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

Taking the pulse of Māori public health

Restoring equality and addressing health outcomes for Māori comes with many challenges.

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Taking the pulse of Māori public health

COVER: Health inequalities for Māori remain, but much progress is being made getting the right sort of help

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REGULARS

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

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

NZ Drug Foundation
4th Floor, 265 Wakefield Street
PO Box 3082, Wellington,
New Zealand
p +64 4 801 6303

COVER PHOTO CREDIT: Rangi Kipa 2008, Staron(TM), marine resin.

THE DIRECTOR'S CUT

Could Kelly van Gaalen's jail sentence be the start of the downfall of our obsolete drug law?

Kaikohe mother of three, 38-year-old van Gaalen was sentenced last month to two years' jail for possession of cannabis for supply. She was charged with having 684g of cannabis, 24 times the personal use limit of 28g.

The cannabis was found at her home by Police who were called by her husband following a violent home invasion. He was originally charged for the cannabis until Kelly admitted it was hers.

ROSS BELL
Executive Director

Kelly is a highly respected community member. She was on her community board, chair of the community arts council and promotions manager for the local business association – roles she resigned from following her arrest. Last year, she was one of 15 Northlanders to receive a Local Heroes medal.

There was no evidence of commercial dealing or that she was profiteering by supplying cannabis to minors. Yet Crown prosecutor Catherine Gisler asked for a three-year sentence, arguing deterrence was important. Kelly's lawyer Doug Blaikie sought community detention.

When handing down the jail term, Judge John McDonald said, "To say this sentencing has troubled me is an understatement… It is not for this court to comment whether that is a just law or not."

Many mainstream media commentators have questioned the judge's ruling. Jake Tame was curious why a discharge without conviction or community sentence wasn't applied. The *New Zealand Herald*'s Brian Rudman highlighted similar cases where lesser penalties were used. Others found much more violent and nasty offences that received shorter terms. Russell Brown slammed the judge's claim that his hands were tied as risible, untrue and cowardly. It is right to question the proportionality of the judge's decision.

Recent analysis of arrest data by *Salient* has also uncovered a clear policy decision by Police to shift its focus away from cannabis possession offences. And so it is also right to question Police actions in pursuing this case.

But clearly our attention must turn to Parliament, whose members remain ultimately responsible for their stubborn refusal to repeal our obsolete, 40-year-old Misuse of Drugs Act. The just-released National Drug Policy has few signals in it to give us hope that this may be about to change.

But the widespread public unease about this case could well generate the necessary community-driven demand for fundamental reform – silver lining unlikely to be of much consequence to Kelly van Gaalen's 5, 7 and 16-year-old children.

SOCIAL

@KEITH_NG So it turns out that, on asking conference speakers for their preferences for gifts, many don't actually want alcohol. #fyi JUN 29

@LIVENEWSDESK BREAKING: Kiwi Antony de Malmanche has been sentenced to 15yrs in prison for smuggling drugs into Bali JUN 30

@WIMON_SONG Intermission at Sleeping Beauty on Ice and tbh, it probably would be better if it was about drugs. JUL 1

@GEORGETAKEI Oregon legalizes recreational marijuana. They will likely reap benefits such as: higher tax revenue, less crime, and increased pizza sales. JUL 2

@DOMPOST After Alex Renton's death, **@PETERDUNNEMP** says medical cannabis treatment was still worthwhile. http://bit.ly/1HvGJgv JUL 2

@DAIHENWOOD Games like last night make me happy I don't drink. I would have thrown the TV through the remote and been grumpy this morning. JUL 9

@SANHOTREE #Naloxone could've prevented it easily. RT @ClassicPixs: Philip Seymour Hoffman left us 1 year ago today. R.I.P. JUL 12

@LAIGLO #US President commuted prison terms of 46 non-violent #drug offenders this week. Many more deserve this 2nd chance JUL 17

@NZDRUG With 1000 NZers infected with Hep C yearly – a figure unchanged since 2000 – action critical say Needle Exchange NZ. JUL 27

KEY EVENTS & DATES

2-5 SEP	**20th Cutting Edge Conference – It's all about Whanau, Nelson , New Zealand** **http://www.cuttingedge.org.nz/**
7-9 OCT	**3rd National Cannabis Conference, Melbourne, Australia** **https://ncpic.org.au/2015conference/**
15-19 OCT	**Healing Our Spirit Worldwide, Hamilton, New Zealand** **http://hosw.com/**
18-21 OCT	**2015 Int'l Harm Reduction Conference, Kuala Lumpur** **http://www.ihra.net/**
18-21 NOV	**Reform Conference, Washington DC, USA** **http://www.reformconference.org/**

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NZ.

01

Helpline moving

The government's long talked about plans to merge telehealth freephone lines will become a reality from 1 November. In June, Homecare Medical was awarded the contract to run Healthline, Quitline, the poisons helpline, the alcohol and drug helpline and the helplines for depression, gambling and public immunisation advice. Homecare Medical is a partnership between two of New Zealand's largest PHOs.

Announcing the new arrangements, Health Minister Dr Jonathan Coleman said, "The public can still contact services using current phone numbers. Behind the scenes, the new national service will be more seamless and ensure people access the right advice, at the right time, no matter where they live."

ADANZ CEO Paul Route, whose organisation has run the Alcohol Drug Helpline since about 1990, says the intent of the new service provider is that consumers will initially not notice a difference when the service switches over except that it will be available 24 hours a day. Ultimately, anyone calling will be able to access integrated assistance for a wide range of coexisting problems whether addiction, mental health or other health issues.

Losing its core contract means ADANZ will no longer be viable as a stand-alone organisation and most staff will be made redundant.

"The Board is in discussion with another organisation regarding a possible merger which would allow our ongoing services to have a sustainable future," Rout said.

ADANZ is working closely with Homecare Medical to ensure a smooth transition with opportunities for staff to be employed in the new service.

02

Tougher new alcohol rules in Rotorua

A ONE-WAY door policy, a ban on single RTD sales, no new outlets within 1 kilometre of an existing off-licence and a blanket 10pm closing time for all liquor stores are some of the new alcohol measures proposed in Rotorua.

Speaking to the Rotorua Lakes Council Local Alcohol Plan (LAP), Councillor Merepeka Raukawa-Tait said the policy was geared towards addressing the potentially harmful effects of alcohol.

The proposed LAP was approved by the councillors on 26 July. Barring appeals, it could come into force in early 2016. Any appeals could see implementation of some form of delay for another year.

03

Festival hangs on to BYO

R&V

CONCERNED AT unruly festival goers spoiling the party, Rhythm and Vines organisers have lowered the amount people can drink. Anyone camping in the official campsite will only be allowed a maximum of 24 cans of BYO beer over the three days of the event.

The move comes after fights broke at out at the neighbouring BW Summer Festival last year. It was reported that around 90 people were injured and 63 arrested after alcohol-fuelled party goers let loose.

Alcohol legislation is seen as the propelling factor behind the more stringent BYO rules.

11%

11% OF NEW ZEALAND ADULTS USED CANNABIS (IN PAST YEAR)

1 IN 3 USE WEEKLY

87%

DID NOT REPORT ANY CONCERNS FROM OTHERS ABOUT THEIR USE

1.2%

RECEIVED HELP TO REDUCE OR QUIT

42%

REPORTED MEDICINAL USE

SOURCE

Cannabis Use 2012/13, New Zealand Health Survey (released May 2015)

04

'Support. Don't Punish.' around Aotearoa

SMALL GATHERINGS of supporters, large protests, music events, dance displays, flash mobs, sport tournaments, seminars, debates and workshops were some of the many activities that took place on the 'Support. Don't Punish.' global day of action.

In New Zealand, people working at the treatment frontline paused to acknowledge the vital work they do providing practical support to people with drug problems. Informal events were held in Auckland, Wellington, Christchurch and Dunedin. Pictures snapped here as part of the worldwide photo project joined those taken in places as diverse as Macedonia, Tanzania and Thailand.

RESOURCES

supportdontpunish.org/photoproject

05 Dry bar in Auckland short-lived

WHILE MUCH hope greeted the opening of a booze-free bar in Auckland's Karangahape Road, the public had little thirst for the non-alcoholic nightlife.

Nightclub owner Grady Elliott opened Tap (The After Party) in response to Auckland Council's new alcohol rules on licensing and bar closing times. Tap opened for five weeks from midnight to 7am on Fridays and Saturdays. Instead of beer or wine, punters could purchase a wide range of non-alcoholic drinks.

"We gave it a shot, and Auckland drinking culture just didn't tie in with the dry bar. No one showed up," Elliott told the *New Zealand Herald*.

07 Just add water

H2O

AS IF THERE weren't already enough ways to imbibe alcohol, along come sachets of dried booze. Some stores are selling dried alcohol for $1.50 a packet, with the equivalent strength of half a standard drink.

Both Alcohol Healthwatch and the National Addiction Centre have raised concerns about the providing of yet another way for people to drink. Alcohol Healthwatch director Rebecca Williams said these products were predominantly used by young people trying to smuggle alcohol into restricted areas at sports and music events.

08 Problem with opioid painkillers

249%

INCREASE IN OXYCODONE PRESCRIPTIONS

SCIENCE WRITER Roger Hanson says New Zealanders need to be wary of the over-prescribing of opioid drugs and related problems, which is at near epidemic proportions in the USA.

Writing in the Taranaki Daily News, Hanson reports on statistics published by Best Practice Journal (BPJ) NZ that show the dispensing rate of oxycodone has increased by 249 percent between 2007 and 2011 in New Zealand.

"The tragedy is that bad decisions on the dosage and applicability of powerful opioid drugs – decisions made by pharmaceutical companies, governments and doctors – have already led to many lives ruined by drug dependency," Hanson writes.

06 Drug survey take-aways

25%

OF THOSE SURVEYED USED ILLEGAL DRUGS IN THE LAST MONTH

"IT SEEMS having more drugs available simply led to most existing users adopting a broader range of drugs," says Global Drug Survey founder Dr Adam Winstock.

Results from the 2015 survey show that, of those who said they had used a legal high during the regulated period, almost two-thirds carried on using other drugs as they had before.

While just 13.5 percent of the 3,400 New Zealanders surveyed used legal highs, most did use drugs in the past month. Most drank alcohol (96.7 percent), with cannabis the second most commonly used substance (63.5 percent). About half surveyed used cannabis weekly or more often.

The findings could fill pages, so jump onto the Stuff website to explore the full results.

RESOURCES

http://nzdrug.org/gds15-nz

World.

01 Malmanche sentenced to 15 years

Whanganui man Antony de Malmanche was caught with 1.7 kilograms of methamphetamine in his backpack in Penang. Avoiding the death penalty, Malmanche will instead be imprisoned for 15 years.

The lead lawyer for the defence, New Zealander Craig Tuck, told the New Zealand Herald, "There were 'volumes of material' we could have put before the court, but the judges wanted to hear all the evidence in one afternoon."

While a decision on an appeal has yet to be made, Tim Lindsey, a law professor from Melbourne, recommended against appealing because the original sentence could be replaced by the death penalty.

02 Ecstasy on the streets of Amsterdam

FOR a single day, ecstasy was allegedly sold from a shop in downtown Amsterdam.

The youth wing of the Dutch Liberal Democrats set up the shop to highlight how legal supply of ecstasy would create less criminality and safer pills, and keep the drug out of the hands of minors.

With half a million Dutch people having tried ecstasy or some form of MDMA at least once in their lives, change is seen as inevitable. The store closed after 24 hours with no-one coming to harm, as sales were restricted to placebo pills.

03 OECD weighs in on booze

"THE COST to society and the economy of excessive alcohol consumption around the world is massive, especially in OECD countries," said OECD Secretary-General Ángel Gurría, at the launch of Tackling Harmful Alcohol Use: Economics and Public Health Policy report.

As well as analysis of where things stand, the report contains recommendations targeting both heavy drinkers and wider social practices. While individualist approaches are given priority, the OECD acknowledges broader approaches may also be needed. This includes raising costs, for example, through increased taxes, or by imposing minimum prices on cheaper alcohol.

Across the whole OECD average drinking has dropped by two litres of pure alcohol per capita since 1980 to 9.2 litres. Alcohol consumption by New Zealanders sits at exactly the same level as the OECD average for 2013.

