



Where there is life, there is hope

Harm reduction is about saving lives and treating people with respect. While we led the world with the first government sanctioned needle exchange 20 years ago, what is the current state of harm reduction services, and how can they be scaled up for greater impact?

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COVER: Harm reduction is about saving lives and treating people with respect. While we led the world with the first government sanctioned needle exchange 20 years ago, what is the current state of harm reduction services, and how can they be scaled up for greater impact?

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Become a member

The New Zealand 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 Drug Foundation lies in its diverse membership base. As a member of the 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

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I F YOU want to go fast, go alone. If you want to go far, go together."

So says the African proverb underpinning the major shift in strategic direction we launch this month.

We're very proud of our achievements so far but, we're now turning the dial to 11 with a strong focus on leading change in how New Zealand deals with 'the drug problem'.

ROSS BELL
Executive Director

We have built a strong, sustainable and successful organisation through effective advocacy on critical issues, expansion of our drug information services and increased

investment by government and others.

We've remained innovative with our communications, including greater use of social media, and we've broadened our relationships with the AOD sector and beyond.

As we head into our 25th year, we can now use this strong foundation to lead and influence greater change and make a powerful impact.

Our vision of an 'Aotearoa New Zealand free from drug harm' doesn't change, but our mission – being a catalyst for broad action on drug harm reduction – and our way of working will.

Being a catalyst means inspiring others to do better and recognising we can't do things alone. So we're informed by the concept of 'collective impact', which demands commitment from across different sectors to a common agenda.

It means being a critical friend, especially to government, to help improve its drug harm prevention responses. We are committed to building enduring consensus for new health-focused drug policy and legislation.

It also means we will invest effort into engaging with stakeholders. We understand the increasing importance of social media, not only as an engagement tool, but also because it means organisations can stop talking at people and start two-way conversations.

We have identified key stakeholders to work with, but we want to make special mention of certain groups: those most affected by drugs and drug policy including people who use drugs, especially young people, consumers of services, Māori and Pasifika people.

We also want solutions based on people's and communities' strengths. We want to lead efforts that reduce the stigma faced by people most affected by drug policy.

Good communication will be vital. We reckon our style can be described as communicating 'evidence with attitude'. We use the best public health science in a way that provokes positive change.

Five core outcomes underpin our new plan:

1. Law and public policy will encourage more positive drug harm prevention.
2. The AOD sector's impact on prevention and treatment will be more effective.
3. Attitudes and behaviours around drug use will change positively.
4. Effective responses will be found for new and emerging drug harm challenges.
5. Young New Zealanders will stay engaged in education.

We hope you will share this sense of purpose and help support our work.

Contact me for a copy of our new statement of strategic direction:

ross.bell@drugfoundation.org.nz ■

@PUBLICADDRESS Quinoa: it's not worth it. 2 AUGUST

@ALIHKRAM Saying NZ has a "drinking culture" is a bit misleading we had a "smoking culture" a few years ago but made a decision to change. 23 JUNE

@CHRISISWHOIAM Was going to tweet a joke about drug testing but I'd just be taking the piss. 17 JUNE

@BOOBSRADLEY Talk to your kids about drugs. Talk to your stepdads about jazz. Like, just generally be polite and ask people about their interests. 24 JUNE

@JAMESDUNNENZ oh my stars who thought slapping the skycity bill in ahead of the #legalhigh bill was a good look #nzpol. 11 JULY

★ KEY EVENTS & DATES

12-14 SEPTEMBER

Cutting Edge 2013: Crossing the Border (into community care)

Rotorua, New Zealand

DAPAANZ is hosting Cutting Edge again this year with the theme Crossing the Border 'into community care'. There will be workshops on the days before and after for those interested.

www.cuttingedge.org.nz

23-26 OCTOBER

Reform Conference

Denver, Colorado, USA

Join your colleagues in the drug policy reform movement to learn, network and strategise.

www.reformconference.org

4-6 NOVEMBER

Issues of Substance

Ottawa, Canada

CCSA welcomes you to their biannual Issues of Substance conference with the theme From Knowledge to Know-how: Learn Inspire Change.

www.issuesofsubstance.ca

27-29 NOVEMBER

Through the Maze: Cannabis and Health

Auckland, New Zealand

The New Zealand Drug Foundation is hosting a conference about cannabis. Essential to attend for all AOD people.

www.drugfoundation.org.nz

20-25 JULY 2014

20th International AIDS Conference

Melbourne, Australia

Work together to strengthen efforts across all regions and around the world and build on the momentum of recent scientific advances

www.aids2014.org

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drugfoundation.org.nz/connect



NZ.



Associate Minister of Health Todd McClay and MP John Hayes say goodbye to harmful highs.
Photo credit: Christine McKay Dannevirke News

PSYCHOACTIVE SUBSTANCES ACT

In a world first, the New Zealand Government has regulated the sale of psychoactive substances.

The Psychoactive Substances Bill, which creates a legal market for low-risk synthetic drugs, was passed in early July and came into effect the day it was signed into law.

Associate Minister of Health Todd McClay said that the Bill is squarely about public safety and will ensure that the onus will be on anyone wanting to produce a psychoactive product to show it poses no more than a low risk of harm.

“The suppliers and distributors of these products have told us they want to be responsible. They’ve told us they want to make low-risk products and market them responsibly. This is their chance to prove it,” Mr McClay said.

New Zealand Drug Foundation Executive Director Ross Bell said the law is a world first.

“This is a cutting-edge and pragmatic approach to new psychoactive substances which will reduce the harm they cause in our communities,” Mr Bell said.

For a full overview of the Psychoactive Substances Bill, from inception to legislation, check page 20.

RESOURCES

- For a synopsis of the Bill, visit nzdrug.org/YwYAso
- For the Drug Foundation’s submission and latest news, visit nzdrug.org/PSBsubmission
- The full Bill and progress through Parliament can be seen here: nzdrug.org/psychoactivesubs

02 Ibogaine death



A WOMAN undergoing ibogaine drug detox treatment has died at the Te Whare Rongoa treatment centre in Kaitia.

The Director of Te Whare Rongoa, Dr Cornelius van Dorp, has said that, since February 2011, over 50 people had used the ibogaine treatment but refused to comment on the death until an investigation was complete.

New Zealand Drug Foundation Executive

Director Ross Bell said there had been concerns over offering the treatment in New Zealand.

“It’s promoted as a miracle cure for entrenched methamphetamine and heroin addiction, without there being a good clinical base to support those claims.”

Only two treatment centres in New Zealand offer ibogaine as a detox treatment.

The New Zealand Drug Foundation has lodged a complaint with the Health and Disabilities Commissioner, and the death has been referred to the Coroner.

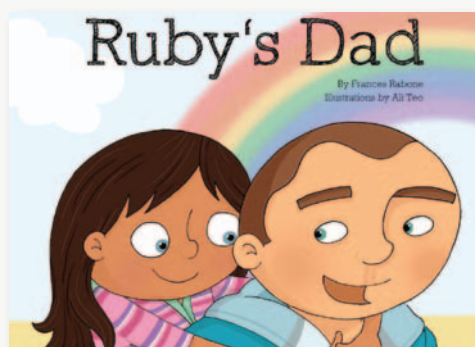
03 Thinking of the kids

A NEW resource for children dealing with their parent’s addiction has been launched by the Health Promotion Agency and the Skylight Trust.

Ruby’s Dad, written by Frances Rabone, is a children’s book that can be used to start conversations with parents and young people about addiction.

“The book is a powerful new tool that can be used to shift clinical practice in adult addiction services, family services and services working with children so that the impact of addiction on children is reduced,” said HPA Principal Advisor Addiction Sue Paton.

Copies of *Ruby’s Dad* can be ordered at www.alcohol.org.nz or by phoning the Health Promotion Agency on 0508 258 258.



04 Contaminated houses

2,000

THERE ARE growing concerns that the number of houses contaminated from the manufacture of methamphetamine might lead to a nationwide problem.

Recently announced figures show that over 2,000 labs have been closed down by Police in New Zealand, with many more going undetected.



07 Pūtāruru bans legal highs

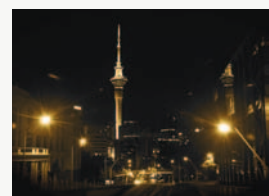
AS THE government regulates the 'legal high' industry, the Waikato town of Pūtāruru has united to stop the sale of the products.

The community-led initiative has Police and local health workers' backing as well as full support from the retailers who had been selling 'legal highs'.

Pūtāruru Police Sergeant Jason Shailer said there was a mistaken belief that the products were safe and that once the facts were put in front of dairy owners, they took the products off their shelves.

Co-owner of the K Beez Pūtāruru dairy Sid Patel said that the lure of big money – about \$100,000 a year – made them selfish. "Profit wise, legal highs are crazy, but selling them was the wrong thing to do. I should have stopped selling them a long time ago," Mr Patel said.

08 Begging ban –Auckland



AUCKLAND Council has moved to pass a bylaw that would make begging illegal in the city.

A group of inner-city businesses including Smith & Caughey, the Heart of the City business group and the Onehunga Business Association have pushed for the ban, saying that people who beg intimidate shoppers.

But Auckland Councillor Dr Cathy Casey said making begging an offence will serve only to criminalise beggars and give the Police powers that they neither want, need nor have the manpower to enforce.

"Begging is a social issue, not a crime. People who beg are among society's most vulnerable, often trapped in poverty, addiction and deprivation," Dr Casey said.

05 STATISTICS NEW ZEALAND 2012 YEARBOOK



1,750 750 5,750

NUMBER OF CANNABIS-RELATED CHARGES IN 2012

NUMBER OF METHAMPHETAMINE-RELATED CHARGES IN 2012

NUMBER OF DRUG OFFENCE APPREHENSIONS OF PEOPLE UNDER 30 MADE BY NEW ZEALAND POLICE IN 2012

06 Submissions

4,060

NUMBER OF submissions to the Christchurch City Council on its draft local alcohol policy (LAP).

Councils around New Zealand have been calling for submissions on LAPs after the passing of the Alcohol Reform Bill last year.

LAPs allow communities to set restrictions on the number of licences allowed and density of liquor outlets.

 **FOR MORE INFORMATION ON LAPs**

■ nzdrug.org/alcoholpolicies

World.

01



Harm reduction beats war on drugs

A **15-YEAR** study of Vancouver's HIV and overdose epidemic has shown that harm reduction methods have reduced drug use and improved public safety.

The study, which ran from 1996 to 2011, showed a decline in drug use, decrease in prevalence in injecting, a dramatic decrease in sharing injecting equipment, an increase in those accessing addiction treatment and a small decline in violence.

Co-author of the report and co-director of the Urban Health Research Initiative Dr Rhomas Kerr said that a public health emergency had been declared

in Vancouver so the city took a public health approach to the crisis.

"This is probably the city with the most aggressive harm reduction approach, yet we're seeing declining rates of drug use within this community," Dr Kerr said.

Despite this, Canada's government continues to fight harm reduction programmes despite the evidence showing the benefits of harm reduction strategies.



TO READ THE FULL REPORT

Visit nzdrug.org/vancouverstudy

03 Mexico/US border

877,450 KG CANNABIS

3,384 KG COCAINE

773 KG METHAMPHETAMINE

149 KG HEROIN

91 KG OTHER DRUGS

According to figures from the United States of America's border patrol with Mexico, cannabis is the number one seized drug in 2011.



FOR INVESTIGATIVE REPORTING TO FIND OUT MORE

Visit nzdrug.org/drugseizures

01

03

09

06

02 UK bans khat



IGNORING expert advice, Britain's Home Secretary Theresa May has banned the herbal stimulant khat. Khat, a plant with mild stimulant properties, is widely used in the UK by the Somali and East African population.

Earlier in the year, the Advisory Council on the Misuse of Drugs (ACMD) recommended that the plant remain legal in the UK, with specific harm reduction policies rolled out in communities where its use is prevalent.

May has stated the main reason for the ban centres around fears khat is re-exported from the UK to countries that have banned the plant and involvement of terrorist organisations in its production.

UK-based drug policy foundation Transform said that, due to khat's short lifespan, there isn't time for it to be transited through multiple destinations.

"It is clear therefore that the Home Secretary is not only responding to a problem her expert advisors say does not exist but is also set to create the very problem she is claiming to be responding to – exactly as her advisors have explained will happen," Transform wrote.



