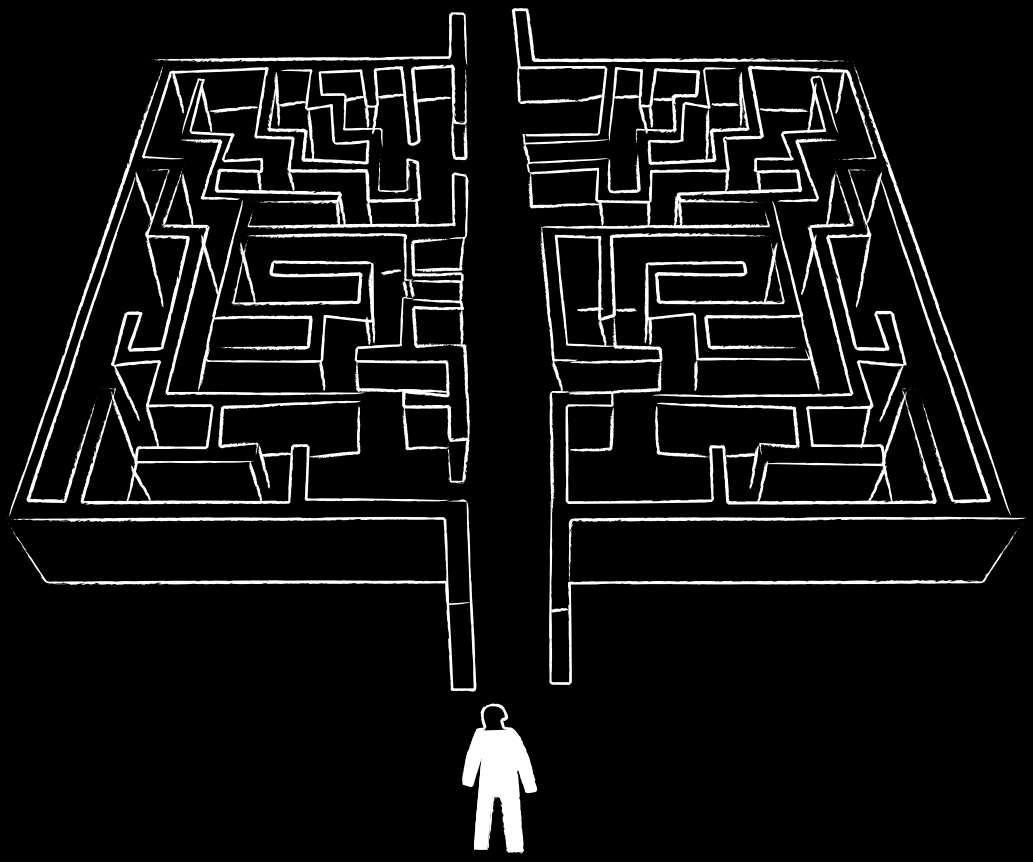
matters of substance

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

February 2009



Through the maze – healthy drug law reform

The Misuse of Drugs Act was drafted in 1975 when the way we understood drugs was very different. With this year's review, we can bring our drug law in line with modern knowledge and current public health policy objectives.

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

Brand development/graphic design
Origin Design +64 4 801 6644
info@origindesign.co.nz
www.origindesign.co.nz

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

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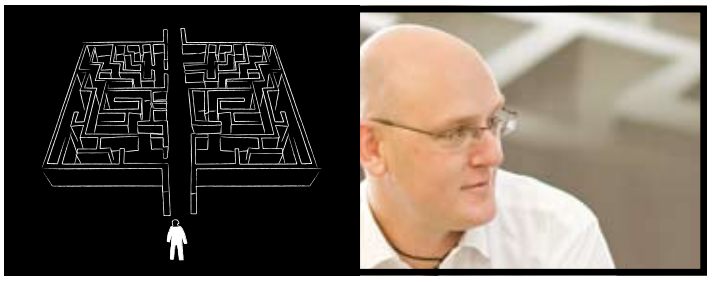


"THIS HAS never, ever worked, so let's keep on doing it."

Why do we expect that one of the most complex social and health issues can be solved through tough action by Police, the courts and prisons? The faith many have in the criminal justice system to fix social ills is misplaced. Indeed, the system itself can be the cause of some of those ills.

Getting 'tough on drugs' or fighting the 'war on drugs' doesn't create communities free from drug harm.

We need to understand that the social and health harms from drugs can only be addressed through humane social and health policies and interventions. We do them a disservice when we demand Customs, cops and courts to fix the problems created by social exclusion, poverty, the human condition and even genetics. They are simply not equipped or qualified to do this – yet this is where we invest our energies and resources.

In Australia (we don't have New Zealand data, but confidently assume it will be comparable), 57 percent of expenditure on illicit drug policy goes to law enforcement, with only 23 percent to prevention efforts, 17 percent to treatment services and 3 percent to harm reduction initiatives. Acknowledging there is still debate about the best mix of investment, it's safe to say we have a long way to go before we even reach a balance of approaches.

Our cover story argues that New Zealand's obsolete drug law must be reformed so that it can complement the more balanced National Drug Policy. We argue that a health-based drug law would respect human rights, including the right of people to equal access to health services. It would reduce the barriers that currently stop people seeking help for drug-related problems and make it easier for them to access services such as harm reduction programmes or treatment.

Do not be mistaken. This is not a debate about 'hard' versus 'soft' drug law. Recent World Health Organisation research illustrated that "drug use is not simply related to drug policy, since countries with more stringent policies towards illegal drug use did not have lower levels of such drug use than countries with more liberal policies."

Instead, we hope that, as New Zealand reviews its domestic drug law, and as the international community reviews global drug control, we need to be open to new approaches, informed by the best evidence, and be prepared to challenge previously held tenets.

David Cameron, UK's Conservative Party Leader, has lamented, "If one takes a slightly progressive – or, as I like to think of it, thoughtful – view [of drug control], one can sometimes be accused of being soft. I reject that utterly." So do we.

Happy reading, Ross Bell. ■

Key Events and Dates

3rd International Conference of the International Society for the Study of Drug Policy
2–3 March, Vienna, Austria
This conference, hosted by the United Nations Office on Drugs and Crime, should be of interest to a wide array of disciplines including anthropology, economics, epidemiology, political science, public health and sociology.
www.issdp.org

School of Addiction 2009
4–6 March, Auckland
The biennial school, jointly hosted by DAPAANZ and the Pacific Centre for Motivation and Change, is offered to experienced clinicians and practitioners in the field of addiction treatment.
www.matuaraki.org.nz

3rd International Conference on Fetal Alcohol Spectrum Disorder 2009
11–14 March, Victoria, BC, Canada
This conference will be a catalyst for change around the globe by integrating research and policy into practice to assist governments, parents, services and caregivers who strive to prevent FASD.
www.interprofessional.ubc.ca

1st Conference of the Connections Project
25–27 March, Krakow, Poland
Joining the Dots: Criminal Justice, Treatment and Harm Reduction will aim to facilitate the development of knowledge and an evidence base for how different harm reduction and drug free interventions can be incorporated across criminal justice processes.
www.connectionsproject.eu

International Harm Reduction Association Conference 2009
20–23 April, Bangkok, Thailand
The conference theme is Harm Reduction and Human Rights. Asia has been consciously chosen to host the conference based on many countries in that region failing to provide vital health and harm reduction services to which drug users are entitled.
www.ihra.net

Outside In: Community Responses to Complex and Diverse Needs
6–8 May, Sydney
Today's community service providers acknowledge there are co-existing problems for many people accessing services. This conference will help explore innovative and creative community sector approaches that will provide meaningful responses to people's diverse needs.
www.nada.org.au

Working Together Conference
14–15 May, Wellington
Be part of the gathering momentum to reduce the harm of alcohol in our communities. Come and share your stories, highlight progress you're making and learn from others. ALAC is currently seeking presentation abstracts.
www.alac.org.nz

Youth Week
22–31 May
Start planning now to get involved. Keep an eye on the website for updates.
www.youthweek.co.nz

World Smokefree Day
31 May
www.worldsmokefreeday.org.nz

International Day against Illicit Drug Abuse and Illicit Trafficking
26 June
With this campaign, UNODC aims to raise awareness of the major problem that illicit drugs represent to society.
www.unodc.org/unodc/en/about-unodc/26-June.html

2009 Cutting Edge: Our place, our future
10–12 September, Wellington
www.dapaanz.org.nz

Publicise your own event online at
www.drugfoundation.org.nz/events

Through the maze – healthy drug law reform

Our Misuse of Drugs Act has been around for nearly 34 years. It was first developed at a time when our understanding of good drug policy was in its infancy and patterns of drug use were very different from today. It is now being reviewed, providing a rare opportunity for New Zealand to bring its drug law into the 21st century. In this essay, the **Drug Foundation** puts the case for reforming the Misuse of Drugs Act from a criminal justice-focused law to one that explicitly supports the health of people who use drugs and reduces drug harm across our communities.

THE frontiers of human discovery advance at a remarkable pace. The way we see the world changes as events and knowledge alter our understanding of our environment and of each other.

The challenge for policy makers is to ensure that legislation keeps pace. Sometimes, important laws are allowed to fall out of step with public attitudes and scientific learning. That is the case with New Zealand's now 34-year-old drug control law.

Our world is radically different from that of 1975, when a Bill Rowling-led government drafted the Misuse of Drugs Act. Back then, many New Zealanders

had little or no exposure to drug use. Today, nearly half of New Zealanders under 65 acknowledge using cannabis at least once.

Some things have not changed. We know, as we did in 1975, that the misuse of drugs can hurt communities and individuals, but we have the benefit of 34 more years of scientific research, leading to a much better understanding of the best ways to reduce the harm drugs can cause. When it comes to policy and legislation, we know what works and what does not.

Since 1975, New Zealand politicians have made amendments to the Misuse of Drugs Act on several occasions. Unfortunately, many of these changes were driven by short-term political considerations. Today, we are left with a patchwork quilt of poorly considered amendments and outmoded assumptions.

In 2008, the Government asked the independent Law Commission to comprehensively review the Misuse of Drugs Act. This provides a long overdue opportunity to update the law, to ensure that it is ready for the future and supports the drug harm minimisation goals of our drug and health policies.

Ending the war on drugs

Experience has discredited the 1975 approach, which saw drugs purely as a matter for the criminal justice system and the deterrence and punishment of people who use drugs as the sole purpose of drug law. This is sometimes known as the 'war on drugs' approach, a term first used by President Richard Nixon in 1971 and usually linked with the harsh drug control tactics used in the United States that greatly inflated prison populations.

It is an approach that has proven ineffective both overseas and here. In isolated examples, strong law enforcement initiatives have contained the overall scope of a drug market, but researchers have struggled to find solid evidence for a straightforward link between efforts to clamp down on supply and a sustained drop in the availability or use of illegal drugs.

"Viewing the issue of drug use through the prism of health and social policy sharpens our understanding of the best ways to reduce the problems that drugs can cause."

Fruitless attempts to prohibit alcohol last century demonstrated that trying to stamp out the supply of a product is a poor way of eliminating an entire market. Thai economist Pasuk Phongpaichit noted in a recent paper about his nation's drug problem, "If you attack her supply but do little about demand, then the result is rising prices, rising profitability, and hence increased entrepreneurship."

Entrepreneurship within the drug industry has thrived. Despite the fierce war on drugs waged by the United States and its allies over more than three decades, the global drug market has expanded exponentially.

Today, policy reform advocates believe that viewing the issue of drug use through the prism of health and social policy sharpens our understanding of the best ways to reduce the problems that drugs can cause. This means that we look at both drug demand and supply, which offers a wider range of up-to-date policy tools.

Social researchers also tell us that it is necessary to acknowledge the simple fact that people will continue to use legal and illegal drugs, no matter what legal approach is taken. While we will always want to reduce drug use, this fact means that we have an obligation to try to make drug use as safe as possible for people who use drugs and for the communities around them and that people can access essential health services.

In New Zealand, it is important for us to learn from the emergence of ecstasy, party pills and other designer drugs, and the phenomenon of diverted pharmaceuticals such as benzodiazepines and morphine sulphate. Our drug law has proved poorly prepared for such developments. New substances or variations of existing substances will continue to surface.

The outdated approach underpinning the Misuse of Drugs Act ensures that it has a heavily punitive focus on banning illicit drugs and attempting to control supply. The law is not adaptable. When new drugs emerge, they need to be fitted into a matrix of 'harm' and a political response planned.

The 34-year-old law divides drugs into classes, ostensibly on their risk of harm, and sets out the penalties for their possession, manufacture and supply. It gives power to the Police and Customs. In keeping with attitudes when it was first drafted, there is no emphasis on attempting to dampen demand, or on attempting to reduce the dangers to people who use drugs.

