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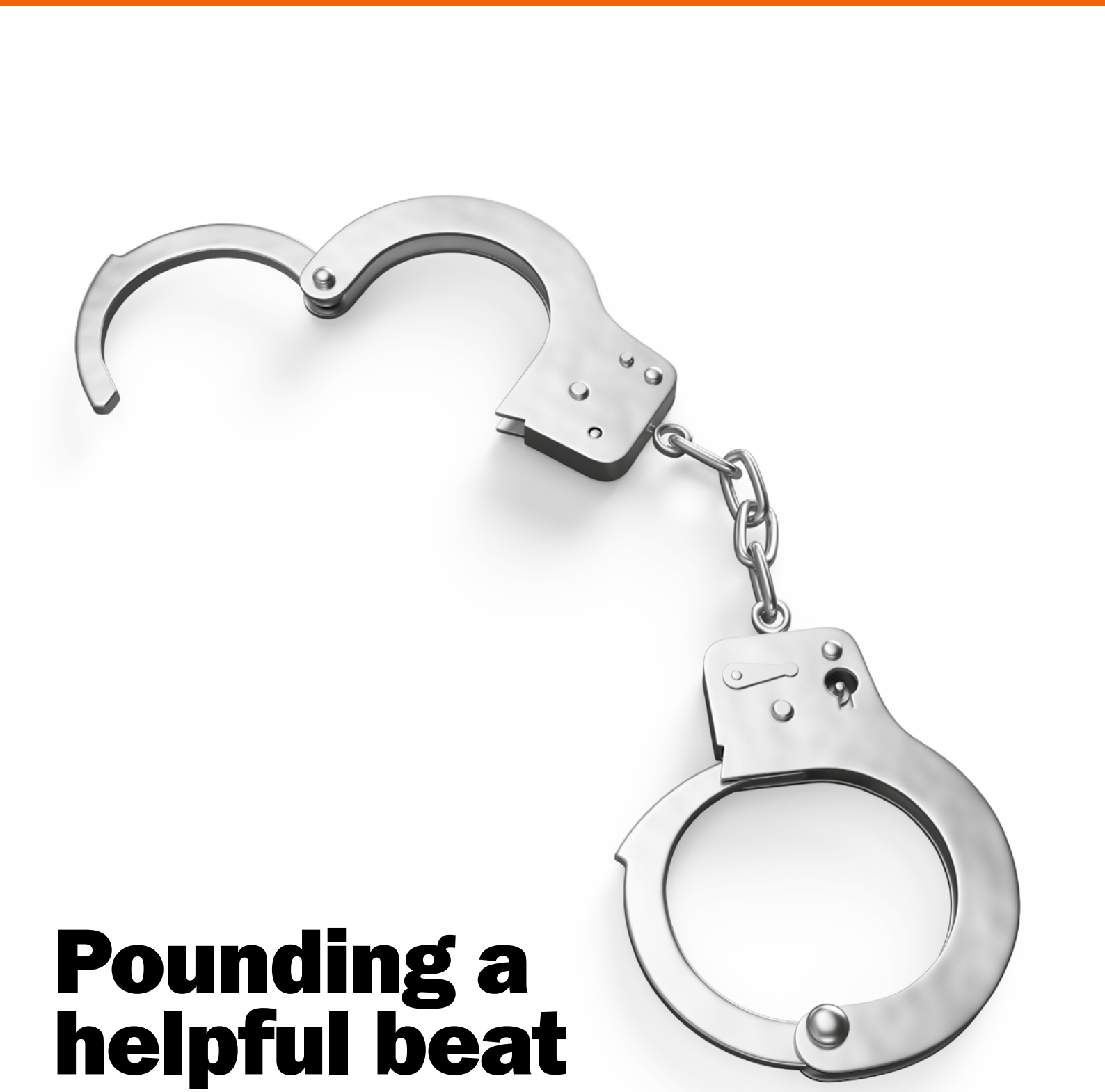
AT THE HEART OF THE MATTER, NZ DRUG FOUNDATION.
Te Tūāpapa Tarukino o Aotearoa



Pounding a helpful beat

Police and others at the front line are offering support, something that is being well received. How can we get more?

