, are invariably hypocritical and cross the usual political boundaries."**

The policy interventions for each drug bear no relationship to the problem each drug presents or the efficacy of those interventions. Instead, they have everything to do with the drug's history and the preservation of the historical status quo.

Nándor and Don see eye to eye on drug policy but not much else.



It's the nature of drug policy that people's views on drugs vary widely, are invariably hypocritical and cross the usual political boundaries. Nándor and Don would not agree on much – but they did agree on cannabis.

The problem is that any policy move on any drug sparks instant and polarised political opinion. Politicians have no room to discuss or debate the issues. Minds are made up already and votes are instantly lost.

This is why politicians don't want to talk drug policy. To succeed in an election, political parties must win party votes from a wide collection of individuals, and the same goes for electorate MPs. Debate on drug policy divides the vote. Constituents will have diametrically opposed views, and many will hold those views so strongly that drug policy becomes a vote changer.

The political wisdom is that drug policy doesn't win votes but it sure can lose them.

Does that mean what we have now is as good as it gets for drug policy? Not at all. What it means is that any rational discussion on drug policy has to occur well away from politicians, who will be the last ones to get on board with any proposed change. They are followers on drug policy, not leaders.

I suggest there needs to be a broad grouping of organisations and individuals to develop good drug policy.

There need to be developed clear principles to underpin policy for all drugs. These principles have to be general enough to capture diverse political views. I suspect the goal of harm minimisation is the place to start, and few could disagree.

"The point is all the more dramatic because they come from opposite ends of the political spectrum and demographic."

There needs to be developed a framework within which all drugs and the policy for them can be consistently and coherently viewed.

Facts and evidence are paramount; what are the real facts about the risk, the harms, the extent of use and the potential for use? Within the framework, there would need to be the full array of possible policy interventions and, most critically, the available evidence here and overseas for their success.

There needs to be acknowledgement and acceptance of the large gaps in knowledge. That builds the credibility of what researchers and those with practical experience do know.

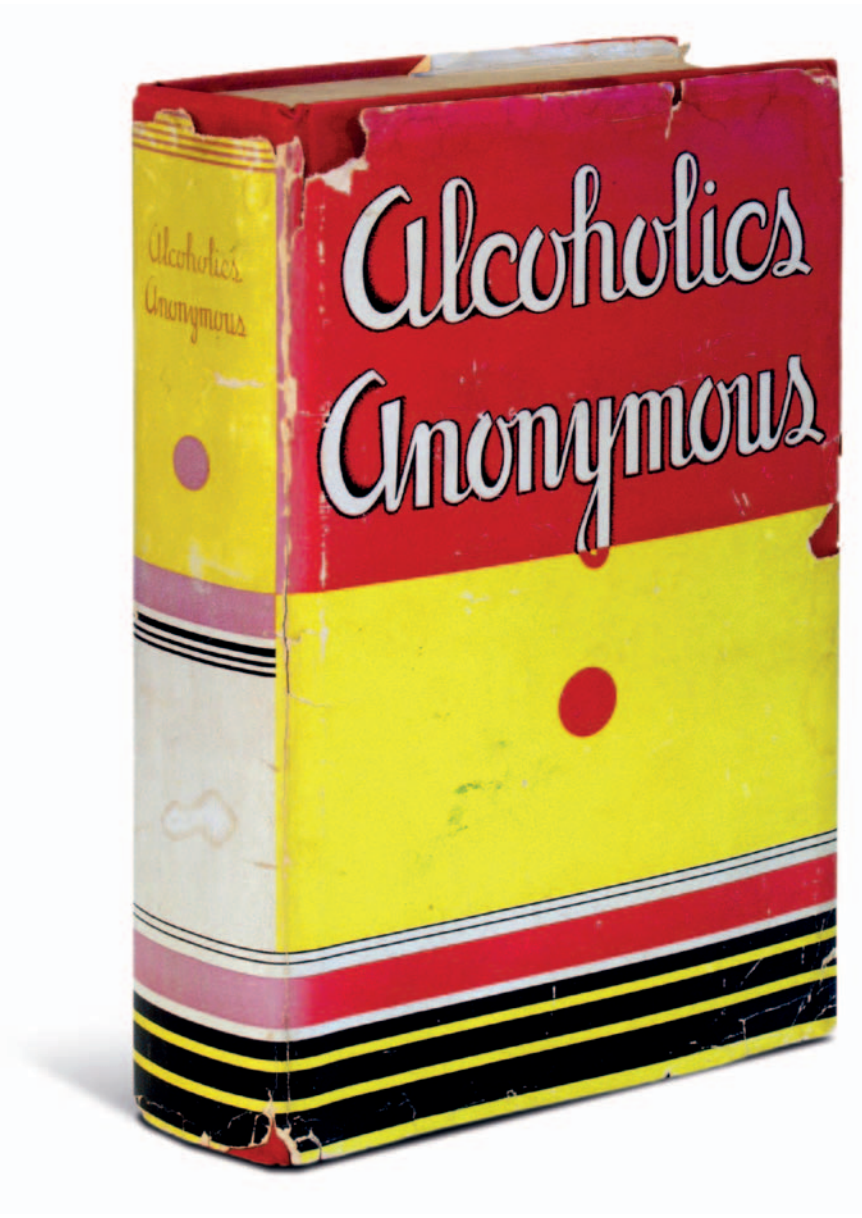
I don't think building such a policy framework is difficult. The hard part may be getting agreement on the framework and the way of thinking about drug policy amongst the array of organisations and individuals involved. There's no need to rush to the media and to the public. The critical first step is the solid framework to guide policy, the facts and the evidence. That's what's powerful. That's what will deliver. And that's what will dampen the hysteria and the kneejerk political responses.

Wider public debate can only begin once the framework is established amongst the experts, the organisations involved, the practitioners and interested individuals. I think that will take years, and Parliament and politicians will be the last to the party.

But without a solid framework, I am afraid New Zealand will be left muddling through with incoherent drug policy imposing a huge cost on our people and our resources. ■

Rodney Hide is a former Member of Parliament for Epsom and the Act Party.

Recovery ruffling feathers across the Tasman



'Recovery-oriented systems of care' is a recently born US concept that is shaping drug treatment policy in the United Kingdom and is now gaining ground in Australia. But not everyone agrees on just what this 'new recovery' means, and that, warns **Patrick Griffiths**, could have serious implications for developing systems, including those here in New Zealand.