The inevitable result of this narrow approach is that far greater governmental resources go to control and enforcement than to programmes that focus on prevention or that deal with the harm that drugs cause.

It also means that artificial distinctions are made between legal drugs – notably alcohol and tobacco – and illegal drugs. In terms of economic impact and lives lost, tobacco is clearly New Zealand’s most harmful and costly drug, followed by alcohol.

As long ago as 1994, an advisory group told the Ministry of Health that “as a philosophical basis for drug policy, the justice perspective is very limited. Its underlying premise, that illegal drugs are ‘bad’ while legal drugs are generally ‘good’, is too black and white to be credible.”

Questioning the deterrence effect

The criminal justice approach relies on faith in the law’s power as a deterrent, as well as the idea that people choose to use drugs because they expect the rewards to be higher than the risks. In this context, criminal sanctions are intended to deter people from trying drugs or shifting to more harmful ones.

Looking at the world from this angle, we would expect the reduction of punishments (including through decriminalisation or legalisation) to cause the use of drugs to rise, and when a drug becomes illegal (as BZP did in 2008) or penalties are strengthened (as when methamphetamine was reclassified from Class B to Class A in 2003), use of that drug should fall.

In practice, things do not appear so clear cut. A 1999 report into United Kingdom drug laws by the Police Foundation found that “such evidence as we have assembled about the current situation and the changes that have taken place in the last 30 years all point to the conclusion that the deterrent effect of the law has been very limited.”

Deterrence critically relies on individual perception. Everybody has a different perception of risks and rewards, influenced by their social context, personal psychology and core values. This makes the provision of information a vital – and often neglected – element of deterrence-based public policy. People cannot be deterred from doing something if they do not understand the risks involved.

Health: the first principle of drug policy

It is often forgotten that health is the first principle of drug policy. Improving security (against drug traffickers and dealers) and promoting development (to enable farmers to find sustainable alternatives to growing illicit crops) are necessary, but not sufficient, measures, because even if you eliminate the world's entire supply of cannabis, coca and opium, and even if you could seize all drugs in circulation, you would still have 25 million drug users looking for ways to satisfy their addiction. So the key to drug policy is reducing demand for drugs and treating addiction – and that is very much a healthcare issue.

Concern about the health effects of drug use was the chief motivating factor for the 1961 UN Drug Control Convention. Yet, over time, public security has taken priority over public health. This is reflected in resource imbalances (around 3:1 in favour of spending on security) and policy priorities. I fear this is political expediency: to focus on quick wins, like seizures and arrests (that reduce the problem), rather than on agents of slow change, like prevention and treatment (that can solve the problem).

It is also the result of the fact that the challenge of reducing demand for drugs has been left to individual states, whereas interdiction and reducing the world's supply of illicit drugs are the focus of multi-lateral agreements. There are Guiding Principles of Demand Reduction (1998), but they do not carry the same weight as an international convention. The practice is even more remote from the statements of principle.

It is time to redress the balance and bring health back to the mainstream of drug policy. That means putting more resources into prevention and treatment, as well as research to better understand what makes people vulnerable to addiction.

Then there is the question of reducing the harm caused by drugs. It is not only a question of handing out condoms, clean needles, disinfectants and bowls of soup. What is needed is a comprehensive package of measures to reduce vulnerability, treat the drug illness and prevent the spread of diseases that precede and accompany drug use, like HIV and hepatitis.

But let us be more radical. Let us reach out to people who need treatment, on a non-discriminatory basis. Drug therapy should be mainstreamed into high-quality and accessible public health and social services – not ghettoised. There is also no point in throwing all drug users in jail. We must promote alternative measures to prison for drug addicts, offering them rehabilitation programmes. Furthermore, all forms of addiction should be treated: there is no consolation for stabilising drug trends if people turn instead to other substances.

Finally, and most importantly, let us make drug control a society-wide issue. Drug abuse is an illness. Let's treat it that way.

Antonio Maria Costa, Executive Director of the United Nations Office on Drugs and Crime, www.unodc.org.

For some people, the very fact that a drug is illegal will deter them from using it. For similar reasons, people may choose not to jay-walk or to ride a bike without a helmet. However, legal status has clearly not proven a strong barrier to cannabis use in New Zealand, which is among the world's highest.

According to sociologists and psychologists, legal sanctions may be less important than other factors in discouraging drug use. Their research tells us that social sanctions may prove more important, such as public exposure and shame if one is exposed as a person who uses illicit drugs. People are also affected by the fear of the effects of a drug, the fear of looking 'uncool' and the fear of embarrassing their family or community.

New Zealand research shows that non-cannabis users are much more likely to say they are simply "not interested" in the substance than to cite the risk of legal sanctions as their reason for abstaining.

Evidence shows that perception of health risks can be more important than legal sanction. The UK Police Foundation report concluded that "the public sees the health-related dangers of drugs as much more of a deterrent to use than their illegality." The declining rate of smoking in New Zealand during the 1980s and 1990s highlights the potential benefits of a strong public information campaign about health risks associated with a drug.

Sending messages through drug classification

A flawed belief in the principle of deterrence underpins the Misuse of Drugs Act's classification system, which was considered groundbreaking back in 1975.

In theory, the classification system is designed to associate greater legal risks with harder drugs that cause more damage for society and people who use drugs.

Of course, for a classification system to be effective, people using or selling the drug must be aware of the classification and its punishments. There is scarce

“Drug law focused on reducing the harm around drugs would help those communities that are particularly vulnerable to drug misuse, rather than exacerbating social exclusion.”

research in New Zealand or elsewhere that proves that this is the case.

The classification of drugs is intended to be evidence-based. The Expert Advisory Committee on Drugs (EACD) makes recommendations to the Minister of Health based on factors including the likelihood of abuse, risk to public health, ability to create dependence and the classification decisions made by other countries.

In 2003, on EACD advice, the government reclassified methamphetamine from Class B to Class A. The Police Minister noted in November 2008 that, since then, the methamphetamine industry has grown. Despite a legal system designed to deter use, it would appear that industry participants perceive the rewards associated with methamphetamine creation and use as higher than the risks of legal sanction.

One apparent goal of pegging classifications to penalties is to deter somebody who tries a Class C drug like cannabis from moving ‘up’ to a Class A drug like methamphetamine.

Although most New Zealanders who have tried cannabis have not gone on to harder drugs, there is a widespread notion that Class C drugs – cannabis in particular – can serve as a ‘gateway’ to other drugs.

Indeed, this belief is consistent with American research that shows the use of cannabis is roughly associated with a stronger likelihood to try cocaine or psychedelics later. On the other hand, there is no evidence that the use of, say, ecstasy (a Class B drug in New Zealand) is followed by greater likelihood of using heroin (Class A). Research published in the *Journal of Policy Analysis and Management* concludes that the gateway concept remains controversial because a causal link between trying cannabis and trying harder drugs has not actually been established. This supports New Zealand research showing such ‘pathways’ exist, but that the ways they work are unclear.

The classification approach has been adopted in many countries. In the United States, drugs are divided into five schedules, but different states have their own legislation for scheduling drugs and for punishments. This means that one drug like ecstasy has different classifications and different punishments in different legal environments, which must undermine the deterrent effect.

In the United Kingdom in 2006, the House of Commons Science and Technology Committee took a close look at that country’s drug classification system and the workings of its equivalent to the EACD. The United Kingdom system is very similar to that of New Zealand: it has a three-tier drug ranking system of Class A, B and C.

The committee was troubled by the lack of research anywhere into such a system’s effectiveness. It cited evidence from the Chair of the Association of Chief Police Officers Drugs Committee that, “I cannot envisage any user – a dependent drug user, that is – having any kind of thought as to whether it was a Class A, B or C drug they were consuming.”

At the very least, this points to an information problem: if people who use drugs are not informed of the legal risks associated with different drugs, the deterrence effect will be fuzzy.

There is even anecdotal evidence that some people might see a Class A classification as an incentive to try a particular drug.

The committee was not sold on the argument that a classification system sends out 'signals' to drug users or potential drug users. Based on reported ballooning drug use in the United Kingdom, the committee felt that using the criminal justice system to send out public health messages about drugs was, at best, inefficient.

In the United Kingdom, the process by which drug classification decisions are made is often undisclosed and can be ill-defined, opaque and seemingly arbitrary. While New Zealand's EACD goes to some lengths to promote transparency, the classification of drugs remains more of an art than a science.

In theory, three main factors determine the harm associated with any drug: the physical harm that the drug causes the individual user, the tendency of the drug to induce dependence and the effect of the drug's use on families, communities and society.

In some cases, this is straightforward. Drugs that can be taken intravenously – such as heroin – carry a high risk of causing sudden death from respiratory depression and therefore score highly on any metric of harm. Methamphetamine also carries the risk of heart failure and seizures, and long-term chronic use can cause psychosis, aggression and violent behaviour. Cocaine induces very powerful dependence because higher doses are needed to obtain the same effect over time and because they create intense cravings and withdrawal reactions.

On the other hand, so does nicotine, which is a legal drug, and hallucinogens do not encourage physical dependence or carry a massive risk of causing sudden death, yet rate highly on both the United Kingdom and the New Zealand classifications. Because the longer-term effects of newer drugs like ecstasy are unknown, they can be difficult to classify.

Harm to society can be caused by many factors, including the damage to family and social life, as well as the costs to the health, social and justice systems. It is interesting to note that a legal drug – alcohol – creates a lot of accidental damage to users and to property through drunken behaviour and car crashes, while tobacco incurs higher costs on the healthcare system than any other drug.

In 2007, a research paper published in *The Lancet* used a group of independent drug addiction experts to attribute mean harm scores to illegal and legal drugs. One author of the paper was the chairman of the committee that recommends drug classification decisions to the British government.

"The results of this study do not provide justification for the sharp A, B or C divisions of the current classifications," the researchers

concluded. "Neither the rank ordering of drugs nor their segregation into groups… is supported by the more complete assessment of harm described here."

From a scientific perspective, the researchers noted, the exclusion of alcohol and tobacco from the Misuse of Drugs Act was arbitrary.

The addiction professionals rated the drugs in the following order: heroin, cocaine, barbiturates, street methadone, alcohol, ketamine, benzodiazepines (e.g. Valium), amphetamine, tobacco, buprenorphine (e.g. the painkiller Temgesic), cannabis, solvents, 4-methylthioamphetamine, LSD, methylphenidate (e.g. Ritalin), anabolic steroids, GHB, MDMA (ecstasy), alkyl nitrates, khat.

The House of Commons Science and Technology Committee concluded there are startling differences between this ranking and that of the United Kingdom's Misuse of Drugs Act. The same conclusion is reached when it is compared with New Zealand's ranking.

One of the research paper authors told the select committee that the classification system "is antiquated and reflects the prejudice and misconceptions of an era in which drugs were placed in arbitrary categories with notable, often illogical consequences." Even the Association of Chief Police Officers acknowledged that the classification system was "pretty crude".

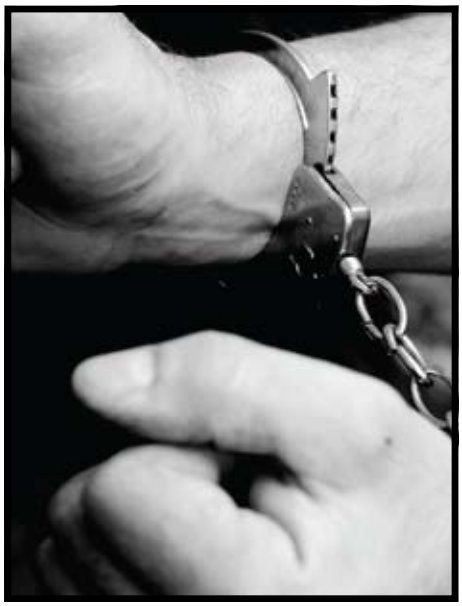
The committee recommended that the government decouple the harm ranking of drugs from the penalties for possession and trafficking. This would allow a more sophisticated and scientific approach to assessing harm and the development of a scale that would be responsive to new research.

The committee pointed out that a more scientifically based scale of harm would have greater credibility than a system where the placing of drugs in a particular category is ultimately a political choice.

Relying on politicians to make decisions about drug classifications can lead to science being overruled by short-term concerns such as media attention. The British system's credibility was undermined between 2000 and 2007 when five successive Home Secretaries all sought to readdress the classification of cannabis amid a heated public debate. Eventually, the UK government ignored its scientific advisors' recommendations and re-classified the drug.

Under our similar system, the same thing could occur in New Zealand. While we have not been engaged in a heated and politicised debate on cannabis recently, this is perhaps largely because successive governments have agreed in coalition deals not to revisit its legal status. This, in itself, has largely cut off the potential for evidence-based scientific input to public discourse.

Another advantage of decoupling the scientific harm metric from penalties would be that tobacco and alcohol could be included in a scientific scale to provide the public with a better sense of the relative harms involved with different drugs, legal or otherwise.