More-constructive approaches to drug crime

COVER: Friday night in the Counties-Manukau Police watch-house demonstrates the power of a more supportive approach to addiction.

FEATURES

REGULARS

Become a member

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

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

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

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THE DIRECTOR'S CUT

Here we go again. It's an election year and the dog whistling about people who use drugs has already begun. It was astounding to recently hear Prime Minister Bill English claim the country's skill shortage is due to young people failing workplace drug tests. To paraphrase, young Kiwis are lazy stoners.

There are many things we could unpack from the PM's comments, but let's just look at the facts. For a data guy, Bill's been sloppy.

For starters, the government's own data shows about 150 people failed pre-employment drug tests in the past three years. With an average of 30,000 tests a year, that's a failure rate of less than 1 percent.

A major private sector testing company, citing its own figures, said that, despite a massive increase in pre-employment and workplace random testing, only about 5 percent of tests are non-negative.

So although the PM has heard lots of anecdotes from lots of employers, drug use isn't really the barrier to employment on the scale implied.

If he's concerned about young people not getting work, the PM should look no further than our failed drug law. Recent Ministry of Justice figures show that, over a seven-year period, 16,700 people aged 17-25 were convicted of drug or drug utensil possession. Having a drug conviction has a lifelong impact on a person's employment and travel prospects.

But the PM's use of anecdata isn't the only thing that bothers me. If he really believes what he says, what's he going to do about it? Is it right for him to muse as he did without outlining a plan to fix the problem?

Well, here are a few suggestions for the government:

Remove the drug conviction barrier by decriminalising drug use (this would have the added bonus of freeing up law enforcement to address serious crime).

Invest in good drug prevention, education and treatment programmes, and eliminate treatment waiting lists. Less than a quarter of the government's spending on drug control goes to health interventions; the lion's share goes to Police, Customs, courts and prisons.

Provide incentives for employers to recruit people new in recovery. This is what Portugal did at the same time they decriminalised drug use. Having a job can be a really important part of someone overcoming drug dependence.

Finally, help employers develop better ways of building a strong health and safety culture in the workplace that doesn't rely on simplistic and ineffective drug testing programmes. You don't build trust in the workplace by having your staff pee in a cup.

That New Zealanders use drugs isn't in debate here. But the complex matters of drug use, employment, drug testing, and health and safety deserve more than lazy scapegoating.

We expect better-quality debate and analysis in this election year.

ROSS BELL
Executive Director

SOCIAL

@DrJessBerentson Bill English has talked nothing but quality data for 5 years. This regression to anecdote is bizarre ... FEB 27

@SharynCasey So glad the massive waiting lists for rehabs in NZ is being addressed, nice work @TheProject_NZ ... FEB 20

@Tim_Watkin An interesting canary down the conservative cannabis coalmine. Nikki Kaye open to improved medicinal cannabis access ... JAN 27

@chipmatthews After reading "Patched" the inevitable StopTheGangz election cycle thing becomes more and more apparent, s/o @JarrodGilbertNZ ... JAN 27

@PaceSociety We're just people & some people use drugs. Let's top using the term "addict" to label people. Replace "addict" with people who use drugs ... JAN 9

KEY EVENTS & DATES

2–5 MAY 2017	**8th Australasian Drug and Alcohol Strategy Conference 2017, Wellington** event.icebergevents.com.au/adasc2017
14–17 MAY 2017	**25th International Harm Reduction Conference, Montreal, Canada** hri.global/conference-2017
15–17 MAY 2017	**4th Australian and New Zealand Addiction Conference, Gold Coast, Australia** addictionaustralia.org.au
17–19 MAY 2017	**11th International Society for the Study of Drug Policy (ISSDP) Conference, Aarhus, Denmark** www.issdp.org
5–6 JUL 2017	**Parliamentary Drug Policy Symposium, Wellington** drugfoundation.org.nz
27–28 JUL 2017	**The Australian Winter School: Connecting the alcohol and drugs sector, Brisbane** winterschool.org.au
6–8 NOV 2017	**27th IFNGO Conference: Understanding Addiction, Treatment, Prevention and Harm Reduction Policy, Macau** ifngo2017.org

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NZ.