RESOURCES

nzdrug.org/oecd-harmful-drinking

04 Facing up to alcohol and family violence

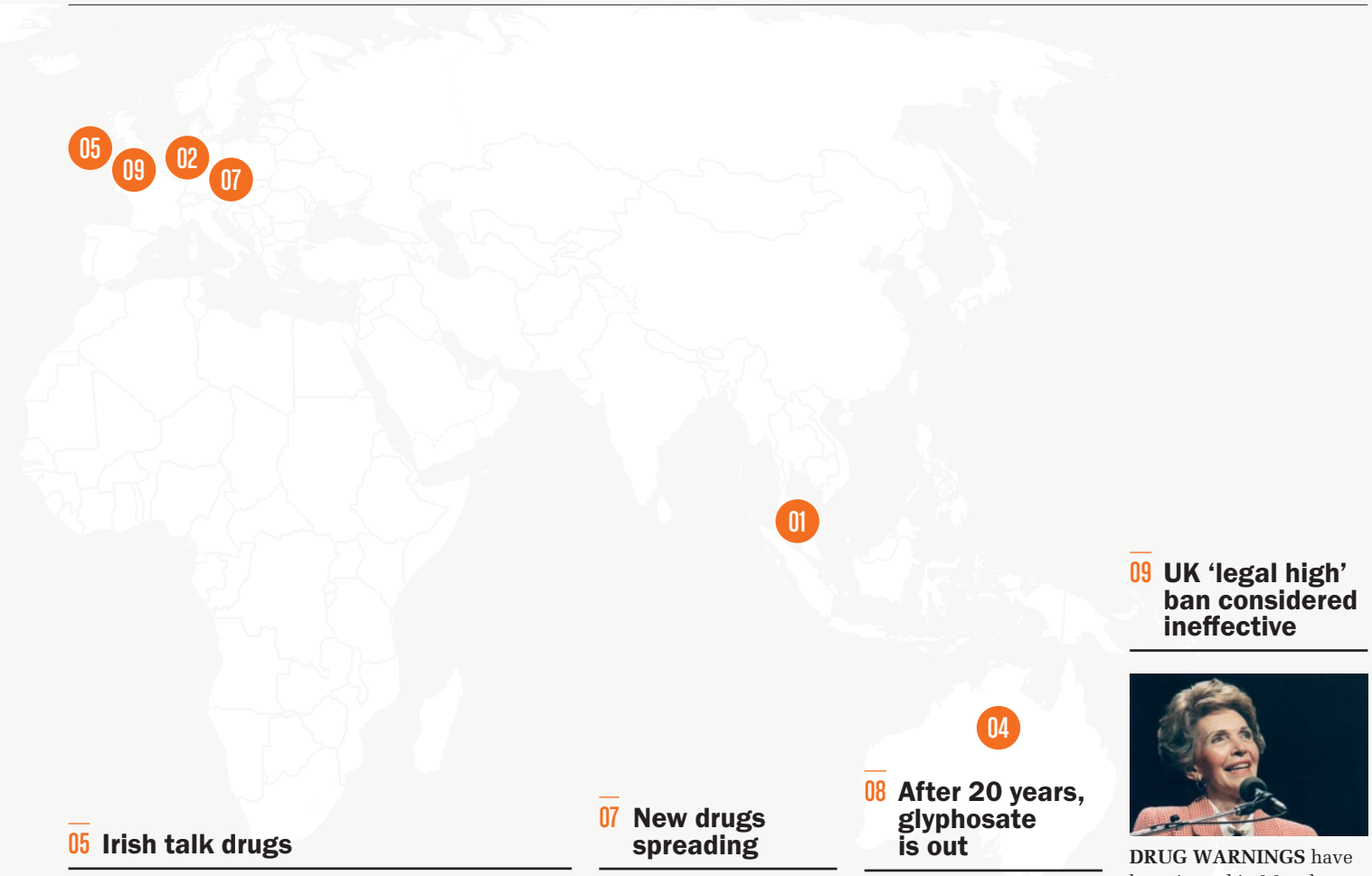
fare
STOPPING HARM CAUSED BY ALCOHOL

CANBERRA-BASED FOUNDATION for Alcohol Research and Education (FARE) is calling on all levels of Australian government to urgently implement measures that would prevent and reduce alcohol-fuelled violence.

Evidence presented by FARE shows alcohol is involved in up to 65 percent of family violence incidents reported to Police and up to 47 percent of child abuse cases in the lucky country.

Launched on 17 June, the National framework for action to prevent alcohol-related family violence includes recommendations for policies and programmes that all Australian governments are urged to implement.

Speaking at the launch Australian of the Year Rosie Batty said, "The involvement of alcohol and its impact on family violence must be acknowledged and must be addressed."



05 Irish talk drugs

THE IRISH public were given just over a month to have their say on the country's drug laws by the Oireachtas Justice Committee. As part of a wider review of drug policies, submissions were invited "in relation to arguments in favour of and against altering the present approach to sanctions for possession of certain amounts of drugs for personal use".

A delegation from the same committee talked with policy makers, health workers and politicians in Lisbon. In an official report, the committee concluded the Portuguese approach "has not resulted in an increase in drug taking nor has it resulted in Portugal becoming a destination for drug tourists".

It is hoped the Irish Misuse of Drugs Act will be updated by the end of 2015.

06 Delaware decriminalises dak

Possession and private use of up to an ounce of cannabis will no longer attract criminal sanctions in Delaware, one of the smallest states in the USA. If caught using cannabis publicly, Delaware's 900,000 citizens will face a $100 civil fine, and Police are still permitted to seize the drug. The law comes into effect in December 2015.

The move follows the lead of nearly 20 states that have already eased penalties for personal consumption.

07 New drugs spreading

541

NEW SUBSTANCES

NEW PSYCHOACTIVE substances keep being manufactured, according to the latest United Nations drug report. Up to last December, UNDOC experts identified a total of 541 newly synthesised drugs – 20 percent more than the previous year.

The new drugs have been found in 95 countries, including this year for the first time in Peru, the Cayman Islands, Montenegro and the Seychelles.

Overall drug use remains stable around the world reports the United Nations, with about 246 million people – about 5 percent of the global adult population – using drugs.

RESOURCES

unodc.org/wdr2015

08 After 20 years, glyphosate is out

THE message that liberal spraying of glyphosate is not good for people or the environment has finally got through in Colombia. The powerful herbicide has been sprayed from the air in efforts to destroy coca crops since 1994.

The World Health Organization warned in March that glyphosate, known more widely as Roundup, is 'probably carcinogenic'. In response, President Juan Manuel Santos said he would ask the National Drug Council to suspend glyphosate spraying.

Described as Colombia's Agent Orange, the chemical has been sprayed on over 1.3 million acres of Colombian farm, range and forest land.

09 UK 'legal high' ban considered ineffective

DRUG WARNINGS have been issued in Manchester, Newcastle, Swansea and many other UK cities and towns. Police and health authorities are reacting to harmful side-effects of people taking 'legal highs' and are issuing blanket warnings for people to avoid all substances.

Meanwhile, in the House of Lords, a Government bill to ban legal highs has been subject to intense challenge. With even the Government's own drug policy advisers calling the legislation unenforceable, hopes the political response will meaningfully address problems are at an all-time low.

Ifor Glynn, CEO of Welsh drugs charity Sands Cymru and Cais, told the BBC, "The fact that it's illegal doesn't have any impact on people using it. It doesn't drive the problem away. There are people out there who are buying and wanting these drugs. We need to educate people about the risk of these drugs."

Taking the pulse of Māori public health

Māori have been over-represented in drug, alcohol and smoking statistics in comparison to Pākehā seemingly since records began. The situation is rooted deep within New Zealand's colonial history. Are things improving for Māori? What approaches are working, and what else needs to be done to address inequities? **Matt Calman** talks with four figures from the sector about the state of the Māori nation in terms of treatment and harm reduction.

MATT CALMAN

Photo credit: Rangi Kipa 2008, Staron(TM), marine resin.

Photo credit: University of Otago Magazine

> **“You can concentrate on the person and their treatment, but there is a political and societal context to this as well, which to me is about human rights.”**
>
> TUARI POTIKI

> **“Some might say you can do it in the bush with rongoā (traditional Māori medicine). Maybe, but if you’re a chronic alcoholic, you can die from just giving it up straight away.”**

Tuari Potiki, like scores of New Zealanders, grew up in a family that liked to drink alcohol. He was drinking regularly with his mates by the time he left school. By age 28, he was in court-ordered residential treatment in Hanmer Springs for intravenous drug use. He was in and out of residential drug and alcohol facilities over the next five years. His treatment included counselling and methadone. It was five months after leaving his last residential placement in late 1989 that he became drug free, and he has maintained sobriety ever since.

When asked about his struggle with drug use, he smiles and says wryly, “I didn’t really struggle. I just let it happen. When I was a junkie, I used to think naively that all I had to do was stop putting needles in my arm, and it would be okay, but there was a bit more to it than that.”

Potiki has seen treatment from both sides. After successfully giving up, he studied for a couple of years and then began helping others as a drug and alcohol counsellor in Christchurch. In the early 1990s, there weren’t many other Māori alcohol and drug counsellors. There were a handful of Māori treatment centres, but the overwhelming majority were mainstream. There were a couple of “old Māori women who were full on into it” who enticed Potiki to the job.

“It was sort of the beginnings of the Māori alcohol and drug sector really, so it was quite pioneering in some ways,” Potiki says. “They were on the lookout for people to move into this kind of work. I got the bug.”

Potiki, who is of Ngāi Tahu, Ngāti Māmoe and Waitaha descent, has worked in various parts of the sector – at the coalface, in the office and in the boardroom. For years, he counselled Māori in prison. For seven years, he worked at the Alcohol Advisory Council of New Zealand (his role involved engaging communities to take action around alcohol). For the last three years, he has been Director of Māori Development at Otago University. He currently chairs the New Zealand Drug Foundation Board.

How are Māori served today in terms of treatment options compared to when he started counselling in the early 90s?

“I think it’s changed a lot,” Potiki muses. “There are a lot more specific Māori alcohol and drug services around the country, and many of them are attached to iwi or Māori health organisations.”

While the vast majority of treatment centres remain mainstream, some Māori programmes were flourishing, such as Te Utuhina Manaakitanga Trust in Rotorua and Ngāti Toa’s Rangataua Mauriora youth programme in Porirua. Ngāi Tahu is one

Cover story image:

Rangi Kipa 2008, Staron(TM), marine resin.
The parata is a prow-figure usually found on traditional fishing canoes and references Kipa’s navigation of new pathways into the contemporary art world, this was part of a series exhibited in his solo show in NY in 2008.

iwi that has begun providing some health support for its members, Potiki says.

"The whole Māori world has changed, and Ngāi Tahu is a good example. Fifteen years ago, it was all new, and they were just getting into their settlement. Now that they've got a few runs on the board, they're moving into the health sector as well. However, Ngāi Tahu has been reluctant to put tribal money – which has taken 175 years to get – into things that should actually be being provided by the government through our taxes."

While access to Māori services has improved, the vast majority of Māori still go to mainstream treatment centres, Potiki says. Some parts of the country have more options because of stronger Māori population, such as in Auckland, but the options are far more limited in other regions.

"It still depends on where you go. If you went to the Dunedin CADS service, I don't think there'd be any brown faces in there."

Potiki says there has been significant improvement in academic qualifications for clinicians since he studied. Today, there are postgraduate certificates and diplomas in drug and alcohol treatment, and there is now a professional addiction practitioners' body, DAPAANZ. While there is still a dearth of Māori clinicians, inclusion of tikanga Māori in current courses means Pākehā graduates will at least have some grasp of Māori culture when dealing with Māori clients.

"Initially, there wasn't really a profession as such. It was sort of treated a bit like a poor relation of mental health. It's become much more professional."

Auckland-based Papa Nahi, General Manager of Hāpai Te Hauora Māori Public Health, agrees that services are still mainly clustered where Māori populations are. She says there remains a lack of investment in increasing the numbers of Māori in the treatment sector.

"If we don't have that [commitment], then it's difficult to try and get any progress," says Nahi, who is of Ngāpuhi-Nui-Tonu descent.

Hāpai Te Hauora is a national Māori public health organisation funded by the Ministry of Health. Jointly owned by three Māori public health providers, these organisations then undertake much of the organisations health promotions work, including for drugs and alcohol. Its focus is very much on harm reduction rather than treatment.

Nahi says getting out to where Māori are is key, and she is seeing some exciting

"But it is important that approaches don't put Māori in one stereotypical box of "this is what Māori do or that's what Māori look like"."

community-based results. She cites smokefree-promotion YouTube videos by local waka ama clubs and the Otahuhu Mangere Youth Group's stand against liquor stores opening near their community's schools as examples of people taking action on an issue to improve health and inspire others.

"We're bombarded with statistics that are not pretty however. When you've got a story of young people getting together and taking a stand on an issue to do with alcohol and drugs, it's really inspiring, and that motivates all Māori to take action," Nahi says. "I really believe that strength-based approaches are the way to go."

By "strength-based", Nahi means framing things in a way that empowers people, allowing them to "have a sense of their own mana" and helping them consider action they can take in order to move forward. It's about buy-in and ownership.

Raukura Hauora O Tainui, one of Hāpai Te Hauora's owners/ sub-contractors, has been working with sports clubs and community groups around the drug and alcohol kaupapa. In response, the Redhill Rocketz Softball Club in Counties Manukau made banners and went smokefree, and some of the members had gone without alcohol, Nahi says.

Another of the three owners/ subcontractors, Te Whānau O Waipareira, based in West Auckland, offers an eight-week-long alcohol and drug-counselling programme. Many of its clients are referred to Waipareira's four-strong team of counsellors by the probation service.

Waipareira AOD Addictions Counsellor Louise Graham says many of the clients come feeling whakamā (ashamed) and have been forced to attend by the criminal justice system, and some don't want to be there. Others want to be good parents and role models but lack the skills to do it. If clients require drug and alcohol treatment, they are referred to an appropriate treatment facility. The values that underpin the organisation are key to the success of the counselling programme. They include upholding respect, dignity, equity, fairness and a commitment to value all Māori regardless of their circumstances.

Graham, a Cook Islands Māori, came to Waipareira seven years ago inspired by her own upbringing in alcohol and an extended whānau that "dabbled in drugs". She says some of her clients don't grasp the impact their substance use has had on their families and others.

"We work with the client's own resources to find an outcome that is individual and meaningful for them," Graham says. "We identify and enrich the facets of their life that encourage resilience in the face of outside pressures and distractions."

Graham says one technique that is working well is narrative therapy, which encourages clients to talk about their own story in order to "separate the addiction from the person".

Another successful technique is interactive drawing therapy, where the clients express their inner thoughts and feelings by putting them to paper.

"It's very successful, if they aren't able to describe what's really going on for them. It helps them get it out. The picture finally tells the story of what's happening in their lives."

Is it important to tailor programmes for Māori? And what does a Māori approach look like compared to a mainstream approach?

Potiki describes the fundamental difference is that the mainstream approach will tend to focus solely on a client's addiction. He likens it to how the frayed ends of a rope represent different parts of a person: the physical wellbeing, mental wellbeing, whānau and culture.

"When you go to a non-Māori service, you hang those ones up, and you just take [the addiction] in, and that's what they deal with. All of those other bits are there too, but it's as if they don't connect. If you want the rope to get strong, however, they have to."

While there is no one model that encapsulates the Māori approach, it is generally much more about inclusion and being part of the greater whole.

"Us versus I. [It's about] connecting to whakapapa, connecting to your sense of belonging, identity, all of those things that come with connecting."

Some will just want to get off whatever they are using and have little interest in the cultural side of things.

"If you need to detox, you need to detox. Some might say you can do it in the bush with rongoā (traditional Māori

Associate Professor Marewa Glover, outside Massey University campus.

Photo credit: Peter Meecham

> **"In my view, there are as many different ways to be Māori than there are Māori."**

medicine). Maybe, but if you're a chronic alcoholic, you can die from just giving it up straight away without a proper medical detox."

Potiki says, when he counselled Māori in prison, he would see them as Ngāpuhi or Te Arawa or whatever their tribal affiliation was rather than prisoners, rapists, murderers or robbers. It is about seeing them as Māori and also seeing the person sitting there, he says.