PATRICK GRIFFITHS

THE concept of 'recovery' within alcohol and other drug treatment is far from new, and many programmes have claimed recovery as their aim since as far back as the 19th century. The emergent 'new recovery' philosophy is more contemporary, however. It rose in the mid to late 1990s and now underpins drug and alcohol treatment approaches in England and Scotland.

The first Australian test of the new recovery paradigm, the Victorian Government's *Roadmap – New Directions for Alcohol and Drug Treatment Services*, was released in June.

The good news is that, in this document at least, the baby has not been thrown out with the bathwater as some feared it would be. Harm reduction remains firmly front and centre and is regarded as completely consistent with recovery.

Director of the National Drug Research Institute (NIDRI) Professor Steve Allsop said the Victorian document was an example of recovery being used constructively.

"But you've got a good minister. What we have to be mindful of is that [recovery] can be narrowly defined in a way that is not helpful for the field but, more importantly, could contribute harm to consumers."

Anex is a leading public health voice in relation to drug issues. Its CEO, John Ryan, first became concerned after hearing recovery discussed at the 2010 International Harm Reduction Conference in Liverpool.

"Unravelling the genealogy of 'recovery' was not an easy feat when we decided to unpack its meaning in order to at least shape what we felt was its inevitable arrival upon our shores," he said.

This resulted in the release of the discussion paper *Australian Drug Policy: 'New recovery' and harm reduction.*

A prolific and influential advocate associated with the emergent recovery agenda is US writer William White, who was once of the view that methadone clients were outside the definition of recovery. He is now clear that new recovery paradigms can and should include people on pharmacotherapy, saying that "denying medically and socially stabilised methadone patients the status of recovery is a particularly stigmatising consequence".

> **"Because each individual must choose for themselves the most appropriate path and technique of recovery, there is no justification for forms of prescriptive public policy in this area."**
>
> John Ryan

Professor Thomas McLellan was President Obama's number two drug policy guru and was involved with promoting recovery while at the same time endorsing the benefits of needle exchange. He has lost a son to a drug overdose and has direct family members struggling with addictions.

Professor McLellan said recovery-oriented systems include "the full continuum of care; everything from prevention, through early intervention, expansion of standard treatments of all types, but also expansion of recovery services, such as drug-free housing, parenting assistance and legal help to try and reverse some of these problems".

In England, greater emphasis is being placed on the narrow outcome of abstinence in drug treatment policy and funding frameworks, which is not consistent with a holistic focus on improving the overall quality of life.

This prompts Professor Allsop to caution that there is a very real risk that the term 'recovery' is open to being politically captured with unintended adverse outcomes.

"There are examples of that in some of the discussion that has occurred, for example, in England. Indeed, if you look at some of the writing, recovery has been used to narrowly focus on 'getting people off drugs' with less attention given to the broad range of important outcomes.

"For me, a critical purpose of what we do is to aim to help people access a higher quality of life. For many people, of course, a key means to this goal is coming off drugs, but it is not the only approach we should employ. And that's where some of the debate can end up getting quite heated – it then becomes polarised, a clash of paradigms between 'abstinence is best' versus a harm minimisation approach. That simply isn't helpful or necessary."

In February 2012, the Cameron Government announced that the treatment strategy in England involved greater emphasis on individuals entering "full

“What we have to be mindful of is that [recovery] can be narrowly defined in a way that is not helpful for the field but, more importantly, could contribute harm to consumers.”

Steve Allsop

recovery”. It recognised that entire systems transformations would be required but did not commit the extra funding needed to achieve that. It announced that 20 percent of treatment funding would be tied to a payment-by-results system in which services may receive payment for people who complete treatment and do not re-present for at least six months.

Professor McLellan says the recovery movement is definitely not a front for AA, but that, in America, more people have gotten sober and into recovery from AA than in just about any other way, and that recovery is a state of being, not a method.

“Fine, don’t use AA. Get a priest, get a buddy, take a medication, go to a drug court, find a good woman – whatever. There are 50 ways to get into recovery.”

Professor Allsop says it is important for the Australians to be clear on what they do and don’t mean by recovery to “stop somebody else capturing the debate” and the polarisation of the field that won’t help anyone.

John Ryan has proposed a definition that he encourages New Zealanders to consider.

“We’ve looked carefully at the various streams of thought and the definitions floating around. We certainly don’t agree with the mainstream US definition of recovery because there’s just too much of that underlying abstinence philosophy in there. And they don’t tackle harm minimisation or harm reduction at all,” he says.

“We reckon recovery can be defined as ‘a voluntary self-determined process toward wellbeing through minimisation or cessation of drug-related harms. This involves fostering healthy supported connections, such as with self, family, peers and community, and is premised upon fair access to prerequisites for wellbeing’.

“When you think about it, the Australasian view of recovery is a non-prescriptive form of harm reduction, fostering improved health and wellbeing, with cessation of alcohol or other drug use a common aspiration and outcome.

“I agree with Professor McLellan, who is one of the pioneers of US concepts of addiction as a chronic relapsing condition. There are many sources and pathways of recovery. Recovery should be self-determined rather than being imposed by others.”

“Transformation toward new recovery approaches would require large-scale investments and should not be at the expense of already underfunded harm reduction programming.”

Martin Barnes

He said he was concerned by trends in the UK and the distinct possibility that similar approaches may be forced upon health systems in Australia.

“Because each individual must choose for themselves the most appropriate path and technique of recovery, there is no justification for forms of prescriptive public policy in this area.”

CEO of Drugscope in the UK Martin Barnes says there are few additional resources being channelled into transitions toward recovery-oriented systems. This is despite evidence from the US that large systems-level changes are required, including substantial investment in training for drug treatment service staff.

“The biggest challenge facing the sector [in England] is the transfer of responsibility [from April 2013] for drug and alcohol treatment to local authorities as part of a new public health service. The National Treatment Agency will also be abolished and its functions transferred into a new agency called Public Health England,” he says.

“A key issue is the risk of disinvestment. There will be a ring-fence around the new public health budget but no ring-fencing for drug and alcohol treatment funding. Up to half the local public health service budget will represent current spending on drug and alcohol services. There is a plan to incentivise local authorities to continue to invest in drug treatment – which is positive – but drug and alcohol services are one of 17 potential responsibilities for what will be called Health and Wellbeing Boards [including tackling obesity, smoking cessation, reducing winter-related deaths, etc].”