01 MEDICAL CANNABIS

The rules have been tweaked, and the first import of oils containing THC and cannabidiol for pain relief was eagerly received at Auckland's Middlemore Hospital last month.

While announcing changes to New Zealand's medical cannabis laws in February, Associate Health Minister Peter Dunne took a bit of a swipe at GPs, accusing them of being too conservative about prescribing medical cannabis. The New Zealand Medical Association was quick to respond. Some doctors take the view that a conservative approach to unproven, untested products is plain common sense, while others are already convinced and await wider access.

Dr Giles Newton-Howes from the University of Otago said the current evidence of benefits is "relatively weak", while the harms of cannabis have been well identified, so it's important to follow the usual regulatory process for medicines.

Meanwhile, medical student Victoria Catherwood is well on her way towards raising $9000 through a PledgeMe campaign to create a documentary resource for medical practitioners, in order to better educate and inform doctors about "the line between best practice and the law and how to walk it finely without reproach".

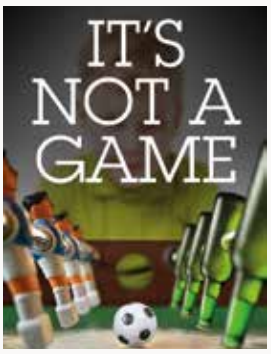
02 New Year's Honour for Marion Blake

THE DRUG Foundation whole heartedly congratulates Platform Trust CEO Marion Blake, who was recently awarded the New Zealand Order of Merit for services to people with mental health and addiction issues.

We have worked on various projects with Marion over the years, and we are pleased to see someone in the treatment sector being recognised for this very important work. Marion has been a tireless champion for New Zealanders in need and has also encouraged open debate between government departments and NGOs.

CONGRATS MARION.

03 Ads on sports field critiqued



ALCOHOL SPONSORSHIP hit the headlines again in January, after *The New Zealand Medical Journal* published a report that found television audiences were exposed to high levels of alcohol marketing during sports broadcasts. The authors called for the All Blacks in particular to end their long-running partnership with Steinlager.

The issue received plenty of coverage and calls to end alcohol sponsorship. Statistics show problem drinking is still on the rise in New Zealand, and there is plenty of evidence, both anecdotal and research-based, to support a link with sports sponsorship.

04 Hīkoi takes anti-P message to Waitangi

AS CONCERN grows about the level of methamphetamine use in New Zealand, a hīkoi to Waitangi arriving on 5 February focused on raising public awareness of the problem, and where people can go for help.

Marchers accused iwi leaders and the government of failing to act against the "scourge" of methamphetamine. They walked from Cape Reinga to Waitangi over five days, attracting more supporters along the way, and more than 500 people took part in the final stage of the hīkoi from Te Tii Marae to the Treaty Grounds.

09 Government axes gang meth treatment programme

THERE WAS an outcry last month when the government axed funding for the Salvation Army's Hauora Programme, which partners with the Notorious chapter of the Mongrel Mob to help gang members overcome meth dependency.

The heartfelt plea from a woman who had successfully completed the programme resonated with many people, and commenters on the Drug Foundation's Facebook page overwhelmingly called for funding to go towards support, instead of prison and enforcement.

The Health Ministry said the programme was aimed at too small a group, and it wanted to focus on schemes that help larger groups. We are still hoping this surprising decision could be revisited.

05 Is drinking good for your health?

WHILE MODERATE drinking is often thought to be good for your health, new research from Massey University's College of Health shows socioeconomic status probably has more to do with it than alcohol use.