"It's hard to explain, but if you can see that, then it helps them to see that too."

——

Starting and finishing the sessions with karakia and waiata was an important part of "how we did everything", aside from it being the obvious example of what Māori do differently to others.

It works the same way in the community. If someone comes to a session, they symbolically bring their whānau, their hapū and their iwi with them, Potiki explains. Making that connection with them is usually a positive.

"They don't feel alone. They feel connected to something. If they're going to give up the identity of being an alcoholic or a drug addict, it leaves a hole that needs to be replaced with something. Often for Māori, that's where the journey begins. They get into te reo and they go to wānanga (university), and they do all sorts of things."

But it is important that approaches don't put Māori in one stereotypical box of "this is what Māori do or that's what Māori look like", Potiki says. For example, while many Māori believe wairua (spirit) is an intrinsic concept to being Māori, it is less important to others.

"In my view, there are as many different ways to be Māori than there are Māori. It has to be individualised. It has to be meaningful to the person, otherwise it's just religion in drag."

Graham says Waipareira offers a holistic wrap-around service and can refer clients to other arms of the organisation, including to the marae-based tikanga Māori programmes. It incorporates the Māori view that taking alcohol and drugs harms a person's wairua (spirit). The clients are told the counselling is based on the kaupapa Māori model and asked if they're happy to continue. Most are.

"The majority of them actually want to tap back into their culture, into their roots," Graham says.

Nahi says tailoring programmes to have Māori at the centre has to be a "core component of everything we do" if we're serious about restoring equality and addressing health outcomes for Māori. She would also like to see Pākehā build more dialogue with Māori and listen to what Māori want.

"Drug abuse isn't tikanga Māori. It's been brought here. Back in the day, Māori have responded by saying 'Look, this isn't right. We want to do something about this.' We're just continuing that on today."

Massey University Research Centre for Māori Health and Development Associate Professor Marewa Glover is more familiar than most with the desperately unfavourable Māori health statistics when compared to Pākehā. Glover, of Ngāpuhi descent, has been a leading researcher in tobacco control for more than two decades, has helped design smoking-cessation programmes and is an expert on smoking prevalence among Māori.

What is clear to Glover is that measures such as smokefree legislation, increasing tobacco taxes, grim warnings, gruesome images of smoking-related diseases on packaging and treatment approaches have reduced smoking rates, but things have now hit a brick wall. There is still a large group of Māori who have not been able to quit and another group within that who have never even tried to quit.

For Glover, it's personal. She took up smoking at 13. Her sister also started in her teens. They grew up exposed to the smoking of their parents "in the house, car, everywhere". By her early 20s, Glover had developed chronic bronchitis and needed a year of physiotherapy to recover. She used willpower to quit and believes she saved herself from chronic illness and "quite probably" lung cancer.

"I have been smokefree long enough now that I can expect to live as long as a never smoker would," she says.

The Ministry of Health New Zealand Health Survey revealed 39 percent of

Papa Nahi, General Manager of Hāpai Te Hauora Māori Public Health.

Photo credit: Peter Meecham

Māori adults were current smokers in 2012/13, down just 1 percent since 2006/07. A current smoker smokes at least once a month and has smoked more than 100 cigarettes in their lifetime. The overall adult rate was 18 percent.

Glover says, historically, Māori smoking rates had long been stuck at around 50 percent, and the rates had been even higher for Māori women. In fact, Māori women have had among the highest rates for smoking (and smoking-related diseases) for women in the world, mirroring rates of other indigenous groups of women such as Aboriginal Australians and Canada's First Nations.

Glover says, in explanation, smoking was introduced to Māori by sealers and whalers in the late 1700s and early 1800s, and it became an item of trade. Māori women had been smoking for more than a century by the time it become fashionable for women in Europe, England and America during the 1920s and 1930s. Māori children had been exposed to both parents smoking for generations, making it much more likely for them to smoke. Since the first concerted quit-smoking campaigns in the 1980s, all groups had come down at a similar rate, but the Māori rate started higher. However, recent Otago University research suggests the disparity gap for Māori is starting to widen again, Glover says.

While she has long since quit – she doesn't even drink coffee now – her sister still smokes, despite trying everything from quit-smoking medication Champix to nicotine patches and gum.

> **"I have been smokefree long enough now that I can expect to live as long as a never smoker would."**
>
> MAREWA GLOVER

"It always keeps in mind for me how the work we're doing nationally for a lower socioeconomic solo mum on the benefit is in the wops! It's not working for them. We've got to do something else. And not just for my sister, but for all the other Māori who are not touched by the mainstream smokefree activities."

Glover says Māori need extra resources to address the inequality, though there is always a backlash when Māori are seen to be given extra.

"People actually think we get extra, but you really see it in the outcome. We're getting the same, and now we're possibly getting less. It really comes down to that."

Potiki says just about every major health statistic, including for alcohol and drugs, sees Māori suffering more than Pākehā, and it is easy to become "immune" to seeing it reported all the time.

"The problem is, though, that sometimes you have to make the problem explicit before people will do anything. I think there's a fine line between being deficit focused and pointing out why something needs to change."

Potiki says that, for many Māori going through drug and alcohol treatment, a self-awareness occurs that includes cultural, historical and political awareness of why things are the way they are.

> **“It’s the history of colonisation. You know, the gun and the Bible and alcohol are three of the primary tools that have been used to dispossess.”**
>
> TUARI POTIKI

Marewa Glover asks if e-cigarettes will help curb entrenched smoking by Māori.

Photo credit: Peter Meecham

“With alcohol, it’s part of the history of colonisation. You know, the gun and the Bible and alcohol are three of the primary tools that have been used to dispossess,” Potiki says. “When you look across Australia or North America or anywhere where there is an indigenous population, you see exactly the same pattern and the same results. There are socioeconomic factors, absolutely, but there are historical reasons why those socioeconomic conditions exist.”

In his current role, Potiki has been analysing the NZQF results of 2,800 Otago University entrants. They had achieved NCEA credits at the same rates as non-Māori, but it appeared they had been given poor advice regarding the right credits to take for their chosen careers. While this might not appear to be linked to drugs and alcohol, Potiki says it is very much linked. Citing other examples, Potiki says Māori today are more likely than non-Māori to be imprisoned rather than given a community-based sentence, are more likely to be convicted of a crime than given diversion and are accessing doctors at similar rates but are more likely to be told to exercise rather than given medication and referrals to specialists.

“There are absolutely systemic issues that contribute to the stats being the way they are now. You can concentrate on the person and their treatment, but there is a political and societal context to this as well, which to me is about human rights.”

Nahi agrees inequality in the system needs to be addressed. “These issues are complex, and usually, the presenting health issues are the tip of the iceberg. What’s under the water is this huge complex social issue. We can’t focus on the top presenting issue without addressing these other things.”

Nahi is a member of the National Waipiro Harm Action Group, which was formed at the end of 2013 to address the lack of progress for Māori on drugs and alcohol. The group aims to inform and engage Māori.

“We saw there was a lack of a voice for Māori in this area. It’s the start of a process to help Māori be involved in decision making around drugs and alcohol.”

Glover has seen how “institutional racism” and inequities across the health system have held Māori back over the last two decades of her career.

“It’s always been there, and we still grapple with it. Who’s making the decisions, and how do they interpret the data? Pākehā are still dominant, and they’re still making the decisions for Māori. They’re still not listening to us or our analyses.”

Glover, however, remains hopeful. She argues the smoking-cessation sector is on the cusp of a worldwide revolution. Fresh from hearing speakers at the Global Nicotine Forum in Warsaw in late June, she says the vaporiser (e-cigarettes) industry has the potential to end the grip of the tobacco industry and save countless lives. You can buy e-cigarettes here but have to import the nicotine e-liquid (which goes inside to produce the vapour), as it is classed under our current laws as an oral tobacco product. This creates a barrier to the product for lower socioeconomic groups who may not have access to a credit card or the internet, Glover says. The simple reason it has proved popular among smokers trying to quit is it carries nicotine in higher concentrations than other products such as patches or gum, Glover says.

She says one of the problems with smoking-cessation products is that none, until now, have measured up to the real thing. Her sister had texted recently to report vaporisers were “better than smoking”, which further steeled Glover’s support for the products.

“We can’t keep doing what we’re doing. We have some smokers out there, and nothing impacts on them. Then along comes e-cigarettes and, I mean, my mind is blown. We are on the edge of a revolutionary product that could set fire to everything, and the traditional combustible market really is facing its end.”

Glover says e-cigarettes are essentially a clean syringe, with minimum harm, that

Te Whānau O Waipareira AOD Clinicians Auina Forsyth, John Winther and Louise Graham.

Photo credit: Te Whānau O Waipareira

> **“We work with the client’s own resources to find an outcome that is individual and meaningful for them.”**
>
> LOUISE GRAHAM

could help the last group of smokers for whom nothing else had worked. She is calling for an amendment to the Smoke-free Environments Act to allow new non-combustible, non-therapeutic nicotine products to be able to be imported and sold in New Zealand. They could then be added as options to smoking-cessation programmes.

However, New Zealand has never embraced a harm-reduction approach with smoking, Glover says. A harm-reduction approach has always been interpreted as “it’s okay to cut down”, but with smoking, the next cigarette could be the one that triggers a cancer, she explains. She also says it seems nicotine has been “demonised” by the health sector even though it is the toxins in a cigarette’s smoke that kills rather than the nicotine. Yes, nicotine is addictive, but so is coffee, she argues. She is excited by the potential for e-cigarettes but also “very afraid” that some of her public health colleagues will succeed in having it shut down.

“It’s almost like it’s just about power and control, and that’s not what it should be about. The ones especially against e-cigarettes have no skin in the game. Yes, I’m Māori, and I have skin in the game. Lots of Māori do. We want to save all of our people. And these people who are against it, I hope, in the end, they will end up on the margins in this.”

Potiki says the drug courts, which were started in late 2012 in Auckland with a focus on recovery rather than punishment, have been “incredibly positive”, but he would also like to see the Misuse of Drugs Act overhauled to become more health focused rather than punitive. He argues the people who import or deal illegal drugs would still be identified and punished, but it would mean the people who use drugs, or the easy-to-pick “low-hanging fruit”, were not saddled with the irreversible stigma of criminal convictions.

“[The Act] needs to include in its description of alcohol and drug-related harm the harm that occurs through application of the Act. Once you’ve got a criminal conviction, you’re stuffed to do a lot of things for the rest of your life. For most people, it’s a time in their lives or it’s an occasional thing, and it doesn’t cause any problems. For some, it does, and they’re the ones who need a bit of help.”

Graham says there is enough help there for people in her community who need it and for those she counsels and that it’s hugely rewarding seeing them turn their lives around.

“Some clients come in, and their head’s down, and they’ve got their hoodie over their head, just real whakamā. But maybe after the fourth or fifth session, we see a dramatic change in them. They come in, and they’ve washed, and they’ve got nice clothes on, and they’ve really made an effort with themselves, [and] they’re talking more with their whānau.”

> **“For some Māori going through drug and alcohol treatment, a self-awareness occurs.”**

While she employs specific counselling techniques at Waipareira, there is nothing fancy about the values underpinning a successful approach. What works has always worked – making people feel welcomed, loved, connected and accepted.

“We have a couple of lovely ladies on the desk who are the first people our clients see. We offer them a cup of tea or coffee and say there’s kai available. [We tell them] ‘It’s a safe place. It’s confidential. We’re not here to judge you, to tell you what to do. Basically, our role is to support you, educate you and give you some resources.’ Once they actually hear that, you see the barriers drop from there.” ■

Matt Calman is a freelance journalist based in Christchurch.

The cruel C

Hope for hepatitis sufferers?

The outlook for those suffering from hepatitis C is pretty bleak. It's an unwelcome disease with unwelcome symptoms, both physically and psychologically, and sometimes the cure is the most unwelcome of all. At least here in Godzone. **Russell Brown** looks at the New Zealand situation and some encouraging treatment developments overseas.

RUSSELL BROWN

1992 was a bad year.

That was the year hepatitis C notifications in New Zealand jumped nearly fourfold over the previous year to 89 cases.

There were a number of reasons for the spike, including that awareness of the new liver disease had recently spread amongst doctors – the hepatitis C virus was only formally identified in 1989, and it was still being notified as 'non-A, non-B' in this country – but it was the first real sign of what would come to be called the 'silent epidemic'.

This year, between 700 and 1,000 new cases of hepatitis C will be notified, adding to a population of at least 50,000

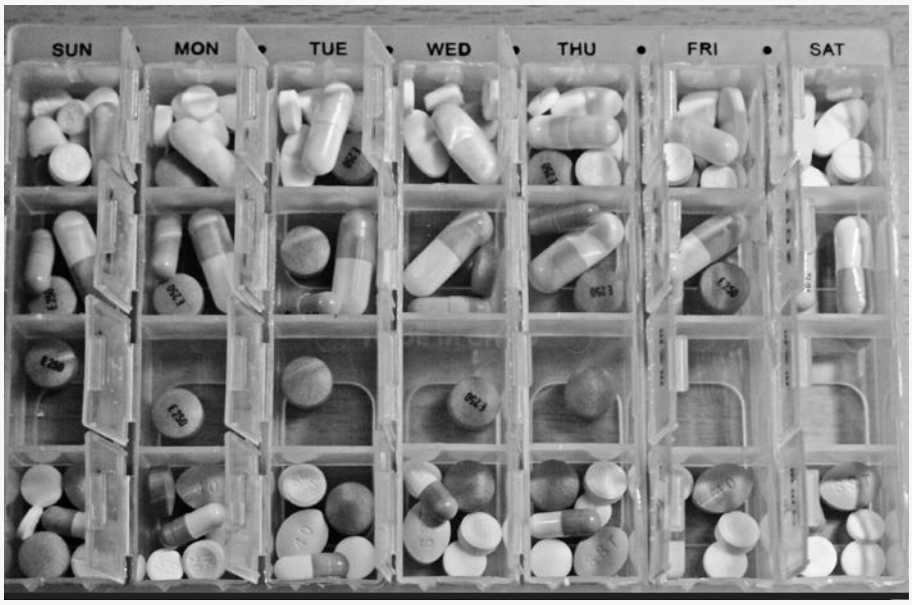


Photo credit: flickr.com/photos/tray_edgun

> **“…at least 50,000 New Zealanders, many of whom have no symptoms and do not even know they have the disease.”**

New Zealanders, many of whom have no symptoms and do not even know they have the disease. The numbers could be higher. Unlike Australia, our system only notifies acute infections and not patients with chronic disease who may have been infected for 20 years but have only recently sought help.