He warns against rushed wholesale changes without sufficient funding.

“If new recovery was to become an agreed strategy, it should only evolve over many years at the frontline and be preceded by substantial and cautious policy development arising from

> **Fine, don't use AA. Get a priest, get a buddy, take a medication, go to a drug court, find a good woman – whatever. There are 50 ways to get into recovery.**
>
> Tom McLellan

widespread consultation.

"Transformation toward new recovery approaches would require large-scale investments and should not be at the expense of already underfunded harm reduction programming."

But Ryan remains open-minded and is hopeful that, amid the winds of change, the better elements of recovery systems, including strengthening recognition of the role of self-support groups, can be included without undermining the successful mixed-methods approach that sets Australia's long-standing policy frameworks.

"Appropriately adapted recovery models and rhetoric should be considered, but must not be used to either mask or justify erosion of the lifesaving and cost-effective approach of harm reduction throughout Australia.

"Given the weak evidence base, wholesale shifts toward the new recovery paradigm, as it is currently framed, involve significant risks. In a contemporary context of government budget pressures, this risk is heightened. Adopting the 'new recovery' philosophy without serious localisation for our culture and health systems is potentially quite dangerous."

Leading US recovery advocate Bill White stresses that needle exchange and recovery are highly compatible – a position endorsed by Professor McLellan.

"Syringe and needle exchange, naloxone distribution and other medications including opioid maintenance medications are all part of a recovery-oriented system of care and can help people move to a healthier, better way of life," he says.

Ryan says that, based on how the debate unfolded gradually in the UK and then the sudden way that it has loomed large in Australia, colleagues in New Zealand should probably start discussing it soon.

"The recovery movement operates in an organised fashion, so I expect it will not be long before it bubbles up in New Zealand. We are very open-minded about it but nevertheless starting out from a position of healthy scepticism, because in the wrong hands politically, it could be negative – possibly in the area of methadone maintenance treatment.

"But there are many positive aspects to it – particularly recognising that treatment systems need to be better integrated with other social services and that, for people to overcome serious problems, they may need help with housing, jobs, mental health services and the like.

"New recovery principles, if adapted, could make a valuable contribution to drug policy and practice, particularly when fostering community linkages to support people." ■

Patrick Griffiths is a former journalist working for Anex, an Australian non-profit organisation working to increase understanding around problems arising from the use of illicit drugs, pharmaceuticals and alcohol.

RESOURCES

- Get a copy of *Australian Drug Policy: 'New recovery' and harm reduction* here: **nzdrug.org/MvH1K7**
- Watch a recovery story: **nzdrug.org/NCmrri**

QUOTES OF SUBSTANCE

> **The award is possibly the biggest travesty of justice even by the UN and the World Bank's weak ethical standards.**

Pranay Lal *of Union Southeast Asia, a lobby group fighting tuberculosis and lung disease, expresses some discomfort that the World Business Council for Sustainable Development awarded the Indian Tobacco Company its highest prize for improving the environment and removing poverty. The prize was presented by UNDP Administrator Rt Hon Helen Clark.*

> **UNDP will not participate in these awards in the future unless companies like this are excluded.**

Helen Clark *claims a serious oversight in the award process and says UNDP is reviewing its rules and regulations to ensure such an incident won't happen again.*

> **I'm not sure why they are tweeting that. I presume it's an attempt to be funny and I don't think it's particularly funny.**

We are not amused says ALAC spokesperson **Lynne Walsh** *on a tweet Drug Foundation Executive Director Ross Bell sent about ALAC staff doing yardies at their farewell function.*

> **Might be a good idea to test some of these MPs when they come to the house as well.**

Mana Party Leader **Hone Harawira** *in response to proposals to drug test beneficiaries.*

continued on page 33 ▶

Don't hesitate

ELLE HUNT

Why do some people hesitate to call for help in a life-and-death situation? **Elle Hunt** investigates emergency responses to overdoses in New Zealand.

DESPERATE times call for desperate measures. Last year, the state of New York – where more people die from accidental drug overdoses than in car accidents – passed legislation designed to reduce the number of such fatalities. Known as the 'Good Samaritan 911' law, it offers protection from prosecution to people seeking help in the event of an overdose. Governor Andrew Cuomo expressed support for the measure, arguing that "the benefit to be gained by the bill – saving lives – must be paramount".

That similar immunity laws have been passed in other states, including New Mexico, Washington and Connecticut, is testament to the extent of the epidemic in America. There, the number of accidental drug overdose deaths from both legal and illegal drugs increased more than 400 percent between 1980 and 1999. In 2007, around 27,000 such fatalities were reported nationwide, compared to fewer than 17,000 homicides.

Drug overdose fatalities can be prevented if emergency services are alerted quickly enough, as death rarely occurs immediately. But part of the reason the number of fatalities is so high, even though most overdoses occur in the presence of others, is that most witnesses don't call for help. Findings published in *Drug and Alcohol Dependence* in 2005 estimated that between 10 and 56 percent of individuals who witness a drug overdose contact emergency services and even then only after their own attempts to revive the victim have failed.

> **"We would only involve police … if there was a suggestion of a crime taking place or that our safety or that of any individual was at risk."**
>
> Sue Gullery

According to findings submitted to the *British Medical Journal*, studies suggest witnesses to drug overdoses hesitate from calling for medical attention because they fear police intervention. Many fear they will be held liable themselves under laws against possession and use of illicit drugs. The limited shield from charge, prosecution and arrest offered under the Good Samaritan legislation creates an opportunity to save lives.

Drug overdose deaths are nowhere near as frequent in New Zealand, but they do occur. Charles Henderson of the New Zealand Needle Exchange Programme estimates there are around 12 each year: "I'd say that, per capita, that reflects a lot of other places."

Because drug overdoses in New Zealand are infrequent, there is no need for a response as wide reaching as New York's Good Samaritan legislation.

"We don't treat [overdoses] as a potential crime; we treat them as a supposed poisoning," explains Sue Gullery, Clinical Manager at St John New Zealand. "We would only involve police – and this is across the board – if there was a suggestion of a crime taking place or that our safety or that of any individual was at risk."

Police, too, assess each reported overdose on a case-by-case basis. "Decisions around prosecutions will be judged on the merits of what's happened," says New Zealand Police Chief Media Advisor Grant Ogilvie.