Using data from the Health, Work and Retirement Longitudinal Study, researchers found that older men and women considered moderate drinkers, reported better health than non-drinkers or heavier drinkers. However, they also found that these same moderate drinkers had higher socioeconomic status than non-drinkers or heavier drinkers. Taking this into account, the researchers controlled their analysis for socioeconomic status and found the original relationship between moderate drinking and health was significantly reduced for women and completely disappeared for men.

"There is little evidence of any health benefit of alcohol use for younger or older people that cannot be explained by other lifestyle factors," Dr Towers says.

06 Liquor lobby blocks Local Alcohol Policies

COMMUNITIES PROMISED greater control on alcohol use in their communities are being blocked by strong opposition from the alcohol industry.

The new Alcohol Healthwatch report, released late last year, found the Sale and Supply of Alcohol Act and Local Alcohol Policy Act had done little to change the regulation of alcohol sales. As the central feature of the Sale and Supply of Alcohol Act 2012, Local Alcohol Policies (LAPs) allow each council to develop its own policy on the location, number and trading hours of liquor stores, technically giving locals greater input into the process.

However, the report found legal appeals by the alcohol industry had resulted in significant compromises being made by local councils, and most were falling back to the status quo.

07 Alcohol restrictions lead to pre-loading and rubbish

LOCALS CLAIMED they were left cleaning up piles of bottles, cans and boxes after each night of January's Rhythm and Vines music festival in Gisborne, as festival-goers pre-loaded to get around alcohol bans in the vicinity.

Residents said festival-goers were partying at Waihirere Domain, outside the liquor ban area, as well as down nearby side roads, then dumping their rubbish to avoid checkpoints on their way in to the festival.

Community members, who were otherwise supportive of the festival, wanted something to be done. Rhythm and Vines organisers said they did everything they could.

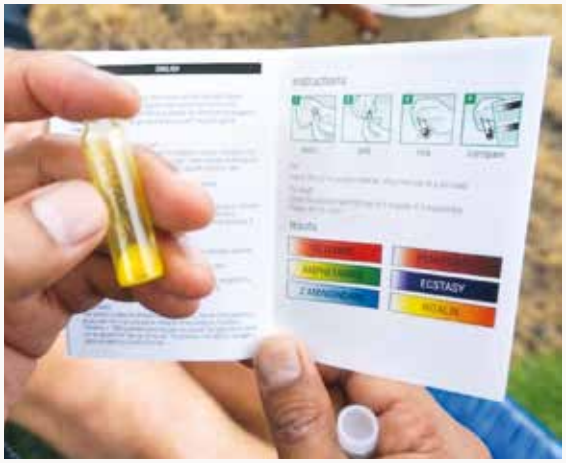
08 Drug Foundation gets behind Waitangi Tribunal claim

THE DRUG Foundation is supporting former Corrections officer Tom Hemopo's Waitangi Tribunal claim against the Department of Corrections. Mr Hemopo's claim asserts that the Department of Corrections has failed to reduce the Māori reoffending rate.

Principal Adviser Gilbert Taurima joined lawyer Roimata Smail, who is representing Mr Hemopo, to outline the case on Radio New Zealand's Waitangi Day special.

"The disproportionate number of Māori serving sentences for minor drug offences is a driver to the high numbers of Māori incarcerated," Gilbert says. "I think you'll find there are many, many people in the Corrections Department who are frustrated."

World.



01 PILL TESTING GAINS TRACTION IN AUSTRALIA

Australian politicians still don't want a bar of it, but pill testing is increasingly being touted across the ditch as the most effective way to keep young people safe. This follows a string of drug-related deaths and other incidents at night clubs and music festivals.

In a recent incident, over 20 were hospitalised after taking GBH at Sydney's Electric Parade music festival. In January, three deaths at a Melbourne nightclub were attributed to adverse reactions to fake ecstasy, and five young Australians died last year.