"It is not only a question of handing out condoms, clean needles, disinfectants and bowls of soup."

Reducing drug harm and promoting health

Promoting such health messages is part of the 'harm minimisation' approach. This pragmatic approach accepts that drug use will continue to be a part of society and that eradicating drugs by trying to stamp out supply is simply not feasible. Instead, the focus is on identifying the specific ways that drug misuse can harm individuals and society and then responding with strategies to reduce those dangers.

"Drug users are vulnerable people. They suffer from inadequate medical assistance. They experience discrimination, invasion of privacy, Police harassment and social marginalisation. They have to endure the arbitrary deprivation of rights."

New Zealand's National Drug Policy is based on this concept. The National Drug Policy is a regularly updated framework that was developed by the government in the 1990s to encourage action plans and community programmes to reduce the problems that drugs cause.

The National Drug Policy's stated aim is "to prevent or delay the uptake of drugs, reduce drug-related harm, make families and communities safer and reduce the cost of drug abuse to individuals, society and government."

Unfortunately, this dynamic up-to-date policy framework exists around a piece of legislation – the Misuse of Drugs Act – that has become dusty and irrelevant, with its limited goal of reducing supply.

The competing philosophies of the drug policy framework and the legislation create tension and confusion. The law's strict focus on eradication of supply undermines health measures that would accept continued drug use. These could involve providing basic information on avoiding drug-related harm, or setting up needle exchange schemes and other harm reduction services.

The answer is not to throw out the criminal justice approach altogether. Nobody engaged in serious dialogue about the future of drug policy advocates creating an unregulated drug market in which traffickers and sellers go unpunished. However, it is important to broaden the legislation's ambit. Genuine, effective attempts to reduce supply should be viewed as one tool that can be used to reduce the cost of drugs to society.

Drug use is different from drug production and supply. Too often, we lump everything together. Drug use is primarily a health issue and should be addressed through health-based responses. Drug production and trafficking, on the other hand, should usually remain the domain of a drug control system.

After years of viewing drug use through a criminal justice lens, it can seem jarring to consider the 'rights' of people who use drugs. However, international agreements like the Universal Declaration of Human Rights and the World Health Organization's Constitution make it clear that everybody has a fundamental right to decent standards of health. In the midst of a 'war on drugs' approach, this right is often denied to people who use drugs.

As Hungarian civil libertarian and researcher Judit Fridli points out, "Drug users are vulnerable people. They suffer from inadequate medical assistance. They experience discrimination, invasion of privacy, Police harassment and social marginalisation. They have to endure the arbitrary deprivation of rights."

In many ways, incarcerating non-violent minor drug offenders has added to the damage harmful drug use causes, both to people who use drugs and to their families and communities.

Incarcerating users instead of providing appropriate healthcare might temporarily shut away the problem from society, but it means that we do

not identify the underlying factors that cause somebody to use drugs in the first place or come up with a suitable long-term solution to an individual's drug use. Overlooking drug users' rights ends up costing society.

Research into different health-based responses to drug use has identified a number of initiatives that work effectively. Well-designed prevention programmes can support children to make healthy choices. Comprehensive harm reduction services can reduce the health, social and economic damage associated with using illegal substances.

These programmes work best in an environment of support and openness that is very difficult to foster when drugs are seen purely as a criminal justice issue. The fear of legal sanctions strongly deters people who use drugs from seeking help and stigmatises them. That means we miss out on opportunities to help people to give up drugs or to switch to safer forms of drug use.

New Zealand is not alone in trying to update the way it deals with drugs. Policy reformers have suggested changes in the United Kingdom, Australia and Canada in an effort to introduce a harm minimisation approach to drug control law.

In Canada, the Health Officers' Council of British Columbia believes "The balance point for determining public health policies for currently illegal drugs would be that which minimises the prevalence of harmful use and negative health impacts, and also minimises any indirect or collateral harms to society from regulatory sanctions."

And in the United Kingdom, Tom Wood, Scotland's 'Drug Tsar', told a newspaper in 2006, "I spent much of my Police career fighting the drugs war and there was no one keener than me to fight it. But latterly I have become more and more convinced that it was never a war we could win. We can never as a nation be drug-free. No nation can, so we must accept that. So the message has to be more sophisticated than 'just say no' because that simple message doesn't work."

There is an obvious analogy with efforts to reduce the incidence of sexually transmitted infections. Research has shown that campaigns to promote chastity are usually ineffective, so a better approach is for campaigns to focus on encouraging safer behaviour.

Drug law focused on reducing the harm around drugs would help those communities that are particularly vulnerable to drug misuse, rather than exacerbating social exclusion by relying on incarceration to deal with people who use drugs. Law that is based on public health analysis would aim to reduce inequality. It would also recognise that, to reduce or stop drug misuse, recovery must be supported by the provision of social services, such as housing and employment.

A new Misuse of Drugs Act based on the principle of harm minimisation would make its top priority efforts to reduce the damage caused by drug use. It would recognise that many of the harms we currently experience from drugs are related to their legal status.

A health-based law would respect human rights, including the right of people to equal access to health services. It would reduce the barriers that currently stop people from seeking help for drug-related problems and make it easier for them to access services such as needle exchanges and other harm reduction programmes, treatment or emergency care for overdoses.

Such laws would complement other national public health laws and strategies, including the National Drug Policy framework.

Sociologists and researchers have provided us with a wealth of information about what would work better than our current law. The next step is to put these lessons to good use.

We have spent 30 years trying ineffectively to stamp out supply under the mistaken belief that drugs should be dealt with solely as a criminal justice matter. It is time to take heed of more than three decades of experience. Our drug law must be adaptable for the future instead of rooted in the past and, most importantly, supportive of drug and health policies. ■

Feedback

You can provide feedback on this essay on our Misuse of Drugs Act review pages on our website **www.drugfoundation.org.nz/moda**, where we will publish papers, videos, case studies and other resources to support broad community engagement during the Law Commission's review. A full list of references used in this essay is also on the website.

Sentencing for serious drug crime – how tough are we?

Is drug dealing a more serious crime than murder or rape or terrorism? You'd think so according to drug laws in many jurisdictions, and New Zealand is no exception. **Graeme Edgeler** outlines your likely time if you do the crime.

SERIOUS drug crime attracts serious penalties. At its upper levels, maximum penalties are comparable to those for our most serious crimes. Dealing in Class A drugs (that is, importing or exporting, producing or manufacturing, supplying or administering, selling, offering to sell or supply or administer, or possessing for any of the preceding purposes) carries a maximum sentence of life imprisonment. This is the same as the maximum penalties for murder and manslaughter and more than you could receive for being part of a terrorist group (14 years) or for rape (20 years).

Of course, it's not quite that simple. Many crimes with identical maximum penalties see markedly different sentences imposed. Although importing, manufacturing and possession for supply all count as 'dealing' drugs and attract the same maximum penalty under the same offence, the courts do treat them differently. The possession of 5 grams of methamphetamine for supply is treated more leniently than the importation of a kilogram of the stuff.

In reaching a sentence, a defendant's *culpability* is taken into account, and different offending, even involving the same offence, is treated differently.

Guilty pleas and prior criminal history are also considered. Two people charged over the same aggravated robbery might see the one who physically carried the gun serve longer, and two people involved in a similar aggravated robbery that didn't involve a gun at all will likely receive lesser sentences. Different levels of involvement in dealing with drugs result in different sentences too. The Court of Appeal has stated that:

"All other things being equal, a manufacturer is more culpable than an importer and an importer is more culpable than a supplier."

Despite the technical availability of long prison terms, low-level Class A drug dealing does not result in sentences as high as for rape.

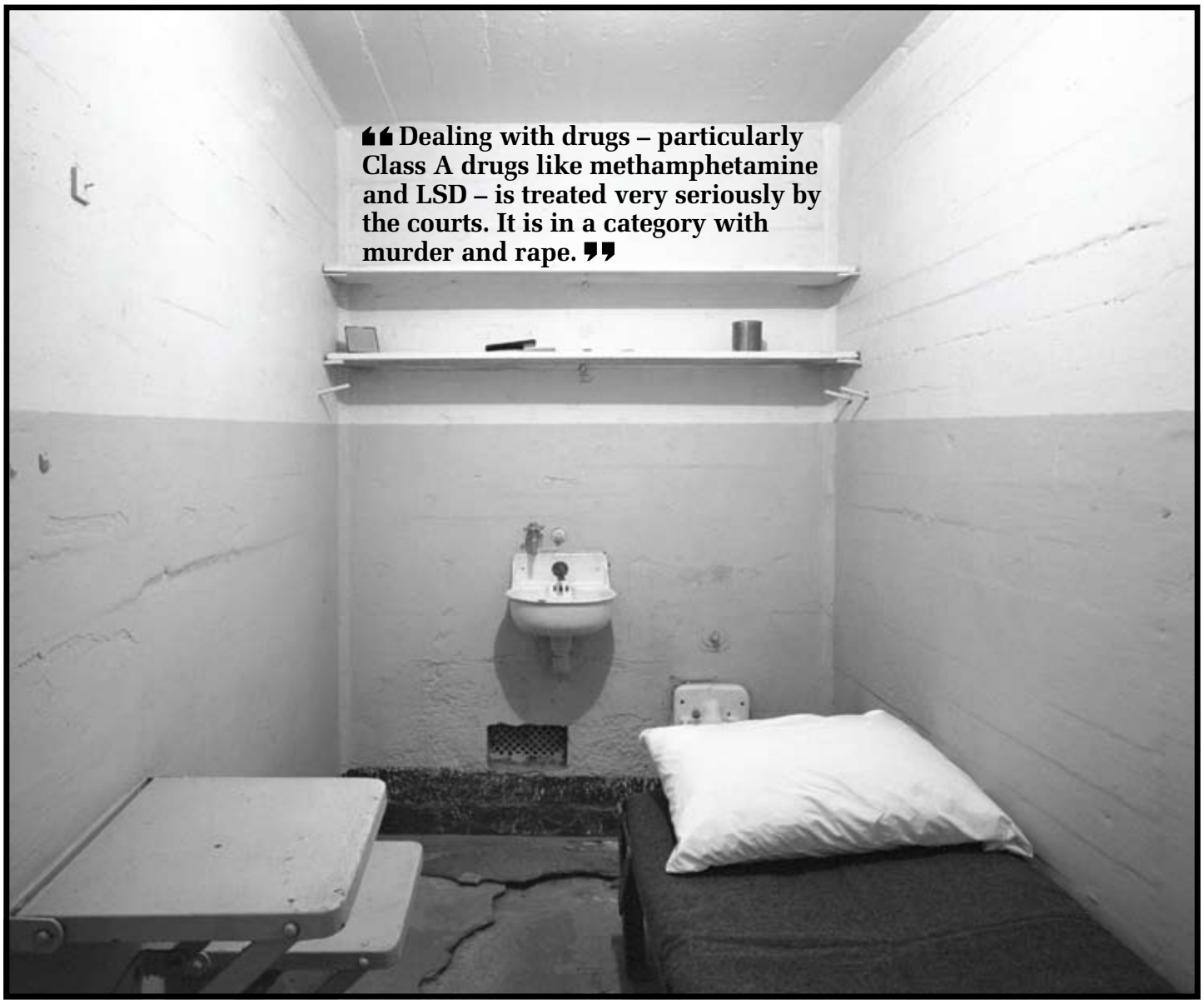
But serious drug crime does.

Dealing with drugs – particularly Class A drugs like methamphetamine and LSD – is treated very seriously by the courts. Dealing with Class A drugs is in a category with very few other crimes – murder and rape – where the law *requires* (in all except the most limited of circumstances) that those convicted receive prison terms. Not even all those convicted of crimes like attempted murder or manslaughter will necessarily receive prison terms (perhaps getting home detention or even community service or fines). But Parliament has decreed that dealing with Class A drugs is in a different league – so serious that a special section of law insists that prison is the only option.

And it's not just *some* prison time. Not only are maximum possible sentences high, the actual sentences imposed for dealing Class A drugs are also substantial. Even a low quantity of drugs can result in lengthy prison terms, and as the quantity increases so to do the sentences imposed. The Court of Appeal has elucidated starting points for those convicted of dealing with methamphetamine, beginning for low-level supply at 2–4 years, with at least 13 years anticipated for large-scale manufacturing (see table). The starting point of a sentence is not the actual sentence imposed. It's what is considered appropriate to given offending, before taking into account the offender and any aggravating factors (like prior criminal history or the fact offending occurred while on bail) and mitigating factors (like a guilty plea, previous good character or a diminished intellectual capacity). Actual sentences can be higher or lower. Guilty pleas may result in a reduction of up to a third.