"Any prosecutions that we do take have to meet the Crown Prosecution Guidelines, which include a public interest test and an evidential sufficiency test... and even if we did decide to prosecute and it went through the courts, particular circumstances could be taken into account in terms of sentencing.

"Our overarching priority would always be the welfare of the individual, and we would always encourage someone to call 111."

> **"In reality, police are only interested in dealing with it on a criminal basis, and that's their job."**
>
> Charles Henderson

For these reasons, the fear of police intervention in the act of reporting a drug overdose to emergency services is "not an issue" in New Zealand, says Dr Paul Quigley, Emergency Medicine Specialist at the Capital & Coast District Health Board.

"Law enforcement is not interested in an overdose unless it leads to death," he says. "There are no real barriers to IV drug users seeking help in emergency situations – in fact, you're more likely to be prosecuted for not giving assistance if you find someone in a collapsed or overdose situation."

Such a charge would likely come under the crimes against the person outlined under the Crimes Act 1961, which detail "duties tending to the preservation of life". But, as Henderson points out, this presents a Catch-22 situation. "Any admission of use of drugs or administration of a drug to another is likely to cause the police to get involved, and on that basis, they can charge people under the Misuse of Drugs Act."

Moreover, he adds, police have been known to appear at the scene of an overdose without having been notified – "and we're unsure as to why they come but they do," adds Henderson.

"Frankly, in reality, police are only interested in dealing with it on a criminal basis, and that's their job."

The Needle Exchange Programme cautions its clients to display discretion. "Our advice is don't say anything during the 111 call as to what drugs are used; say the victim isn't breathing and is unconscious," says Henderson. Then, when ambulance staff reach the scene, they can be informed that they are dealing with a drug overdose.

> **"You're more likely to be prosecuted for not giving assistance if you find someone in a collapsed or overdose situation."**
>
> Dr Paul Quigley

"We take that typical harm reduction approach: we present the facts and the mechanisms to keep people safe, legally as well as physically. That's all we can do, frankly."

Though drug overdoses are infrequent in New Zealand, Henderson warns fear of criminal sanctions can prevent people from seeking help in emergency situation. "What you end up with is people not wanting to know. They drop the victim in the street or outside A&E. They won't ring the ambulances, and what good does that do?

"Now some people may argue that they should get busted and go to prison, but we think there's more harm in taking that approach than trying to encourage people to either get treatment or get off drugs themselves.

"But it's really this age-old problem around treating illegal drugs as a criminal issue instead of a health one. That's always going to come to the fore." ■

Working together to prevent overdose

THE NEEDLE EXCHANGE PROGRAMME (NEP) has enjoyed a relatively good relationship with police and has formed part of a training video for pharmacists primarily to do with policy and operational edits promoting the health consequences and its concerns of blood-borne viruses and the added aspect of police safety concerns where injection equipment is well hidden and not identified during police searches (which was reported to occur before the NEP).

Effective intersectoral dialogue and common understanding of what the issues are at the ground level, such as law enforcement practices that disrupt services, agreement on not arresting/targeting NEP workers, and treating NEP outlets (particularly dedicated needle exchanges) as safe places for people who use drugs.

At a regional level, all the dedicated needle exchanges (NEXs) actively maintain a local connection and liaison. This can involve presentations to whole squads (or even the whole establishment at the station) to regular phone contact and liaison at a managerial level. The NEX workers themselves are very cognisant to ensure there is no compromising of client anonymity to maintain these contacts. Police presence at the exchange site was and is avoided at all costs for the obvious connotations that the behaviour in question is illegal.

The Misuse of Drugs Act was amended in 2005, and anecdotal reports from personal communications and operational directives show it was clearly explained to the police frontline what this meant in legal terms

On the basis of a review of the NZ NEP, it was recommended that the NEP develop a relationship with the Police College and engage in providing a harm reduction curriculum to officers so there is a greater awareness of the implications of harm reduction in policing work. It is hoped this will be fruitful, resulting in a greater understanding by police of the health implications of injection behaviours and how the adoption of an intersectoral approach as set out in the National Drug Policy can collectively minimise these harms to benefit the individual and the wider community.

Drugs and development: THE REAL THREAT

ANN FORDHAM

To coincide with the International Day against Drug Abuse and Illicit Trafficking on 26 June 2012, the United Nations (UN) General Assembly (GA) held an 'informal' debate in New York on the issue of drugs and crime as a threat to development. **Ann Fordham** suggests the real threat, however, remains the same old tired and failed thinking that is entrenching, rather than reducing, harms from the international illegal drug trade.

UNODC Executive Director Yuri Fedotov

THE call for this debate reflects UN discussions about transnational organised crime and its link to the illicit drug trade. In September of last year, UN Secretary General Mr Ban Ki Moon set up a UN taskforce, to be led jointly by the UN Department for Political Affairs and the UN Office on Drugs and Crime (UNODC), to mobilise the UN in a co-ordinated and coherent response.

The challenge to the UN of developing a system-wide response on the issue of drugs and organised crime should not be taken lightly. For many years, civil society actors have been calling for UN agencies to 'speak as one' on an evidence and rights-based response to reducing drug-related harm among people who use drugs.

HIV prevention in particular has been at the top of this agenda. There has been some progress on this issue, with broad acceptance across UN bodies (after many years of sustained civil society advocacy) of life-saving harm reduction interventions such as needle and syringe programmes and opioid substitution therapy as key interventions for the HIV response.

However, in recent months, we have witnessed a concerning roll-back by the UNODC on harm reduction and a misrepresentation of the agreed best strategy for HIV prevention among people who use drugs. This was well illustrated by my colleagues from the International Network of People who Use Drugs and Harm Reduction International in their guest editorial in the May 2012 edition of this publication. There, they discussed the censorship of civil society voices at this year's 55th Session of the Commission on Narcotic Drugs and moves by UNODC to reframe abstinence-based drug dependence treatment as effective HIV prevention.

The UNODC's misguided leadership on this issue is particularly worrying given it is the lead UN agency for responding to HIV prevention among people who use drugs under its mandate as a co-sponsor of UNAIDS. These recent developments highlight the ever-pernicious tendency to promote zero-tolerance approaches to drug use in an unfortunate recycling of the powerful 'drugs as a threat' narrative, despite the overwhelming evidence for both the failure and negative consequences of this approach.