Drug Policy Australia CEO Greg Chipp argued recently that, instead of protecting young Australians, prohibition laws are killing them. Professor Alison Ritter, the Deputy Director of the National Drug and Alcohol Research Centre, said a lack of information about the content of specific pills meant drug users could not make informed choices.

Both agreed the appetite among politicians to introduce pill testing in Australia remains weak. This is largely because of the perception that it would encourage illegal drug taking.

"Clearly, prohibiting and criminalising drug use is not stopping young Australians from using drugs, nor is it making it safer," Chipp said.

02 Cannabis decriminalised in Israel

ISRAEL HAS officially decriminalised cannabis for personal use, placing the emphasis on public information and treatment instead of criminal enforcement. Cannabis use is fairly common in Israel, with a reported 9 percent using the drug. Official figures show enforcement has dropped by 56 percent since 2010, with only 188 people arrested in 2015. Medical marijuana is already legal under permit.

Meanwhile, in neighbouring Turkey, cannabis cultivation has been legalised in 19 new provinces – but only for medicinal and scientific purposes and under strict conditions. Growers will be required to provide a written contract stating they have not been involved in unauthorised cannabis production or drug trafficking.

03 Careful approach to cannabis reforms

VOTERS IN Massachusetts may have supported retail cannabis sales, but politicians are in no rush. Governor Charlie Baker has upset would-be entrepreneurs by delaying the opening of cannabis shops until mid-2018.

Lawmakers argued more time is needed to consider issues that were not addressed in the ballot question, which was approved by a narrow margin late last year.

In a time when even the Dutch Government is considering updating its drug laws, change is advancing quickly in some parts of the world. There is a real risk that economic interests could have too great an influence over policy decisions.

04 More legalising of medical cannabis

ACCESS TO medical cannabis continues to become more available in many countries. Dispensaries have just opened in Puerto Rico, and Germany has put plans in place to have a cannabis-growing programme up and running in 2019.

Puerto Rico changed its laws nearly two years ago to allow manufacturing and distribution of medical marijuana. Since then, nearly 2,000 patients have registered with the island's health department to obtain the drug. Germany plans to set up a "cannabis agency" to oversee its growing programme, and will import medicinal products until state-supervised cannabis plantations can be established. Previously, Germans had to obtain special authorisation to access medical cannabis – similar to the system that now operates in New Zealand.

05 Consumption room in Seattle a first for USA

AS SEATTLE and King County finalise plans to set up the US's first safe consumption sites, treatment providers across the US are concerned that, if, President Trump repeals Obama's Affordable Care Act as promised, their work will be wiped out.

Michael Botticelli, former Director of the White House's Office of National Drug Control Policy under President Obama, has warned that repealing the Affordable Care Act would mean disaster for public health officials and for people trying to access treatment for substance use disorders.

The two sites, stocked with the overdose-reversing drug naloxone, would aim to save lives and connect people dealing with addiction to treatment services.

06 The rising price of naloxone

500%

PRICE INCREASE

ATTEMPTS TO increase access to the lifesaving overdose-reversing drug naloxone are being undermined by steady price rises due to lack of competition in suppliers and manufacturers, says the *New England Journal of Medicine*.

Authors Ravi Gupta and Joseph Ross say naloxone uptake is surprisingly slow, given its efficacy and the attention it has received worldwide. They put this down to suppliers increasing the price as much as 500 percent, part of an overall trend of rising prescription drug prices.

The authors called for more regulation of the market. "Taking action now is essential to ensuring that this lifesaving drug is available to patients and communities."

07 2020 World Cup outlook: dry

IT WILL be interesting to see how FIFA negotiates the conflicting demands of Qatari officials, sponsors and fans as they head towards an alcohol-free World Cup in 2020.

Public consumption of alcohol is prohibited in Qatar, although people can get a drink at a licensed hotel, restaurant or bar. Local residents need a permit to buy takeaway alcohol.