Behind the numbers are the human stories – people who have lived impaired lives of constant fatigue and disability or who have succumbed to hepatitis C’s twin end-game: liver cirrhosis and failure or liver cancer. Some live with the knowledge that they have infected loved ones or their own new babies.

And then there is the stigma. Although medical ‘bad blood’ infection is among the leading causes of death in people with haemophilia, and there has been an increase in recent years of sexual transmission between men who have sex with men, the overwhelming cause of infection is injecting drug use. Even if it happened 30 or 40 years ago, it’s not something you want your workmates to know. At times, past drug use has even been cited to deny treatment.

Cruelly, the ‘cure’ is, for many, worse than the chronic disease. The established treatment for hepatitis C, interferon, involves weekly injections supplemented with six daily tablets of ribavirin for 48 weeks. Interferon bolsters the body’s immune system in the hope that it can overcome the virus, but it also depletes the brain’s stock of serotonin, inducing symptoms of clinical depression in most patients.

“Let no-one say otherwise,” author and historian Redmer Yska has written of his own experience with interferon, “it is inhumane treatment.”

And even though results have improved considerably over the past 25 years, nearly half of those who undergo the ordeal of interferon will find, as Yska did, that it has not cleared their virus.

What if there was a way to make all that go away – to even eliminate hepatitis C itself? There is, but in New Zealand, the bargain has yet to be struck.

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In 1992, Dr Ed Gane travelled from Auckland to Britain to find out about hepatitis C. At the time, little was known about its long-term effects, and some specialists had even declared that it was not harmful. Gane found otherwise.

“In 1992, I tested 500 samples from people who’d been transplanted and found out that, yes, indeed, the most common cause for liver failure was hepatitis C, and that was really the first time that had been demonstrated,” he says. “So I was very lucky to be in the right place at the right time.”

Gane, now Deputy Director and Hepatologist at the New Zealand Liver Transplant Unit at Auckland City Hospital and Clinical Professor of Medicine at the University of Auckland School of Medicine, is still, as he modestly puts it, “in the right place at the tight time”.

Over the past four years, principally through a partnership with the US drug company Gilead, Gane has overseen trials of a new generation of direct anti-viral drugs that have shown a 98 percent cure rate for hepatitis C. Treatment – one tablet a day for 12 weeks – has no side effects.

Nearly 1,000 people have been cleared of the virus by participating in the trials in Auckland, Christchurch, Hamilton, Tauranga, Wellington and Dunedin, and a smaller group of very sick patients with liver failure has been treated in Auckland and Christchurch under a compassionate programme agreed with Gilead. Those patients can be cleared of the virus before receiving a transplant – meaning the new liver won’t be infected. In some cases, the eradication of the virus may enable the patient’s liver to recover to such a stage that they no longer need the liver transplant.

Patients I spoke to for this story talked with emotion about regaining their lives. Those who had been under Gane’s care all praised him personally.

Although Gilead’s product, Harvoni, has been approved for use in New Zealand by Medsafe, it is not yet funded by Pharmac, and a 12-week course of treatment will cost around $80,000 or more.

Allison Beck, a peer health worker and educator with the Hepatitis C Resource

“Let no-one say otherwise,” author and historian Redmer Yska has written of his own experience with interferon, “it is inhumane treatment.”

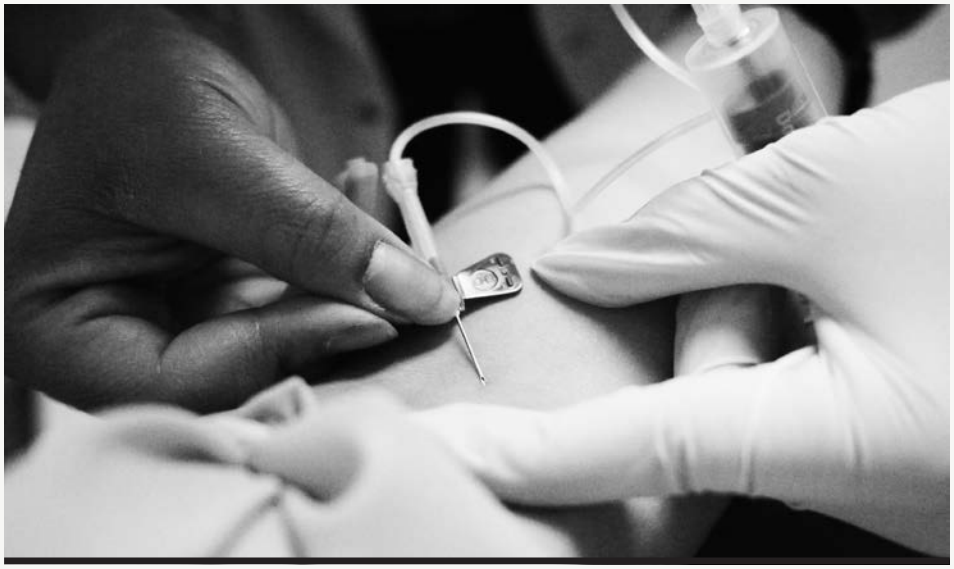


Photo credit: flickr.com/photos/thirteenofclubs

Centre Otago Southland, says many of her clients are aware of the new drugs and ask about them.

“But generally, my clients don’t have $100,000.”

Beck’s client base is an ageing one, mostly male, aged 50–60, “heading towards liver disease”. Many have vulnerabilities and are unwilling to embark on interferon treatment.

“For them to put themselves at risk psychologically is something they’re quite scared about.”

Gane says many of those with the virus are now holding off interferon in the hope that Pharmac will fund one or more of the new anti-virals. The numbers are “steadily decreasing”, and only 300–400 will be treated this year through Pharmac-funded therapy.

A deadline is looming. Pharmac is negotiating with Gilead and others on price, but with three new drugs trialled already in New Zealand and another two likely next year, trials could be over within two years.

The new anti-virals are available through the public health systems in France and Germany and via health maintenance organisations in the US (who have complained publicly about the $1,000 a tablet price tag, in some cases threatening to ‘warehouse’ patients in anticipation of cheaper drugs). They’re also available in India and Egypt, which both have epidemic infection rates (Egypt’s is around 15 percent of the population), for as little as 1–2 percent of the developed-world price. Both Gane and Beck acknowledge that New Zealand patients are looking at Indian-based online pharmacies but agree it’s hard to know how legitimate the sites are.

“I’m not trying to say don’t do it,” says Gane. “I’m just not sure of how you access it legitimately, how you pay for it and how you can be sure the drug is not a fake.”

The number of new anti-virals is in itself a hopeful sign. Gane notes that, when a second drug from AbbVie was approved in the US last year, the price of the first fell immediately. With Merck’s recent entry to the field, specialist publications are calling it a “race”.

There is little doubt that funding even an expensive anti-viral would represent a long-term saving for the taxpayer. Caring for a liver cancer patient is very costly – a liver transplant even more so.

Gane notes a study in Melbourne in which doctors are treating current injecting drug users, “and they’ve been able to turn off all new infections in Victoria. What that shows is that we don’t just treat the sickest people on the waiting list, we have to treat everyone. And if you do that, including those people who are sill injecting, it’s what we call treatment as prevention – and we will actually eliminate hepatitis C without a vaccine within the next 15–20 years.

“In our clinic, instead of treating, say, 10 people a year, we could easily treat 100 people a year with no increase in numbers of people we need in the clinic. It’s so easy. I truly believe that, once the prices come down, treatment won’t be in the hospital any more, it’ll be in the community.”

The benefits will be even greater outside Auckland. Beck notes that her region has no liver transplant unit, and Invercargill has only one specialist nurse able to administer interferon.

There’s also a social problem: the stigma.

“There’s a lot of stigma, a lot of discrimination against people with hepatitis C, purely because they’ve acquired it through practices like injecting drug use. What we would love to have is more people, more patients being advocates for people with hepatitis C. We’re trying to work on that.”

Beck agrees her status as a former hepatitis C patient (she was cleared with interferon) helps clients pluck up the courage to go to medical professionals.

The bottom line, says Gane, is that the disease is completely curable. “Every death from hepatitis C is a preventable death. We have the means to not only cure individual patients but also to eliminate [the hepatitis C virus] from New Zealand. We just have to somehow get the government to pay for it.” ■

Russell Brown blogs at publicaddress.net.

Very human stories

'Jean' – *senior civil servant, infected through IV drug use, cured in an Auckland drug trial with sofosbuvir, ribavirin and ledipasvir.*

"One of the most memorable things was when they told me about my viral load – it had gone from over 3 million per millilitre of blood to undetectable in a period of two weeks … I think the psychological impact has been the most profound – it was like having the sword of Damocles lifted. For years, every time I had an ache or pain, I would worry that something was wrong – liver cancer had got me. I didn't count on a future old age or feel confident making those sorts of plans. It was quite subtle really, but once it was gone, I was able to see how much it had impacted on me."

Redmer Yska – *author, infected through IV drug use in the 1970s, virus returned after interferon treatment, cured last year via a three-month trial with Sovaldi and interferon.*

"After 40 years of living with this horrible virus, it is finally out of my system. I feel lighter, my brain feels like it is working better. Most of all, I'm chuffed that, along the way, I played my part in looking after myself. And I did that by not drinking and making things worse."

'Jean' – *mental health worker, infected through IV drug use in the 1970s.*

"A friend and I have just finished three months on the new Viekira Pak. We are both genotype 1A, the difficult one to treat. I'm clear a month after treatment. I was in the first protease inhibitor trials years ago. We have been waiting years for this after finding the old interferon/ribavirin treatment too brutal to finish the course. I am very grateful to Ed for giving us this treatment – there were only eight compassionate doses available in Auckland. Some side-effects but not nearly as bad as the old interferon regime."

George Henderson – *musician, infected through IV drug use in the 1990s, cured last year via the Auckland -based 'Vulcan' trial with sofosbuvir and GS-5816.*

"Amazing. Pharma made something that worked, cured a disease that, as far as I'm concerned, had no cure before."

'Maisie' – *council officer, infected through IV drug use in the early 1980s, cured in an Auckland drug trial.*

"Within two weeks, I knew I was on the drugs not the placebo – the change was very powerful. I had so much energy, I had to check with my nurse that I wasn't having some kind of manic episode … Things continued to get better, the fog was clearing. My terrible sleep patterns became seven hours of good solid sleep, aches and pains lessened, feelings of anxiety and general malaise disappeared.

"Four years on, I feel like one of the luckiest people on the planet. I would likely have died early after years of shit health. I have a pretty damaged liver, but it's not struggling against a virus and is doing fine. I have a beer or two now and then and sometimes wish that I hadn't made such bad choices back in the day but, hey, who doesn't?"

'Reg' – *probably infected during surgery in Christchurch in the 1980s, cured with interferon and an early anti-viral in 2007.*

"I think the worst thing about hep C was the reaction of the mainstream and some friends. I was so surprised at how many of my friends owned up to having it, but talking about it had its risks. I had life insurance back then – the premium tripled and cut off at 50, so I abandoned that. Telling dentists or doctors got an instant negative reaction and made you feel like a leper – often left alone while hushed, scared voices worked out how they would approach it. I just stopped telling as I realised I was limiting my options."

'Barry' – *infected 20 years ago through IV drug use.*

"I was diagnosed by chance three or four years ago and didn't think much about it. I declined interferon because of what I'd heard about it. Then last year, I pretty much threw up and shit out all my blood for about a week. I figured I was dying. I had up to four blood transfusions a week, and when I was somewhat stabilised this year, they got me on a compassionate six-month course of Sovaldi. Still a couple of months to go."

Photo credit: flickr.com/photos/mag3737

"It's so easy. I truly believe that, once the prices come down, treatment won't be in the hospital any more, it'll be in the community."

DR ED GANE

What are the drugs?

Trialled at various sites in New Zealand so far:

Gilead Sciences' Harvoni –
a combination tablet of sofosbuvir (a polymerase inhibitor sold separately as Sovaldi) plus ledipasvir (NS5A inhibitor). Already approved in New Zealand but not funded.

AbbVie's Viekira Pak –
a combination of paratevir (protease inhibitor) and ombatisvir (NS5A inhibitor) and dasabuvir (polymerase inhibitor). Expected to be approved in New Zealand later this year but not funded.

Merck's combination MK2 –
a combination of grazoprevir (protease inhibitor) and elbasvir (NS5A inhibitor). Expected to be approved in New Zealand next year but not funded.

The UNGASS 2016 primer

The next UNGASS on drugs has been brought forward from 2019 to 2016. That's still a year away, but at a UN level, this amounts to blistering urgency. So are we poised for drug policy reform at the highest level? We'll have to wait and see, but in the meantime, here is your guide to the impending session and all things UNGASS.

Why is this being held?

The last United Nations General Assembly Special Session (UNGASS) on drugs was held in 1998, and its focus was the total elimination of drugs from the world. Ten years later, member states met in Vienna to discuss progress and agree on a new political declaration and plan of action. That was due to expire in 2019, and an UNGASS on drugs was scheduled for that year.

However, in September 2012, the Presidents of Columbia, Costa Rica, Guatemala and Mexico called on the UN to host an international conference on drug policy reform. Mexico subsequently sponsored a provision in a UN drug policy resolution bringing forward the UNGASS to 2016. It was co-sponsored by 95 other countries.

The UNGASS on drugs comes at a time when there have been growing calls for drug policy reform across Latin America. These countries bear the brunt of the War on Drugs, and there is a strong feeling that current policies are not working. For the first time, sitting presidents – such as Colombia's Juan Manuel Santos and Guatemala's Otto Pérez Molina – are questioning the underlining premises of the international drug control paradigm and calling for debate on alternative approaches.

NGO/civil society representation at UNGASS

If you haven't already been accredited by the Economic and Social Council (ECOSOC), you won't be able to take any part in the official UNGASS proceedings. Registration as a non-governmental organisation formally in consultative status with the UN closed on 1 June.