It is this 'drugs as a threat' narrative that was used to frame the GA debate on 26 June. While there is absolutely no doubt that the power and reach of transnational organised crime and the activities in which such groups are engaged seriously undermine global development objectives enshrined in the Millennium Development Goals, presenting the issue in these terms reinforces the idea that people who use drugs, farmers engaged in producing drug-linked crops and the 'little fish' in drug distribution networks are also the 'threat'.

This conveniently ignores the fact these groups are often the most marginalised in society and their involvement in the drug trade is based on a complex combination of factors such as socio-economic status, marginalisation, vulnerability and geography. The 'drugs as a threat' discourse has justified punitive measures towards consumers of drugs, crop eradication schemes and resistance to pragmatic harm reduction measures on both the demand and supply sides of the drug market.

The actual GA debate was chaired by Mr Yuri Fedotov, the Executive Director of the UNODC. As predicted, it was fairly uninspiring, which is typical of these large diplomatic gatherings. There were the many routine and hollow statements from most member states echoing those we hear each year at the CND. There were, however, a few progressive interventions that reflect the recognition by an increasing number of governments that the drug control system is in need of modernisation and reform.

The US, for so long the main proponent for prohibition, reiterated its statement that we need to prioritise treatment over punishment. Guatemala robustly defended its call for a review of current drug policies and Luxembourg highlighted the need to take under serious consideration the recommendations of the Global Commission on Drug Policy.

These cracks in the consensus are heartening. Yet, to really shift the debate towards reform, there needs to be clear acceptance of a number of inconvenient truths – the greatest of which is that the huge political and financial commitments to eradicating the illicit drug market have failed. The global drug trade has not been contained and is estimated to be worth some US$300 billion, most of which is in the hands of organised crime.

The second inconvenient truth is that many of the security and law enforcement-focused strategies employed to this end have only served to exacerbate the problems: the illegality of the market fuels the profits of organised crime and drug market violence; the criminalisation of people who inject drugs drives the HIV epidemic and leads to the overburdening criminal justice and prison systems; and harsh supply reduction strategies lead to the destruction of the livelihoods of some of the most marginalised communities for whom the only existing viable economic option is the drug trade.

In understanding the multi-faceted nexus between drugs and development and how to respond effectively and appropriately, there must be a coherent strategy in which drug control objectives do not adversely affect the same communities that development policies are designed to support but that instead are integrated, sophisticated and pragmatic.

The real threat to development would be to complacently recycle wasteful, failed and counterproductive strategies. ■

Ann Fordham is the Executive Director of the International Drug Policy Consortium. www.idpc.net

A slug of the drug

Recent research by the Canadian Centre on Substance Abuse has given substance to something we've long suspected. Combining alcohol and caffeine is not a good idea. **Rob Zorn** looks at why the researchers say these drinks increase harm and at some of their suggested solutions.

ROB ZORN

CAFFEINATED *alcoholic beverages in Canada: Prevalence of use, risks and recommended policy responses* is a new report examining evidence linking the combined use of alcohol and caffeine to increases in harms including severe intoxication, dreadful hangovers, drink driving and being on the giving or receiving end of sexual assault.

Caffeine and alcoholic beverages (or CABs for short) are becoming more and more popular in Canada, as they seem to be here.

Though it has a myriad of lesser known competitors, Red Bull is considered the standard energy drink for CAB concoctions just about anywhere. Red Bull and vodka – or the Vod-Bomb as it's otherwise known – is a "classic drink" according to the Red Bull website and one of the most popularly ordered drinks around the world.

Red Bull's aggressive marketing campaign targets teenagers around the world by sponsoring extreme sports events and athletes as well as video games and musicians. Kiwis bought NZ$30.3 million worth of Red Bull in 2010, a 7.5 percent increase from 2009. In 2011, Red Bull recorded an 11.4 percent increase in sales internationally, which was also reflected in New Zealand.

Reasons students gave the Canadian researchers for their copious CAB consumption range from the innocuous – they taste good or give me energy – to the downright troubling – I can stay awake to party longer, get a quicker buzz or drink more without feeling drunk. Research in Australia has found similar motivations.

The report distinguishes between two categories of CAB use: those that are pre-mixed and sold in liquor outlets and those that are hand-mixed by consumers themselves. Hand-mixed CABs are the riskier option because they typically involve more alcohol and caffeine.

There are a couple of explanations for the increased harm from CAB consumption. Firstly, caffeine interferes with the consumer's perception of their own intoxication, so they feel less drunk than they actually are. However, the caffeine doesn't interfere with the alcohol's effects on the body, including deficits in motor co-ordination and reaction time. In other words, the mind doesn't realise it has to step in, as it normally might, to put the damper on activities like driving or other risky behaviour.

The second explanation is that caffeine masks some of the depressant effects of alcohol upon the central nervous system leading to longer and more active drinking sessions. Normally, the consumer would realise they're dangerously drunk and stop drinking or they'd pass out. However, the caffeine means the consumer often continues to drink and be more active despite being physically and mentally impaired.

So what can be done to reduce this lethal cocktail of harm? The researchers suggest increasing price (through increased excise) and restricting hours of sale are the most effective measures for reducing CAB consumption. And to these, the National Addiction Centre's Prof Doug Sellman would add getting rid of marketing.

"Effectively what we have here is multiple drug use – alcohol and caffeine mixed with sugar making these drinks all the more dangerous. Of course they should be highly taxed to reflect their danger, to disincentivise their use and to fund society having to clean up their mess. And to allow these hazardous substances so be so freely marketed just doesn't make any sense."

The Canadian researchers warn, however, that increasing the cost of pre-mixed CABs could encourage consumers to shift to hand-mixed drinks, which involve more risk – but Prof Sellman doesn't buy that that argument.

"There are always some people who do the opposite of what you intend, but not everybody will. The simple fact is, if you increase price and restrict availability and marketing, consumption will go down."

The researchers suggest that other measures, including public education campaigns and warning labels, can influence knowledge and awareness but are generally less effective than price. In fact, 86 percent of students questioned said they were aware of but ignored the "Do not consume with alcohol" warning printed on some energy drink labels.

Sellman agrees, but says there are ethical reasons why warnings should still be mandatory.

"Warnings probably aren't all that effective because we're not rational beings – we're human beings. But consumers still have the right to be fully informed about the product they are being encouraged to purchase. It should be made very clear that there is caffeine present that will mask the effects of alcohol."