Officials are firm on the stance, which could lead to difficulties for FIFA, notably due to the fact that one of its biggest sponsors is Budweiser brewer AB InBev.

FIFA Secretary General Fatma Samoura has reportedly said they "respect" Qatari culture regarding the sensitive issue.

08 Duterte "going to hell"

THE PHILIPPINE Catholic Church has condemned President Rodrigo Duterte's vicious crackdown on those allegedly involved in the drug trade in his country, and former Colombian President César Gaviria has warned him he's only making the problem worse. But Duterte remains unrepentant about his part in over 7,000 killings since he took office, reportedly saying he will happily go to hell for his actions.

The disbanding of the national Police drug unit after the suspicious death of South Korean businessman Jee Ick-Joo has been slammed by US-based Human Rights Watch as an empty public relations gesture.

09 Home-brewed deaths

WHEN ALCOHOL is banned or hard to access, it seems people will find riskier ways to get it. In Russia, a state of emergency was declared earlier this year in Irkutsk, after more than 60 people died from drinking Boyaryshnik, a bath tincture known for its high alcohol content. Figures show alcoholism is high in Russia, particularly amongst the poor, so drinking "surrogate" alcohol including medical ethanol, window cleaner and perfume has become commonplace. Medical professionals estimate that between 10 and 12 million Russians drink this type of alcohol, and President Vladimir Putin is said to be considering tightening laws to try and stop the practice.

Pounding a helpful beat

What would happen if Police and the justice system put less emphasis on punishing people and more on steering them towards support? **Catriona MacLennan** looks at three recent New Zealand initiatives aimed at reducing drug crime recidivism and increasing community engagement. The results are surprising even the boys and girls in blue, but will these new approaches be allowed to take?

CATRIONA MACLENNAN

Photo credit: Peter Meecham.

Watch-house nurse Sally Crene.

Mid-evening at the Counties Manukau Police watch-house on a Friday night, and activity rapidly starts amping up. A procession of Police cars pulls into the underground garage, ready to transfer those arrested to the custody unit.

People who have been arrested are searched, advised of their rights, fingerprinted and photographed. As soon as control is transferred from the arresting officer, authorised staff do a risk assessment. They ask detainees whether they have taken drugs, been drinking or are suicidal. This helps determine whether a doctor or psychiatric team needs to be called and how frequently those in custody should be checked.

Working alongside the Police in the underground complex is 46-year nursing veteran Sally Crene. She is in the watch-house four nights a week, observing from the time detainees are brought into the custody suite. Her long years of experience and training as both a mental health nurse and a general nurse mean she can rapidly identify people who need mental health care or immediate medical assistance.

She says at least half the people who come through the custody unit are affected by mental health problems or drugs or both.

"For me, it's about deciding which is the primary one and then the urgency. Some people I see again and again and again."

Crene's computer gives speedy access to previous medical histories and a raft of other information. Detainees she thinks might need help are put in one of three observation cells in front of the central hub so she can watch them and start her own risk assessment.

Crene says it is difficult to identify heavy cannabis users as they don't display any signs. She regards methamphetamine, synthetic cannabis and cheap alcohol as the most dangerous substances.

"It seems to turn them into raging demons. You see that when they sober up, and they say, 'Did I do that?'"

She can often establish a better rapport with people than the Police can, as she is not seen as an enemy in the way those who have arrested detainees are.

"They can be absolutely foul to the Police, and I get 'Ma'am'."

The assessments she does are forwarded to a multidisciplinary team for review at a later time. If Crene thinks people are suffering from drug dependence, she refers them to the Alcohol and Drug Helpline. She also hands out an Alcohol and Other Drug Services map, which leads people through a series of questions and then gives them a range of options for seeking help.

"All I can do is a little motivational stuff – put an idea into their heads. Give them choices. There are so many social issues that complicate this. It's not just alcohol and drugs. It's chaotic family background plus or minus abuse; an education system that cannot cope or won't cope with behavioural issues. For every person you have with a drug or alcohol problem at that level, you have got a whole family affected."