Currently, there are 3,900 organisations registered with ECOSOC. These include a handful of organisations with drug policy credentials, such as Association Diogenis, Drug Policy Dialogue in South East Europe, Center for Alcohol and Drug Research and Education, Drug Prevention Network of Canada and International Drug Policy Consortium. Pre-registration for some events is also required, so even though the Drug Foundation is now accredited, there may still be other hoops to dive through.

Photo credit: flickr.com/photos/unicphoto

Who to watch out for

Yuri Fedotov

UN Office of Drug and Crime (UNODC) Executive Director

Former Russian Ambassador to the United Kingdom Yuri Fedotov has headed the UNODC for five years. Due to his position, he is generally conservative when it comes to calling for reform. However, in his statement on the International Day against Drug Abuse and Illicit Trafficking, he focused heavily on "meeting the challenge of drugs with human rights-based responses" and called for a greater focus on treatment. This stands in marked contrast with his home country's drug policies, as Russia is currently dismantling the treatment sector.

Ban Ki Moon

UN Secretary General

The most senior figure at the UN and progressive, Ban Ki Moon has previously called drug addiction "a disease, not a crime". His predecessor, Kofi Annan, is an outspoken advocate for the legal regulation of drugs, saying, "Drugs may have killed people, but I maintain that wrong governmental policies have killed many more." Ahead of UNGASS 2016, Ban Ki Moon has urged member states "to conduct a wide-ranging and open debate that considers all options", which is a diplomatic way of saying that the current system isn't working, and we need to change tack. While he won't lead the charge for reform, he will certainly embrace it if it occurs.

Michael Botticelli

White House Office of National Drug Control Policy Director

Known as the 'drug czar' of America and a cautious reformer, Michael Botticelli is a former alcoholic who has said to people with drug problems, "You are my people." All of his predecessors came from military or Police backgrounds, but he's worked in drug policy all his life. Although he maintains America's hard line against drugs crossing the Mexican border, he takes a harm-reduction approach at home. He's called for Police to be trained to use naloxone (an opioid overdose prevention medicine) and the distribution of clean syringes for intravenous drug users. He's in a unique position – America has traditionally been a big supporter of the War on Drugs, but its liberalisation of drugs at home means it's shifting its stance abroad.

Arthayudh Srisamoot

Commission on Narcotic Drugs (CND) Chair

The CND Chair is a rotating position, held this year by Thailand's Arthayudh Srisamoot. Thailand is very conservative on drugs – it has the death penalty and has, up until recently, pledged to eradicate drugs from the Southeast Asian region. Srisamoot is conservative – he calls drugs a "menace" – but he is more progressive than the Thai Government. At the Commission on Narcotic Drugs in Vienna earlier this year, he said, "The important thing is to strike a balance between the regulatory framework, which also relates to addressing widespread drug abuse and criminal aspects, and taking care of the human dimension."

Helen Clark

UN Development Programme (UNDP) Administrator

Helen Clark is the third most senior figure at the UN and a reformer. Earlier this year, her agency blasted the War on Drugs as a failure, saying that "policies and related enforcement activities focused on reducing supply and demand have had little effect in eradicating production or problematic drug use". This is a change in position by the agency and is likely a result of Clark's leadership. In 2013, she said that "there's no doubt that the health position would be to treat the issue of drugs as primarily a health and social issue rather than a criminalised issue". Clark's concern is developing countries, which means the UNDP is particularly focused on harm reduction to prevent HIV/AIDS.

Werner Sipp

International Narcotics Control Board President

Werner Sipp previously worked as a medical doctor in addiction treatment, so he has seen the power of rehabilitation. At this year's Commission on Narcotic Drugs in Vienna, Sipp said, "A well balanced drug control system must not rely solely on restriction and law enforcement but must provide sufficient access to prevention, treatment, medication, reduction of the adverse consequences of drug use, rehabilitation and social reintegration for individuals affected by drug use and addiction." This is significant, as the head of the Narcotics Control agency is supporting a policy of harm reduction.

Leading up to New York

The United Nations General Assembly agreed to hold the UNGASS in 2016 and has tasked the CND to engage in the preparatory process.

Vienna: CND final intersessional

New York: 70th Session of the General Assembly

Vienna: CND reconvened session and UNGASS special segment

Interactive civil society hearing

Vienna: 59th Session of the CND

NGO/civil society preparation

Although nation states will hold the most sway at UNGASS (each state has an equal vote), the non-governmental and civil society sectors will still be able to bring community voices to the United Nations. In the lead-up to the special session, a number of events are being held to ensure the input of affected individuals and advocacy groups working in the drugs sector.

CIVIL SOCIETY TASK FORCE: Formed in March this year, the task force is comprised of 27 members – 18 regional representatives and nine representatives from affected populations. There's also a four-person steering committee. The task force will conduct regional civil society consultations. The Drug Foundation's executive director Ross Bell is on the task force, representing Australia, New Zealand and the Pacific. His focus is on the effect global drug policies have on indigenous populations.

CIVIL SOCIETY SURVEY: The task force has also launched a global survey that is designed to provide an initial assessment on the civil society work in the field of drugs as well as to measure the awareness and level of knowledge and interest in participating actively at the UNGASS 2016 initiative at the regional and global levels.

PRE-UNGASS MEETING: The task force has committed to co-hosting a meeting for all NGO, government and other stakeholders prior to the UNGASS, whose conclusions would be an officially recognised document that will be presented to the UN.

REFORM CONFERENCE: In November this year, the Drug Policy Alliance is hosting the Reform Conference in Washington, DC. Hot topic: the best strategies for the non-governmental sector in the lead-up to UNGASS.

SSDP MODEL UNGASS: Students for Sensible Drug Policy will run a model UNGASS at the Reform Conference. Attendees will be given a country, and then a mock special session will be held.

Where is it being held?

UN delegates meet in the recently refurbished General Assembly Hall. Among the many repairs necessary was replacing the gold-leafed background behind the iconic UN emblem, which had become caked with cigarette tar and nicotine. Many environmental improvements were introduced, so energy use is down by half. Each of the member nations (193 at time of print) has six seats, with the 600 remaining seats available for guests, translators, UN secretariat staff and members of the public. It is unclear what access ECOSOC-accredited representatives will be granted.

Book in advance to get an apartment via airbnb for under NZ$200. The closest apartment currently listed is on 41 Street and 2nd Avenue, with a nightly fee of NZ$169. In a city with over 50 million visitors per annum, there is plenty of choice of hotels, whose prices have dropped 13 percent in the last year. Rates average NZ$202 per night.

What is going to happen?

At 4.20pm on 20 April, a Drug Peace March is expected to take to the streets of New York. The European Coalition for Just and Effective Drug Policies is already talking with activists about how to make this happen. Security restrictions mean any rallies are unlikely to get closer than four blocks away from the entrance used by top-level diplomats.

Apart from this, little else is definite. The formal agenda has yet to be set, but it is likely to follow the format adopted at previous special sessions. A preliminary paper and draft resolutions will be prepared by the CND – something the Vienna-based UN body has begun. Although the CND only meets annually, a number of intercessional meetings are scheduled. Much of what has been discussed to date has been procedural, with the beginning of debates on real substance just beginning in June. UN members are now invited to put forward ideas for inclusion into the zero (or first) draft.

Over the three days allocated in April 2016, country representatives and a few others will speak to the resolutions tabled. In 1998, each speaker was restricted to seven minutes, and 158 people spoke over nine UNGASS 20 plenary sessions, including 23 heads of state, eight prime ministers, one vice-president and seven observers. Joining the discussions were several United Nations agencies and programmes as well as some NGO representatives. Speaking on behalf of the New Zealand people was Tuariki John Delamere, Minister of Customs and Associate Minister of Health, who was a New Zealand First MP at the time.

In 1998, there were many side events held alongside the UNGASS. These were hosted by many august international agencies, including the International Labour Organisation, World Health Organisation , UNAIDS, Interpol and numerous NGOs.

With just 50 member states, CND reflects only a quarter of the countries within the UN system. Hosting a drug policy debate at the General Assembly is expected to bring some areas currently off limits in Vienna into the limelight.

> **“Drugs are every nation’s problem, and every nation must act to fight them – on the streets, around the kitchen table and around the world.”**
>
> PRESIDENT BILL CLINTON

Photo credit: flickr.com/photos/minexguatemala

Official declarations

- 2014 CND (57th session) high-level review of 2009 Political Declaration and Plan of Action implementation, Joint Ministerial Statement.
- 2009 Political Declaration and Plan of Action.
- 1998 Political Declaration and Plan of Action.
- 1990 Political Declaration and Programme of Action.
- 1987 Declaration of the International Conference on Drug Abuse and Illicit Trafficking.

How times have changed – 20th UNGASS 1998 – world drug problem

Enhanced action to tackle the world drug problem lies at the heart of the political declaration from the 20th UNGASS (A/S-20/4). Prefaced with recognition of how widespread the drug problem is, the declaration bares it motivation for action: “Drugs are a grave threat to the health and well-being of all mankind, the independence of States, democracy, the stability of nations, the structure of all societies, and the dignity and hope of millions of people and their families.”

While supporting better access to treatment and efforts to reduce demand, particular attention is devoted to efforts to curtail illicit manufacture, trafficking and consumption of synthetic drugs and a quest to eliminate or reduce the illicit manufacture, marketing and trafficking of precursors. The need to eliminate drug crops was also stressed. The declaration concluded with the pithy refrain: *“Together we can meet this challenge.”*

Here are quotes from the General Assembly floor:

Bill Clinton

President of the USA

Drugs are every nation’s problem, and every nation must act to fight them – on the streets, around the kitchen table and around the world. This is the commitment of the United States. Year after year, our Administration has provided the largest anti-drug budgets in history.

Let us leave here determined to act together, in a spirit of trust and respect – at home and abroad, against demand and supply, using all the tools at our disposal – to win the global fight against drugs and build a safe and healthy 21st century for our children.

Tuariki John Delamere,

Associate Minister of Health, Minister of Customs – New Zealand representative

Our efforts to strike a balance between supply control, demand reduction and the management of drug problems have helped us reduce significantly the harm associated with illicit drugs in New Zealand.

I note that there are those who vehemently oppose methadone or needle exchange programmes. For me, the answer, “Well, it works”, seems to be the best response to these critics, who I suspect would have us blindly march down the road towards a “war on drugs”, a philosophy that many would consider has not worked.

In many countries, the indigenous people are overrepresented in national statistics on drug-use problems. This, unfortunately, is also true for Māori, New Zealand’s indigenous people, to whom I belong. I think we need to do much better at empowering indigenous people to understand how they can control the factors that influence their health, such as drug use.

Photo credit: flickr.com/photos/unicphoto

Kofi Annan,

UN Secretary-General

It is my hope that they will record this as the time when the international community found common ground in the mission to create momentum towards a drug-free world in the 21st century. It is time for every nation to say "no" to drugs. It is time for all nations to say "yes" to the challenge of working towards a drug-free world.

RESOURCES

Report of the UN Drug Debate, April 2015 Drugreporter – http://drogriporter.hu/en/cnd2015

IDPC UNGASS 2016 pages – nzdrug.org/idpc-ungass16

Official UNGASS 2016 website unodc.org/ungass2016

1998 UNGASS declaration at 10 years

In 2009 Ross Bell, Drug Foundation Executive Director, said this about the lack of progress after the 1998 UNGASS.

I have no problem with aspirations – after all, wouldn't we all love world peace? But 10 years on, meeting recently in Vienna to assess their progress towards their goals, I believe our political and diplomatic leaders have been hugely irresponsible. They've neglected any honest assessment of progress towards the objectives they themselves set. Instead they've engaged in mutual back-slapping while ignoring the realities of human suffering around the world – much of which is caused by their own policies.

One significant highlight did emerge from the Political Declaration. This was the recognition that global drug control efforts must be taken in full conformity with international human rights law. For too long the world has seen systematic and egregious abuses of human rights in the name of drug control. ■

RESOURCES

Full analysis: nzdrug.org/1Phs0HM

QUOTES OF SUBSTANCE

"Feels like I got punished for synthetic cannabis products that weren't mine."

Entrepreneur **Matt Bowden** muses after the mortgagee sale of one of his properties.

"Perhaps we need to be speaking easier to each other about why we have such a demand for drugs, legal and illegal."

Best-selling author **Tommy 'Kapai' Wilson** says ban has not diminished demand in Tauranga.

"Police have been monitoring your Facebook profile and established that you are engaged in a Facebook group that actively sells and trades in controlled drugs."

NZ Police resorted to licking stamps in an effort to warn off people suspected of online drug dealing.

"We were not levelling cities as we did in WWII with bombs, but with prosecution, prison and punishment."

Retired US federal judge **Nancy Gertner** reflects on drug sentences that destroyed lives.

A school's core business

This is the second in our series of articles looking into new approaches to protecting young people from drug-related harm being adopted by New Zealand schools. **Rob Zorn** visited Ōtaki College where a restorative practice approach is keeping young people caught with drugs engaged and in class – instead of out on the streets.

ROB ZORN

"It doesn't take a rocket scientist to work out that there's a back story to why these young people are doing these things, and you've got to get to that back story. You can't do that by excluding them."

Ōtaki College is a decile 4 school, averaging between 400–450 students, nestled in Horowhenua north of Wellington. More than half the students identify as Māori, and a large percentage come from poorer backgrounds. Sadly, both these demographics punch way above their weight in terms of alcohol and drug use, youth crime, violence and exclusions from school.

I'm only there for a couple of hours but sense a real calmness in the atmosphere. Principal Andy Fraser has a warm smile, and he's never far from a laugh. There's an openness about him, too. He admits the school's had problems (still has them) and that its journey is far from complete. As he leads me around the school, I see a similar openness reflecting from the students he interacts with.

Unsurprisingly now, Ōtaki College is a demonstration site for the Ministry of Education's Positive Behaviour for Learning (PB4L) initiative. This means other schools can visit the college to learn how to build similarly positive environments.

Things were not always this way.

"When I started teaching here back in 2007, the standard approach to students caught with alcohol or drugs was just to stand them down or get rid of them," he says.

"Attendance rates were poor, and our suspension rates were significantly above national and decile averages. Things just weren't flash."

He tells me that, at the same time, there was a lot of youth crime in the local community.

"It was all angry stuff like smashing windows, breaking letterboxes and that sort of mindless, wilful damage, and invariably, the young people who were doing these things were those who had been disenfranchised from school.