In contrast, the starting point for a standard rape charge is usually around 8 years. And although murder carries a life sentence, the non-parole periods start at 10 years – or 17 years for particularly bad murders (such as those involving a home invasion, a child victim or multiple victims).

Undoubtedly, the penalties for dealing with Class A drugs could be made harsher. The maximum life sentence can't be increased, but other jurisdictions – notably the United States – impose mandatory minimum sentences. In the US federal jurisdiction, trafficking of more than 50 grams of methamphetamine carries a minimum sentence of 10 years. (Other aspects of



	Sale/Supply	Importing	Manufacturing
Low level (< 5g)	2–4 years	2½–4 years	Not applicable
Commercial quantities (5–250g)	3–9 years	3½–10 years	4–11 years
Large commercial quantities (250–500g)	8–11 years	9–13 years	10–15 years
Very large commercial quantities (500g +)	10 years – life imprisonment	12 years – life imprisonment	13 years – life imprisonment

dealing with drugs – manufacture and supply – are generally prosecuted by states.)

New Zealand has very few crimes that attract mandatory minimums (the life sentence for murder is one, the 6 month loss of licence for drink driving another) – even crimes involving serious violence like wounding with intent do not have mandatory sentences (although some prison time is highly likely).

What about lesser drugs? The penalties for Class B and Class C drugs are substantially lower at their maximums and in practice. However, drug classifications can change, as occurred in 2003 when methamphetamine was moved from Class B to Class A. The strategy behind such a move, of course, is to control a drug by empowering the courts to punish its use more heavily. ■

Graeme Edgeler LLB is a Wellington-based law specialist and blogger.

Enforcing to reduce harm

Drug markets are extremely resilient to supply-side enforcement efforts and will quickly adapt without any significant long-term effect on street-level availability. However, as **David Blakey** explains, drug control enforcement agencies do have a role to play in reducing drug harms.

AN enforcement approach that aims to reduce drug harms is already widely accepted among the agencies responsible for tackling drug markets and trafficking networks. For instance, the Serious Organised Crime Agency (SOCA) explicitly aims to reduce the harm from the illegal drugs trade within the UK. The 2008 drug strategy *Drugs: protecting families and communities* also has a similar emphasis in the chapter on law enforcement.

However, despite the general consensus that enforcement should focus on reducing harm, there is no shared understanding of what it means in practice or how success in this area should be measured. Traditionally, 'harm reduction' is associated with schemes undertaken by health agencies such as needle exchanges that aim to reduce the spread of blood-borne viruses and drug-related deaths. But what could 'reducing drug harm' mean for enforcement agencies?

It is possible to identify at least four potentially different approaches through which enforcement agencies might reduce harms caused by drugs.

1. Reducing availability

A 'traditional' enforcement model interprets reducing drug harm to mean reducing availability, which, it is assumed, will lead to a decline in the number of users and therefore a decline in overall harm. As a result, enforcement efforts are often judged by the amount of drugs or dealers taken out of the market and the extent to which they have increased drug prices or reduced drug purity (as proxy measures for reduced availability). This is reflected in the UK strategy, which states:

"…there is evidence from other countries of enforcement-driven price effects. As part of the wider drug strategy the Government believes that taking action to increase the price of drugs is worthwhile. We would expect higher prices to deter new users, encourage those reaching the end of their drug-using career to stop and reduce to some degree the consumption of current users."

"It is very difficult for enforcement agencies to demonstrate that even the largest drugs hauls have had any significant impact on street-level availability, let alone levels of use."

The drug strategy also emphasises that supply-side activity will focus on tackling the drugs that cause the greatest harm: Class A drugs.

However, there are some serious questions about this approach as a means to reducing harm. As the review we published indicates, it is very difficult for enforcement agencies to demonstrate that even the largest drugs hauls have had any significant impact on availability, let alone levels of use. Evidence suggests that both the drug market and the drug user adapt to changing circumstances. Dealers will reduce purity to keep drugs at a price that can be tolerated by the market, and drug users may simply choose to use an alternative drug, or commit more crimes to cope with rising costs. Thus, reduced availability may have unintended consequences that could actually increase harm, such as increasing levels of crime or damage to health through the use of harmful cutting agents.

2. Reducing demand

An enforcement approach to reducing demand could take several forms. For instance, a crackdown on drug use followed by stiff sanctions might provide a 'deterrent effect' for some existing or potential users, although the evidence for this is thin. It might also mean involving Police and other agencies in drug education programmes but, again, evidence suggests this is not an effective way of reducing demand (although it may be effective at delivering other outcomes, such as improving knowledge).

However, another approach widely used in the UK seeks to reduce demand by encouraging problem drug using offenders into treatment. An earlier report from the UK Drug Policy Commission, *Reducing Drug Use, Reducing Reoffending*, concluded that evidence does support criminal justice interventions, such as arrest referral schemes and Drug Treatment and Testing Orders (DTTOs), which link enforcement and drug treatment. The use of opportunities within the criminal justice system to encourage drug using offenders to engage in treatment has been shown to lead to a reduction in their drug use and associated harms such as crime.

3. Adopting 'traditional' harm reduction practices

A third approach uses a more traditional understanding of harm reduction, as directly reducing the harm caused by drug use on drug users. This approach may mean enforcement agencies adopt traditional harm reduction practices themselves, for instance, introducing needle exchange schemes within custody suites, or it may mean partnering with treatment and harm reduction agencies. Evidence suggests such partnership approaches are likely to be more effective at reducing drug harms than traditional enforcement in isolation. The International Harm Reduction Association explains:

"The use of opportunities within the criminal justice system to encourage drug using offenders to engage in treatment has been shown to lead to a reduction in their drug use and associated harms such as crime."

"Harm reduction approaches seek collaboration with entire communities, and law enforcement personnel are essential front-line workers when it comes to any interventions for drug users (both as a result of acquisitive, drug-related crimes and the criminalisation of drug use itself). Police officers are often in contact with drug users when they are at their most vulnerable. As such, they have a key role to play in harm reduction best (and worst) practice."

4. Focusing on the most harmful markets and dealers.

An approach that focuses explicitly on the harms or 'collateral damage' caused by drug markets has the potential to differ from one that focuses on reducing drug use and availability across the board. Drug markets themselves are associated with a range of harms such as gang violence, prostitution, people trafficking and corruption, and can also undermine community confidence through open drug markets, and fear and intimidation. Therefore, whilst reducing availability might be one approach under this model, other approaches also become possible.

For example, it may be that by focusing on prosecuting the most violent drug dealers, you are not intending to reduce availability (other drug dealers are likely to fill the void) but you are aiming to reduce gun crime and gang-related deaths (if the replacement dealers are less violent). Alternatively, focusing resources on open markets in residential neighbourhoods that cause considerable nuisance and fear, rather than on dealers operating within closed markets that have less impact on the community, aims to reduce community harms rather than availability per se. There are many examples like this where drug harms might be reduced by enforcement agencies without necessarily affecting either supply or demand. This, of course, could lead to some uncomfortable and challenging decision-making where certain less harmful drug markets and drug dealers are tolerated as the 'lesser evil' to more harmful drug markets. Yet these types of decisions are already being made, implicitly, within enforcement agencies. Without unlimited resources, prioritisation of what to enforce and how is always necessary.

The benefit of an explicit focus on drug harms should be that it encourages the development and dissemination of new approaches to enforcement and focuses assessment on what matters most: the harms associated with drug markets, rather than more traditional indicators (price, purity, seizures etc) that are easier to measure but undersell the good work already underway that is focusing on reducing harm. ■

David Blakey CBE QPM is a Commissioner for the UKDPC and was formerly Chief Constable of West Mercia, President of ACPO and HM Inspector of Constabulary, www.ukdpc.org.uk.

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Twenty years young

The Drug Foundation turns 20 this year. We thought we'd start our birthday celebrations with a look back on our formation, which was not without its complications.

THE New Zealand Drug Foundation was launched on 19 December 1989 with a Telethon grant of $500,000 and just a little controversy.

The Foundation's initial objective was to reduce the prevalence and severity of drug-related problems by co-ordinating the efforts of non-governmental organisations working in the drug area. It would provide existing agencies with accurate and credible information about drug and alcohol issues while representing their interests at government level.

The impetus to set up a foundation came from a drug education conference in May 1989 when workers representing 25 organisations unanimously supported a call for one body to co-ordinate drug education. The then Health Minister, Helen Clark, and Education Minister, Phil Goff, both said school boards had been faced with the prospect of choosing between many competing programmes, with isolated schools often missing out.

Our first cash injection was provided by the Home and Neighbourhood Trust, set up to distribute the $5.25 million given to the 1988 Telethon. Auckland University Professor of Medicine Sir John Scott would chair the Foundation. Past President of the Māori Women's Welfare League Elizabeth Murchie and Wellington School of Medicine Professor Dr Eru Pomare were appointed as trustees. Together, they would appoint a further four trustees to the board.

But this didn't all happen without some hullabaloo. National MP and Misuse of Drugs Spokesman Graeme Lee said the money should have gone to assist the drug fight instead of establishing a foundation, although he did admit that something needed to be done to co-ordinate drug education services.

Mr Lee also criticised the appointments of Ms Murchie and Dr Pomare, who were already members of the Home and Neighbourhood Trust, pointing to a conflict of interest. He also said the Foundation would likely adopt a policy in favour of decriminalising marijuana if John Hannafin, Chair of the Drug Advisory Committee, was appointed as the new Chief Executive.

Mr Lee was not alone in his criticisms of the new venture. The National Society for Alcoholism

and Drug Abuse (NSAD) and the Alcoholic Liquor Advisory Council (ALAC) said they had only heard about the Foundation a week earlier.

"There should have been a closer look at the priorities needed in fighting the drug war," said NSAD Chief Executive Michael Lynch, adding that he did not object to the Foundation's establishment.

However, NSAD was also annoyed at having missed out on some funding. "We were bitterly disappointed, because we were relying on the money, but we won't be going out of existence."

ALAC Chief Executive Keith Evans said the Foundation's real value would come when it could "weld together" the voluntary groups. "Co-ordination of approach is not high in people's minds."

How times change. While they had a crack at us 20 years ago, this month, NSAD (now the New Zealand Society on Alcohol and Drug Dependence) is co-hosting, with the Drug Foundation, one of the most significant drug policy meetings ever to take place in New Zealand.

Happy birthday to us! ■

Quotes of Substance: a history

"Alcohol advertising works on the basis that New Zealanders are basically well-informed, and they're going to make well-informed decisions about alcohol regardless of what they see in the media. But the fact is that New Zealanders aren't well-informed: we're horrendously badly informed about alcohol health issues."

Ross Henderson, Executive Director, 10 March 1993

"This is a complex issue that requires carefully thought out solutions. Our first step is to see exactly what is going on – to stand back and take an overview, not blinkered by the fact that alcohol is legal and cannabis is illegal."

Chris Spence, Executive Director, 14 April 1997

"Prime Minister Jenny Shipley was dreaming if she thought lowering the drinking age wasn't going to cause more harm to young people."

Sally Jackman, Executive Director, 1 June 1999

"It's time the Government, political parties, communities and parents all took alcohol policy and alcohol-related harm more seriously. Not only is it estimated to cost New Zealand a net $2.4 billion to $16.1 billion a year – choose your economist – but it's putting our children at risk."

Ross Bell, Executive Director, 11 June 2004.

Down but not out – the findings of Youth'07

New research suggests college students smoke less tobacco and cannabis, have better mental health and improved nutrition and exercise more than students in 2001. However, not all the news is good. Researchers expressed concern around the numbers of students who binge drink, experience physical or sexual abuse, or witness violence in their homes.

YOUTH'07, A New Zealand-wide secondary school health and wellbeing survey, was conducted by Auckland University's Adolescent Health Research Group. The researchers collected the data from 9,107 randomly selected secondary students and compared them to the 2001 results.

Students' cigarette and cannabis use has declined. Only 8 percent reported smoking cigarettes weekly or more in 2007 compared to 16 percent in 2001. Fewer students had tried smoking cigarettes – 32 percent in 2007 down from 52 percent in 2001. The decline in smoking is supported by the findings of the 2007 Action on Smoking and Health (ASH) study, which showed that the number of Year 10 smokers had dropped by 28.6 percent between 1999 and 2006. The number of students who have used cannabis has also decreased from 39 percent in 2001 to 27 percent in 2007.

Dr Simon Denny, the study's principal investigator, says the survey is the largest and most comprehensive health and wellbeing survey of young people in New Zealand. "It's about young people themselves telling us how they see their lives – from their perspective."

Dr Denny says one of the concerning areas is the frequency and amount of alcohol young people are drinking. "We need to be getting the message out to the teens' family and friends, as they need to be aware of the problems with alcohol use among young people."

Drug Foundation Director Ross Bell says New Zealand's long-running anti-smoking campaign, focusing on how smoking damages the lungs, may have influenced teens' perception of all forms of smoking, including cannabis. "Young people are transferring the view that smoking is bad for you to anything they smoke, whether it's pot or tobacco."