Unsurprisingly, our Canadian researchers failed to isolate a silver bullet solution, and Prof Sellman admits he can't find one either. But based on evidence from successful campaigns on health issues such as drink driving and smoking, the report suggests a combination of policy, regulatory and educational interventions should be used to bring about a long-term shift in cultural norms.

Our government may be willing to tinker with minimum pricing, but unless it starts to take the marketing and sponsorship bull by the horns, any change is likely to be very long term indeed. ■

Rob Zorn is a Wellington-based writer.

RESOURCES

- Download the CCSA report: **nzdrug.org/MjwAVk**

EXPERIENCE

Hannah

HANNAH IS 21, works in retail but wants to be a police officer. She drinks caffeine-alcohol mixes because she enjoys the taste and finds them easy to drink. Her favourites are Pulse (vodka/guarana) and Jäger-bombs (Jägermeister and Red Bull). She'd drink about eight of these on a typical night out, and knows they're about 8 percent alcohol. She sometimes mixes her own at home, but prefers the cheaper and more convenient pre-mixes.

Hannah doesn't notice a lot of bad effects from drinking CABs other than feeling quite dehydrated the next day and finding it harder to sleep. She doesn't think they lead to dodgy sexual behaviour any more than any other alcoholic drink.

"I've seen my friends go home with some blokes and thought they're probably going to regret it – but I wouldn't blame that on caffeine. That's been happening since long before we had alcopops."

She says the same is true for getting into cars with drivers who've been drinking, but that's something she would never do.

> **"The one thing that might work is if you put a limit on how many kids can buy."**

"I want to become a cop and mixing alcohol and driving is bad for my career options so I always take a taxi or make sure my ride is safe."

Hannah thinks overindulging on caffeine and alcohol drinks is mainly something teenagers do and that most people in their 20s start to drink less but with more variety. She doesn't think warnings about consuming energy drinks with alcohol would make any difference and can't ever recall having seen one.

"The one thing that might work is if you put a limit on how many kids can buy. If they could only get one four-pack instead of three, then I think they wouldn't be able to drink so much."

Fit to start?

New Zealand's interlock programme

In mid to late 2012, the Land Transport Act 1998 will provide New Zealand judges with the option of sentencing high-level drink drivers to use alcohol interlocks. But does the government's insistence on users having to pay mean this promising harm reduction initiative is starting off on the wrong foot?

AN alcohol interlock is like a breathalyser hardwired to a vehicle's starting system. The driver must give a breath test, and the vehicle will not start if the result is over the pre-programmed blood alcohol concentration (BAC) level, which, in New Zealand, will effectively be zero.

Judges will have discretion to sentence a repeat drink driver or a first-time drink driver with twice the legal BAC or more to have an alcohol interlock installed in their cars after a mandatory three-month disqualification. Release from the interlock programme will be based on meeting criteria such as having no violations for six months or no violations for three months plus completing an alcohol assessment.

Interlock data will be downloaded to NZTA on a monthly basis for monitoring of both violations and circumvention attempts, and there will be penalties for those who tamper with their interlock or try to get someone else to blow in it.

There are anecdotal stories of people attempting to use balloons to fool the machine, but interlocks now measure breath temperature. One fellow is said to have forced his breath through a pipe immersed in ice water (believing this would remove the alcohol) and he then had a blowtorch heating the pipe at the other end to fool the temperature gauge. These sorts of attempts, no matter how elaborate, almost always fail, and in New Zealand, various safeguards will be used, including blow/suck or blow/hum technology or the option of a camera to ensure it's a real person and the right person blowing into the device.

Canada, Australia and Europe have interlock programmes, and they've been used in the United States for 30 years. Ministry of Transport Senior Adviser Kathryn MacIver says that means we have the benefit of starting with the very latest technology, but it also means there's an existing solid evidence base for their effectiveness.

"What makes interlocks often a better option is that offenders can drive again after just three months, and international evidence shows that's much more powerful – in terms of behaviour change – than disqualification. Each time they get into their vehicle, they're physically reminded they must be sober in order to drive."

Evidence from overseas reveals 75 percent of people will continue to drive while disqualified, and MacIver thinks that's also likely to be true here because we are so dependent on our cars.

"In contrast, when alcohol interlocks have been fitted, quite often there's a 60, 70, up to 90 percent reduction in reoffending."

The Ministry of Transport website estimates that, when the interlock programme reaches a 60 percent participation rate, it could save two lives and prevent 25 injuries each year, reducing the annual cost of road injuries by around $10 million. With further compliance, those savings will be even more.

One wonders, then, why it has been decided that the considerable costs involved with interlock systems will have to be met by the offender. Figures have not yet been finalised but, based on Victorian costs, are likely to be around $150 per month to lease the device along with a $200 application fee.

For many on low incomes, these expenses will be a barrier to applying or to ongoing participation, potentially leading to increased costs to the government in enforcing compliance. Many offenders claiming hardship could request a fine and longer disqualification instead, potentially removing the benefits of the interlock system from a significant chunk of the drink driving demographic.

Another worry is that these fees effectively amount to a disproportionately hefty fine for the offender. The Ministry of Transport's own Regulatory Impact Statement admits fees are likely to amount to around $2,000 in the first 12 months, "far in excess of the average fine given through the Courts".

MacIver acknowledges these costs are a concern but reminds that the current system puts financial pressures on offenders that would reduce if their period without a licence was just three months.

"Remember that these are more serious drink drive offenders, often with longer disqualification periods. How much does it cost in time and money to rely on public transport for a year? And is an interlock more or less costly than losing your job?"

Offenders who enter the interlock programme won't receive fines, and financial assistance is planned for people who can't afford to pay. But that assistance will be funded from the monthly leasing fees paid by those who can afford them. This means some people will receive a greater financial penalty than others for the same crime, so it's not just those on low incomes who may become disgruntled with the system.

The Drug Foundation supports the use of interlocks but believes they should be funded by the government if they are to have maximum effect in reducing drink drive-related harm. Keeping the current fine system in place (and using fines to help fund the programme) would be more just, ensure better levels of co-operation and compliance and result in fewer people driving drunk.

It may be true that every other interlock system in the world is based on user pays, but New Zealand has often stood out internationally when it comes to looking after its wounded, and it won't be the first time we've taken a stand in contrast to the rest of the world. ■

QUOTES OF SUBSTANCE

"If we could take alcohol out of young people's hands we could take 80 percent of the violent offences out of the Youth Court."