"But as we started making changes to the way we looked at these young people and these problems and as our stand-downs fell away and our exclusions approached zero, you could just about map over that the reduction of youth crime and all the destructive stuff.

"It doesn't take a rocket scientist to work out that there's a back story to why these young people are doing these things, and you've got to get to that back story. You can't do that by excluding them."

The Ōtaki College Board of Trustees Chair agrees that community youth

Ōtaki College gate.

“During the process, they come to see it’s not about tripping the young person up and kicking them out of school but about putting as much support as possible around them.”

crime has declined dramatically and in close correlation to culture change at the college. He should know. He’s Sergeant Slade Sturmey, in charge of Ōtaki Police.

“Even things like behavioural issues at the community library have gone down a lot. We used to have to deal with 20 or more of these each year. Now, there’s maybe just one, but because we have such a useful relationship with the school, we just come in here and deal with it together,” Slade says.

Andy says the students see Police units at the college all the time, and they’re here for a lot more than to deal with offending. They provide educational programmes, support driver licensing and coach sports teams, so “it’s normal for students to see the Police in a positive way”.

So how and why have things changed?

Andy says the journey commenced in about 2008 shortly after he became Deputy Principal. It was based on ‘student voice’, particularly from Māori students who felt they weren’t getting the right deal from some teachers.

“They said that, where they had good relationships with teachers, they would work hard for them, but where they didn’t, they would be disruptive or not care, and student management became more problematic. That’s telling you something right there, and we now listen to the student voice a lot.

“I would have some teachers banging on my door saying they never wanted a particular student in their class again and insisting we boot the kid out. It took about four years before we started seeing a shift becoming embedded in the school-wide culture, where teachers were feeling the place was calmer and that they could engage much better with students.

In 2008, Ōtaki College began developing its Te Whakaruruhau initiative, which collaboratively involves staff, students, whānau, victims, professional counsellors and the Police. It’s a restorative practice approach targeted at students with drug and alcohol issues. It encourages them to take responsibility for their actions while being supported by teachers and qualified professionals. In line with Whole School objectives, a restorative school is one that has a culture of care that is about enhancing mana and is solution focused.

When a student is caught with or under the influence of drugs or alcohol, they may be stood down for one to three days to allow for the college to prepare for a restorative conference. Then the student and their whānau meet with the Board of Trustees to discuss a way forward that will not result in exclusion.

The contract

“It was found to be more effective if there was some sort of contractual agreement at the end of these meetings that outlines decisions attributing accountability,” Andy says.

Through the contract, the student agrees to undergo counselling, to address their wrongs and to submit to random drug testing. Whānau and teachers agree to what they will do to support the student. Students invariably sign, and the contract has never once been questioned by a parent.

“During the process, they come to see it’s not about tripping the young person up and kicking them out of school but about putting as much support as possible around them,” Andy says.

“And I think students understand that the drug testing is not a punitive thing so that, if they fail, they’re down the road. It’s a way for them to see their own progress, and many use it as a deterrent, a reason to give their mates as to why they don’t want to use.”

This is no soft option. Slade says the consequences of not fulfilling the contract are also explained to the student at signing – that the matter will be handed back to the Police or to the courts.

“There may be further hours of community work or even a criminal conviction, depending on their age.

Andy Fraser by the school gate. Māori carvings either side depict Maia (representing the mana of women) and Manawanui (representing the mana of men).

> **“No young person needs a drug conviction on their record.”**

> **“Hopefully, when the students come through the gate, they understand the richness, the importance of each other’s mana – but also of working collectively, regardless of gender, to strengthen their community.”**
>
> ANDY FRASER

That can have devastating consequences for life, but fortunately it has never gotten to this stage. No young person needs a drug conviction on their record.”

Drug and alcohol counselling is provided by Margaret Smith who works for Whaioro Trust, an iwi service covering Horowhenua. Ōtaki College is one of two schools she visits weekly. Assisted by school Guidance Counsellor Jo McInerney, she assesses referred students and follows up with weekly or fortnightly counselling sessions. The number of students she’s regularly seeing has fallen to 10 (her contract actually provides for 15 per school).

“The main focus is education,” Margaret says.

“We see it as a health matter. If they’re using at this age, the main thing should be supporting them to make better choices.”

So Te Whakaruruhau is working then, I ask.

“Hell, yeah, absolutely,” says Andy.

“As a restorative school, we’re working with people, rather than doing it to people. In an overall sense, the programme is very much about the whole community. Once students understand that everyone cares, it’s so much easier – when they come to you with a problem and immediately see you stop and say, ‘Let’s deal with that.’

“In terms of drugs and alcohol, well, they come at a huge cost to young people and to families, so as a school, you’ve got to see dealing with that as part of your core business.”

Jo McInerney says the college has noticed a real difference between students who start in year 7 – and travel all the way through – and those who come in from outside.

“Some of these young people have been pretty challenging, but when they’ve been here for a bit, they don’t seem to feel they have to behave in the same way as at their previous schools. Perhaps that’s because they don’t get backed into as many corners by teachers or other students. They understand they can talk to people here and explain stuff and be honest about what’s happening at home. It’s hard work for teachers, but they do see the benefits of getting these young people into the school and socialising.”

Drix

An example is Drix, who became part of the school’s core business early this year.

Drix was living in Hastings and spent 18 months on the streets when things broke down with his whānau. Though not even midway through his teens, he ended up with a massive youth justice record (Andy says it’s the size of a small novel). The offences were mostly assaults and robberies. As part of the family group conference process used to address his offending, he ended up coming to live with his uncle in Ōtaki.

“So he was an interesting one, but in the end, Ōtaki College agreed to enrol him and give him a chance,” Andy says.

“He’s actually quite a personable fellow now, though he was pretty wild and woolly around the edges when he first arrived. There were soon some issues involving theft and cannabis, so he has gone through the programme and is now back on track.”

Drix is just 15. He’s pretty tall for his age and, reportedly, a very good rugby player – like amazingly good – and when I get to meet him, I find him open, approachable and calm. I like him

From left to right: Hamish Wood (Deputy Principal), Andy Fraser (Principal), Margaret Smith (Whaioro Trust), Sgt Slade Sturmey (Board of Trustees Chair), Jo McInerney (Guidance Counsellor).

immediately and can't imagine him assaulting anyone.

He's been using cannabis for the last three years. While in Hastings, he was stoned pretty much all the time, but he cut back using weed significantly when he started at Ōtaki College because of the way it affected his sport training.

One day, he arrived pretty red eyed after smoking up on the way to school and was 'snapped' by Andy while in class. He was stood down for a day and then was asked to attend a meeting with Andy, Slade and some of the Board to work out a restorative process.

"My uncle was there too, and he was pretty disappointed. He gave me a real growling about it, and that was pretty hard," Drix says.

"They asked me to sign this contract giving them the right to drug test me whenever they want, but they didn't kick me out. I think they actually gave me quite a big chance, and I'm pretty thankful, eh. I don't mind the drug tests. They mean I have a reason not to do it – to say no to it."

Drix has been drug tested only once so far (it's still early days). He doesn't know the result of the test yet, but he doesn't appear too worried. He says he's not really missing the cannabis at all and is enjoying having "heaps more spare money".

"They sort of did a deal with me, talked about me staying on Cactus (a school fitness programme run by Police) and still being able to do what I normally do here at school. That was important to me. I really like all the exercise stuff. I play rugby and touch, but I'll play any sport where you can run around and get hurt."

He tells me about how weed made him tired all the time, which was no good for his training, but he just laughs when I say he might be slipping on the black jersey one day.

Drix didn't go to school while on the streets in Hastings but says the education he has had has been exclusively Māori.

"I'm not good at English, and when I came here, I didn't know how to write in English at all, but I can spell some pretty big words now."

So what does he think would have happened had they expelled him?

"I think if they kicked me out, I probably would have ended up just walking around all day, smoking weed and being really bored – just waiting for my mates to get out of school."

He says he likes the teachers and thinks they've been really good to him, and he tells me about one or two of his favourites.

"But actually," he says, "I've got heaps of mean teachers around here" – and I'm sure he means that in a good way.

"Schools may be reluctant to talk about these issues because they don't want people to think they have a drug problem," Andy says.

"In terms of drugs and alcohol, well, they come at a huge cost to young people and to families, so as a school, you've got to see dealing with that as part of your core business."

"But every college in New Zealand and every community has a drug problem. We don't have the perfect model, but we have one that is making a difference, and if it's a model that could work for other schools and communities, then we're more than happy to talk about it."

I leave thinking I'd have been happy to have my own children go here, and I'm also making a mental note to watch out for Drix in future All Blacks line-ups. Thanks to the Whole School restorative approach at Ōtaki College, that may very well become a reality. ■

Rob Zorn is a freelance journalist based in Wellington.


alpha-
PVP

Alpha-pyrrolidinovalerophenone – also known as α-PVP, alpha-PVP, gravel, flakka or niff – is one of a number of recreational drugs in the 'bath salts' (or cathinones) family, so called because they resemble bath salts and because they have sometimes been sold disguised as them.

Originally synthesised in the 1960s, alpha-PVP usually comes in a crystal form that can be smoked, snorted, injected or swallowed. The high can last for three to five hours, but many users report it can be subtle at first and slow to come on. This has caused some to 're-dose' early and use more than they intended – with unpleasant results.

Alpha-PVP is an analogue of methylenedioxypyrovalerone (MDPV), a powerful stimulant with similar effects to methamphetamine. It has been sold as a designer drug, originally in the US, since the early 2000s. There has been very little research done on it. Its toxicity – and even exactly how it works – are not known with any certainty. The few studies that have been done, however, lend scientific weight to the frequent assertion alpha-PVP can really mess with your mind.

A 2014 study published in Neuropharmacology, for example, found alpha-PVP acted as a stimulant for rats and that their behaviour became increasingly bizarre at higher doses.

THE EFFECTS LAST

3–5 hrs

FIRST SYNTHESISED IN THE

60s

SOLD IN THE US SINCE THE

00s

We don't seem to need the rats. Weird stories abound in the media. In April this year, the Associated Press reported that a man who had taken alpha-PVP ran naked through a Florida neighbourhood, tried to have sex with a tree and told Police he was the mythical god Thor. Two others tried separately to break into jail because they thought people were chasing them. One wound up impaling himself through the buttocks on a fence.

"It actually starts to rewire the brain chemistry. They have no control over their thoughts. They can't control their actions. It seems to be universal that they think someone is chasing them. It's just a dangerous, dangerous drug," Don Maines, a drug treatment counsellor in Fort Lauderdale, told Associated Press.

In New South Wales, 44-year-old Glenn Punch and his partner Rachael Hickel injected a legally purchased alpha-PVP product known as 'Smokin' Slurries'. Punch died of a cardiac arrest while wrestling security guards after jumping a fence naked into a shipping yard. Hickel fell off a truck, injuring herself badly, and ran off topless and covered in blood yelling, "Help me, help me!"

These are sensationalised stories that make excellent media fodder and likely reflect the bizarre behaviour associated with having taken high doses of alpha-PVP. Nevertheless, purely positive user experience reports are hard to come by, even with more moderate doses. Matters of Substance could find only one on the drug education and harm-reduction website Erowid, and that was by a user who insisted his drug use was extremely disciplined.

He reported euphoria and increased focus, but most other reports suggest the elation (and the tinglings, warmth, erections and clarity) soon gave way to anxiety.

One user described alpha-PVP as the devil in crystal form. He said his trip was terrifying and that, after a short period of euphoria, he felt completely hopeless, unhappy and incoherent. He was unable to sleep and plagued with "the worst thoughts". Nevertheless, he felt a strong compulsion to take it again. This (and erotic feelings alongside reduced ability to perform sexually) seem to be common side effects.

"It actually starts to rewire the brain chemistry. They have no control over their thoughts. They can't control their actions."

Alpha-PVP is around and used in New Zealand but does not appear to be commonplace – with just one solitary review on the New Zealand TripMe website. Police and Customs have reported intercepting its importation since at least 2012. As recently as April this year, four Wellingtonians were caught importing more than three kilograms of alpha-PVP (it originates mostly from countries like China and Pakistan).

Detective Senior Sergeant Brent Murray said in a media statement that alpha PVP is one of the emerging drug threats, which is usually sold in capsule form here, for around $40, and is snorted.

It is not explicitly scheduled under the Misuse of Drugs Act but is treated as a Class C substance due to its significant structural similarities to other Class C drugs.

In the US, it is only technically illegal in a handful of states, but it has been placed under a temporary nationwide ban effective from February 2014 – no doubt due mostly to the naked and darkly amusing exploits of its users who made the news.

Only one Australian state has made it specifically illegal. That is, of course, New South Wales, after the death of Glenn Punch and of another young man who jumped off a balcony while high on a similar substance in Sydney. ■

Alcohol advertising: what's the problem?

While advertising of alcohol keeps spreading and spreading, the industry denies this leads to more harms. The evidence says otherwise, and something needs to be done about it, says Australian Catholic University's **Professor Sandra Jones**.

PROFESSOR SANDRA JONES

Despite what the industry may tell you, systematic review of longitudinal studies on adolescent alcohol use, published in Alcohol and Alcoholism in 2009, concluded that "alcohol advertising and promotion increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol".

What is particularly disturbing about that conclusion is that most of the included studies only considered limited forms of alcohol advertising – typically print and/or broadcast – and collected data between 1985 and 2005. Firstly, advertising is far broader than traditional media channels – in Australia, the advertising industry describes 'marketing communications' as any material designed to promote the product. Secondly, the advertising (and media) landscape has fundamentally changed over the last decade.

Countries such as Australia and New Zealand continue to allow the alcohol industry to self-regulate its own advertising, despite decades of evidence that self-regulation even of traditional advertising is ineffective and that young people perceive messages in alcohol advertisements that directly contravene the industry's own codes. Further, the very nature of Australia's self-regulation suggests it has been developed to protect marketers rather than consumers. For example, alcohol advertisements are only allowed on TV during periods of M, MA or AV programmes except during the live broadcast of sporting events on weekends and public holidays. Similarly, the Outdoor Media Association

"Australia and New Zealand continue to allow the alcohol industry to self-regulate its own advertising, despite decades of evidence that self-regulation even of traditional advertising is ineffective."

has limited "the advertising of alcohol products on fixed signs that are located within a 150 metre sight line of a primary or secondary school" except "where the school is in the vicinity of a club, pub or bottle shop or any other venue that sells alcohol products".