European drugs experts found a similar downward trend and say the reason could be our changing attitudes towards cigarette smoking. Ross Bell says New Zealand's fall in tobacco use had been expected, but the cannabis drop was surprising. These findings suggest that one of the most effective ways to tackle illicit drug harm might be to target alcohol and tobacco.

Alcohol Advisory Council Executive

Officer Gerard Vaughan says the binge drinking figures are going in the right direction, but are still concerning.

"Young people's drinking has to be seen in the wider context of the adult drinking culture in New Zealand. Young people learn their drinking behaviours from those around them; until we change the adult drinking culture, we will not change the behaviour of young people.

"We also have to look at the wider environment, the cheap price of alcohol, increased availability and new products that appeal to youth."

Vaughan says it can also be difficult to communicate with teens. "Young people are risk takers. It's hard to tell young people, who feel they are bullet proof, to think of the consequences of their actions."

ALAC have been working with people at events such as the Pacific Youth Symposium on ways ALAC might effectively communicate with youth.

Christchurch's 198 Youth Centre sees around 7,000 teenagers every year. Its Director, Dr Sue Bagshaw, says, while the results of Youth'07 are interesting, she would like more research done on alternative education schools. "We want to know what is happening with those students as they are much more at risk."

Dr Bagshaw says binge drinking at teen age is a "rite of passage" in New Zealand and that nothing will change unless the marketing of alcohol, and alcopops in particular, is restricted. "If they are less available, people will do it less. Look what we have achieved with nicotine."

But the restriction of advertising will not work on its own, says Deb Fraser, Manager of Dunedin's Mirror Youth Trust. "Sometimes, the parents will provide their child with a one-litre bottle of vodka, and not actually follow up where their child is going," she says.

"At times, it is challenging to educate those parents because they drink and smoke in the same way as their kids. It is not about not supplying alcohol at all, but doing it in a responsible way and leading by example."

But Ms Fraser is very pleased to see the overall reduction in smoking and cannabis use. "It is pleasing to see such comprehensive surveys done in New Zealand. The results certainly confirm a lot of what we see." ■

The full report is available at www.youth2000.ac.nz.

Youth'07 Results

Smoking	■ Almost 8% of students reported smoking cigarettes weekly or more often. Smoking was more common among female students (10%) than male students (6%). ■ Among students who smoke, 37% buy their own cigarettes. Of these, the majority (60%) are not routinely asked to show ID.
Alcohol	■ 72% of students have tried alcohol, 61% currently drink, and 30% drink once a week or more. ■ 34% have engaged in binge drinking (five or more drinks within four hours) in the last four weeks. ■ Substantial numbers of students reported problems from drinking alcohol, such as unsafe sex (14%), unwanted sex (7%) or injuries (22%). ■ 6% of current drinkers had been told by friends or family they needed to cut down their drinking. ■ The most common sources of alcohol for students were their parents (54%) and friends (53%). 14% of students buy alcohol themselves, and 35% get someone else to buy alcohol for them.
Illicit drugs	■ Nearly 5% of students use cannabis weekly or more often. Among students currently using cannabis, about one in four use it before or during school. ■ Almost one-third of students using cannabis have tried to cut down or stop using it. ■ Use of other drugs such as acid, heroin, methamphetamine, speed or ecstasy was uncommon among students. Only 1.2% of students reported using methamphetamine, and of these, most had used it only once or a couple of times. ■ Party pills were the most common of the 'other drugs' used by students, with just over 11% of students having tried them.
Māori youth health and wellbeing improved	■ The figures for Māori students in 2007 have also improved compared to 2001 but are still higher than the national average figures. ■ Māori students are less likely to drink alcohol or use cigarettes and cannabis. Fewer reported they had ever tried alcohol (84.5% compared to 89.5% in 2001). ■ Fewer reported having ever smoked a cigarette (50.1% compared to 66.6% in 2001). ■ Fewer reported having tried cannabis (47.8% compared to 57.7% in 2001).

On the RISE for youth

Youth RISE (Resource. Information. Support. Education.) is an international youth network for reducing drug-related harm. **Caitlin Padgett** introduces the movement.

MANY young people live in a world where illicit drugs are more readily accessible than the education, resources or treatment necessary to reduce drug-related harms. Often, drugs are available where social services are not.

Currently, there are an estimated 13.2 million people who use injecting drugs in over 155 countries worldwide. Up to 30 percent of all new HIV infections worldwide are attributed to injecting drug use, and many are young people. In addition, estimates from the UN General Secretary state that 92 percent of people who use injection drugs in low- and middle-income countries have no access to HIV prevention, and less than 5 percent have access to treatment, care or support.

In many regions, the average age of first injection is decreasing, and in some countries, it is as low as 15 and 16 years of age. Yet young people who use drugs are some of the most marginalised, stigmatised and criminalised individuals in society. They are systematically excluded from life-saving prevention services and support, and proven harm reduction strategies are deemed too controversial. Barriers such as the lack of disaggregated data, lack of youth-friendly and peer-to-peer youth services, limited research on drug use and sexual behaviours, legal barriers in access and stigmatisation all contribute to the further marginalisation of young people who are affected by substance use.

Over the past three years, Youth RISE has seen an increase in interest and engagement amongst young people and youth allies within the harm reduction and HIV movement, and a small number of international policy makers are starting to take notice.

Youth RISE advocates for the rights of young people who use drugs because, when the resources and support for young people needed to reduce drug-related harms are unavailable and when sexual and reproductive health services do not address the link between substance use (including alcohol) and sexual health risks, our right to the highest attainable standard of health is being denied.

When young people who use injection drugs or are affected by drug use are excluded from global and regional HIV/AIDS and drug policy design and implementation, our right to participation is being denied. And when education fails to honestly address drug-related harm and sexual and reproductive health, our rights to education and to freely access information are not being respected.

In this fight towards equality and equal access, Youth RISE has sought to provide a voice for some of the most marginalised youth worldwide. We have participated in many conferences such as the international AIDS conferences in both Toronto and Mexico, the first global methamphetamine conference, the Harm Reduction Coalition conference and the last two international conferences on reducing drug related harms in Warsaw and Barcelona and the upcoming one in Bangkok. We have also been involved in the High Level Meeting on HIV/AIDS and the Beyond 2008 NGO Consultation on Drugs. We have done this to advocate for the greater inclusion of young people within harm reduction programming and planning.

We are a network of young people affected either directly or indirectly by substance use and drug policies, and of allies who believe harm reduction can be an effective approach for young people. We now have more than 200 members worldwide, representing 62 different countries!

Please check out our website if you'd like to get involved and sign up as a member, or you can just email us with questions or for further information. The Youth RISE Team looks forward to hearing from you! ■

Caitlin Padgett is the International Co-ordinator of Youth RISE, www.youthrise.org.

Take Two to Thailand

Youth RISE is asking organisations to sponsor young leaders to attend the 20th International Harm Reduction Conference in Bangkok, Thailand, April 2009 (see back page advertisement).

The Take Two to Thailand campaign encourages organisations to sponsor a young person to attend the conference in addition to (or instead of) their staff or representatives. A similar principle was used for the 2006 International AIDS Conference where over 100 young people attended courtesy of 31 organisations.

Young people are disproportionately affected by both substance use and drug policies worldwide. However, they are often excluded from global discussions and decision making processes around harm reduction – despite various international commitments that explicitly state young people's right to participate. By providing young people with the opportunity to participate in events such as Harm Reduction 2009, you can help Youth RISE and future harm reduction pioneers gain invaluable experience, networking opportunities and knowledge.

BEYOND THE CANNABIS STALEMATE

Despite cannabis being the most widely used illicit drug worldwide, it is rarely the focus of international drug policy control discussions. In light of this, The Beckley Foundation has released a report claiming prohibition is doing more harm than good and calling for urgent discussions on cannabis policy. If the 'War on Drugs' must continue, **Rob Zorn** asks, is it time we removed cannabis as one of its targets?

AT THE United Nations General Assembly Special Session held in New York in June 1998, the international community agreed on a 10-year programme towards eliminating or significantly reducing illicit manufacture, supply and demand for drugs. The optimistic slogan under which the programme was agreed was 'A drug free world – we can do it!'

In March 2007, the UN Commission on Narcotic Drugs met in Vienna to decide on issues of global drug control, and one can only guess at the levels of subdued unease delegates must have felt. The 10-year deadline was approaching but, since 1998, drugs had only become cheaper, purer and more readily available.

At that Vienna meeting, it was agreed that a high-level political gathering would be held in the spring of 2009 to review progress and to agree the way forward for the next 10 years. It is difficult to think of an optimistic slogan that could underpin this meeting given there has been no significant progress in controlling illicit drugs pretty much anywhere.

Influenced largely by the United States' 'zero tolerance' policies, the 10 years of drug control efforts worldwide have mostly amounted to a 'War on Drugs' approach, with drug policy options for governments limited to little more than varying the severity of penalties for drug offences.

Cannabis is the most widely used drug in the world by far, with an estimated 160 million people using cannabis in 2005. Despite this, cannabis has received little direct attention in international drug policy discussions.

> **"Policies introduced to control cannabis have had little impact on its prevalence, and most of the harms associated with it result from prohibition itself."**

This, then, is the context in which UK think tank The Beckley Foundation convened a team of international drug policy experts, the Global Cannabis Commission, to prepare an overview of scientific evidence around cannabis and the policies that attempt to control it. Its report, *Cannabis Policy, Moving Beyond Stalemate,* was published in 2008, with the aim of bringing cannabis issues to the attention of policy makers and informing discussion at the 2009 United Nations Strategic Drug Policy Review meeting.

Should cannabis be legalised?

YES

There is little evidence that cannabis use would increase as a result of legalisation but, even if it did, the harm reduction benefits gained would greatly outweigh any negatives.

Compared to the devastations wrought by alcohol and tobacco, which are legal, the harms associated with cannabis are relatively minor.

Legalising cannabis would remove the drug's supply channels from the hands of criminal groups.

The illicit cannabis industry generates tens of billions of dollars – money that governments could be collecting in taxes and spending on harm reduction.

NO

Legalising cannabis would lead to a significant increase in its use, which might encourage people to try harder drugs.

Once cannabis is legal, it would only be a matter of time before other more serious drugs were made legal.

We need to send the strong message to society that drug use is harmful. Making illicit drugs legal undermines that message.

Some forms of cannabis, such as skunk, are very harmful and have been linked to the onset of mental health problems.

MATE

The Global Cannabis Commission's recommendations to countries contemplating legalisation of cannabis

Any regime that makes cannabis legally available should:

1. involve state licensing or state operation of entities producing, wholesaling and retailing the drug (as is true in many jurisdictions for alcoholic beverages)
2. either directly, or through regulation, control potency and quality, assure reasonably high prices and control access and availability in general and particularly to youth

While acknowledging that cannabis is not a safe substance, the main thrust of the report is that policies introduced to control cannabis have had little impact on its prevalence and that most of the harms associated with it result from prohibition itself – particularly the social harms arising from arrest and imprisonment.

These findings will not be a surprise to those who have long felt something is seriously out of whack with cannabis laws worldwide.

As the report acknowledges, cannabis can have a negative impact on both physical and mental health. In terms of relative harm, however, it is considerably less damaging than alcohol or tobacco, both of which are freely available and legal. While there have only ever been two deaths worldwide attributed to cannabis, alcohol and tobacco cause literally millions of deaths each year.

More than half the arrests for drugs worldwide are for minor cannabis offences and, suggests the Commission, the damage done by criminalising these minor offenders appears to far outweigh the damage cannabis causes to individuals or society.

In addition to the substantial government resources needed to enforce prohibition, very large secondary costs and suffering result at a personal level. For example, a criminal conviction for cannabis possession can exclude an individual from certain jobs and activities, and arrest can impose humiliation. Cannabis users can be drawn into the criminal world and, in countries where data are available, arrest rates are sharply higher for minority and socially disadvantaged groups.

The report makes several recommendations towards improved cannabis policy, ranging from the mild (police giving low priority to enforcing cannabis laws) through to decriminalisation and legalisation.

In a decriminalised system, offenders could be processed outside the justice system, fines would be low and counselling and education could be offered instead of imprisonment.

If cannabis was made legal, governments could use a variety of mechanisms to regulate it such as taxation, availability controls, minimum legal age for use and purchase, labelling and potency limits. This would greatly increase harm minimisation possibilities such as delaying onset of use until early adulthood and encouraging users to avoid driving after taking cannabis. However, as the report states: "That which is prohibited cannot be regulated."

The report favours a decriminalised, regulated market in cannabis as the best option, but it acknowledges that those working for decriminalisation, legalisation or any significant reform face an uphill battle.