Principal Youth Court Judge **Andrew Becroft** *on changes to New Zealand's liquor law.*

"I believe all illegal drugs are bad."

Top US Drug Enforcement Agency official **Michele Leonhart** *was put on the spot by Democratic congressman. Jared Polis after she refused to admit that crack was worse for a person than cannabis.*

"I got so drunk by the time I went on at 2am I had forgotten the words to my own songs ... It was the worst thing ever."

Singer **Adele** *comes clean about her drinking problem in her biography.*

"Are we witnessing a new trend in product placement? We get enough brand names creating visual clutter around and on the pitch. Must we now endure audible product placements by the commentators during the game?"

MediaWatch listener **Malcolm Hunt** *on the incessant use of the word 'pure' by rugby commentator Ian Smith during a test match between New Zealand and Ireland sponsored by Steinlager, which happens to have a brand called Steinlager Pure.*

Should you give your teenagers alcohol?

Viewpoints presents the arguments on both sides.

THE CASE AGAINST

THERE'S a very good reason the legal drinking age is 18 and not younger. Alcohol is a drug, and minors shouldn't be able to purchase and consume drugs. If we make it illegal for minors to purchase alcohol for their own good, then why on earth would we sanction it being given to them by parents?

Giving a teenager alcohol is unsafe for their physical growth and development. A teenager's brain is still developing, a process that can be detrimentally affected by even the smallest amount of alcohol. Scientists don't yet know the exact effects of alcohol on a developing brain, but they do know it impedes long-term thinking and memory. Research has shown that animals fed alcohol during developmental stages show permanent impairment as they age.

And the brain isn't the only organ affected. Elevated liver enzymes, an indication of liver damage, are found in adolescents who drink alcohol, and again, studies of animals experiencing puberty show alcohol has adverse effects on the maturation of organs and the reproductive system.

But physical dangers are just the beginning; there are mental and emotional dangers as well.

Parents who introduce their teens to alcohol run the risk of their child developing a casual attitude to the substance. They see their parents giving them alcohol as validation. After all, if it really was a dangerous substance, their parents wouldn't give it to them, right?

This can be dangerous for a teen. They're at a stage of their lives where many view themselves as bulletproof new adults and can tend to be a little reckless. Combining this with alcohol can result in a number of unfortunate consequences such as violence, injury, unprotected sex and suicide.

Research shows that children who first use alcohol before age 15 are five times more likely to abuse alcohol than those who first use alcohol at age 21 or older. That's why Chief Medical Officers from the UK and Australia have recently said that the longer teenagers can abstain from alcohol, the better for their ongoing physical and mental wellbeing.

Lastly, young people do not need to drink to learn how to use alcohol safely. The best way to teach your child about the safe use of alcohol is by being a good role model and being very careful about the example you set.

In just about every country around the world, thousands of minors die annually as a consequence of alcohol-related incidents, and this is equally true in New Zealand. Alcohol is a serious and potentially harmful drug and not one we should treat casually when it comes to our young teenagers. ■

As a parent, the responsibility for managing your teenager's drinking lies solely on you – as both an authority figure and a role model. But at what age do you allow your teenagers alcohol? Should you try to keep them completely safe by enforcing absolute abstinence until they're 18, or do you slowly ease them into drinking as they approach their late teens?

THE CASE FOR

DRINKING alcohol is part of our culture, and most people accept that it has a legitimate place. It's a reasonably easy product to procure, which means your teen will probably have plenty of opportunities for experimental drinking – with or without your knowledge and probably despite your role-modelling and good intentions.

As a responsible parent, you want to have some influence over the way your children drink. An important part of making sure their experiences with alcohol are safe – both before and after they turn 18 – is guiding and familiarising them with it in a responsible way.

Telling teenagers they can't have something must always be done with care lest you create a case of forbidden fruit. Denying them alcohol could potentially create a certain mystique around drinking. You increase the risk of your teenager dangerously drinking unsupervised behind your back because your stance has been so hardline. Or if your teen is of the less adventurous variety, they could suddenly reach the legal purchasing age and have no experience or understanding of alcohol and the consequences of its consumption. Both situations are potentially very harmful.

When they turn 18, your teen is free to buy alcohol without your knowledge or consent. By giving them the occasional drink, say a glass of wine with Sunday lunch or a beer at a family barbeque, and by role-modelling responsible drinking yourself, you're more likely to remove 'forbidden fruit syndrome'. Your teen will see alcohol as no big deal (in a good way) and may even wonder what all the fuss is about.

Further, teenagers are very good at picking up on double standards, so parents who preach to their teenagers about the dangers of alcohol while continuing to drink themselves run the risk of undermining themselves as authority figures. Don't tell them something's bad for them but OK for you. Instead, show them how to drink responsibly, which is exactly what you want for them in the long run.

By denying your teenager alcohol before they turn 18, you leave it to them to discover drinking for themselves, and they'll probably learn most at parties and unsupervised gatherings. And can you be sure about what attitudes towards alcohol your teen's mates' parents have instilled? ■

YOUR VOICE

YOU DECIDE

What do you think? Have your say:
www.drugfoundation.org.nz/viewpoints

Charles Chauvel

Commissioner,
Global Commission on
HIV and the Law

The Global Commission on HIV and the Law was established by the United Nations Development Program under the leadership of the Rt Hon Helen Clark. The Commission studied the impact of the law on people living with HIV and recently made recommendations on how the law can better support universal access to HIV prevention, treatment, care and support.

It comprised a number of eminent people including Fernando Henrique Cardoso, former President of Brazil, Festus Gontebanye Mogae, former President of Botswana, and Dame Carol Kidu, the only women in Papua New Guinea's Parliament.

Labour MP Charles Chauvel was appointed to the Commission in June 2010 and answers our questions about his work and the relationship between drug use, HIV and the law.

Q What was your role on the Commission?

A I served as one of the 14 Commissioners. Eight of us were serving or former politicians with experience in dealing with laws that relate to HIV (I was a member and then the Chair of the New Zealand AIDS Foundation in the early 1990s as well as a board member of the Public Health Commission). The other Commissioners were politicians, judges, academics or journalists with comparable experience.

Q How much work does New Zealand need to do to fulfil the Commission's recommendations?