TO READ THE ACMD'S REPORT ON KHAT

Visit nzdrug.org/khatreport

04 Russia to drug test children

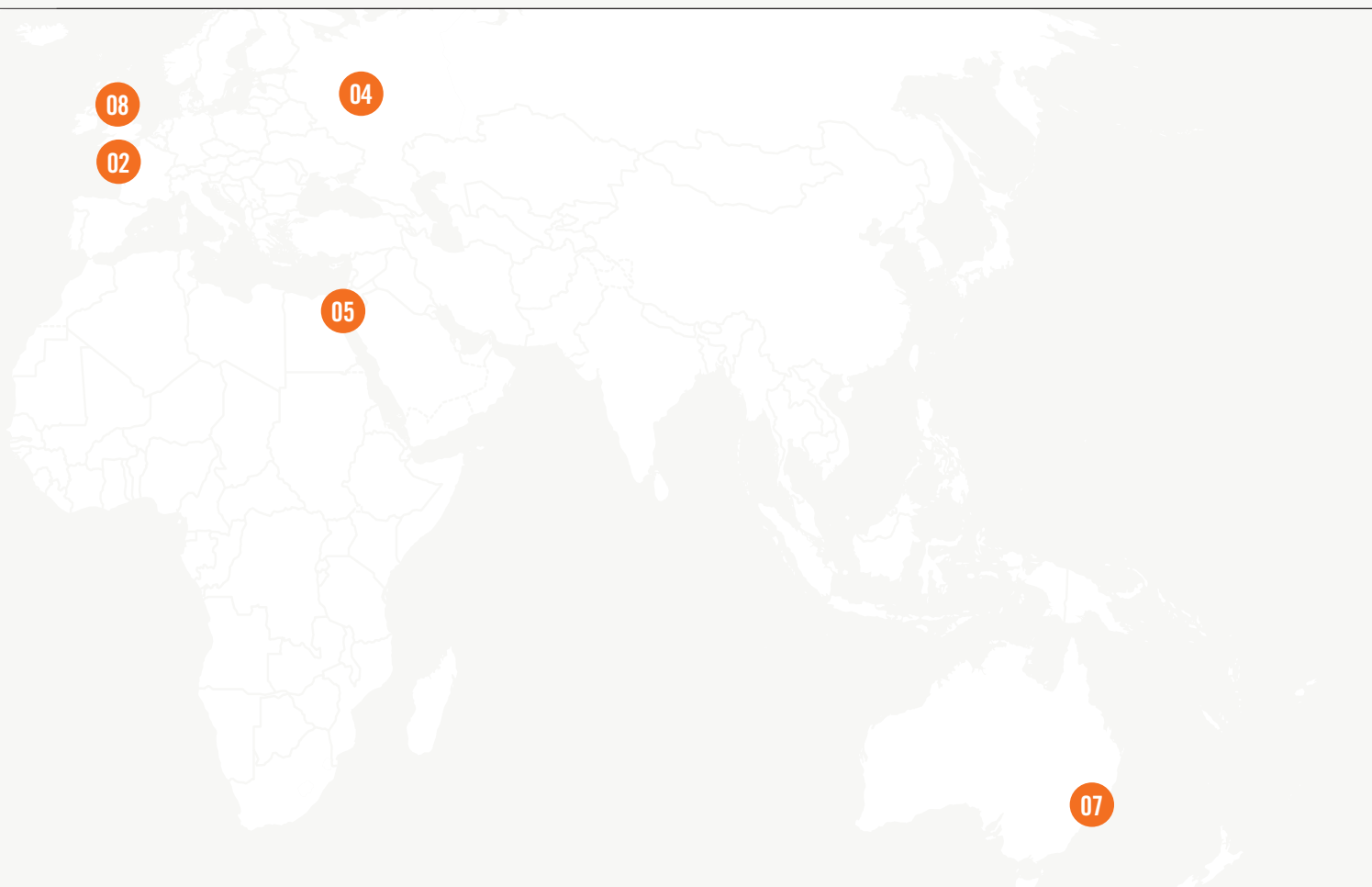


RUSSIA has passed a federal law that will allow school children to be drug tested if they are suspected of using drugs.

The law means children may be asked to "voluntarily" sit a written psychological test followed by medical checks. Children younger than 15 will require consent from their parents to undergo the testing.

If a student comes back with a non-negative test result, they will be sent to a treatment centre.

The law is set to come into effect from December 2013.



05
11,000



NUMBER of Israelis who have prescriptions for medicinal cannabis. Recently, Israeli orthodox rabbi Efraim Zalmanovich ruled that medical cannabis is kosher. While cannabis can be prescribed for over 30 chronic conditions, it remains illegal under Israeli law for recreational use.



06 Coca growers protest



MOVES in Colombia to eradicate coca plantations in the Catatumbo region have sparked protests, with four people dead and dozens injured. Since June, thousands of villagers have been blockading roads in a show of civil disobedience against the destruction of their only source of income. The farmers are demanding subsidies until legal crops can be phased in, but Colombia's President Santos has refused to meet with them stating it is "unjust and illogical" for them to strike any more.

07 Australia bans legal highs



NINETEEN brands of synthetic cannabis were banned in New South Wales (NSW) in early June in a move by the state to force the federal government to take responsibility for regulating 'legal highs'. With support from Queensland, Victoria, South Australia and the ACT, NSW Fair Trading Minister Anthony Roberts called for the government to stop "hiding" over the issue. In response, Home Affairs Minister Jason Clare announced legislation would be developed to ban 'legal highs', and an expert panel is being commissioned to consider options like the system in New Zealand and Ireland.

08 Champagne surgery



AN NHS-funded hospital in Hampshire has applied for a licence to sell alcohol to patients staying in a private ward. Basingstoke Hospital spokesperson Donna Green said that it was usual for private patients to have the option of alcohol with their meals. Local authority member Jack Cousins said he would be opposing the application. "It's a hospital, not a hotel. The NHS spends a huge amount of money encouraging people to cut down on alcohol and on treating people with alcohol-related illnesses, and we don't need hospitals sending this kind of mixed message."

09 No such thing as 'crack babies'



A 25-year-old study of babies born in Philadelphia has found poverty is a bigger influencer of developmental outcomes than having a mother who smoked cracked cocaine while pregnant. "Poverty is a more powerful influence on the outcome of inner-city children than gestational exposure to cocaine," lead researcher Hallam Hurt said. The research followed 224 babies, half of whom had mothers who used cocaine during pregnancy. The study found no significant difference between the two groups but did find that all the subjects had lower IQs than national averages.

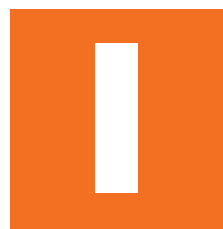
Where there is life, there is hope

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The exchange



IT'S BRISK business at Wellington's needle exchange. About every five minutes this Monday afternoon, the bell rings as someone enters

from rain-soaked upper Willis Street into a brightly lit, functional interior. The walls of a small waiting area are lined with health pamphlets about preventing HIV, preventing hepatitis C and safe sex.

Two large square holes are set into the bare counter with bright yellow bins beneath – one for loose used syringes and needles and one for the same equipment housed in specially created plastic containers.

Debby, friendly and matter of fact, chats with the people who come in about the awful weather as they drop used equipment into the bins. She then issues them with fresh kits, encased in an anonymous plastic bag. They're in and out in seconds.

In 1987, New Zealand became what is thought to be the first country in the world to introduce a national needle exchange programme (NEP) in response to the HIV/AIDS pandemic. Dr Michael Baker, now Professor of Public Health at the University of Otago, was a medical advisor in then Minister of Health Michael Bassett's office. He became an advocate and chief architect for the NEP.

“The traditional response was to be tough on drugs, but there was a pervading air of reform about the Lange government, and they were willing to consider a different approach.”

“There was uncertainty about how to respond to the emerging HIV/AIDS epidemic, which was starting to cause explosive outbreaks in injecting drug user populations in the UK and USA,” Dr Baker said.

“The traditional response was to be tough on drugs, but there was a pervading air of reform about the Lange government,

Just some of the equipment available at the needle exchange.



PENNY
MACKAY

and they were willing to consider a different approach.

"Even at that time, there were individual pharmacists who sold needles and syringes so users could inject more safely, so there were precedents for the programme.

"It was not plain sailing. The government's AIDS Advisory Committee was very wary. They were worried about unintended consequences such as an increase in the supply of needles and syringes fuelling the HIV epidemic. There was also concern because a national NEP had not been tried elsewhere. But everyone was well briefed on what we wanted to do, including opposition MPs.

"In the end, the legislation went through smoothly. I think there was by then a fairly pragmatic approach in New Zealand towards preventing HIV/AIDS."

There are now 21 needle exchange outlets, which have adopted a peer service model, meaning former injecting drug users are encouraged to join the staff. There are about 180 pharmacies involved and dozens of sexual health centres, Prostitutes Collective offices and base hospital and community clinics. In 2004, the scheme was enhanced by the 1-4-1 programme

“A 2002 international review indicated that, for every dollar spent on the programme, it saved taxpayers more than \$20 in downstream health costs.”

providing new 3ml barrels with any needle free to customers who brought in used syringes and needles. Today, the programme provides in excess of two million sterile needles and syringes each year to people who inject drugs (PWID).

The success of the programme is highlighted by the fact that among people who inject drugs and who use needle exchanges, the HIV rate is just 0.3 percent. (In the American capital, Washington DC, where there is no formal needle exchange programme, the rate is 50 percent.)

A 2002 international review indicated that, for every dollar spent on the programme, it saved taxpayers more than \$20 in downstream health costs.

At Wellington's needle exchange – officially The Drugs, Health and Development Project (DHDP) – Debby explains why the NEP is so successful. "Our job is to issue equipment that will

An insight into Insite

POSSIBLY THE finest example of harm reduction in the world, Insite in Vancouver, opened its doors in 2003 to intravenous drug users as a place where they could inject safely and connect to services like addiction counselling and treatment and to social services such as housing.

Insite was the result of at least 10 years of unceasing agitation by its prime movers, who never missed a chance to talk publicly about the absolute need to prevent overdose deaths and the spread of blood-borne viruses and HIV/AIDS. They handed out pamphlets to motorists, appeared in the media, presented at conferences and worked with anyone they thought could help: journalists, educators, researchers, drug users' families.

They were energised by the soaring rate of overdose deaths in Vancouver's East Side community, which, in 1997, reached 400. HIV was also endemic, with about one in four having the virus.

"It was such a sad and painful time for us," says Liz Evans, a nurse and one of Insite's creators. "We lived in the community, and we knew and were really fond of the people who were dying. Then one day, and I remember this really well, Bud (poet, singer and champion of the homeless Bud Osborn) came back from yet another funeral, and he was so angry and he said to me and Mark (Liz Evans's colleague and partner Mark Townsend) and our colleague Kirsten, "We've got to do something about this".

"And we said, 'Okay, we gotta do something' We didn't really know what – just something".

In 1993, Liz Evans had founded the non-profit Portland Hotel Society to run one of Vancouver's 'single room occupancy' hotels: budget accommodation for otherwise homeless people.

"We realised many also had serious illnesses and complex social problems, and we found, in that first year, about 88 percent of people we were housing were injecting drugs."

Support services were also desperately needed for the 6,000 drug injectors in the East Side. "There really wasn't anyone around who was watching what was going on."

So the fight for something better began. "There certainly wasn't much appetite back then for a big change from traditional drug treatment and enforcement. But after about a decade, the health authorities were on board, there was enough political leadership to make the funding thing happen, the Police were onside, and it was kind of miraculous really."

Today, Insite operates through an exemption from Canada's Controlled Drugs and Substances Act. Clients inject pre-obtained illicit drugs under the supervision of healthcare staff who supply clean equipment and know what to do if an overdose occurs. (There hasn't been a single death at Insite, despite more than 1,400 overdoses.) Wounds and infections are treated, immunisations given.



Liz Evans offers an insight into the fight for good harm reduction practices.

One floor above Insite is Onsite, where clients wanting to withdraw from drug use can be accommodated and looked after. Once clean, they get all-around support to plan their post-addiction lives.

Surveys indicate public support for Insite is about 70 percent, and the facility's funder, Vancouver Coastal Health, says it does "outstanding" work, has made a positive impact on thousands of clients, saved lives and provided vital health services to a vulnerable population.

Insite has been the subject of about 50 reports and peer-reviewed papers in prestigious scientific journals. They indicate that people who inject drugs who visit the facility are more likely to enter treatment and counselling, that it reduces the spread of HIV and hep C, reduces injection-related infections and improves public order. Its annual budget of \$3m is also worthwhile economically. For every \$1 it spends, Insite's benefits are calculated to be worth up to \$4.02.*

Despite the positive findings and widespread public support, in 2006, the federal government eliminated harm reduction as a pillar of Canada's anti-drug policy (the other three being prevention, treatment and enforcement) and began to threaten Insite with suspension of its precious drug law exemption. The battle went all the way to the Supreme Court, which, in 2011, ruled unanimously in favour of Insite's continued operation.

But in June, the federal government introduced tough new regulations over Insite's annual application for its exemption, the Health Minister saying, "sanctioned use of drugs obtained from illicit sources has potential for great harm in the community". Insite's lawyers are now looking at the implications.