Even traditional alcohol advertising has changed since these earlier studies, as marketers have become increasingly savvy at developing products and advertising that target vulnerable segments of consumers. For example, we now see alcohol advertisements in 'health' magazines promoting 'low carb' or 'natural' alcohol products and in women's magazines promoting alcohol that is 'low calorie' or presented as a fashion accessory.

Other aspects of alcohol advertising and promotion are poorly regulated (such as online) or largely unregulated (such as point of sale). For example, research shows point-of-sale promotions are abundant in packaged alcohol outlets and that these promotions promote purchase of large quantities of alcohol, link desirable products to volume alcohol purchases and, not surprisingly, increase the amount of alcohol people purchase.

Alcohol 'advertising' is no longer a passive one-way communication – something we see on television or read in a magazine. It is now a conversation between alcohol brands and potential consumers in which consumers become the co-creators and distributors of alcohol advertising. A disturbing proportion of young people own alcohol-branded merchandise, and there is an association between this ownership and drinking-related attitudes and behaviours – let alone that it makes them walking alcohol advertisements that further influence their peers.

The majority of alcohol brands have a web presence, which arguably promotes their products to 'adult' consumers, while using questionable age-verification methods that allow underage consumers to evade entry rules. Most brands also have multiple social media pages – including Facebook – which encourage consumers to like, comment, share, engage and build a relationship with the alcohol brand and thus introduce their new 'friend' to their network.

As mentioned, the majority of the studies exploring the links between alcohol marketing and consumption were conducted over a decade ago, when alcohol was a product we had to go to a store to purchase. The increasing array of places one can purchase alcohol not only makes it more accessible, it further blurs the line between 'place' (distribution channels) and 'promotion' (advertising).

It is now possible to purchase alcohol online from anywhere at any time. Group buying sites (such as Our Deal and Catch of the Day) and retailers (such as Vinomofo) target consumers with offers for large quantities of alcohol delivered to the door at prices substantially lower than bricks and mortar competitors. For those who can't wait for the postman, major alcohol retailers now offer online or telephone orders that can be delivered the same day for a small delivery fee.

"Alcohol 'advertising' is no longer a passive one-way communication – something we see on television or read in a magazine."

Alcohol advertising: what's the solution?

Given the extensive evidence that industry self-regulation of alcohol advertising is ineffective (if the purpose is to protect the consumer rather than the marketer), there is a clear need for government or independent regulation. Such a regulatory system should include a monitoring function (rather than being dependent on consumer complaints) and penalties for non-compliance. To begin to address the nexus between alcohol and sport – and particularly young people's exposure to a barrage of alcohol advertising – there should be a ban on alcohol sponsorship of sport and on alcohol advertising during sporting events.

This monitoring and regulation should extend to online channels – including websites, apps, video games, social media and video and photo-sharing services. Alcohol companies that use online advertising should be required to incorporate effective age restrictions on entry pages, and these should be monitored and enforced.

Point-of-sale marketing within alcohol outlets should be recognised and regulated as alcohol advertising and should extend to promotions that are

"Given the extensive evidence that industry self-regulation of alcohol advertising is ineffective (if the purpose is to protect the consumer rather than the marketer), there is a clear need for government or independent regulation."

associated with sporting events or that tie desirable 'gifts' to high-volume purchase (such as two four-packs) and drive increased consumption. Such regulations should also incorporate rules on price-related promotions to prevent multi-pack pricing that makes it cheaper to buy a larger quantity and promotions that enourage high-volume purchases (such as discounts on wine that are available only when purchasing more than three bottles).

The elephant in the room

We know, based on several comprehensive reviews of the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harms, that some of the most effective strategies are increasing price, reducing availability and banning alcohol advertising. The changes recommended by New Zealand's Ministerial Forum on Alcohol Advertising and Sponsorship last year is exactly the type of approach we need to follow. Among other things, they called for the government to ban alcohol advertising during streamed and broadcast sporting events, ban alcohol advertising where 10 percent or more of the audience is younger than 18, further restrict the hours for alcohol advertising on broadcast media and introduce additional restrictions on external advertising on licensed venues and outlets.

What we need now – in Australia, in New Zealand and across the globe – is governments that are brave enough to stop doing what doesn't work (like allowing the industry to regulate itself) and start doing what does work. ■

Professor Sandra Jones is Director of the Centre for Health and Social Research (CHaSR) in Australian Catholic University's Institute for Health, Melbourne.

Rising PIED use – should we be concerned?

Performance and image-enhancing drugs (PIEDs) are substances taken by people who want to improve their sporting performance or their physical appearance – in many cases, both. Generally, they aid recuperation from exercise and help you train harder and longer, increasing your fitness and musculature and (hopefully) your sex appeal.

PIEDs include steroids (help grow and repair muscle tissue), peptides (stimulate the release of human growth hormones and are difficult to detect) and varieties of pure hormones. Most of these substances have genuine medicinal uses, such as for recovering from injury, and many are classed as prescription medicines, meaning it's illegal to import them for personal use in New Zealand under the Medicines Act. Offences are punishable by up to three months jail or a fine of up to $500. It is not strictly illegal to possess or use them, but it is illegal to sell or supply them. Penalties for the latter are significantly higher than for personal use.

Is use becoming more frequent?

PIEDs have been around in New Zealand for decades, but there is mounting evidence that their use is becoming more widespread.

Former bodybuilding champion Justin Rys (Mr Big), who was jailed for importing fantasy with a street value of $2.1 million, told The Press in September last year that use has probably increased 10-fold over the last five years.

YES

While we don't know the long-term effects of some of these substances because they are so new, what we do know about the overuse of steroids, for example, is alarming. They can lead to high blood pressure, liver damage, changes to the heart, breast growth in men and shrinking of the testicles.

And we could ask Justin Rys about the long-term effects of these substances – if he were still alive. Unfortunately, Rys, who had become a campaigner against the use of PIEDs, died in June 2015. He was just 38. Doctors struggled to identify what was causing his illness, but Rys was in no doubt, describing himself as the author of his own misfortune and using his illness as part of his anti-PIEDs campaign.

In short, PIEDs can kill you, but before they do, they also bring with them all the additional risks associated with other injecting drug use, including infection, transmission of disease through needle sharing and other problems caused by incorrect injecting and lack of hygiene.

A particular problem with PIEDs is that they are often purchased over the internet without medical advice from entirely unregulated markets. There is no control over the quantities people might take or what they might take, and there is no opportunity for supervision by a medical professional. Some PIEDs in common use are research chemicals not yet approved for human use or not meant for human use at all.

And when buying in unregulated markets, there is always the danger that substances are not what they claim to be. In one recent investigation, Police found a supplier was ordering products in bulk and labelling them before selling them on. Detective Superintendent Ray van Beynen told The Press in September 2014 that what was actually contained in the products the supplier was peddling was quite different from what the labels advertised.

"In those cases, it is users who pay the price," he said.

Rys said something very similar before he died: "It's not pure any more. It could be fucking anything."

Another problem – more to do with buying products locally from others who have imported them illegally – is that young buyers become exposed to unsavoury characters who may encourage them to buy other 'products' or lead them into dangerous situations. We've already seen the links between PIEDs and organised crime in Australia, but similar links are evident in New Zealand.

World Anti-Doping Agency Director General David Howman says the availability of PIEDs in New Zealand and other countries is a ''major concern''. Global intelligence revealed organised criminal links to the trafficking of PIEDs, and there was ''stack loads of money to be made''. Remember, these are people whose primary concern is not their customers' health but to get people to buy more drugs.

Lastly, and perhaps most tragically, there is the damage done to young people's sporting careers through sanctions when they are caught. On 5 June 2015, DFSNZ announced an under-19 representative and Lincoln University rugby player was banned from all sports for two years for importing the human growth hormone precursor GHRP-6.

"This young man has paid a high price for a poor decision, which has affected his immediate future in rugby," Steel said – and he was dead right. ■

"Now it's anyone who ever wants to look good, anyone who wants to get bigger to get girls – it never used to be like that."

That same month, Fairfax Media made its own inquiries and found that PIEDs use was now more wide-reaching than just bodybuilding circles, with many recreational gym goers seeking a quick fix.

The same article reporting this finding quotes Drug Free Sport New Zealand (DFSNZ) Chief Executive Graeme Steel as saying he receives regular reports that the use of PIEDs is growing within the recreational arena.

"Some of the country's leading gyms were at the heart of the problem," he said.

Amid growing concern about drug use among young people, DFSNZ undertook a study on seven of the country's top first 15 rugby teams in late 2014. The study was prompted by young South Africa and UK rugby players being caught doping.

While the research found widespread use of nutritional supplements, only two of the 142 players surveyed had taken prohibited substances. However, a significant 20 percent said they felt they were at risk of taking them. The researchers also noted there was a lot of pressure on young men to look good and that this may impact on drug use in sport.

"It confirms our idea that [young people] are vulnerable. The dangers of supplement use don't seem to be as clear to them as we would like," Steel said.

Ministry of Health figures also suggest PIEDs use is on the rise, and seizures of parcels by Customs more than tripled between 2008 and 2013. In 2013, around 340 parcels containing PIEDs – with an estimated street value of about NZ$590,000 – were intercepted by authorities. In 2008, just 89 similar packages were seized.

PIEDs also gained huge media attention across the Tasman in February 2013, when an Australian Crime Commission report linked organised crime to providing these substances to professional AFL and league players.

Given what is happening elsewhere, it should be no surprise that PIEDs use also seems to be on the rise in New Zealand.

Should we be concerned?

ON

It's easy to get carried away imagining hordes of young people shooting up unknown substances in gym room toilet stalls, but that's probably the extreme end of the picture. In the scale of things, however, PIEDs use in New Zealand is not a widespread problem in comparison to other drugs like alcohol, cannabis, methamphetamine and tobacco, where our harm-reduction efforts require significant attention.

Note, for example, that DFSNZ research found only two out of 142 young sportsmen had taken illegal substances. That's much less than 1 percent – a tiny drop compared to many other drugs. Where PIEDs use is an issue, sporting bodies have the systems in place to police it (or should do). There's national support from many agencies including Police, DFSNZ, Sport NZ and the Health Ministry. Let's leave it up to them and concentrate on the drugs that do most harm.

And there isn't overwhelming evidence for health harms resulting from PIEDs use. In most cases, large doses have no greater effect than the correct dosage, so overdose is not a significant risk. Unlike substances such as alcohol and tobacco, it is very hard to link PIEDs use with death, and Justin Rys's death is hardly robust evidence for such a link. By all accounts, he took atypical and excessive amounts of these substances, and excessive amounts of anything will kill you.

There just isn't the strong evidence to show any links with organised crime. Late last year, Associate Minister for Sport and Recreation Murray McCully told Fairfax Media that a recent Sport NZ-led assessment found no evidence of widespread drug use or organised crime in New Zealand sport. Fairfax Media approached Associate Health Minister Peter Dunne's office about the potential for tougher legislation surrounding PIEDs. A spokesperson said, ''The level of concern raised about this issue at this stage does not warrant legislative action.''

In the same article, Medsafe Group Manager Dr Stewart Jessamine said he had not seen evidence that suggested the use of PIEDs was widespread in gyms, and large numbers of people were not being admitted to hospital as a result of using the drugs.

Five of the country's leading gyms were also approached by Fairfax and all were found to have zero-tolerance policies to drugs and said any illegal activity would be referred to authorities (and in a few cases, it had).

So, in short, the evidence for harms from PIEDs use is just not robust enough to justify us getting all 'het up'. Increasing PIEDs penalties, certainly just for use, will only produce more criminals, and New Zealand already has too many people going to jail for drug use or dealing with the stigma that stops them seeking help. Until we've got conclusive evidence, there seems little need to do anything more. Maybe we should just let the PIEDs users deal with the side effects and any impacts on their sporting careers. That's probably punishment enough. ■

Photo credit: flickr.com/photos/cjsmithphotography

A brave, new drug policy

The National Drug Policy 2015-2010 is finally out. How does it stack up? Drug Foundation Principal Policy Advisor **Andrew Zielinski** looks at the pros and cons and whether the policy will take us where we need to go.

ANDREW ZIELINSKI

The curiously long wait for a new national drug policy had some of us concerned about the government not prioritising drug harm reduction. But the National Drug Policy 2015–2020 is now out and despite the delay, there are aspects to applaud. Minister Peter Dunne's concepts of compassion, proportionality and innovation herald a promising new direction.

The old policy's harm-minimisation goal, based on the familiar strategies of supply control, demand reduction and problem limitation, remains a sound approach. However, a range of useful objectives and priority areas have been added to the policy's framework. These give it more logic and flow and make it more self-contained. It's unfortunate, though, that the 'Reducing alcohol and other drug-related illness and injury' objective doesn't extend to reducing social harms. Interestingly, tobacco has completely dropped out of the policy, focussing it on alcohol and psychoactive drugs.

We're particularly happy to see focus on a new objective: 'A shift in attitudes towards alcohol and other drugs'. Reducing social stigma towards people with alcohol and other drug problems is vital to address the issue of the 50,000 people a year who want help to reduce their alcohol and other drug use but don't get it.

Another important improvement is the addition of indicators to assess progress with objectives. While we would have liked to see more illegal drug-related indicators, like a criminal justice indicator or two, the indicator on opioid poisonings is very welcome.

We also welcome the priority areas added to the policy, particularly 'Improving information flow', 'Getting the legal balance right' and 'Shifting thinking and behaviour'. We've long been highlighting the need for better information to inform drug policy and it's frustrating that 'Evidence online', as promised in the old policy, has not yet eventuated.

The addition of specific actions for completion by 2017/18, associated with priority areas, is also positive. We particularly welcome an action supporting schools to keep students in education, but we consider there should have been an action on opioid overdose prevention work including naloxone use, which will save lives.

Finally, it's especially promising to note the addition of the 'Getting the legal balance right' priority and associated action to "develop options for further minimising harm in relation to the offence and penalty regime for personal possession within the Misuse of Drugs Act 1975". However, this brings us to our main concern with the policy – a lack of focus on more comprehensive drug law reform.