A The Commission produced six key recommendations:

- Remove discriminatory laws and policies that stop effective HIV treatment.
- Do not criminalise HIV transmission, exposure and non-disclosure.
- Protect key at-risk populations – IV drug users, sex workers, men who have sex with men, transgender people, prisoners and migrants – from irrational laws and policies that put them at increased risk of infection.
- Empower women, especially women in developing countries, to be safe in their sexual relationships.
- Protect the sexual and reproductive health of younger people.
- Revise international intellectual property rules to make treatments much more widely available.

New Zealand has a generally good record in these areas, but there is room for improvement, especially in some areas of immigration policy and in the adequacy of our drug laws. Sadly, in the Pacific – our neighbourhood and the place where most of our aid dollars are spent – it's a very different story. Repressive public policy – as in Samoa at the moment, with three retrograde bills on the parliamentary order paper – hampers prevention messages and creates a fear of coming forward for testing and treatment. I greatly fear the conditions for a regional epidemic are in place.

Q How are HIV and drug use connected?

A The principal link between HIV and drug use is apparent in jurisdictions where the epidemic is concentrated among IV drug users. The former Soviet-influenced countries in Eastern Europe, Russia and Central Asia have such epidemics.

I chaired the Commission's Regional Dialogue in Chisinau, Moldova, last year and was able to observe that the spread of HIV in those countries was entirely preventable. If adequate health promotion, education and health protection measures had been put in place following the fall of the Berlin Wall in 1989 instead of the repressive measures that largely remain the response to the epidemic there, the situation would be very different.

Compulsory registers of HIV positive people, bans on their intermarriage or cohabitation with HIV negative people, an almost total absence of information on how to keep oneself safe from infection, especially if one is in an 'at risk' group, and a ban on harm reduction-based programmes are all typical features of the bleak prevailing public policy in countries where IV drug use-based epidemics are rife and where, tragically, the numbers of those infected are still rising.

Q This is not the first report to call for a different approach. Do you think there is a growing momentum for a change in global drug laws?

A Our report is merely one of a number of recent international reports to have found that the evidence shows the prevailing approach to drug policy is failing. As the Law Commission reported last year, we need less of an emphasis on drug use as a criminal matter and more on it as a health matter. We need more focus on the organised crime interests that are often behind dealing and less on the criminalisation of individual consumers.

Expert opinion and views based on the evidence can reach no other conclusions. So despite all the rhetoric and the vested interests that line up against drug law reform, I am confident the tide will turn on drug policy – eventually. It has to.

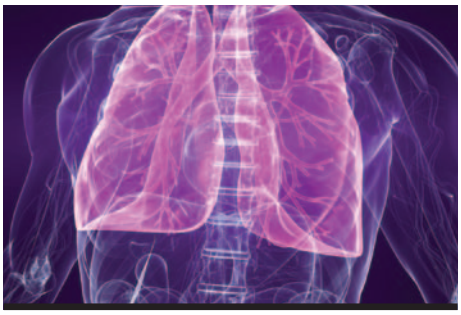
RESOURCES

- Read the Commission's report: **www.hivlawcommission.org**

Substance and Substantiation

Cannabis 20 times more carcinogenic than tobacco?

Recently, the British Lung Foundation claimed that, contrary to popular belief, smoking a cannabis cigarette is up to 20 times more likely to give you lung cancer than smoking a tobacco cigarette. This is a bold claim from an esteemed body, but is the evidence there to back them up? Mythbusters investigates.



THE purpose of the British Lung Foundation's (BLF's) June media release was to announce its special report on the impact of cannabis on the lungs. The report claims cannabis is 20 times more carcinogenic than tobacco despite also saying "studies on the subject have yielded conflicting evidence: some suggest there is a link between smoking cannabis and lung cancer while others don't. Further research is needed to confirm these findings and to explain why smoking a cannabis cigarette might pose a greater risk than smoking a tobacco cigarette."

Mythbusters is starting to feel less confident already, but, unfortunately, it gets worse for the BLF.

The report references three studies on the connection between cannabis and lung cancer, but not one of these provides any solid evidence to suggest the BLF's claim is true.

The first study, conducted in 2008 in New Zealand, claimed to have found a link between cannabis and lung cancer. However, the '20 times worse' statistic is, according to Professor David Nutt, "the most alarming interpretation of the most alarming evidence [in the research] possible" and a highly dubious one.

The findings and methodology of this relatively small study have since been seriously questioned on more than one occasion, but the BLF chooses not to mention this at all.

The second study gets only a small mention, possibly because it found only a 2.4-fold increase in the risk of lung cancer. The third study gets no mention in the text at all even though it looked at more people's cannabis use over a longer time than any of the other studies and so could be argued to be the most valid. One suspects the BLF largely ignored it because it found zero correlation between cannabis smoking and lung cancer.

There is a fourth study the BLF could have included, but we're not surprised it didn't. Donald Tashkin of the University of California has studied the effects of cannabis on the lungs for three decades and found that even smoking as many as 20,000 cannabis joints does not increase the risk of lung cancer.

To what must be the BLF's horror, he goes on to speculate that cannabis could even have a positive effect on the health of a smoker's lungs. The active ingredient tetrahydrocannabinol or THC may have an "anti-tumoural effect" in which cells die before they age enough to develop mutations that might lead to lung cancer.

Whether Tashkin's findings will stand the test of time remains to be seen, but it seems we can say truthfully that the evidence connecting cannabis smoke and lung cancer is far from conclusive and that there is no scientific basis for the BLF's claim.

To the BLF's credit, it did acknowledge there was a need for more research to verify these findings. However, Mythbusters thinks they're guilty of mishandling the evidence in the meantime. And while we cannot doubt the BLF had the best of intentions to inform and protect, attention-grabbing reports such as these could have the opposite effect.

What we do know is that inhaling any smoke is bad for you. Smoke is a bunch of particulates and gases released during combustion, and both tobacco and cannabis smoke will contain harmful substances such as sulphur dioxide and carbon monoxide. Putting these things into your body is not likely to be good for your health long term.

The BLF acknowledged more research on the subject needs to be done before any claims can be made then made a claim anyway for which there was little evidence. Mythbusters thinks that's disappointingly poor form. ■

REFERENCES

- Visit the Mythbusters page on our website for the references used in this column: **drugfoundation.org.nz/mythbusters**

THE VALUES OF HARM REDUCTION

JUNE 9 - 12, 2013 | VILNIUS, LITHUANIA

HARM REDUCTION
INTERNATIONAL CONFERENCE 2013

www.ihra.net/conference

organised and presented by:
HARM REDUCTION
INTERNATIONAL