Liz Evans says much of the opposition to Insite is based on ideology, fear and ignorance. "It flies in the face of voluminous evidence that it saves lives and limits the spread of disease. It's frustrating because, when something has been so robustly researched, it seems like these things should not be in question any more. I don't want people to use harmful drugs either, but they are a reality. Research shows Insite does not motivate drug taking, but it does save lives, misery and money." ■



REFERENCES

* Insite for Community Safety
www.communityinsite.ca/numbers.html

*Needle Exchange New Zealand's
Charles Henderson.*



“The money spent would be more than justified when you think what will need to be spent down the track, especially on health.”

keep clients safe while they inject. It's not to get them to detox, go on methadone or anything else.

“I don't ask questions, judge or advise,” she says.

Sometimes clients ask for contacts of a doctor, dentist or counsellor. Once a month, a nurse specialising in hepatitis C – the scourge of the drug injecting community – visits. In Wellington, a GP used to hold a Wednesday afternoon clinic, but funding ran out.

Rachel, another staff member, tells me the DHDP would make a great hub for health and social services.

“We have a rapport with our clients. They trust us, and through us, they could engage with the support they need.”

Rachel runs through a wish-list: Work and Income, budget advisors, housing, an onsite nurse and/or doctor, career advisors.

“The money spent would be more than justified when you think what will need to be spent down the track, especially on health.”

But such services look likely to only remain on a list of wishes for now.

DHDP General Manager Carl Greenwood says one of the biggest problems he encounters is the shame pervading the drug-using community. “The stigma of being a person who injects drugs means they try to be invisible, and that prevents us getting health information to them, which stops them engaging with services they really need.”

Rachel says a national awareness campaign highlighting drug injection as a health issue, while de-emphasising it as a criminal activity, would help reduce that stigma. The Ministry of Health's Director of Mental Health John Crawshaw says the idea has possibilities. “We are willing to discuss the evidence for this issue and actions to address it,” he says.

While the programme has been spectacularly successful in keeping HIV out of the PWID community, hep C, as the programme's General Manager Charles Henderson explains, is an entirely different story.

“The stigma of being a person who injects drugs means they try to be invisible, and that prevents us getting health information to them, which stops them engaging with services they really need.”

CARL GREENWOOD

“Hep C was already established in the injecting community by 1987. It's much harder to eradicate a virus from a population than it is to prevent it becoming established in the first place. Seroprevalence studies of HIV, hep B and hep C in needle exchange attendees in 2009 indicated one in two had been exposed to hep C, but that was down from 70 percent in 2004.”

Carl Greenwood hopes Wellington's DHDP will become a focal point for the prevention of liver-destroying hepatitis C. “So we're not just a centre for education, but also for rapid testing – with results in minutes not days – counselling and on-referrals. We have our clients' trust; it makes sense to use that.”

But the Ministry of Health, which funds the needle exchange programme at \$4.3 million a year, will only say non-committedly that it is “keen to continue to work with providers about how the programme can be improved”.

Charles Henderson says the programme could achieve much more.

“Whether New Zealand needs facilities like Vancouver’s Insite (see sidebar page 9) is a moot point,” he says. “We do not have as much street use of drugs, and the types of drugs involved are different.

“But we do need similar services: nurse-led health clinics, better links to mental health services, nutrition and housing. We could have vaccination programmes and an outreach co-ordinator in every centre to support hard-to-reach people who inject drugs: those in rural areas, youth, new initiates, same sex-oriented individuals, steroid users and Māori.”

Charles Henderson sees the growing toll of doing nothing about this.

“Liver clinic extrapolations show 50,000 New Zealanders have been exposed to the hep C virus – the large majority via injecting drug use. Research indicates that people who inject drugs are very ‘health services intensive’. We cannot afford to do nothing and hope the problem will go away.”

Opioid treatment

A Wellingtonian who decides they have had enough of life dependent on illicit opioid drugs can make their way to the Opioid Treatment Service (OTS) on the northern fringe of the city’s CBD. Here, they can put their lives into the hands of the specialist team there, one of 18 around the country. It’s where I met Peter, who’s been on the opioid substitute methadone for four years.

“When I got here, I reckon I had about six months left in me,” the 56-year-old father of three grown sons says.

Peter injected opioids from the age of 17, with a 15-year gap when he was raising his family. He is here to prepare for a move to general practice care in the community. He’s been coming to the service each month for 48 months to pick up a methadone prescription and going four days in seven to a local pharmacist to get his dose.

A new client to the OTS undergoes rigorous assessments for physical and mental health. Then their first real test begins – the wait for treatment.

“The waiting is terrible,” says Peter. “You make this really big decision you don’t want to do this any more and you want to be well. So you come here, you have to have all these tests, and your head is getting ready to make the big change, but then you have to wait. So you keep using.”

Team leader at Wellington’s service

Clarissa Broderick says there are about 20 people currently waiting about six months for treatment. “While that’s down from about 100 people waiting up to two years back about 2005, we do still lose them, they move, they go to jail.”

One of the other major reasons for waiting lists is the lack of general practitioners willing to prescribe opioid substitutes, usually methadone, to patients out in the community.

These patients have already been with a specialist opioid treatment service for a while, have stabilised on the right dose for them, got other aspects of their lives back on track and are now ready to transfer to GP care.

“That normalises their condition as chronic and treatable, no different from type 2 diabetes,” says Clarissa Broderick. “Also, a GP can treat their health as a whole.”

But at many services, stabilised clients are log jammed at the exit. This can happen in areas like the Kapiti Coast, where there aren’t enough GPs, but also because many doctors are reluctant to take on methadone patients.

Alistair Dunn, a GP and addiction medicine specialist in Northland, surveyed fellow doctors about joining up to the OTS. Of those not already prescribing an opioid substitute, 75 percent didn’t want to. They were worried about their lack of knowledge and experience, about work overload, time constraints, pressure from patients to increase doses, about the effect of their presence in the waiting room and the perceived complex and challenging nature of the patients

But Dr Dunn’s colleague Andrew Miller, who has prescribed methadone for about 15 years, says he’s never experienced stress or risk with his patients.

“They are motivated for me to prescribe because they don’t want contact with ex-associates still under specialist care, and they’re keen to have methadone seen as a normal medication. I’ve formed very satisfying relationships with my patients, and I’ve seen many come right off methadone,” Miller says.

Blair Bishop, liaison between Wellington’s Opioid Treatment Service and local GPs, says the region could do with double its current 60 prescribing doctors. He says many find the paperwork around controlled drugs tedious and time consuming.

“There is no monetary compensation. If Care Plus, for instance, was available to a patient, then that would largely cover

the face-to-face costs of the GP practice and help cover the cost of the visit for the patient. But ironically, since Care Plus is available only to patients with at least two conditions, our healthiest clients do not qualify. They are sometimes the most reluctant to move to GP care because of the cost of seeing the doctor and the monthly prescription.”

Andrew Miller says cost for his patients has been removed by subsidies from Northland District Health Board.

One way of managing the waiting lists is interim prescribing of methadone, enabling a specialist service to prescribe a small dose of methadone for people who have not yet begun formal opioid substitution treatment. But many services have not taken it up, regarding it as “sub-optimal” treatment and its use likely to hide the problem of excess demand.

“I’ve formed very satisfying relationships with my patients, and I’ve seen many come right off methadone.”

National Addiction Centre research in 2008 found an estimated 10,000 people in New Zealand had a daily opioid dependence and about 4,600 were receiving treatment. It looked at why more did not seek help.

One of the other major bones of contention for client-patients is that of ‘takeaways’: doses of opioid replacement given to clients by pharmacists to tide them over a few days. Normally, clients swallow the dose in front of a regular pharmacist, and that means possibly daily trips to the pharmacist – before work, if people are holding down jobs. Clients complain it ties them to a certain pharmacist and a certain area. They want more flexibility with takeaway doses but, as Raine Berry of the National Association of Opioid Treatment Providers (NAOTP) explains, it is not a simple issue.

“Opioid Treatment Services have to balance the needs for client autonomy and the mitigation of potential harms caused by the inappropriate use of takeaway doses. There is a market for ‘diverted’ methadone, so prescribers have to be constantly aware of the safety of the community. But the lack of flexibility can be frustrating for clients who want to engage in spontaneous or unplanned activities such as going to the beach for the day or spending the night



somewhere other than at home. There is no easy way to manage this, unfortunately.”

A second barrier to a number of would-be OTS clients is the attitude towards them of staff. Although national guidelines for opioid treatment providers state that staff with “higher punitive and abstinence orientation (are) associated with lower retention of clients in programmes”, the country’s 18 services do vary in their approach to the people they are treating.

NAC researcher Dr Daryle Deering says that’s because they depend very much on the philosophy of the clinical leaders at each centre.

“Some are more paternalistic and take an approach counter to the literature on effective treatment,” she says. “For example, they insist other drug use – other than nicotine or perhaps cannabis – has to stop before a client starts receiving opioid substitution treatment, and that is reinforced later by regular urine tests. If other drugs consistently show up in those tests, rather than taking a clinical individualised approach, a contractual protocolised approach is taken, leading to a loss of privileges should the client not meet service ‘rules’.

The danger of such an approach is that those people with the most complex issues are excluded from treatment. In some cases, those services who do not demand strict compliance with rules will be able to take people faster than those whose criteria for entry includes stopping other drugs.”

A third major barrier is the stigma associated with being a person who injects drugs – perhaps reflected by the fact that GPs are allowed to refuse to treat a patient requiring an opioid substitute, but no other.

“Even we feel the disapproval of other health workers,” says Clarissa Broderick. “And the stereotypes of an opioid treatment client makes my blood boil.

Methadone helps them get their children back from care, hold down jobs, find homes. They have vastly improved physical health and re-engage with life and their community. The programme reduces criminal activity and the risk of transmitting blood-borne viruses to other New Zealanders. What is so awful about all that?”

Dr Daryle Deering says what is needed are positive recovery stories, aimed at people who inject drugs and the wider community, highlighting that opioid treatment is effective.

And it certainly is. A 2004 study investigated the costs and benefits of methadone treatment amongst a Christchurch client sample and found treatment saved \$25,000 per life year.

Those on the frontline of providing opioid treatment would like some more of those savings returned to them. In addition to treating opioid dependence, they are expected to support and improve their clients’ psychosocial wellbeing and that of their families. They say they could do that a lot better if they had adjunct services to provide a more holistic approach: employment advisors with concrete options for job training, housing advisors, parenting skills workshops, budgeting advice and counselling.

Wellington methadone client Peter believes housing is a top priority. “To get away from people hassling you for your methadone, somewhere that’s yours and secure and warm, that’s essential to recovery. I’ve seen people here transform from really jittery to really calm in weeks, just because they’ve got stable and safe accommodation.”

But such services cost money, and Clarissa Broderick, for one, says her team is just trying to work smarter with the resources they have because they know no more money is coming.

That is despite the World Health Organization declaring in 2004 that “every dollar invested in opioid dependence treatment programmes yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs and theft alone. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12:1.”

NAOTP Chair Eileen Varley says the welfare sector can also benefit through reduced family stressors and may help divert children from CYFS involvement in their lives, as well as individuals having the potential to move from benefits to employment.

“These savings have both financial and social benefits, and it leads to the question of whether the justice and social welfare sectors could contribute to a service that has such direct benefit for them.”

Charles Henderson questions why the government continues to pursue illicit drug use as a largely criminal justice issue when research and overseas experience points to fewer taxpayer dollars being spent if it is treated largely as a health issue.

“It would be a pragmatic response to illicit drug use and its related harms, just as setting up the world’s first national needle exchange programme was a pragmatic response to the HIV/AIDS epidemic.”

Clarissa Broderick agrees, saying the irony of imprisoning someone who is waiting to access opioid substitution treatment is that methadone is inexpensive. “Packing someone who injects drugs off to jail makes no economic sense.”

So maybe the easiest method of reducing stigma and shortening those queues to access help lies with the GPs.

Whangarei GP Geoff Cunningham, who has prescribed methadone for 15 years, says he would encourage his fellow doctors to climb on board.

“Our patients have been selected very carefully to transfer from specialist to GP care. They are stable and well managed, and I’ve had nothing but good experiences with them. They are colourful, delightful characters, and it is easy to build rapport with them. In some ways, it is the most rewarding aspect of my practice. These guys are successfully rebuilding their lives and health, and you get to be a big part of it. Who wouldn’t enjoy an opportunity like that?” ■

Penny Mackay is a Wellington-based radio and print journalist.

The wait

Opioid Treatment Services (OTS) are regionally operated around New Zealand. In some areas, people are waiting up to six months to get onto a service. For people in other cities, it is a matter of days.

 x20 | 6 months

Wellington

OTS Team Leader Clarissa Broderick: We have been two full-time case managers down for about six months. It is hard to recruit the right people and then hold on to them when they face heavy workloads of sometimes complex and challenging cases. Premature burnout is not rare. We expect applicants to have specialist qualifications and a particular skill set. I'm uncompromising on that because we value the standard of care we provide.

 x2 | 6 months

Whanganui

Mental Health Clinical Director Frank Rawlinson: We have a capped number of places that are based on general population. This means no one can enter the programme until someone else is stabilised enough to move on. We could do with more GPs out in the community willing to prescribe opioid substitute.