The case for drug law reform

The Misuse of Drugs Act (MoDA) is 40 years old and should be comprehensively redesigned to reflect drug harm reduction

best practice. MoDA was developed in the 1970s when New Zealand's cultural context and drug scene were very different. Back then, the average New Zealander not part of the 'hippie' counterculture had little or no exposure to illegal drugs. Today, nearly half of New Zealanders have tried something illegal. The prevailing international approach was that drug use was a criminal justice matter best controlled through legislated deterrence and punishment. President Nixon started the 'War on Drugs' in 1971.

New Zealand's drug market is also radically different from the 1970s when cannabis, heroin and psychedelics like LSD prevailed. While cannabis continues to be our most popular illicit drug, new 'designer drugs' like ecstasy (MDMA) have arrived, and methamphetamine now features on the scene.

The most fundamental change, though, has been the growth of new psychoactive substances not necessarily covered under MoDA. Many different and potentially harmful new substances are available – most recently, synthetic cannabinoids and drugs like 'synthetic LSD' in the risky NBOMe class. We had around 200–300 new psychoactive substances on the market prior to the Psychoactive Substances Act 2013. These substances are cheap to make and hard to detect, with little available safety information for consumers. And they will keep coming.

The internet has also dramatically altered the drug market, with 'dark-net' sites like Silk Road (replaced by new sites like Agora and Evolution) enabling people to buy drugs anonymously using digital currency.

So, our drug scene has changed markedly. But while MoDA has been amended 18 times in the past eight years, it's failed to keep pace with changes and now exists as a patchwork of poorly considered amendments and outmoded assumptions.

Internationally, recognising that strict prohibition has failed to reduce illicit drug demand or harms, there have been various innovative reforms. Fifteen countries have decriminalised the personal possession of all drugs. Portugal decriminalised all drug use in 2000 and developed strong new policies on prevention, treatment and harm reduction. This approach is working, with drug use, offenders in prison, court cases, HIV infections and overdoses all decreasing.

In the US, cannabis is decriminalised or legal in some form in 27 states and the District of Columbia. Four US states have legalised recreational cannabis. South

"This brings us to our main concern with the policy – a lack of focus on more comprehensive drug law reform."

Australia decriminalised minor cannabis offences almost 30 years ago in 1987, with the Australian Capital Territory and Northern Territory following suit in the 1990s.

Our Psychoactive Substances Act is potentially a globally innovative way to control newly emerging drugs by regulation, only allowing safe products. Unfortunately, amendments to that Act have meant continued prohibition, and problems with black market supply are emerging. Meanwhile, MoDA retains a strict prohibition approach for all our established drugs, with harms persisting. Statistics NZ figures record that in 2014 there were 871 people aged 17 and over prosecuted for illicit drug use/possession as their most serious offence, with 661 of those convicted and 26 of those imprisoned – yet we still have some of the highest drug use rates in the world, with one in 13 adults over 15 years smoking cannabis at least once a month.

So, what type of reform do we need?

Our approach needs to shift from being predominantly criminal justice based towards a health and social focus. We must acknowledge that MoDA's punitive approach, heavily weighted towards supply control, is ineffective and harmful. As the UK Home Office recognises:

> *"The disparity in drug use trends and criminal justice statistics between countries with similar approaches, and the lack of any clear correlation between the 'toughness' of an approach and levels of drug use demonstrates the complexity of the issue."*

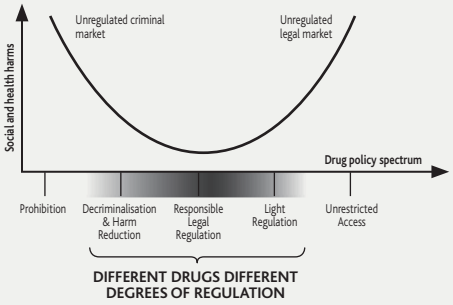
We must align our law more with harm-reduction principles. This means addressing the health and social problems underlying demand for drugs and minimising the problems arising from inevitable drug use. A wealth of evidence since the 1970s tells us this is what works. A first step would be not criminalising people for personal use/possession offences but using such 'infringements' to caution, give information, make health assessments and offer treatment (akin to the Law Commission's recommended mandatory cautioning scheme).

But if we're really serious about drug harm reduction, we need to start thinking about smarter control of more of our currently illicit drugs. This means making drugs available under strict regulation in much the same way we've been trying to deal with new psychoactive substances. It doesn't mean liberal availability and promotion as is the case with alcohol.

MoDA's prohibition model works against the harm minimisation principles of our national drug policy by leaving non-pharmaceutical drug production and sale in the unregulated hands of criminal elements. To best enable harm reduction, control of the whole drug market should, carefully, begin to be taken back by government and wider society. This concept is well expressed by the Global Commission on Drug Policy's diagram below:

REGULATE DRUG MARKETS TO PUT GOVERNMENTS IN CONTROL

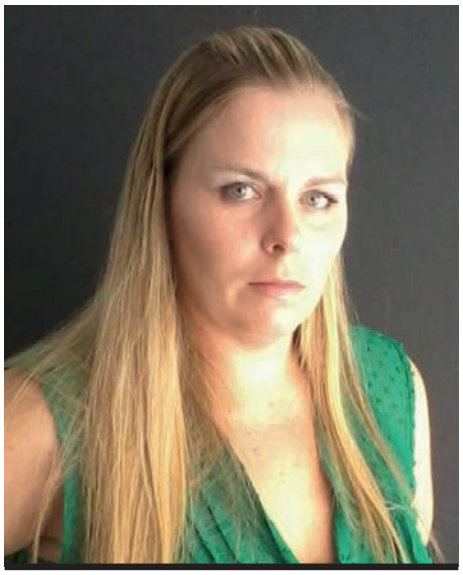
The regulation of drugs should be pursued because they are risky, not because they are safe. Different models of regulation can be applied for different drugs according to the risks they pose. In this way, regulation can reduce social and health harms and disempower organised crime.



Source: Global Commission on Drug Policy (2014). Taking Control: Pathways to Drug Policies That Work (Summary).

Right now New Zealand is, understandably, socially and politically uncomfortable with making currently illicit drugs legally available, even by strict regulation. However, that we enacted the Psychoactive Substances Act shows some level of willingness. Regulating to give control of the drug market back to the government is not radical policy. Actually, it's the prohibition approach that's radical, because it removes the levers governments normally use to regulate markets.

Many of the drug harms we currently see are there because profit-motivated criminal drug suppliers are not concerned with public health harm minimisation principles or bound by product safety regulations. If we're looking boldly towards future drug harm reduction, we need to consider smarter drug regulation. ■



Cannabis medicines will help

Toni-Marie Matich is co-founder of the New Zealand branch of United in Compassion (UIC), set up to advocate for the introduction of medicinal cannabis and as a community for patients and carers.

The mother of five began investigating the potential of medicinal cannabis after all other treatments for her teenage daughter, who has a rare form of epilepsy, did not alleviate severe, unrelenting seizures.

Q Why is it so important to improve access to medicinal cannabis in New Zealand?

A Access to medicines that could improve diseases and illnesses where nothing else is working, and in particular increase quality of life, is a human right. Around the globe, we already see various medicinal regimes. It's currently used in 21 countries and 20 states of the USA. We know it is effective to varying degrees in treating diseases/illnesses and reducing symptoms. This is particularly important for people with diseases and illnesses where all reasonable medical options and treatments have failed, with patients continuing to suffer. This often includes putting up with the intolerable side effects of those failed treatments.

Facilitating New Zealand-based cultivation and research into the therapeutic benefits of medicinal cannabis is something we'd like to see. Creating an opportunity to reduce the stigma associated with cannabis for medicinal use will allow mature discussion and policy frameworks to progress. Somehow, we've got to separate recreational use from medicinal.

Q Based on your knowledge and research, what are the most proven/promising areas for prescribing medicinal cannabis?

A The list is quite long! The most common would include HIV/Aids, glaucoma, cancer, chemotherapy, multiple sclerosis, epilepsy, chronic pain, autism, ADHD and Crohn's disease.

However it is used, it's important realistic cautions are understood. There are insufficient conclusions about safety and efficacy particularly when a patient is on other medications. Possible contraindications are largely unknown and constantly evolving. We also need to understand ratios and profiles of cannabinoids in relation to which illnesses/diseases and symptoms they are best suited for. Medicinal cannabis isn't a single strain (as compared to one particular pill) that works for any one condition. Research is vital in better understanding both the positives and negatives.

I always make it very clear there is no way of knowing whether an individual would or wouldn't benefit from medicinal cannabis. People need to be very realistic – you see online and social media stories go viral without evidence to back them.

Q What do you recommend as the most appropriate way for people to access medicinal cannabis?

A I recommend the government allows for the introduction of a compassionate access scheme. Any individual who has exhausted all reasonable medical treatments or is considered 'out of time' should be granted access. With the only available medicine priced out of reach – GW Pharmaceuticals' Sativex derivative – something needs to be done about the cost.

Another priority recommendation is permitting clinical trials so medicinal cannabis can be researched and studied in order to be introduced as a new medicine.

Both these recommendations would be via safe legal products that are manufactured to a pharmaceutical grade with strains/ratios consistent and matched as best possible to an individual's needs.

Until this happens, we are likely to see people sourcing products through the black market and risking being sold unsafe, laced products or 'snake oil'.

Q What role does UIC have to play?

A This newly launched charitable trust is set up to educate the public on medicinal cannabis and support New Zealand-based cultivation and research into the therapeutic effects of cannabinoid-based medicines. Our purposes are based on education, compassion and logic.

The New Zealand chapter is an alliance with the Australian branch, and we are forming a research and development team with them.

We also continue to build our scientific and medical advisory board, so we can provide support and advocacy to New Zealanders who would like access to legal medicinal cannabis.

Q So far, what has UIC been doing in New Zealand? What is next?

A So far, we've been working hard on getting formally set up and establishing the frameworks to deliver on our purpose.

We're here to help parents/caregivers and individuals from all walks of life and circumstances, so we've been spending time forming relationships and engaging people all around the country. These individuals are what motivate and drive us.

We are also working with decision makers and influencers from the Police, medical professions and universities.

Later in the year, we aim to run a national symposium on medicinal cannabis, so we are very busy and excited too.

Q What does a perfect/better future look like for you?

A A perfect and better future would be one where there is access to safe, legal medicinal cannabis products through a supported and moderated regime. This won't happen overnight, but I do believe it is possible! In the meantime, we need some sort of compassionate access scheme. ■

It sounds too much

Photo credit: flickr.com/photos/governmentofalberta

A drugs bust on the Indian Ocean, described as the biggest in New Zealand's naval history, seized 260 kilograms of heroin worth a reported NZ$235 million in June. The frigate HMNZS Te Kaha was taking part in a United States-led international maritime operation targeting people trafficking and smuggling drugs, which were, apparently, part of a funding chain for terrorists.

Two months earlier, the UK's Royal Navy intercepted a tugboat carrying 3 tonnes of cocaine off the coast of Aberdeen. The discovery was said to be the biggest Class A drug seizure on record in Britain and worth £500 million (more than NZ$1.19 billion).

Estimated values of seized drugs can be mind-bogglingly huge, and these recent, record-breaking hauls must be seen as a win for the authorities. Police and other enforcement agencies such as the Royal New Zealand Navy and New Zealand Customs Service are understandably keen to publicise their efforts to curtail the supply of illegal drugs, but exactly how are the values quoted in these stories calculated, and how accurate are they?

Mythbusters asked the New Zealand Navy how it estimated the value of its recent drugs bust. Lieutenant Commander Mike Peebles, the executive officer of HMNZS Te Kaha, says a United Nations Office on Drugs and Crime report provided heroin price information for the United States market from 2012. Using a price of US$800 per gram for pure heroin, they calculated the value of the 80 percent pure drugs they had seized would be US$640 per gram. Multiplied by 257.5 kilograms, this gave a total of US$165 million, or NZ$235 million.

A New Zealand Police spokeswoman says street value information for illegal drugs comes from a range of Police sources: "These include investigation, open source information, Police drug experts, drug notifications, intelligence and cases we prosecute." She says New Zealand retail prices for methamphetamine remain high compared with other countries, and the drug is generally sold at about $800–1,000 per gram.

The approach used by Police and the navy – using recent information about the street value of a drug and then multiplying it by the number of kilograms seized – is fairly standard. However, Chris Wilkins, a senior drugs researcher at Massey University's College of Health, says this method can "greatly inflate" the value of the drugs. That's because illegal drugs intercepted in large quantities are usually sold at a cheaper wholesale rate compared to the price paid for smaller quantities on the street.

The higher street prices are compensation for the bigger risks suppliers are taking on, such as legal penalties and violence from competitors, so the unit price for a drug increases considerably as it gets closer to sale on the streets of a first-world country. It makes sense that a kilogram of cocaine bought in Colombia can be obtained a lot more cheaply than a kilo of the same drug hitting the streets of a city like New York.

The figures used in media coverage can give the public a misleading impression about the impact drugs seizures have on suppliers, because they are based on the price paid at the end of the line by consumers. He suggests an alternative way of calculating value would be to work out the social harms prevented if a quantity of drugs was intercepted by Police or Customs. These would include reduced health costs, car accidents and loss of life. The savings would be far greater than the simple retail value of the drug.

Dr Wilkins says he would describe Police estimates in media headlines as accurate but "not necessarily highly precise. It's hard for them to take into account what happens to these big kilo lots, where they are sold, how they get cut and what quantity they are going to be sold in."

According to the 2015 Global Drug Survey, which covers 50 countries, Australia and New Zealand are some of the most expensive countries in the world to buy ecstasy or cocaine. Australians report paying Đ207 for a gram of cocaine, while New Zealanders say they pay Đ191 (NZ$317) – about twice as much as someone in Switzerland would pay for the same amount. In Brazil, it can cost as little as Đ9 for a gram of cocaine, with the purer version costing Đ15. Even within New Zealand, the price of methamphetamine is generally higher in Christchurch than in Auckland or Wellington.

Geographic location, purity, availability and the risk of legal penalties are all factors that influence the price paid for illegal drugs, and these will fluctuate over time. It is difficult for authorities to get an up-to-date fix on all of these when they assess the value of drugs seized, so the estimates seen in media coverage should be seen as a rough guide only. Believe the headlines, but take them with a grain (or gram) of salt. ■

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Here are ome of the people who joined in the 2015 day of action in Aotearoa.

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