Firstly, the UN drug control conventions require cannabis use to be an offence (although there is debate over the interpretation of this and the flexibility allowed by the conventions). States that have begun relaxing cannabis laws can therefore expect to be pressured at the UN level. The Netherlands, for example, has been rebuked by the European Union, the United Nations Office of Drugs and Crime, the USA and other countries who say its relaxed cannabis policies undermine international collaborative efforts to reduce illicit drug use, production and trafficking.

A second problem will be in generating sufficient political will to bring about legislative change. There are two reasons for this. Firstly, there is vocal opposition in most jurisdictions to relaxing drug laws by those who say legalisation will encourage increased cannabis use and lead to experimentation with harder drugs. Secondly, popular opinion usually supports retention of prohibition, and in most democratic countries, the majority of politicians' views will reflect the majority of the population's.

Therefore the report's call for a re-think on policy so that it becomes grounded on an evidence-based scale of harm may largely be falling on deaf ears. In the UK, for example, cannabis was downgraded from Class B to Class C

3. ensure that appropriate information is available and actively conveyed to users about the harms of cannabis use. Advertising and promotion should be banned or stringently limited to the extent possible

4. monitor impacts of any changes, including any unintended adverse effects

5. ensure the possibility for prompt and considered revision if the policy increases harm.

when Tony Blair was Prime Minister, making police unlikely to arrest people carrying small amounts and moving Britain closer to the 'relaxed nation' category. However, Home Secretary Jacqui Smith has pledged to reclassify the drug to Class B to avoid "risking the future health of young people". This is despite having read the Commission's report and accepting most of its other recommendations.

Nevertheless, the report outlines four possibilities for governments seeking to make cannabis available in a regulated market in the context of existing international conventions.

The first option is to follow the Dutch model, which technically meets the letter of the law while allowing de facto access to cannabis. Secondly, a nation may simply ignore the conventions, though any government following that route must be prepared to withstand substantial international pressure, the report warns.

A third option would be to denounce the 1961 and 1968 conventions and then re-accede with reservations respecting cannabis. Finally, along with other willing countries, a state could negotiate a new cannabis convention on a supra-national basis.

"We wanted to facilitate an informed debate and then… present some options on what individual countries could do," co-author Benedikt Fischer, a professor of health sciences at Canada's Simon Fraser University, told the *Edmonton Sun*.

"I will say to [Canadian Prime Minister] Mr Harper that, even from a conservative policy point of view, there are many, many good reasons to not be content with the status quo of cannabis use control in this country.

"It costs a lot of money, it's very ineffective and it's counterproductive."

We're now more than 10 years on from the UN General Assembly's declared intention to bring about a drug-free world, and they clearly haven't done it. When it meets again this year, surely alternatives to prohibition will have to be considered. But current conventions have kept cannabis illegal in all countries, and these will not be reversed overnight.

The best we can probably hope for is that a process will be started to change the international drug control conventions to allow a state to implement its own cannabis control strategies within its own borders.

It will be interesting to see what happens, but somehow we're unlikely to see the assembled delegates accepting the slogan: 'A drug free world – we're not even going to try'. ■

Rob Zorn is a Wellington-based writer.

The Global Cannabis Commission report, *Cannabis Policy: Moving Beyond Stalemate* is available at The Beckley Foundation website, www.beckleyfoundation.org.

Quotes of Substance

"I'm like an alcoholic. When I see how much good it's doing, I can't stop."

Hollywood actress **Salma Hayek** admits she is addicted to breast feeding, but perhaps could have used a better analogy.

"I feel extremely strongly about this subject and desperately want to see a reduction in drug abuse and better paths to enable people to get out of it. If one takes a slightly progressive – or, as I like to think of it, thoughtful – view, one can sometimes be accused of being soft. I reject that utterly."

UK's Conservative Party Leader **David Cameron** says he's not afraid to talk about drug law reform.

"P coming on to the market has been great for business, I must admit."

Paul Thomas, former Police dog handler, who is now a managing director of Elite Dog Services – the first private company in New Zealand to use drug detector dogs in the workplace.

"My disgust on this subject is not directed at the vulnerable people caught up in a spiral which leads them to crime. It is directed at people who make money out of other people's misery."

Newly appointed Police Minister **Judith Collins** says where she thinks drug control efforts should be targeted.

"What's the difference between a drug user and the solution? Nothing. They're both no-brainers."

Sensible Sentencing Trust drug spokesperson demonstrates that organisation's caring and sensitive side.

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Alternative development in the Golden Triangle – reality or myth?

Drug control officials have hailed the declining opium cultivation in Burma, Laos and Thailand in the last decade as a great success, but **Martin Jelsma** and **Tom Kramer**, from the Transnational Institute, say indicators are that this is anything but the case.

THE REGION, better known as the Golden Triangle, was once the world's largest opium producer. But, today, that position has been taken over by Afghanistan, which is responsible for over 90 percent of global opium production.

"The Golden Triangle is closing a dramatic period of opium reduction," said United Nations Office on Drugs and Crime Director Antonio Maria Costa. "A decade-long process of drug control is clearly paying off."

In both northern Burma and Laos, opium cultivation declined due to policy decisions by local authorities. Opium cultivation in Burma partly dropped as a result of a number of opium bans declared by cease-fire groups in northern Shan State. In return, they hoped to gain international political recognition and support for the development of their impoverished regions.

The Lao government's policy to eradicate poverty by 2020 has two priorities: to end shifting cultivation and to eliminate opium production. The problems are seen as very much connected, and blame for both is put squarely on small-scale farmers.

The Lao government declared the country opium-free in February 2006. Some small-scale opium cultivation continues, mainly in small, hidden plots in remote mountainous areas.

There is, however, little reason for optimism. First of all, the exact size of the decline is debatable, as there are serious questions about the accuracy of the original Burmese production figures at the end of the 1980s and the early 1990s. Some observers believe that these figures were high and politically motivated to claim credit later for a decline that only existed on paper. Annual opium production in Burma may have never exceeded 1,000 metric tonnes, still roughly double the amount reported for 2007.

Furthermore, recent years have seen a shift in cultivation patterns to new

areas in Burma, and the last two years have once again seen increases in opium production. The main increase has been in southern Shan State. Transnational Institute (TNI) research carried out in 2008 showed that opium cultivation was also up in townships in eastern and northern Shan State. Additionally, double cropping was reported in areas in southern Shan State.

The decline of opium production in the Golden Triangle is not simply the result of policy interventions by local authorities in Burma and Laos. It is crystal clear that trends in the global market contributed significantly to the shift of production from the Golden Triangle to Afghanistan.

Tom Kramer

Children in opium field, Wa region, Burma.

This is not a new phenomenon. Throughout history, there have been various remarkable shifts in the international opium and heroin market. These include the shift in cultivation from Turkey to Iran and Pakistan in the 1970s, and later to Afghanistan, and to new cultivation in areas in Mexico and Colombia. Heroin of Burmese origin has been almost completely pushed out of the European and North American markets by heroin originating from Afghanistan (in Europe) and Latin America (in the US). Virtually all heroin originating from Burma is currently consumed in Southeast Asia, China, India, Australia and Japan.

What is more worrying is that the opium decline has caused major suffering among former poppy-growing communities in Burma and Laos. It is therefore hard to claim this as a "success story". Opium poppy has been cultivated in the mountains and hills of northern Burma, Laos and Thailand for over a hundred years. The fact that opium poppy is highly valued and easily cultivated in remote mountainous areas with undeveloped infrastructure and transportation systems has made it a crop with which it is difficult to compete. Opium poppy cultivation is strongly linked to poverty. Both Burma and Laos score lowest on the human development index in the region, and the traditional poppy growing regions in these countries are the worst off. Most of the cultivators are poor villagers from different ethnic minority groups. Traditionally, they use opium as a medicine against malaria, respiratory diseases and diarrhoea, and as a painkiller. Opium is also used at traditional festivals and ceremonies, including weddings and funerals. Opium seeds are used to produce cooking oil, and opium is also connected to spirit worship and sometimes used instead of money.

Most importantly, opium poppy is the key cash crop for these communities. They can often produce only enough rice to feed their families for four to six months a year, and according to a TNI researcher, "Opium cultivation pays for the household's needs, including children's education, healthcare, food and household materials… People think that cultivation of opium poppy can help overcome the problems they face in their lives."

In Burma, people are unhappy with the ban. "Everything is getting worse," said a 60-year-old former poppy farmer in the Wa region. "People are desperate for food and clothes. They want to know why there was an opium ban in the Wa area when there was no ban in other places."

Farmers in northern Laos face similar challenges. "Opium in Laos is not the big problem any more in the sense of drug production," says a Western aid worker in Laos. "It is a problem because farmers can't grow it anymore."

Current levels of assistance to offset the impact of the opium bans are woefully insufficient. International reactions to the post opium ban crisis in Burma and Laos can best be described as 'emergency responses'. The main problem with the bans is that the policy interventions have

Quotes of Substance

"My immediate reaction is to suggest it's up to your client to prove his or her suitability. That's not going to be easy in the absence of your client."

Judge Unwin shows his displeasure at an applicant's failure to attend a Liquor Licensing Authority hearing at the Porirua District Court. More than 100 residents marched outside the hearing protesting against the application for yet another liquor outlet in Cannons Creek.

"If you place a liquor store in Cannons Creek, then you might as well place a bigger police station there as well."

Youth worker **Fa'amatuainu Wayne Potoa** joins more than 100 Cannons Creek residents at a protest against the growing number of liquor outlets in their community. Mr Potoa added that alcohol has serious consequences for the youth he works with.

"Despite extensive funding, governmental agency support, the employment of professional advertising and public relations firms, and consultation with subject-matter experts, the evidence from the evaluation suggests that the National Youth Anti-Drug Media Campaign had no favourable effects on youths' behaviour."

Lloyd Johnston, principal investigator for the Monitoring the Future study, gives a blunt assessment of the (in)effectiveness of anti-drug campaigns in the US.

"These are hard-hitting ads – that's because we are dealing with a group of people who think they are bullet proof."

The **Australian government** on a new ad campaign targeting youth binge-drinking.

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Quotes of Substance

“A New Zealand survey of 15 and 16 years olds showed that the more often they went into stores that displayed tobacco products, the more likely they were to start smoking. This should not come as a surprise. Clearly advertising works, otherwise companies would not pay for it.”

Cancer Society Chief Executive **Dalton Kelly** wants New Zealand to follow New South Wales legislation to remove retail cigarette displays.

“Pubs play a vital role in communities up and down the country and are an essential part of promoting a more responsible drinking culture. It is hard to avoid the conclusion that a great British tradition is being abandoned.”

British Beer and Pub Association (BBPA) Chief Executive **Rob Hayward** fears increased alcohol taxes will increase pressure on struggling pubs. BBPA says the taxes are the “death warrant” for pubs across the UK.

“This is an idiotic waste of money. People don’t pay their taxes for drunk women to get free flip-flops, they want the police to fight crime. The Police aren’t there to be an emergency supplier of flat shoes.”

Matthew Elliott, Chief Executive of the UK’s Tax Payers’ Alliance, is not impressed with the Police’s latest weapon to tackle binge drinking. Officers and safety officials in Torbay, Devon, were handing out jandals to revellers spotted staggering home in unstable high heels or bare feet.

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been wrongly sequenced. In Thailand, substantial time and resources were invested in creating alternative livelihoods for poppy farmers before the authorities introduced bans, and no deadlines were set for the elimination of opium poppy cultivation. In Burma and Laos, this has not been the case.

There are clearly serious questions about the sustainability of opium bans in Burma and Laos. Early warning signs are already apparent in Burma where opium cultivation has spread to other areas in Shan State. There has been a marked increase in production over the past two years, confirmed by UNODC figures, which may be conservative.

In 1998, a declaration was signed to make the Association of Southeast Asian Nations (ASEAN) drug-free by 2020, and two years later the deadline was brought forward to 2015. Countries elaborated national plans to comply, putting huge pressure on farmers to abandon poppy cultivation. The 2008 status report on progress acknowledges “a target of zero drugs for production, trafficking and consumption of illicit drugs in the region by 2015 is obviously unattainable”.

Over the last decade, there has been considerable progress in understanding the impact and lessons learned through rural development in opium poppy growing areas, usually referred to as ‘alternative development’. Experience has shown that alternative development can address the needs of targeted rural communities and can contribute to a reduction in crops.

Among the important lessons learned is the need for an integrated approach. All actors involved in rural development, including government, development agencies and civil society organisations, should take into account the causes of opium cultivation in their development strategies and plans. It is important that alternative development is not limited to a project approach, but guides national and local development programme design and implementation.