Gisborne – 0 people – No waiting list

Medical Officer for Opioid Treatment Programme Dr Patrick McHugh: Our managers have smaller caseloads than the larger busier centres so they can perhaps spend more time with each client addressing their psychosocial needs. That means we can move them through the service quite quickly. We don't seem to have a problem recruiting staff, and I know all the local GPs so don't really have a problem recruiting them either.

Auckland – 0 people – No waiting list

Tries to take clients from first presentation to first dose within days. **Auckland OTS Manager Toni Bowley:** We are a large service with a large staff and can operate economies of scale. This means we can have admissions based on clinical capacity rather than being restricted to a funded number of opioid substitution therapy places. The criteria for entry to our service is also lower than for some other services. This does not come without its problems, as staff caseloads swell and can become a challenge to manage.

 x2 | 2 months

West Coast

Programme Co-ordinator Paul Eathorne: We have a problem recruiting people to the West Coast and keeping them here, especially prescribing GPs. We are funded for 51 people but currently have 75 on the books, and just five are out on GP authority.

Nelson-Marlborough – 0 people – No waiting list

Addiction Services Manager Eileen Varley: NMDHB Addiction Service has developed a twice-weekly drop-in clinic for stable clients to be seen by clinicians. It enables clinicians to focus their time on other clients with higher needs or circumstances requiring greater time input. The clinic means a more effective use of clinician time, which helps ensure waiting lists can be managed proactively.

Christchurch – 0 people – No waiting list

Clinical Director Speciality and Addiction Services, Canterbury DHB Specialist Mental Health Services Dr Alfred Dell'Ario: We haven't had much difficulty recruiting or retaining staff so don't have any specific difficulties around waiting times. The service is closely aligned with primary care, allowing the majority of clients to be treated in the community. We have 164 GPs willing to prescribe, and 77 of them are engaged with clients currently.

Dunedin – 0 people – Currently no waiting list, but that is about to change

Medical Director CADS Dr Gavin Cape: We are simply not funded for everyone who needs our service. Two or three years ago, we had a waiting list and addressed that using interim methadone prescribing.

Rural Otago – 0 people – No waiting list

This service is at capacity but with no waiting list at present. There are more people being transferred in, especially from Christchurch. **Medical Director CADS Dr Gavin Cape:** The OTS service in Otago has underestimated the number of people in Otago with serious drug problems and CADS has an OTS case load far greater than it is funded for, which has stretched our service provision to the limit. I believe CADS is attempting to respond to the community need but lacks full resource support to continue to do so. ■

Needles and NIMBYs

Challenges to setting up a needle exchange

The cry “Not in my back yard!” is often heard when communities are confronted by a social solution they don’t fully understand. But when implemented with persistence and care, harm reduction initiatives like needle exchanges can win out over fear and misplaced loathing. **Rob Zorn** examines two communities where needle exchanges now work quietly and effectively.



ROB ZORN



MOST right-thinking people would agree that needle exchanges are a good idea. Few of us would want to have to use one, but they help stop the

spread of infectious blood-borne diseases like HIV and hepatitis C, and we all benefit from that.

But how would you feel if one opened across the road from your home? What would it say about you or your neighbourhood if the view outside your window included an injecting equipment dispensing machine and a mounted sharps disposal bin? What would happen to your house price, and how often would you have to shield your kids from dodgy druggies doing dastardly deals on your doorstep?

The setting up of two needle exchanges in recent years has illustrated that NIMBY (not in my back yard) syndrome is alive and well in New Zealand. In Masterton (2008) and Rotorua (2010), objections from fearful community members were among the obstacles that had to be overcome.

The Masterton clinic came about as a result of requests from the community. A local alcohol and drug unit and an active group of local consumers were concerned that having to travel as far as Wellington

or Palmerston North for equipment was becoming a barrier to sterile needle use in the Wairarapa. But it wasn’t popular with everyone.

“It was a difficult project,” says Needle Exchange National Manager Charles Henderson.

“There were lots of stakeholders involved, and many had little understanding of how blood-borne viruses target hidden populations involved in covert behaviours like injecting drugs and how easily those diseases can spread into the general population.

“There were the usual fears the exchange would be dealing drugs or become a hangout for unsavoury people. Others were worried kids might get into the disposal containers and start playing with discarded needles. Business owners on either side of the premises – one a car dealer and the other a tattooist – were quite vocal and tried to rally the community against the exchange.”

The Rotorua outlet was more directly a New Zealand Needle Exchange initiative based on distribution information – and because the one pharmacy dispensing needles there was under pressure to meet demand. There were a few objectors, but the community’s initial reception was more muted than in Masterton. A potential landlord was identified who visited the

WHAT DO NEEDLE EXCHANGE PROGRAMMES DO?

IN LINE with New Zealand’s National Drug Policy, needle exchange programmes seek to minimise drug harm by providing injecting equipment, education and information on reducing drug use. They provide early intervention where appropriate as well as referrals to treatment, medical care, legal and social services. Staff also provide condoms and safe-sex education.

Equipment supplied includes needles and syringes, swabs, butterflies, filters and vials of sterile water along with sharps containers for the safe disposal of used injecting equipment.





Hamilton exchange and came away satisfied, and the Council was quite supportive – until the exchange applied for resource consent to provide an electronic dispensing machine and sharps disposal bin for after-hours use.

The Council turned the application down, saying the exchange had not demonstrated that the 24-hour electronic dispensing machine and disposal facility wouldn't have an adverse effect on the character of the surrounding area. They also said there was a potential for disturbance from clients arriving by car at night and from the activation of security lights.

Ironically, two other 24-hour businesses were already operating in the neighbourhood, one a noisy trucking firm. This convinced Hamilton Needle Exchange Manager Denise Gemmell, who was in charge of establishing the Rotorua exchange, that the refusal was both unreasonable and discriminatory. She visited 20 homes in the neighbourhood and managed to get written support for the exchange from 19 of them.

A lawyer was also engaged to argue that the refusal was groundless in that the exchange had minimised all potential harms and was in full compliance with the law. The Council eventually relented, and the dispensing machine and sharps bin were installed.

There's actually little a community can do to stop a well organised needle exchange from being established, and both Masterton and Rotorua exchanges went ahead without further incident.

Nevertheless, the New Zealand Needle Exchange and the Ministry of Health will do what they can to ensure neighbours and those affected are aware of what's happening, that their fears are allayed and their questions answered. In Masterton, a series of public meetings was held, and in Rotorua, Denise Gemmell visited all neighbours in the vicinity personally. In both towns, Police were informed so that co-operative relationships could be established.

Ms Gemmell says the media sensationalises people who inject drugs

and their effect on the community and paints a picture that is far from the truth.

"The reality in New Zealand is that most intravenous drug users using needle exchanges are living stable and productive lives. They've often got families and want to use clean equipment because they are motivated to keep themselves and others in their lives safe. They have no desire to make trouble and would seriously prefer not to be noticed at all.

"In fact, communities need to be aware of the fantastic service needle exchanges offer them by helping to keep their intravenous drug users safe, informed and disease free."

So are most local residents aware of the great service being run in their neighbourhoods? Probably not, but most would not even be aware the exchange was there in the first place.

Needle exchanges tend to keep a low profile. Signage is very limited and often little more than small blue universal needle exchange arrows and window stickers. You probably wouldn't recognise them if you weren't already in the know. Dispensing machines and disposal containers are easy to get to but not visible from the road. The dispensing machines are protected by a security code only given out to clients, and it would be impossible even for the most resourceful of children to break into a sharps disposal bin. Short-term parking is readily available, and clients come and go quickly, quietly and with a minimum of fuss.

As a result, neighbours seem either quickly to forget about the exchange or to see it as of no concern. Masterton Exchange Manager Brendon Olsen said there was not

a single incident with either the car dealer or the tattoo parlour owner once the exchange went ahead and that relations quickly became neighbourly.

"The car dealer guy was just a bit old school, but he changed his tune and seemed to accept us once we were there."

Detective Sergeant Rick Joblin, who was Area Intel Manager in Masterton in 2008, said he remembers some initial community concerns that unpleasant characters might start loitering outside their new "resort", but he said that hasn't transpired at all.

"I can't remember a single complaint or any time we've been called there to deal with trouble. Quite frankly, for us the needle exchange just isn't an issue."

Denise Gemmell says law enforcement in Rotorua has been a little more guarded with its support, but that she is also unaware of any complaints or Police involvement with the Rotorua exchange.

"On the whole, New Zealanders are generally a pragmatic and egalitarian lot. Once you explain the benefits to them, they tend to take a live and let live attitude and just get on with things. There will always be discomfort with drug use, but once they see nothing nefarious is going to happen in their back yard, many actually become quite supportive."

And if there's a needle exchange on your street and you're worried about your house price when you're selling, just don't tell the new buyers. Chances are they will never know. ■

Rob Zorn is a Wellington-based writer.

THE NUMBERS

20

dollars in health expenditure for every dollar spent on needle exchange

7-10

the amount of times the average needle and syringe are reused

1%

less than 1 percent: the rate of HIV among injecting drugs users in New Zealand is the lowest in the world

25

percent of those imprisoned in the last 12 months used a needle exchange and injected while incarcerated

50,000

New Zealanders carry the hepatitis C virus, many of them unaware

10-30,000

injecting drug users in New Zealand (injected in the last 12 months)



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HAVE USED CANNABIS

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OF PEOPLE WHO HAVE
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Turning tide on compulsory treatment

Slave labour. Torture. Forced participation in medical research. It reads like an account of some bleak, distant chapter of human history – but it's the contemporary reality for around 300,000 people detained in more than 1,000 compulsory, government-operated drug treatment centres in East and Southeast Asia. **Russell Brown** reports.



RUSSELL BROWN



THE LINE between support and punishment for drug users has been blurred in many countries, but the situation in East and Southeast

Asia is particularly dire. Drug users suffer human rights abuses not even inmates convicted of serious crimes have to face. And compulsory treatment fails not only ethically, but practically as well. It's not just cruel; it doesn't work.

A 2009 World Health Organization review of practices in Cambodia, China, Malaysia and Vietnam (with a particular focus on injecting drug use and HIV) found some recent improvement in China but made a series of urgent recommendations as a short-term means to improve practices in the treatment centres, starting with making them non-compulsory.

First, said the authors, a distinction needs to be made between people who use drugs occasionally and drug-dependent people. Those dependent should have the choice to attend a drug treatment facility or not, since the right to health also includes the right to be free from non-consensual treatment.

Further, treatment centres should be age- and gender-appropriate, offer evidence-based medical care, including methadone treatment (evidence shows opioid substitution therapy is the most efficient way to treat heroin dependence) and anti-retroviral therapy. They should offer HIV-prevention advice and be free of charge. Mandatory re-education labour is to be discouraged.

Last year, a dozen United Nations agencies, including the UN Office on Drugs and Crime (UNODC), UNESCO and UNICEF, made a similar call, but much more forcefully. In a joint statement, they called on "states that operate compulsory drug detention and rehabilitation centres to close them without delay and to release the individuals detained".



A prisoner in a Thai drug jail having his head shaved.

As well as threatening the health of detainees, the agencies said, compulsory treatment centres posed a broad threat to human rights. Detention frequently takes place without due process or legal safeguards.

“Furthermore, detention in these centres has been reported to involve physical and sexual violence, forced labour, sub-standard conditions, denial of health care and other measures that violate human rights.”

The agencies’ statement capped a more important and practical move that began in 2010 when international agencies began to withdraw funding from detention centres.

In his recent article for the *International Journal of Drug Policy*, ‘Compulsory drug detention in East and Southeast Asia: Evolving government, UN and donor responses’, Joe Amon notes that UNICEF and other donors have in the past offered donor support to detention centres in Cambodia, Laos and Vietnam as a kind of lesser evil, in an attempt to build the capacity of the existing centres to provide drug dependency treatment and as part of a policy of strategic engagement with government officials.

The force and nature of the UN agencies’ landmark statement might have given the impression that no progress was being made at all. Happily, the news is a bit brighter than that. Indeed, it may be that the tide has begun to turn on the culture of compulsory treatment.

Six months after the joint statement, a UNODC publication hailed Malaysia’s two-year-old network of open-access Cure & Care 1 Malaysia Clinics. It said, “Malaysia has made considerable progress in the provision of drug treatment.”

UNODC noted research visits to the clinics by delegations from Vietnam, Cambodia and Myanmar, countries that all plan to make changes in the way they treat drug dependence. Has Malaysia become the regional exemplar?

“That is a fair conclusion,” says Fifi Rahman, Policy Manager at the Malaysian AIDS Council, “but only in regard to

countries that currently practise worse regimes. It’s important to note that we still have compulsory centres that have not been phased out. People are still being sentenced.”

Daniel Wolfe, Director of the Open Society Foundations’ International Harm Reduction Development Programme, agrees that Malaysia is providing a useful model for other countries, both through direct visits like that by the Vietnamese delegation and via regional conferences.

“But Malaysia may also be a model in another, less desirable way, since most countries in Southeast and East Asia that practise drug detention seem to want to at least keep compulsory centres operational.”

Rahman says Cure & Care clinics, “have methadone provision and basic healthcare services. Vocational training and job placement occurs upon referral to a separate facility. They are trying to integrate services beneath one roof, in a similar way to Switzerland.

“But due to the conservative Muslim sensitivities the government subscribes to and stigma arising therefrom, sexual reproductive services are nowhere near what they should be. Cure & Care clinics also do not allow for needle and syringe programmes. Clinics frequently have quotas and waiting lists, and that impedes treatment. There are some Cure & Care clinics, however, that operate above capacity.”

Rahman credits the Director-General of Malaysia’s National Anti Drug Agency Puan Sri Dato’ Zuraidah Haji Mohamed for the positive change. Government officials, she says, have far less to say and “the media is pretty quiet about the transition to voluntary treatment”.

Wolfe says the local leadership of officials like Mohamed remains the key factor in progress.

“Statements by the UN, criticisms of forced labour by American apparel manufacturers and human rights reports have all likely played a role, but country buy-in has been the single definitive factor. Without local leadership willing to push

for alternative approaches and a move beyond the ‘control and contain’ approach that has been common to many countries, there would be thousands more detainees.”

Both Wolfe and Rahman agree the motivation for change is driven more by the recognition that the old approach was simply ineffective than any ethical qualms.

“I’m not sure if you’ve had many candid conversations with Malaysians,” says Rahman, “but if you ever did, you would realise that ethics is not predominant within their education.”

Efficacy is a much easier sell.

“At the recent International Harm Reduction Conference in Vilnius,” says Wolfe, “a representative from the World Bank presented a slide showing sharply improved success from the Cure & Care centres compared to the compulsory centres run by the same agency.”

Amon writes, “Despite rhetoric that drug users are ‘patients’, not ‘criminals’, the approach in most countries is still driven more by an imperative of maintaining social cohesion, which is seen as paramount over individual rights.”

Inevitably, progress in the region remains uneven, says Wolfe. “And China, which has proven indifferent to many external human rights commentaries and is too big an economic force to be intimidated by threats by outside labour advocates, may be particularly hard to move on the drug detention issue. Other countries, like Cambodia and Laos, are more off the international radar and also should not be forgotten.”

UNODC, which has taken the strongest stance amongst the agencies, might be accused of wishing change into being when it hails progress on reform. Nonetheless, there is a new, cautious optimism that lasting change is now in motion towards a goal that will, says Amon, require “much more work” to reach. ■

Russell Brown blogs at publicaddress.net and hosts Media3.

Psychoactive Substances Act 101

A world-leading piece of legislation has been passed in New Zealand to regulate new psychoactive substances. What is it all about, how does it work, and where do we go from here? **Jackson Wood** and **Catherine McCullough** examine the Psychoactive Substances Bill.



CATHERINE MCCULLOUGH



JACKSON WOOD



ERE at the Drug Foundation, we are just a little bit proud of New Zealand.

Our Parliament recently passed the Psychoactive Substances Bill by

119 votes to one. This almost unanimous support for a Bill that regulates the 'legal high' industry represents a big step forward for New Zealand's drug policy.

The law is a pragmatic and evidence-based approach to recreational drug use, and health and harm reduction are clearly its main purpose.

The history

New Zealand is often considered the birth place of 'legal highs'. As in many other western countries, our drug laws only banned specific substances. In the late 90s, some people cottoned on to the idea that a substance with effects similar to an illicit drug could be legally sold as long as it had not been specifically banned.

The substances that first came out, like benzylpiperazine (BZP), mimicked the effects of banned substances. People purchased them. Other people started to get worried about their effects. Media started doing stories about the drugs.

It was only a matter of time until government took notice, and in 2004, then Associate Minister of Health

Jim Anderton noted that New Zealand's drug law, a relic from the 70s, simply could not handle the rapid development and marketing of new drugs.

In 2007, the Labour-led government asked the Law Commission to conduct an independent review of New Zealand's Misuse of Drugs Act (1975) (MODA). The detailed report the Law Commission released in 2011 supported Anderton's conclusions and outlined a legislative response to the growing problem of emerging psychoactive substances.

Under a National-led government, Associate Minister of Health Peter Dunne brought the Psychoactive Substances Bill before Parliament where it was passed into law in early July 2013.

One reason we are so proud is that, from conception to enactment, this piece of law has had (for the most part) support from all the parties in Parliament, and very little political game playing has taken place. It is encouraging to think that drug policy can be worked out, and even improved, in this non-partisan fashion.

What does it do?

As we moved through the 2000s, it became obvious that, as one substance was banned, another one would pop up to take its place. Meanwhile, the 'legal high' industry was making millions of dollars from products that had no regulation around their manufacture, sale or safety –

“It is encouraging to think that drug policy can be worked out, and even improved, in this non-partisan fashion.”

they sat in a legal grey area.

The Psychoactive Substances Act is an attempt to remove that grey and reverse the situation where substances can be sold without consideration to health and safety.

Put simply, the law sets up a legal framework for the testing, manufacture, sale and regulation of psychoactive products. It reverses the onus of proof so the people who want to sell the substances have to prove that they are 'low risk' before they can be sold.

This means each product has to go through a clinical testing process that will cost the manufacturer around \$2 million. The clinical testing process will answer basic questions about each substance. Is it poisonous or addictive? Is it likely to cause cancer? Will it cause kidneys to shut down or cause psychosis? If the answer is yes to any of those questions, it is highly unlikely the product will make it to market.

This is because the purpose of the law is to “protect the health of, and minimise the harm to, individuals who use

psychoactive substances”. An Authority is currently being set up that will produce guidelines around what constitutes ‘low risk’ and also administer the law and provide recommendations to government.

The results of clinical tests will be publicly available regardless of whether the substances pass the ‘low risk’ threshold. This means the public, health professionals and other countries looking on will have much better information on what’s in these products and what their effects might be.

There are specific restrictions in the law that mean licences will need to be obtained by any company wishing to import, export, manufacture or sell psychoactive substances. Dairies are specifically excluded from being able to sell, and communities will be able to have a say over if, and where, stores that sell psychoactive substances are allowed to open.

The law will apply some of the best harm reduction tools from tobacco and alcohol control to these products. Products will need to come with health warnings, lists of ingredients, contact information for the National Poisons Centre. Advertising or marketing of the products will not be allowed, and importantly, the age of purchase is pegged at 18 alongside alcohol and tobacco.

One key health measure in the law is the provision allowing the Authority to recall products that turn out to cause harm not detected in clinical trials. The Authority will be able to do this without any need for legislation – it will simply revoke the licence.

While there are a number of offences contained in this Bill, people who commit minor offences will not be criminalised.

Those caught with unapproved substances, or buying approved products while underage, will be subject to an infringement notice and fined. Unlike those caught with drugs scheduled under the MODA, they will not run the risk of having a criminal conviction on their record and cannot be jailed. The worst possible outcome is they don’t pay their fine and it gets bigger.

Where to from here?

A transitional period is now under way where products for sale in the three months prior to the Act coming into effect may be granted an interim licence for sale that will last until regulations come into effect. The producers of any of these products can apply for interim licences to continue selling until their

ANIMAL TESTING

The testing of psychoactive substances on animals was a controversial aspect of the legislation. Because of this, the final rules around animal testing are much more robust in protecting animal welfare.

Under the legislation, animal testing is a last resort. An alternative testing technique must be used if it exists. If alternatives to animal testing are not used, the Authority will disregard results.

In circumstances where alternatives do not exist, animal testing can only go ahead if it meets the following criteria:

1. The trial is based on the relevant International Conference on Harmonisation Guidelines.
2. If the trial is undertaken in New Zealand it complies with the restrictions placed on the use of animals in research under the Animal Welfare Act 1999.
3. If a trial is undertaken overseas, it complies with the restrictions on the use of animals in research, testing or teaching that are equivalent to or exceed those in the Animal Welfare Act 1999.

products can be tested, and the Authority has produced guidelines.

Built into the legislation is a requirement that it be reviewed by Parliament within five years. This means that, if certain aspects of the law are not working, they can be fixed, and the focus remains on protecting health and minimising harm.

But the most exciting thing about the passing of this cutting-edge legislation is what it means for all of New Zealand’s drug law.

MODA – at almost 40 years old – is focused on punishing people who use drugs. By comparison, this new legislation is evidence-based and has health and harm reduction at its heart.

The Law Commission’s report provided a blueprint for this legislation but also for the reform of our drug laws as a whole. We reckon it’s time to roll up our sleeves and, with the same spirit in which this law was made, bring New Zealand’s drug law into the 21st century so it becomes sound, health-focused and modern.

But for now, the world is watching New Zealand to see how well this new model works. We are confident it will. ■

Jackson Wood and Catherine McCullough are Senior Advisers at the New Zealand Drug Foundation.



FIND OUT MORE

- Psychoactive Substances Act (2013) nzdrug.org/parliamentpsychoactive
- Ministry of Health information about the Psychoactive Substances Regulatory Authority nzdrug.org/mohpsychoactive
- New Zealand Drug Foundation page about Psychoactive Substances nzdrug.org/PSBsubmission

THE LAW AT A GLANCE

- The Act sets up a legal framework for the testing, manufacture, sale and regulation of psychoactive products.
- Health and harm minimisation are included in the Act’s purpose.
- Products will no longer be sold in dairies, grocery stores etc. People and businesses will need a licence to sell these products.
- There will be restrictions on advertising, marketing and the purchase age (18+).
- As with alcohol, councils will have the option of developing local policies around where stores can be located.
- Products will undergo rigorous clinical testing to determine whether they are ‘low risk’.
- Clear rules around use of animal testing. Animal testing can only be used if there is no alternative.
- If a product is proven ‘low risk’, as long as a person meets certain criteria (e.g. person of good repute, New Zealand citizen), a three-year licence to sell that product can be granted.
- Products that appear to cause more harm than clinical testing showed can be pulled from the market.
- A register of all approved and unapproved products will be publicly available.
- A code of practice for manufacturing and retailers will be in place within six months.

KERI
WELHAM

On a leafy Ōtāhuhu street just off Auckland's Southern Motorway is a new recovery centre called The Retreat. Utilising a ground-breaking residential treatment model developed in the United States, The Retreat harnesses the will and experience of volunteers from the recovery community to deliver its programme. **Keri Welham** reports.



This is Avenue Road East in Ōtāhuhu, and Craig LaSeur thinks it's the perfect location for his suburban sanctuary.

The American clinician has relocated Down Under to run the New Zealand version of The Retreat. The 10-bed facility

AT THE end of an otherwise plain little street, a gap in the trees offers a view of the Tāmaki Estuary and the factories of East Tāmaki.

opened in April, and by early June, it had five graduates and two clients in residence. Each client checks in for 30 days at a cost of \$5,850 plus GST. The substantial saving, compared with many other residential treatment options, comes courtesy of The Retreat's major point of difference – its programme is delivered wholly by volunteers from the recovery community.

The volunteers are hand-picked for their message of hope, their own solid recovery and their ability to connect with guests. While clinicians oversee the programme and control induction, the

volunteers run workshops, chapel, music nights and onsite fellowship meetings. This model saves money, making treatment more accessible for those with limited financial means, and allows guests to see what long-term sobriety looks like up close.

In the women's wing is a guest who is in her 30s. Her bed is made, a book from the vast body of 12-step literature lies on her quilt, and two gorgeous girls beam out of a photograph propped up on a wall.

The bathrooms here look every bit like they belong in the rest home this once was. The doorways are wide, the fixtures are reminiscent of a 1980s school ablution block, and there's an excess of beige. But the bedrooms have particularly plush-looking single beds – a comfort factor the trustees refused to scrimp on – and are decorated in modern, welcoming tones.

There are 10 guest beds, with the capacity to add another 16 eventually.

In the reception area is a photograph of the 1958 Junior All Blacks. Next to Sir Colin Meads, in the row behind captain Sir Wilson Whineray, is Roger Green. The well known and respected addiction practitioner has worked tirelessly over many years to make this centre a reality, and despite being in his 70s, he joins LaSeur as the other clinician on The Retreat's team.

The kitchen is a simple set-up where guests prepare their own breakfast. The chef, himself in recovery, makes lunch and dinner, and the guests, staff, volunteers and occasionally trustees eat together.