The cultivation of opium poppy often takes place in areas plagued by conflict, insecurity and vulnerability. Interventions should comply with the aims of human rights protection, conflict resolution, poverty alleviation and human security. They should also have a participatory approach and respect traditional culture and values. Interventions should be properly sequenced. In particular, there should be no eradication or strict implementation of opium bans unless viable and sustainable livelihoods are in place. Aid should not be made conditional on reductions in opium cultivation.

Without such approaches, it is unlikely that the reduction in opium production will be sustainable. It is vital that the international community does not abandon the Golden Triangle at this crucial time. ■

Martin Jelsma and Tom Kramer work for the Drugs and Democracy Programme of the Transnational Institute (TNI). TNI’s study, *Withdrawal Symptoms in the Golden Triangle – a Drugs Market in Disarray* is available at www.tni.org/drugs.

KADAC

Opium harvest in Pao region in Southern Shan State, Burma.

Something for the pain

Inappropriate restrictions on opioid painkillers are condemning millions of people to an agonising death, says **Rachel Nowak**.

SOON, Afghan farmers will start planting the poppy fields that are the main source of the opiates that feed the world's illegal heroin trade. Billions of dollars will be spent trying to destroy the crops and stop the trafficking.

Drug addiction and the ramifications of the illegal drug trade need to be dealt with. But there is another drug problem that arguably causes far more suffering but gets only a fraction of the attention: the chronic underuse of opiate-based painkillers in poor countries.

Global consumption of these drugs has more than doubled in the last two decades as the alleviation of pain has come to be taken more seriously. Yet in the developing world, they are hardly ever used. According to the International Narcotics Control Board (INCB), 80 percent of the world's population consume just 6 percent of its morphine, the most widely available opioid for treating moderate to severe pain.

If you are dying of cancer, for instance, in most of western Europe, North America or Australia, you can expect a reasonably comfortable end, while in almost any low-income country, you will die in great pain. The pain means you won't sleep, your personality will change, you will lose the capacity to care for your family and you may commit suicide. If it is your child who is dying, you will have to watch helplessly.

"Misplaced fear of addiction means that even terminally ill patients may not get morphine."

Unless urgent action is taken, even more people will be condemned to a similar fate. On top of the existing AIDS crisis, the developing world is facing a cancer epidemic. Extreme pain is a feature of both conditions. By 2020, there will be 16 million new cancer cases globally each year. According to the World Health Organization (WHO), the majority will be in the developing world where fewer people are succumbing to infectious diseases while more adopt cancer-causing behaviours such as tobacco use.

AfrOx, based in Oxford, UK, which aims to tackle Africa's looming cancer epidemic, is one of a number of organisations arguing that pain control should be an immediate medical and humanitarian priority. This can be done relatively cheaply: a month's supply of morphine costs just a few dollars.

So where are the hold-ups?

A major one is the over-zealous regulation of painkilling drugs. Under the UN Single Convention on Narcotic Drugs, which dates from 1961, governments are obliged both to prevent trafficking and abuse of opiates and to ensure that people in pain have access to medical opiates. Unfortunately, most countries concern themselves only with preventing abuse.

Quotes of Substance

“With many young Scots destroying their lives by shooting up heroin and other dangerous drugs, we owe it to their families and our communities to make sure our spending in tackling that is much more than a shot in the dark.”

Scotland’s Community Safety Minister **Fergus Ewing** highlights the importance of getting drug policy spending right.

“It is scandalous that less than 10 percent of injecting drug users have access to evidence-based HIV prevention and care services… Many young people still lack accurate information about how to avoid exposure to the virus. Let us empower the youth with information.”

United Nations Office of Drugs and Crime Executive Director **Antonio Costa** marks the 20th anniversary of World AIDS Day with a new harm reduction resource for young people who inject drugs.

“We should remember that the human rights of vulnerable groups, including drug users and prisoners, are violated every day. Instead of showing compassion, we stigmatise drug users and cast them out as pariahs.”

Top marks to **Mr Costa** again, who, on the 60th anniversary of the Universal Declaration of Human Rights, highlights that the rights of people who use drugs are often violated by drug control measures.

“Heroin is consumed by people on the margins of society, loitering in parks, near underground stations, or congregating around grubby treatment centres.”

Oh dear. ‘Grubby treatment centres’? **Mr Costa** succeeds in insulting the many thousands of addiction treatment workers across the world. ■

As a result, patients are forced to travel hundreds of kilometres to the few doctors who can legally prescribe opiates or the pharmacists permitted to dispense them. Doctors risk arrest if they provide pain relief to children or write prescriptions for more than a few days’ supply of pain medicine. The WHO estimates that, every year, tens of millions of people with severe pain get no effective treatment, in part, because of restrictive drug laws.

Some countries have changed their laws to allow improved pain control. Since 2004, Uganda has abolished laws dating from colonial times that prohibited anyone but doctors from prescribing narcotic painkillers and now allows trained nurses to prescribe them too. This makes sense, as 60 percent of people in Africa will never see a doctor, according to the African Palliative Care Association in Kampala, Uganda. Meanwhile, many Indian states have eased regulations that previously made it difficult to transport morphine from the manufacturer to the hospital.

These measures show what can be done, yet pain control is still out of reach of the majority of people, even in Uganda and India. M R Rajagopal, a palliative care expert at the SUT Academy of Medical Sciences at Thiruvananthapuram in the south Indian state of Kerala, told the World Congress on Pain in Glasgow, UK, that morphine reaches fewer than 1 percent of Indians who need it.

In many places, the officials who organise a country’s supply of opiate-based painkillers are unaware of the unmet need. And such is the fear that patients may become addicted that many doctors are reluctant to prescribe opiates even to those who are terminally ill. This may stem from a mistaken association between medical use of opiates and the violence, poverty and ill health that often accompany dependence on illicit drugs. In fact, only a minuscule proportion of people treated with opiate painkillers develop a compulsive need to continue using the drugs, although they may develop symptoms such as anxiety if a drug is stopped too abruptly.

The 2008 World Cancer Summit in Geneva, Switzerland, endorsed a declaration that makes tackling barriers to pain control a priority. This is an important and commendable step, but dealing with this level of suffering will require a concerted international effort. Illicit trade in medical opiates is extremely rare. Now the signatories to the international convention must show that they can meet another key obligation: ensuring the adequate use of medicinal opiates in pain control. ■

Rachel Nowak is *New Scientist’s* Australasian editor.

Surgeon's story doesn't wash

YOU MAY have followed the story of surgeon Ian Denholm, Head of Orthopaedic Surgery at Wairarapa Hospital, who tried to get off a drink-drive charge by blaming alcoholic handwash. The matter was resolved in November when Mr Denholm, 53, was convicted of drunk-driving, fined $500 and deprived of his licence for six months.

Denholm argued he had an extraordinary ability to absorb alcohol from the gel because of eczema-damaged skin. His arguments failed to wash with the Wellington District Court judge. The judge agreed to defer the disqualification until 23 January, as Denholm was the on-call surgeon for the Wairarapa area over Christmas and New Year period and needed to drive.

New Police Minister vows to fight P peddlers

NATIONAL has pledged to clamp down on peddlers of methamphetamine as part of a promised tough approach to drug crime. Methamphetamine was a "scourge" on society, which could not be allowed to grow, Judith Collins said in her first speech as Police Minister. National planned to ban known methamphetamine dealers from being eligible for electronic bail or home detention sentences.

"We need to do more to make the risks real to people who would embark on this path. The importers, manufacturers, dealers and suppliers… These people are targeting our children and we need to target these criminals instead."

The departed Labour Government had been considering a centralised computer system allowing individuals' purchases of pseudoephedrine products to be tracked and monitored. With 70 percent of methamphetamine precursors being sourced from within the country, a similar programme could be beneficial to New Zealand, Ms Collins said.

Sponsored athletes drink more

NEW ZEALAND SPORTS team members sponsored by alcohol companies drink more as a result. A study of 1,279 athletes found close to half received sponsorship that included free or discounted alcoholic drinks. Study co-author Dr Kypri found that, when free alcohol was provided, drinking rose to harmful levels – which, for most participants, was more than six drinks in one sitting. Even free uniforms were enough to encourage players to drink. Many sponsors provided free alcohol immediately after games and free or discounted bar tabs at their pubs, taverns and hotels.

Many athletes said they felt obliged to drink a sponsor's product after training and games. Dr Kypri said governments should withhold financial support to teams receiving sponsorship from the alcohol industry.

"People talk about sport and drinking as being intrinsically linked, only because we've allowed them to be," he said.

Students cry but binge drink nevertheless

THE Alcohol Drug Association (ADA) ran a nationwide survey that found a third of students had blacked out during binge drinking, with 37 percent reporting binge drinking at least once in the past week.

ADA Chief Executive Cate Kearney said calls received by the Alcohol Drug Helpline included a 19-year-old woman at a South Island university. "I just can't do this any more," she said. "I can't recall what I've done or who I've done it with. I'm feeling sick with embarrassment and shame. You should see all the bruises I've got."

Ms Kearney said alcohol regulation and misuse needed to be an important issue for the new government. Calls to the helpline suggest that it's alcohol rather than methamphetamine that was the scourge of New Zealand. The web-based survey covered the drinking habits over a four-week period of 2,548 students from five universities.

"Squeaky clean" liquor store on school's doorstep

TWO North Shore schools, Rangitoto College and St John School in Mairangi Bay, are opposing a liquor store that could open within 100 metres of their front gates. But business owner, Charlie Singh, said his planning and building certificates were issued by the North Shore District Licensing Agency, and he was told his shop would not breach any city bylaws.

St John School principal Bernard Fitzgibbon said the liquor store's opening would provide young people easy access to alcohol, exacerbating existing problems. He believed putting a liquor outlet on a spot thousands of children walked past daily would normalise the purchasing of liquor for them.

North Shore Liquor Licensing Inspector Peter Richardson said Mr Singh had done everything to meet council requirements. "At the moment, he's squeaky clean." He said because there had been eight objections the matter would be referred to the Liquor Licensing Authority.

SADD school party turns sour

DRUNKEN teenagers at a party funded by a high school's anti-drink-driving group have trashed a rural Southland hall.

Bottles were thrown at passing cars and into a children's playground during the out-of-control party, organised by high school pupils using money from the St Peter's College SADD (Students Against Driving Drunk) committee, last Friday.

Damage to the Waimumu Hall near Gore has disgusted

locals and prompted Police to warn parents against providing alcohol to young people going to parties.

Waimumu-Te Tipua Hall Society President Duncan Falconer said the hirer had given an assurance there would be parental supervision at the party.

"Had we known that would not eventuate, we would have gone down (to the hall) and turned people away."

Sergeant Craig Sinclair, of Gore, said Police were also investigating complaints of assault after fighting outside the hall.

New testing code worries rugby officials

NEW ZEALAND RUGBY Players' Association boss Rob Nichol has voiced fears his sport's clean drug-free image may soon be tainted. The new World Anti-Doping Agency (WADA) code requires athletes to designate a daily reporting hour including their exact whereabouts. Testers can then turn up unannounced. It has been heralded by WADA as a powerful tool in the war against drugs in sports, but it has been decried as a breach of privacy and as over zealous in other quarters.

Nichol believes the principle behind the register is sound but is nervous about rugby's readiness to meet its stringency. "And if someone misses a test for some innocent reason, like there's a change to a training venue, then technically it's deemed to be a refusal. Therefore, they could be branded a drug cheat, and that's crazy. Imagine what would happen if [Dan Carter or Richie McCaw] missed a test? It would make huge headlines throughout the world, so naturally we're pretty concerned."

About 400 Kiwi athletes will be chosen to join the register, but it has not yet been decided how many rugby players would be included.

Drink-drive iPod a waste of breath

POLICE are warning people not to rely on plug-in iPod breathalysers to monitor their drinking this festive season.

An American company has been selling the 'iBreath' – a combined breathalyser and FM radio – which plugs into the bottom of an iPod or iPhone and has a fold-out tube.

Dubbed as a Christmas "must have", the breathalyser, which can be bought on the Internet for NZ$167.50, is not made by Apple but by California company David Steele Enterprises.

Police say relying on the breathalysers would be unwise, and drinkers could be lulled into a false sense of security.

"These devices are not certified to the same standard as used by New Zealand Police devices," a Police National Headquarters spokesperson said.

"While Police welcome anything to improve road safety, the safe option would be not to drink and drive."

Cops save us $300 million. Maybe.

POLICE estimate they have saved the country over $300 million in socio-economic harm in a bumper year of cannabis busts, based on the New Zealand Drug Harm Index. They have destroyed over 124,000 cannabis plants and arrested 780 people in drug raids in the past year.

They are crediting good flying weather and targeted air surveillance for the success of the nationwide cannabis crime effort, labelled Operation Julia, which saw 25 percent more cannabis plants destroyed than last year.

Police also seized 147 firearms, recovered almost $440,000 worth of stolen property and found nine methamphetamine labs in over 640 raids. The operation targeted those that grew, distributed and used cannabis as a gateway drug to other criminal activities.