LaSeur says guests are nervous on their first day. The 12-step culture comes wrapped in a new language of terms and ideas. Often, the only sounds are feet padding down a hallway or pans clanging in the distant kitchen. The television is only turned on one night a week. The goal is a quiet, meditative atmosphere.

In the men's wing is a guest in his 50s. Laid out on his bed are neat piles of reading material.

At one stage, he passes LaSeur's office, and the two bounce off each other.

"What are you up to," LaSeur says, with a warm, exuberant smile.

"Trying to get better," the man calls out, as he strides on by.

LaSeur has been sober 15 years. He went to his first 12-step meeting, on a beach in Hawaii, when he returned from serving in Desert Storm with the US Marines.

"You're not allowed to do crack in the Marine Corps," he says, deadpan.

He was facing drug charges in a military court, the collapse of his marriage and the crumbling of his career, but he wasn't

ready to change. He spent 28 days in jail, his wife left him, and he exited the Marine Corps before he could be kicked out.

Six years later, he was 28, working as a cook in Chicago and addicted to crack and alcohol. He had been sleeping in a park with his rottweiler Magnum. One night, he called his mother and she said, "I love you" and hung up. On a Wednesday afternoon soon after that phone call, he woke up on a cocktail waitress's couch, saw the paraphernalia of another night of drugs and drink, realised it was 2pm, called his stepfather and said he was ready.

“There are those individuals that need that clinical environment, and there are also those that don't. We are not a hardcore programme.”

His parents had been waiting for that phone call a long time. They had a bed waiting for him, a phone assessment booked with the famed Hazelden addiction treatment centre, and he was on a plane to Minnesota 48 hours later.

Today, LaSeur is 43, married to Patricia and they have two sons. Once sober, LaSeur gained a sociology degree and studied at the Hazelden Graduate School of Addiction Studies. He worked in detox, then at Hazelden as a clinician, then at a sanctuary in the Washington State rainforest where he ran a programme for 16- to 24-year-olds with chemical addictions. The challenge of building a recovery centre from scratch was enough to lure him to New Zealand.

LaSeur follows the Blues rugby team, is an enthusiastic new recruit to Facebook and walks around with a colleague's tiny mutt Froggy tucked under his arm. He has the height of a basketballer, a youthful face, a strong handshake and a deep enthusiasm for catering to those who can't afford expensive treatment.

"Having something that's affordable, there's something about that that plucks my spirit."

LaSeur says The Retreat doesn't offer counselling.

"We are not an expert-driven model.

"It's a practical programme of action rather than reflection and self-pity."

He makes sure the guests are safe, well fed and having a good time (by which he means, getting sober).

"I kind of think of myself as a bed and breakfast manager."

LaSeur says the volunteer-led model of treatment on offer at The Retreat is not for everyone. He believes it would never work for teenage males with chemical addictions as they need much more structure and discipline. It wouldn't have worked for him, LaSeur says, as his crack addiction necessitated a complex detox and clinical expertise.

And so, every week, LaSeur refers some potential guests to other facilities.

"There are those individuals who need that clinical environment, and there are also those who don't. We are not a hardcore programme."

The Retreat is run as a charitable trust. If there is ever a surplus of funds, it will be used on scholarships to further discount the fee.

LaSeur says recent independent outcome studies of guests at The Retreat in Minnesota have shown long-term sobriety results as good as – and sometimes better than – those seen in much more expensive programmes.

LaSeur used to volunteer at The Retreat in Minnesota, which is situated in the cathedral-like Wayzata Big Woods just west of Minneapolis. And so, the suburban setting for New Zealand's version of The Retreat concerned him when he first looked up the address on Google's Street View. What if the neighbours had regular parties and the sounds echoing over the fence upset the sanctuary-like atmosphere of The Retreat? What if passers-by were forever trying to get a gawk at the latest arrivals?

As it happens, Avenue Road East is quiet, and the neighbours are a non-event. The beige and brown blocks of the former rest home and children's hospital nestle in between modest homes and a plant nursery. There is no Betty Ford-style glitz, no high hedge, no exclusive address or sense of isolation from the world – and to LaSeur's mind, that's part of the magic.

With its unexceptional appearance, geography and atmosphere, The Retreat offers a picture of everyday suburban sobriety.

"Here's this little gem in South Auckland," LaSeur says. Froggy scuttles around his feet. Wheelie bins line the curb for rubbish day. Autumn leaves create perfect circles of colour at the feet of smooth grey trunks. And for two people sitting down to lunch within the safety of these walls, a rebirth is under way. ■

Keri Welham is a Tauranga-based writer.

HE

Heroin is probably the most infamous member of the opioid family. Opioids are depressants, not because they make you sad, but because they slow down the activity of the central nervous system and messages sent between the brain and the body. Alcohol, benzodiazepines, GHB and cannabis are also depressant drugs.

Heroin is also known as 'smack', 'skag', 'dope', 'horse', 'H', 'junk', 'hammer', 'slow', 'gear', 'harry', 'big harry', 'black tar', 'china white', 'Chinese H', 'white dynamite', 'dragon', 'elephant', 'homebake' or 'poison'. (5 α ,6 α)-7,8-didehydro-4,5-epoxy-17-methylmorphinan-3,6-diol diacetate.

HEROIN was first synthesised in 1874 by English chemist C R Alder Wright, but it did not become popular until it was independently re-synthesised 23 years later by German chemist Felix Hoffmann. Hoffmann was trying to produce what we now know as codeine – a substance similar to morphine but less potent and addictive. Instead, he produced a form of morphine that was almost twice as potent.

Bayer was quick to market the new 'diamorphine' as a cough suppressant and cure for morphine addiction under the trade name heroin. The discovery that it was, in essence, a quicker-acting form of morphine was embarrassing for Bayer and has gone down in history as one of the company's biggest blunders.

In 1914, the US passed the Harrison Narcotics Tax Act to control the sale and distribution of heroin and other opioids, restricting its use to medicinal purposes only. It is now a Schedule 1 substance, which makes it illegal for non-medicinal use in signatory nations to the Single Convention on Narcotic Drugs treaty.

Today, Afghanistan remains the world's largest producer of heroin. In 2004, it was producing 87 percent of the world's supply. However, production in Mexico rose 600 percent between 2007 and 2011, changing that percentage and making Mexico the second-largest producer in the world.

In New Zealand, heroin is classified as a Class A drug under the Misuse of Drugs Act 1975, attracting a maximum term of life imprisonment for importing, manufacturing and/or supplying. Possession carries a six-month imprisonment term and/or \$1,000 fine.

Heroin is always referred to as diamorphine when used in medicine, and it is almost always indicated to treat chronic pain. It is supplied in either tablet or injectable form, often in preference to morphine because it has less severe side effects.

While non-medicinal use is almost universally illegal, a number of countries have been experimenting with diamorphine maintenance programmes to treat users who have failed at other withdrawal programmes.

In 1994, Switzerland began such a trial in which it proved superior to other forms of treatment in improving the social and health situation for illicit heroin users. It was also found to save money, despite high treatment expenses, by significantly reducing costs incurred by trials, incarceration, health interventions and crime.

The success of the Swiss trials led Germany, Holland, Denmark and Canada to try out similar programmes. Some Australian cities (such as Sydney) now have legal, supervised injecting centres, in line with other wider harm minimisation initiatives.

R

In non-medicinal settings, heroin is used as a recreational drug for the rapid onset of transcendent relaxation and intense euphoria it induces. In the 1996 film *Trainspotting*, lead character Mark Renton describes its effects as follows: "Take the best orgasm you've ever had... multiply it by a thousand, and you're still nowhere near it."

The onset of heroin's effects depends upon how it is administered. Intravenous injection is the fastest route of administration, causing blood

concentrations to rise the most quickly, followed by smoking, suppository insertion (anal or vaginal), snorting and ingestion.

Effects can last from five to eight hours, typically peaking at around two or three hours after administration. Heroin's relatively low half-life means dependent users may need to take the drug two or more times per day.

As with most opioids, unadulterated heroin does not cause many long-term complications other than dependence and constipation. It can suppress the immune system, and this may lead to opportunistic infections, which carry their own lasting effects.

However, heroin is usually far from unadulterated by the time it reaches the end user. Figures from the UK, for example, indicate the average purity of street heroin varies between 30 and 50 percent. Heroin seized at the border has purity levels of between 40 and 60 percent.

This variation can increase the likelihood of overdoses. Each set of hands the drug passes through would normally add further adulterants, reducing the strength of the drug. If steps in the distribution process are missed, the purity of the drug reaching the end user may be higher than they are used to, and they may not be able to tolerate the increase.

Also, tolerance typically decreases after a period of abstinence. If this occurs and the user takes a dose comparable to their previous use, they may experience effects that are much greater than expected, resulting in an overdose.

Death from overdose can take anywhere from several minutes to several hours. It usually happens because the breathing

reflex becomes suppressed, resulting in depletion of blood-oxygen levels (anoxia). However, because heroin can cause severe nausea, a significant number of deaths attributed to heroin overdose are actually caused by the unconscious victim choking on their own vomit.

Intravenous use of heroin with non-sterile needles and syringes may lead to contracting blood-borne diseases (e.g. HIV and hepatitis) poisoning from contaminants used to 'cut' the heroin and decreased kidney function, though this may be caused by contaminants or infectious disease rather than by heroin itself.

A range of treatments including behavioural therapies and medications can help addicted people stop using heroin and return to stable lives.

“Choose your future. Choose life... But why would I want to do a thing like that? I chose not to choose life. I chose something else. And the reasons? There are no reasons. Who needs reasons when you've got heroin?”

Mark 'Rent-boy' Renton,
Trainspotting

Medications include buprenorphine and methadone, both of which work by binding to the same cell receptors as heroin but more weakly, helping a person wean off the drug by reducing cravings. Users can also be prescribed naltrexone, which blocks opioid receptors and prevents the drug from having an effect. A more recent, longer-lasting version of naltrexone, administered by injection in a doctor's surgery, can be used with patients who have trouble complying with naltrexone treatment in tablet form.

Heroin overdose is usually treated with an opioid antagonist, such as naloxone, which acts on the brain's opioid receptors to reverse the effects. However, it may also precipitate immediate withdrawal symptoms.

N

It is difficult to think about heroin use in New Zealand without associating it with the Mr Asia Syndicate, which began with Marty Johnstone (Mr Asia) importing 450,000 'Buddha sticks' (cannabis) into New Zealand in 1975. The Buddha sticks had been purchased for 10 cents each in Thailand and made Johnstone (Mr Asia) and his associate Terry Clarke (Mr Big) around NZ\$3 million. They used the money to expand into importing heroin into New Zealand and Australia via Singapore.

In 1978, the import bill for heroin into Auckland alone was around NZ\$34 million, which the syndicate onsold at 400 percent profit. The syndicate fell apart in 1979, however, when Clarke was convicted for arranging Johnstone's murder and sentenced to life in prison.

Since the 1970s, heroin use in New Zealand has declined steadily, and nowadays it is not commonplace. There are a number of reasons for this. The main one is that demand for heroin is low because New Zealand's injecting drug community is well enough served by pharmaceutical diversion – prescription medications and methadone sold illegally on the black market.

Other reasons include effective border controls and the fact that New Zealand does not really have cities big enough to allow for the large but clandestine networks needed to make its distribution profitable.

Exact figures for how many New Zealanders use heroin are hard to come by, but according to the 2007/08 Alcohol and Drug Use Survey, around 3.6 percent of New Zealanders aged 16–64 years had used an opiate (including heroin) for recreational purposes at some point in their lifetime. This equates to about 94,000 people. ■

O

A small triumph

Getting your fix of thought-provoking ideas about addiction recovery and drug policy is hard in a media that saturates us with stigma-laden messages. **Will Godfrey** reflects on the triumph of publications talking about sensible solutions to addiction.



WILL
GODFREY

O**F** **FIRST** ran a publication about drugs without quite realising. It was inside Pentonville, a large Victorian-built prison in inner London. Inspired

by a prisoner's suggestion, one of my education department colleagues and I founded a small newsletter, written entirely by prisoners and read by prisoners and their families. Pentonville's governors, wary of inciting either the volatile prison population or the British tabloid press, ruthlessly censored the content of each issue, including most drug references.

But of course drugs were everywhere. I'd smell cannabis as I walked through the wings every day. Swathes of the population were using heroin. (In a futile prevention effort, staff were banned from bringing in lunchtime sandwiches wrapped in foil.) And in late Autumn, when the heating pipes were turned on, the pungent aroma of hooch – brewed from bread, sugar and orange juice left in a warm place – would be added to the mix.

And as you'd expect, substances (alcohol very much included) were a big factor in people being there in the first place. Battered faces, cracked voices, tales of desperation, suicides and violence were facts of life inside. So was a persistent sense, throughout my four years there, that I was witnessing the perpetration of a mass injustice.

I vividly remember one distraught 22-year-old first-timer who couldn't

understand why he'd received a lengthy sentence for dealing ecstasy: "Just selling a few little things to my friends that they wanted!" I didn't have an answer for him. Other men would come to prison, get released, and then return, often several times in a year, without receiving any treatment for their palpable substance problems. And as you'd expect, hardly any of them were from a middle class background like me – although many people I'd known at school or university used or sometimes sold illegal drugs, no one was ever locked up.

I brought along these memories as I moved to New York and joined the editorial team at *TheFix.com*, which launched in March 2011. As a journalistic enterprise, covering everything related to addiction and recovery, drug policy and treatment, we were occupying a niche that we considered was growing in importance. As an online magazine, we had the power to reach unlimited numbers of people – and to allow them to reach us in privacy. Happily for us, the traffic numbers have since shown just how much people care about this field.

While I was already familiar with various kinds of substance use, I knew far less about 'recovery'. One big difference between the US and the rest of the world is the extent of the dominance here of AA and 12-step, abstinence-based recovery. People I'd known back in the UK who were using substances would sometimes talk about cutting down or quitting. Sometimes they'd do it. In the US, that very specific idea of being 'in recovery' was just one of many phrases and concepts that were unfamiliar

to me. That's changed fast. Many of our readers, contributors and staffers are members of AA, NA and the rest, and much of our content is about 12-step life.

Passions run high about interpretations of this form of recovery – and why wouldn't they, about something that you credit with saving your life? Opinion pieces that we have published that criticise tenets of 'the programme' – such as total abstinence or anonymity at a media level – have seen the comments fields erupt with arguments against or in favour of the writers' opinions. We've also run numerous pieces affirming the values of a traditional 12-step approach, and the same applies; while 12-step fellowships are by far the largest single element of the US 'recovery community', other groups and individuals attack this model – some even call AA an abusive 'cult'.

I certainly don't believe that. Neither do I share the core beliefs of AA. But it's been a privilege for me to get to know many within this community, to attend some meetings and to hear about how people have transformed lives that once seemed hopeless because of addiction. I have nothing but respect for that.

What's sometimes frustrating is the insistence of *some* AA members – and only some – that the 12 steps and total abstinence are the *only* road to recovery. The evidence doesn't support that. There are many people for whom AA doesn't work or who choose other paths. One survey last year indicated that 23.5 million Americans would answer 'yes' to the



question, “Did you once have a problem with drugs or alcohol, but no longer do?” AA’s estimated US membership is 1.3 million (the other 12-step fellowships are much smaller), so it’s interesting to consider what everyone else is doing.

Many find ways to deal with substance problems on their own. But another important answer is harm reduction programmes, which we also cover widely on *The Fix*. ‘Harm reduction’ makes many people think immediately of needle exchange – a vital element, and I was recently pleased to publish an on-the-ground report on one programme – but of course, there’s much more to it.

An uplifting story here in the US has been the advance of so-called ‘Good Samaritan’ laws, which grant immunity from prosecution for drug offences to those who call 911 to report an overdose. Fear of Police involvement is the most commonly cited reason that overdose witnesses fail to call for help. This summer, thanks to tireless campaigning from various groups, Vermont and Delaware became the 13th and 14th US states to enact Good Samaritan laws since New Mexico got the ball rolling in 2007.

These laws save lives. They also show that attitudes to drugs are changing. The wider distribution of naloxone, the life-saving drug that reverses opioid overdoses – fatal overdose deaths attributed to prescription opioids quadrupled here between 1999 and 2010 to over 16,000 – is another case in point. Some initially opposed naloxone distribution, on the basis

that it would ‘encourage’ more opioid use.

But the US still has a very long way to go. The Obama administration passed legislation in 2009 to overturn a longstanding ban on federal funding for needle exchange programmes; Congress reinstated the ban in 2011, and it still stands. And supervised injection sites remain illegal here – despite the success of North America’s only legal supervised injection site in Vancouver, recently confirmed by a long-term study demonstrating its benefits.

A bigger scar on America’s conscience is the appalling inhumanity of its incarceration policies. The US has the highest incarceration rate on Earth, with about 2.2 million people currently behind bars, about half of whom are there for non-violent drug offences. Savage mandatory minimum sentencing laws see many languish for decades. One of our regular contributors at *The Fix* is a writer who is in federal prison. He has been there for 20 years, having received a 25-year mandatory minimum sentence for his first-time offence: selling drugs at the age of 22.

A growing clamour of opinion in the US and around the world – notably including some Latin American leaders – agrees that the War on Drugs has failed, that the human rights violations must end and that legalising or decriminalising drugs is the way to make this happen. As someone who believes that government has no business penalising us for what we put into our own bodies and having seen the damage prison does, I’m with those who see the end of drug prohibition as

the greatest harm reduction of all.

Political reality might be slow to change, but happily, the process has begun in the US. Historically, Washington and Colorado voted to legalise cannabis last November, and with majority support for cannabis legalisation now regularly showing up in national opinion polls, more states should soon follow.

The hope should be that we achieve – at the very least – a drug policy model resembling that of Portugal, which, in 2001, stopped applying criminal sanctions for any drug possession for personal use. Overall drug use in that country has not significantly increased since then, but HIV and hep C infections have fallen, and more people with addiction problems are now receiving treatment; the harms of both drug use and drug prohibition have been mitigated.

With attitudes changing fast, there has never been a more exciting time to run a publication in this field. The complexities, entrenched prejudices and personal passions that you encounter mean there are plenty of pitfalls and stresses. Still, given the amount of stigma that has surrounded this subject, it’s a small triumph that such publications exist at all. ■

Will Godfrey is the now-former Editor-in-Chief of *TheFix.com*. He was right to appreciate his publication while it lasted; just before *Matters of Substance* went to print, costs and complications arising from a board-level lawsuit forced *The Fix* to fold. 2013 was its best traffic year, and it remains online for now.

Hurt people hurt people

Young people are often on the fringe of policy discourse, but JustSpeak, a youth-led organisation, has forged a strong voice on justice and corrections issues. Here, **JustSpeak** explains their youthful perspective on New Zealand's justice system and asks whether positive progress is possible.



HURT PEOPLE hurt people. It's an unfortunate but unavoidable truth within our criminal justice system, and it is no secret that those who offend

are often society's most vulnerable and damaged. It is particularly hard-hitting when a young person caught in the criminal justice system speaks about being broken beyond repair. It forces us to engage with the two major challenges facing New Zealand's legal and correctional systems: how do we prevent youth from becoming 'broken', and if we fail in this, how do we help them put the pieces back together? These are discussions that attract a range of opinions, some more informed than others. However, very seldom do we hear from the individuals who are affected the most by our decisions – the young people of New Zealand.

JustSpeak is an organisation committed to redressing this imbalance by contributing a young, informed and passionate voice to the discussion.

JustSpeak is a non-partisan network of young people speaking to and speaking up for a new generation of thinkers who want change in our criminal justice system. In order to achieve a more just Aotearoa, JustSpeak believes that we need to cultivate a transparent, evidence and

experience-based public discourse on criminal justice. JustSpeak volunteers are working actively within our communities, at our policy tables and everywhere in between with the belief that New Zealand's justice system has a lot of strengths, but it is time that we engage with its challenges.

New Zealand is an exceptionally punitive country and has one of the highest rates of per capita imprisonment

“I don't know if there is anything you can do to help us; we are broken, all of the stuff we have seen and has been done to us when we are little means we are just broken, and you can't fix that.”

in the OECD; 194 prisoners per 100,000 people, compared to Australia's 130 and Canada's 114. While this statistic may be greeted with joy by the average radio talk-back caller, our obscenely high incarceration levels should be a source of national shame. Why? Because sending people to prison is a very crude tool for reforming behaviour. A wealth of research shows that imprisonment has little or no deterrent effect on would-be offenders and is no more successful at

addressing the underlying causes and motivations of offending than community-based interventions.

Justice Minister Judith Collins recently stated that “a key to reducing crime is to stop young people entering the court and justice system in the first place”. So how is this currently done? When a young person is apprehended for an offence, Police have a number of resolutions available to them, including official warnings, Youth Aid, Family Group Conferences or prosecution. Prosecution is intended for only the most severe cases. However, statistics recently released by the New Zealand Police indicate a slightly different reality about the way in which Police discretion is being used.

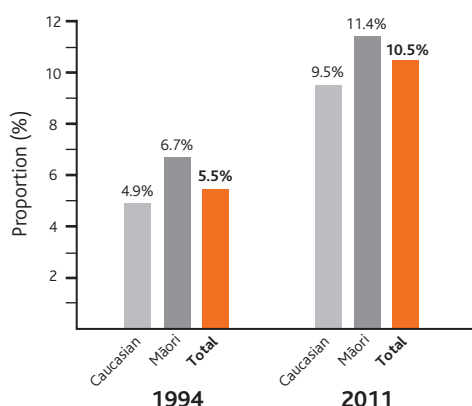
In 2012, youth apprehensions for illicit drug offences made up 4 percent of total youth apprehensions. Two-thirds of these apprehensions were attributable to drug possession and/or use; a majority of the time, the illicit drug in question was cannabis. While total apprehensions have decreased over time, prosecution rates have not. Close to twice the proportion of young people are being prosecuted for drug possession and/or use when compared to 18 years ago, while the number of warnings being given has dropped by 30 percent. That amounts to an additional 55 young people each year who are faced with a response that is meant to be reserved only for the most serious offences. This action

What's changed?

Police discretion

This is the proportion of **drugs possession** apprehensions of **10- to 16-year-olds** leading to **prosecution**

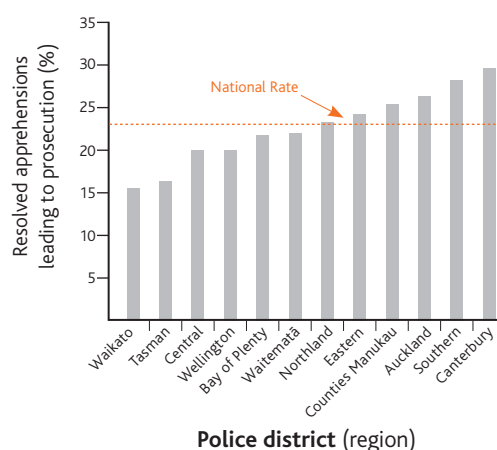
The rate has almost doubled since 1994, while warnings have decreased



Source: stats.govt.nz, JustSpeak.org.nz

Location, location, location

Prosecution decisions of young people for resolved crimes are **highly variable** across Police districts.



Source: stats.govt.nz, JustSpeak.org.nz

violates one of the basic principles that underpins New Zealand's correctional rehabilitation system: interventions should correlate with risk level. Not only do more intensive interventions allow young people to associate with higher-risk offenders (one of the main correlates of criminal behaviour), but they can also severely impact on protective factors such as education and family connections. Potential substance abuse issues only further compound these problems.

This pattern of increasing reliance on prosecution as a response to youth crime is alarming and directly contradictory to what we know is best for our young people. Studies tell us that many young people going to court or receiving custodial sentences fail to get the help that they need to continue their education and deal with mental health or substance abuse problems. Of the 3,500 young people under the age of 17 who came before the courts in 2011, 80 percent had substance abuse issues. However, between October 2010 and April 2012, judges made only 18 orders for treatment programmes. Harsh penalties do not fix broken people. The appropriateness and efficacy of punitive punishment as a response to youth crime, particularly in relation to possession and use offences, is something that needs to be very closely examined.

But there are certainly some silver linings on this rather dark metaphorical

cloud. A number of progressive initiatives are being incorporated into the youth justice sector in New Zealand and are attracting international praise. The diversionary approach that is the main focus of our youth justice system is also one of its biggest successes. While it raises concerns of potential differential treatment (see the infographic on regional prosecution rates released by JustSpeak), any progress made towards reducing the number of youth appearing before the formal court system is progress worth celebrating.

In this vein, a number of novel approaches to the court system have been trialled in New Zealand, largely to successful outcomes. For example, the Christchurch Youth Drug Court (YDC) is an initiative aimed at reducing offending related to alcohol and/or drug dependency amongst young people. Becoming operational in 2002, the YDC aims to facilitate early identification of young offenders with substance abuse problems and targets their needs accordingly. Diversion into this programme is initiated once a potential substance abuse problem is identified in Youth Court, and young people are monitored closely throughout their involvement with the YDC, being released only once they have reached sobriety. The Intensive Monitoring Group (IMG) Court is another specialised court system being developed to target the

needs of young offenders. Based on the YDC, the IMG provides therapeutic intervention to young people with moderate to severe mental health needs who are also at a high risk of re-offending. Unbroken, continuous involvement with judges and social workers, as well as intensive monitoring of the youth, is utilised in the hope of improving the outcomes.