Mayor urges focus on drugs

MANUKAU MAYOR Len Brown wants Counties-Manukau police to add drugs to their priority list alongside domestic violence. Last December, he chaired a mayoral drugs summit of 100 community leaders, which called for zero tolerance of drug supply. Brown is scheduled to meet Prime Minister John Key to discuss the issue. Key's government has promised to fund 300 more Police officers in South Auckland, and Brown now wants them to target methamphetamine labs and 'tinnie houses'.

"If we don't shut this drugs trade down, we are in danger of condemning the next generation of people in our community to something worse than we presently have. We are looking at a designated drugs line, an 0800 line, for people to pass on information."

He said police were already starting to see drug dealers using guns – notably in the murder of undercover Police sergeant Don Wilkinson outside a house with suspected drug trade connections last September. ■

Itemiser – the drug-testing machine

A PORTABLE machine, known as the Itemiser, which can detect the presence of drugs such as cocaine, cannabis, heroin and ecstasy, has been used outside nine different pubs and nightclubs in Aberdeen city centre to test revellers for drugs. The device works by analysing swabs taken from people's hands, with results produced in seconds.

A green reading allowed entry to the pub, while those with an amber reading were given a drug information pack. Those returning a red reading were searched.

The test was voluntary, but customers were refused entry if they did not take part. Police revealed nobody had refused to be tested.

Booze shrinks your brain

THE more alcohol you drink, the more your brain shrinks, a new study by the Texas A&M Health Science Centre College of Medicine has found.

"The take-home message is that, if you drink a lot, you're going to hurt your brain," said Rajesh Miranda, Associate Professor of Neuroscience and Experimental Therapeutics at the College. "This is something we knew, but this is a huge study that quantifies that. It's not surprising that alcohol would cause shrinkage of the brain. That kind of thing has been observed in animal models and smaller studies."

Don't turn a night out into a nightmare

LAST November, the Australian government launched a series of 'in your face' advertisements aimed at tackling the binge drinking epidemic among young Australians. Themed "Don't turn a night out into a nightmare", the campaign demonstrates the violence, injury and humiliation that can result from binge drinking.

The campaign will spearhead the government's National Binge Drinking Strategy and is targeted at teenagers aged 15–17 years, young adults aged 18–25 years and their parents. It includes a range of TV, print, radio and Internet ads, as well as ads in pubs, outside nightclubs and on street furniture. The $20 million campaign will run over two years.

www.drinkingnightmare.gov.au.

Amsterdam to close coffee shops near schools

AMSTERDAM, which has more than a quarter of Holland's tourist-attracting cannabis cafés, will close nearly 20 percent of them to comply with a national ban on having them located within 250 metres of schools. Forty-three shops will have to close by the end of 2011 if they cannot successfully appeal.

Pot is technically illegal but can be sold in small amounts in designated cafés without fear of prosecution. According to data compiled by Holland's Trimbos Institute for Mental Health and Addiction, after 30 years of the Dutch tolerance policy, usage rates in the country are somewhere in the middle of international norms. They exceed those in Germany and the Scandinavian countries, but are below those of France, Britain and the United States.

Anti-drug ads haven't worked

A new study has found a US$1 billion campaign to curb US teen drug use may in fact have encouraged it.

Drug use peaked in the mid-1990s, and since then, rates have fallen over 40 percent among 8th graders, 30 percent among 10th graders, and nearly 20 percent among 12th graders. But University of Pennsylvania Professor Robert Hornik, currently studying anti-drug campaign effectiveness, said the decline in cannabis use "could be due to lots of influences, not just the campaign."

Hornik was expecting the anti-drug campaign to have positive effects, but said they could not find any. In fact, there was a small amount of evidence to suggest the anti-drug campaign may have had the opposite effect for some respondents. Teens who recalled seeing 12 or more anti-drug messages per month were actually more likely to start using cannabis than those who had seen fewer anti-drug messages per month.

Think AIDS before you share

A NEW harm reduction, health promotion resource aimed at young people who inject drugs was launched on the 20th anniversary of World AIDS Day.

Among the estimated 16 million people injecting drugs worldwide, one in five is likely to be HIV positive. Young people are at the centre of the HIV epidemic with an estimated quarter of the 38.6 million people infected aged between 15 and 24. Half of all new HIV infections worldwide are also among this age group. In some parts of the world, and in some marginalised sub-groups, the most frequent modes of HIV transmission for young people are unsafe injecting drug use and unsafe sexual activities.

www.unodc.org/thinkaids

Drug court a success

ADDICTS who commit a drug-related crime are less likely to reoffend if they are dealt with by the New South Wales Drug Court than if they are sentenced through the traditional judicial system, research reveals. A new study found that the Drug Court, first launched in 1999, is more cost effective than sending offenders with a drug

addiction to prison.

Offenders who attend the specialist court's programme are 17 percent less likely to be reconvicted for any offence, 30 percent less likely to be reconvicted for a violent offence and 38 percent less likely to be reconvicted of a drug offence, the research shows. It also shows that the Drug Court costs about $16 million a year, while the estimated cost of dealing with the same offenders through the traditional legal system would be about $18 million.

Methamphetamine linked to heart disease

AUTOPSIES on more than 200 Australians who died from methamphetamine use show disturbingly high rates of heart disease. Studying coroners' reports between July 2000 and June 2005, Sydney researchers found that, in 220 of the 371 cases of deaths caused by methamphetamine use in which autopsy information was available, 54 percent had heart disease, most commonly a narrowing of the arteries.

Study co-author Sharlene Kaye, of the National Drug and Alcohol Research Centre, said one in five also had evidence of brain problems, particularly haemorrhaging.

High hopes for cannabis

GROWING cannabis became legal in New South Wales, provided you are a licensed farmer harvesting hemp for industrial use. The new licensing system has been developed to prevent industrial hemp being grown to camouflage illegal crops of cannabis, which looks almost identical.

Properties growing industrial hemp will be audited and inspected regularly. Two hundred people have contacted the Department of Primary Industries to express an interest in hemp growing. But the peak farming bodies of Australia and NSW said they did not have policies on the crop and were unaware of a major interest in it.

NSW puts tobacco out of sight – will New Zealand follow?

NEW SOUTH WALES has passed ground-breaking new laws to protect children from tobacco marketing, and the Cancer Society wants New Zealand to follow the Australians' lead. Tobacco products will be out of sight in most shops by the end of 2009, limited to a single point of purchase in each retailer, and their sale partly licensed.

"New South Wales children will no longer have tobacco products placed strategically in front of them in shops," said Cancer Society of New Zealand Chief Executive Dalton Kelly. The new government is expected to soon respond to a select committee report on 'powerwalls'. Last December, the UK government announced it will ban cigarette displays in shops.

Swiss back heroin programme but reject cannabis

LAST November, Switzerland became the first country in the world to include prescription heroin in government policy. Final results from a national referendum showed 68 percent of voters supported making prescription heroin a permanent, nationwide health policy.

Under the heroin scheme, started last decade, opiate addicts can receive the drug under medical supervision and accompanied by counselling. Some 1,300 people are said to be part of the programme. Its opponents say it has failed to get the majority of patients abstinent, but supporters counter that it has reduced drug-related crimes and deaths – a major problem in the early 1990s.

A proposal to decriminalise cannabis, the most widely used illegal drug in Switzerland, failed. Opponents said it would increase cannabis tourism and turn the country into a "Mecca for drugs".

HIV/AIDS prevention in prisons

UNODC, WHO and UNAIDS have launched a toolkit on HIV/AIDS in places of detention, for policy makers, prison managers, prison officers and prison health professionals.

The toolkit provides information and guidance to people who work in and with prisons and prisoners. It offers practical guidance on what measures countries need to take in the short term to prevent the spread of HIV (and other infections) among prisoners and how they can provide them with treatment, care and support. It also discusses necessary medium- and long-term reforms to facilitate such measures.

While the toolkit is written primarily for use in low- and middle-income countries, it is also a useful resource for institutions in high-income countries. Its focus is on HIV, but it recognises that other diseases – in particular hepatitis and tuberculosis – are linked to HIV and also represent serious problems in prisons.

www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf

"Awful" ecstasy research

UK Psychology Professor Andy Parrott told the Advisory Council for the Misuse of Drugs that research suggesting ecstasy was less dangerous than alcohol and tobacco was "awful from start to finish". Mr Parrott spent more than a decade studying the harm caused by ecstasy. "It's not a weak drug. It is one of the most powerful of the recreational drugs," he said.

The Advisory Council will pass its verdict on the drug to the Home Office. It is thought to favour a downgrading, but Home Secretary Jacqui Smith will make the final decision. ■

Ketamine: not just for horses, also for badgers

Ketamine is a short-acting general anaesthetic used for both human medical and veterinary purposes. It is termed a 'dissociative', because it impedes the brain's sensory connection to the body. On 26 February 2008, Associate Health Minister Jim Anderton announced Cabinet had approved the reclassification of ketamine to Class C under the Misuse of Drugs Act to take effect as soon as Parliament approves.

In the meantime, however, media reports about the drug have left it 'saddled' with an inaccurate and unhelpful image.

THE MEDIA'S inevitable power to shape society's attitudes is a dangerous game, with stereotypes often hidden under the poker-faced mask of balance and objectivity. Journalists will pick up one idea and blindly run with it until something blatantly unavoidable hits them right in the face. Then they will run with the latest revelation until something else hits them. Rarely does there seem time or motivation for them to provide a more complete analysis of drug policy issues.

This has been the case with ketamine aka 'Special K'. Take, for example, this report from the tabloid *The Daily Mirror*: "Big Brother star Pete Bennett was a regular user of the horse drug ketamine, his friends revealed last night."

Or this one by the BBC: "An anaesthetic used by vets as a horse tranquiliser, but becoming increasingly common on Britain's dance scene, is to be made illegal."

Or this one by the news agency Reuters: "Scientists have unravelled how a horse tranquiliser and hallucinogenic nightclub drug known as 'Special K' can ease depression."

It is not hard to spot a common theme galloping through all of these reports – horses. A recent *Mixmag* cover story on ketamine actually pictured a 'clubber' wearing a pantomime horse head on the dance floor. It is no wonder then that clubbers and policy makers think of ketamine as something used to sedate our big equine friends.

In a study called *It is the most fun you can have for twenty quid* (2008), Karenza Moor and Fiona Measham from the University of Lancaster investigated motivations behind ketamine use in Britain. The following comments were made by the participants during the interviews: "It is embarrassing, cos people that don't understand it are like 'that is a horse tranquiliser'. It's like someone starting taking dog worming tablets, why would you do that? Some people are just like 'why?'"

Moor and Measham also came across a clear distinction made by clubbers between ketamine powder viewed as suitable for human consumption, and ketamine in injectable form for veterinary use, and therefore 'inappropriate for purpose'. "Injecting it would be in liquid form, and that's for knocking out horses," says Cassie, a 22-year-old employed ketamine user.

Mythbusters cannot help but wonder why horses, and not guinea pigs, for example, have been receiving so much mention.

The substance is indeed used as an anaesthetic for horses, but it is also widely used as a human anaesthetic. It is used for the elderly, children and in emergencies because it does not suppress the respiratory system, although the powerful hallucinogenic effects – the reason it is used non-medically – are an unwanted side effect.

Ketamine is used on a whole range of animals, including elephants, camels, gorillas, pigs, sheep, goats, dogs, cats, rabbits, snakes, guinea pigs, birds, gerbils and mice. But why do we never read about the 'gerbil tranquiliser' or the 'bird tranquiliser'? Mythbusters suspects it's because horses are quite large and the term 'horse tranquiliser' provides a more powerful scary drug term for the headline writers than, say, 'guinea pig tranquiliser'.

Indeed, why does ketamine get the animal treatment at all given that many drugs, including morphine and diazepam, for example, used medically and non-medically on humans, are also used on animals? None of these drugs gets referred to in the context of their animal use as does ketamine. The media never seem to write about the 'sheep drug diazepam' or the 'dog drug morphine'.

While it is hard to find any conclusive answers to these questions, Mythbusters suspects the modern link to ketamine probably stems from mid-90s reports of the drug being stolen from vets and misused. That the drug was a stolen veterinary tranquiliser probably just stuck with journalists. This is despite the fact that, subsequently, most of the drug was supplied to Britain from larger-scale illicit or grey overseas markets.

Obviously, the name filtered through to the New Zealand media in the same way. It is a reflection on the inaccuracies and laziness of drug reporting in the media generally. This sort of misunderstanding is not going to help rational policy development or educating young people about harms or relative risks of drugs. ■

Mythbusters acknowledges the Transform Drug Policy Foundation's blog from which much information for this piece has been sourced. See http://transform-drugs.blogspot.com/2008/11/ketamine-badger-tranquilizer.html.

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