While positive progress is being made, the way in which we approach and discuss justice issues in New Zealand needs to change. Change for the good does not necessarily need to be radical. JustSpeak recently advocated in a submission on the Psychoactive Substances Bill for the exclusive use of a diversion system in response to youth substance possession offences. Expanding what is the main strength of our current youth justice system is one step we can make towards a more just New Zealand. Our current justice system most certainly has its challenges, but it's just as certain that the system can be changed in a positive and progressive way. Some of our young people may be broken, but they most definitely can be fixed. ■

JustSpeak is a non-partisan network of young people speaking to and speaking up for a new generation of thinkers who want change in our criminal justice system.

Addiction is an equal opportunity disease

Viewpoints presents the arguments on both sides.

THE CASE AGAINST

NO ONE is immune from drug dependency. But that is not to say addiction is an equal opportunity illness. There are certain types of people who are more likely to form an addiction due their genetics, personalities or their position in society.

Genetic make-up can make a person more likely to become addicted if they carry certain genes. The National Institute on Drug Abuse estimates that 40–60 percent of addiction can be put down to genetic predisposition, so those who have a family history of dependence start off with a bigger opportunity to develop an addiction.

An example of this in action happens here in New Zealand. Māori are far more likely to experience addiction than other ethnicities. A Ministry of Health survey found that over 26 percent of Māori had had a substance use disorder. This is twice the national average of just over 12 percent.

Even if it's not nature, nurture certainly means that addiction is not equal opportunity. Within our society there are certain divisions based on income. It has been shown that people who live in poverty, or close to it, are more likely to develop addictions.

Māori also make up a disproportionate percentage of people in New Zealand's prisons and are at the bottom of most socioeconomic indicators. A major reason for taking drugs is to self-medicate, to compensate for pain and fear, to provide relief from the misery and burdens of daily life. The truth is those who worry about their next meal, those in low-paying unfulfilling jobs and those who face discrimination because their colour or sexual orientation are more likely to 'self-medicate'.

Early and heavy use of drugs by young people increases the chance they will have addiction-related problems in adulthood. Teens' brains are still developing and are very susceptible to the effects of drugs, and teens love to take risks. They may also lack the maturity and foresight to see the danger in what they are doing.

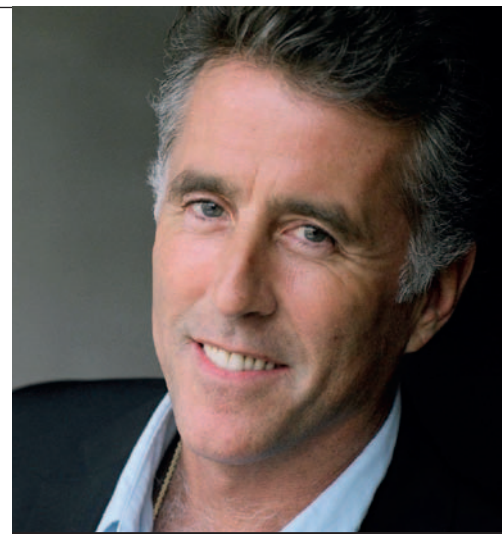
You are more likely to become addicted if certain environmental factors exist for you, such as an abusive home, parents with a dependence or associations with criminals – and the reasons why are obvious.

You are more likely to become addicted if you suffer from psychological disorders such as anxiety, depression, ADHD or even just low self-esteem. Some take drugs to help them deal with their disorder. Others take them because their disorder affects their judgement or impulse control.

The factors that predispose people to addiction goes on. So no matter what Mr Lawford says, there are certain people who will always be more likely than others to form an addiction, and these factors tend to cluster, meaning that, in reality, addiction is not an equal opportunity illness.

Christopher Kennedy-Lawford was a man born to have it all. The son of an actor and a politician, he was a member of a powerful political family with all the privileges money and fame can buy. Yet alcohol and other drugs nearly cost him his life several times. He is now a treatment campaigner and advocate.

Kennedy-Lawford is fond of saying addiction is an equal opportunity disease that can happen to anyone, but is it? It's an important question because how we answer it may also shape how we approach treatment.



THE against side has argued that certain types of people, namely those in poverty or some other form of hardship, are more likely to develop a dependence problem than the well-off and privileged. This is not so. Addiction is no respecter of persons.

Everyone would agree alcohol and other drugs are frequently used to relieve fear, anguish, worry, low self-esteem and other forms of mental pain. But who would argue these anxieties are strictly the realms of the poor?

Things that lead to mental trauma – sexual abuse, parental bullying, family violence, personal tragedies and so on – happen just as much in rich families as they do in poor ones. Two of Kennedy-Lawford's uncles were murdered, for example, and one of them happened to be the President.

But the fact is, there is little evidential base to suggest poverty itself means a person is more likely to develop an addiction. *High Price*, a new book by Dr Carl Hart, shows that up to 90 percent of people who use drugs can manage their drug use – we just don't hear from them at a criminal, policy or health level.


We all know money doesn't buy happiness. Rich people may not have the same worries as poor people, but they have anxieties of their own.

The well-off also have the money to afford to buy greater amounts of substances and take them more often, making addiction even more likely. Rich people are also not immune to genetic predisposition towards dependence or to being young and making unwise decisions.

Addiction is an equal opportunity disease that can affect doctors, lawyers, teachers and managers just as often as truck drivers, cleaners and beneficiaries. Kennedy-Lawford himself estimates 10 percent of Hollywood and 10 percent of Washington has it, and those are places of power and wealth.

So while there are societal and genetic predispositions to addiction, the picture is still fuzzy. Are we just seeing the worst cases and ignoring the ones we don't see? The real issue here is that addiction can affect anyone regardless of colour, class or position.

THE CASE
FOR

 YOUR VOICE



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



Kathryn Leafe

Chief Executive CareNZ

A lawyer who became a probation officer, CareNZ's new boss has worked in harm reduction across the globe. From running treatment centres in prisons to running the Soweto marathon, Kathryn Leafe is committed to reducing the harm drugs cause.

Q You were a lawyer who became a probation officer?

A I went to law school. My tutor at university said to me, "You're the most disinterested lawyer I've ever met, Kathryn. Go and be a probation officer."

So I worked in one of London's big law firms for about 18 months and ended up doing what my tutor said.

Q What are your top priorities for CareNZ?

A I am spending time getting to know staff and services – spending a lot of time out in the field meeting with services users and key stakeholders. I'm also meeting key people within the sector, particularly given that I don't come from a New Zealand drug treatment background, it feels really important to do that.

For me, it's about building on the good foundations and good work that CareNZ does. We've got a solid reputation for our services, interventions, and treatment – with some creative and innovative approaches – so really wanting to maintain that and build on the commitment of the staff.

Q What is the difference between the UK drug treatment sector and New Zealand's?

A There are lots of similarities between the trends and issues within the sectors. Some of the things happening now around the development of drug strategy here in New Zealand and also some of the challenges that come through growth and upscaling service provision are very familiar. Also, the successes seem to be coming from similar strategies as well.

A key difference is working in a bicultural context with Māori. Whilst I have worked internationally in many different contexts, this is my first time working in this region – I have really welcomed the huge learning curve of the last four years.

Q What have you been doing since leaving the UK?

A I might have an English accent, but the West Coast is home. In 2008, I did a little bit of work on the family farm but decided that sheep farming wasn't a good second career option.

I got involved in doing various projects in the West Coast region, including the social services agency where my grandmother was a founding member. Then Pike River happened, and I ended up working with the families of the 29 men. I also got involved in Christchurch, post-earthquake.

Being involved in two of the biggest disasters in the South Island has been one of the biggest challenges in my professional career, but it has also been one of the greatest privileges. It's not a position you ever expect to find yourself in or something you train for.

Q You've also worked for the United Nations?

A The A and D provider I was working for was selected as one of the 20 international best-practice centres to be part of a UNODC programme called Treatnet. I led one of those centres and was involved in UNODC programmes to build capacity and improve the quality of drug treatment internationally.

One of the pieces of work I led was the writing of the good practice guide for working in prisons. This was when I first had contact with CareNZ, and their work in Arohata is referred to in that guide.

I've also worked across Eastern Europe and Central Asia providing consultancy and training in relation to the development of drug strategy and work in prisons.

Q You've done work in a lot of dangerous places. What is the craziest situation you've ever been in?

A I was doing some work in Central Europe, and we went into one of their prisons, which was actually one of the high security prisons, and the governor had put on this lovely meal for us as part of the day there. The service was excellent and the food was great, and we were complimenting him about the service. He was explaining that the prisoners did this as part of their role and that these jobs were privileged positions. The conversation went on, and we said that they mustn't get to do it very often, and he said "No, no, no. It happens every weekend."

"What do you mean?", we asked

"Every Saturday, we open the restaurant downstairs and the local villagers come to the restaurant, and the prison band comes out and plays, and all the villagers dance in the square!"

We're looking at him, and the Governor is like, "You don't do that in England?"

Q What is harm reduction to you?

A Harm reduction services are one of a number of 'entry points' in a recovery journey. It helps keep people safer and alive.

It also builds a foundation for further work – a good experience and positive relationship with services can make it easier to access help and support later on.

We're all always doing harm reduction.

Q A couple of years back, you ran the Soweto Marathon. Done any more since?

A No, but that was one of the best experiences of my life. I ran a couple of London Marathons, then two in Soweto. The first time I ran it – 2,000 metres above sea level, 32 degree heat – I was involved in an HIV project in Johannesburg. We took young people in Soweto, Alex and Tembisa and used theatre to do HIV education. They were all in this Kombi van following me around this marathon hanging out the windows and shouting their support for this white woman with this vest that said, "We're all HIV positive until proven negative", which was a really important message in South Africa.

The next year, I ran it with two of the young people from the project as training partners. I was in London, they were in Johannesburg. ■

New Zealand has the highest drug use in the world

International reports often portray New Zealand as having one of the highest rates of drug use in the world. So is it all Kiwis and Kronik in the land of the long white cloud, or are other factors at play here? Mythbusters investigates.



ANNABIS is the most widely used illicit substance in the world. The United Nations Office on Drugs and Crime's *World Drug Report 2012*

estimated that, while in 2010 2.6–5 percent of all adults globally had used cannabis, Oceania's average – and that's essentially Australia and New Zealand – was between 9.1 and 14.6 percent, nearly three times the global average.

While the report itself specifically says the information it presents is based on estimates, the estimates are based on the submissions of only two out of 14 countries. Professor Louisa Degenhardt from the National Drug and Alcohol Research Centre at the University of New South Wales says that country-level estimates are used for the report to make regional-level estimates.

"Oceania looks high, even though our rates are similar to many other countries and lower than others, as there are other countries with high reported levels," Professor Degenhardt says.

An example of both bad estimates and a high number bringing up the Oceania average is that of Palau, the small Pacific Island nation to the east of the Philippines. The 2012 World Drug report said 25 percent of the population uses cannabis. This estimate was not based on survey data for adults but a survey of the one state high school on the island. A small sample size

with a pretty obvious bias.

The UNODC even acknowledges shortcomings in its data collection. In 2009, they held an expert group meeting on global drug data collection, analysis and reporting, which suggested over 30 recommendations about how to improve reporting of drug statistics from member countries. Most of the recommendations focused on improving data collection systems and substantial changes to process in order to improve the quantity and quality of data collected in the Annual Reports Questionnaire.

The International Drug Policy Consortium review of the 2012 World Drug Report reinforces the issues around data and says that "faced with such a dilemma, UNODC is forced to adopt methods of extrapolation that may be misleading".

No matter, because the *World Drug Report 2013*, released in May this year, no longer puts New Zealand at the top, and the estimated cannabis usage of Oceania is at 10.9 percent, not much higher than North America at 10.7 percent. So even if we are estimated to have a very slightly higher usage rate of cannabis, it's not really by that much.

Also, perhaps the World Drug Report is out of date. The New Zealand Government recently announced that the use of methamphetamine has halved since 2009, something that was not reflected in the UNODC's latest World Drug Report. Government data now shows that only 0.9 percent of New Zealand's population are using methamphetamine, whereas the

UNODC report puts the usage of methamphetamine in Oceania, making specific mention of New Zealand, at 2.1 percent of our population using methamphetamine.

Mythbusters wonders whether there might be another factor muddying the statistical waters. New Zealand has long been known for its general tolerance towards soft drugs, at least in comparison to the US and even Australia. As a result, Kiwis may feel more relaxed about reporting their drug use. Perhaps that's why we tend to rank highly on the world scale.

So the myth that New Zealand has the highest drug use in the world rests on the reliability of data. New Zealand collects some decent data on drug use rates in the world while other countries maintain a lacklustre approach to keeping tabs. Not only that, the data that we and other countries do get can be pretty patchy, with many different methodologies and circumstances in its creation.

Mythbusters is prepared to concede that, per capita, New Zealand is up there with the best of them when it comes to cannabis consumption. But are we the biggest consumers in the world? We think the jury's still out on that or at least only half way through the door. ■



REFERENCES

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



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