One man who was arrested was someone Crene had seen before. She was concerned about his level of distress and realised he was at risk.

The man was a heavy cannabis user, and Crene arranged for medication so he could sleep properly, instead of banging his head against the wall and ramping up his agitation. She then talked to him and explained he could get the medication from his GP, and then told him what other help was available.

"It's sowing the seeds and giving him options. It's tiny, but you take that as positive. On a regular basis, I pick up people nobody else would have identified through the system because I'm here. I can make a difference for people that nobody else can because they fall through little cracks."

Photo credit: Peter Meecham.

> **“All I can do is a little motivational stuff – put an idea into their head. Give them choices. There are so many social issues that complicate this. It’s not just alcohol and drugs.”**
>
> SALLY CRENE

Police Counties Manukau Operations Manager Inspector Tracy Phillips says she keeps in mind that the custody unit is not a place of punishment but a detention area. Those held there have not been convicted of an offence.

“I always think we can do things better.”

Police were given a massive wake-up call when men died in the custody unit in February 2014 and May 2015, and multiple investigations followed. The man who died in 2014 was 20 years old, and the Independent Police Conduct Authority found Police failed to get him urgent medical help.

Phillips says the tragedies showed the Police they had to learn from the deaths and do things differently. Seriously drug-impaired and intoxicated people used to be taken to the cells to sober up overnight, but they now go to a hospital emergency department instead.

Phillips has run a Humanity Project in the custody suite. A Facebook post invited artists to make submissions for decorating the cells. Now, nine of the formerly two-toned mint and green cells are covered in murals done by Papatoetoe High School students, artists and others.

One cell resembles an aquarium, with the walls and ceiling painted blue and fish swimming everywhere. Positive messages are painted on the fish. Other art depicts Kiwiana, including a buzzy bee, Pasifika culture and a beach scene.

Phillips also noticed that almost none of the food given to detainees was being eaten. Different meals were sourced that were far more palatable, as well as being faster for the Police to heat up.

Awareness of the boredom suffered by those in custody led to the creation of a library, and the Health Promotion Agency has provided cards with prevention information.

Staff working in the custody suite are expected to think about how they can improve the unit. Officers are rotated regularly and are encouraged to spend time talking to detainees and giving them options, with force the very last resort.

“It’s really important our authorised officers get this – [the benefits of] the time you spend in talking someone through it rather than typing a Use of Force report.”

A Customer Services Manager interviews people who have been detained to get their feedback and see how improvements can be made. Phillips says the comments are “really varied”, but Police were surprised to be given extremely positive feedback by a driver who was tasered after fleeing and being chased down. The driver said his actions meant the Police response was justified.

Before they leave the custody unit in the morning, detainees are asked if they

> **“It’s sowing the seeds and giving him options. It’s tiny, but you take that as positive. On a regular basis, I pick up people nobody else would have identified through the system because I’m here. I can make a difference for people that nobody else can because they fall through little cracks.”**
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“It has resulted in lives being saved, and that’s something you can’t put a price on. It’s also strengthened our relationships with Police and their understanding of mental health issues in our community.”

TONI GUTSCHLAG

have a drug or alcohol problem and want a referral for help. Phillips says this is left until last, because drug-impaired people probably will not remember what is said if Police officers speak to them when they are first brought into custody.

Phillips is enthusiastic about the benefits of having a nurse based in the watch-house.

“It’s amazing having Sally down here. She can bring value over the weekend.”

The scheme under which Crene works is called the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative and began at the Christchurch Central and Counties Manukau Police Stations in mid-2008.

The pilots ran until June 2010, and an evaluation of the first 18 months of operation was completed in August 2010. The report concluded that the watch-house nurses were “overwhelmingly” meeting the objective of assessing and assisting in the clinical management of detainees experiencing drug, alcohol or mental health problems in custody.

In all, 3,850 assessments were done out of a total of 17,659 people detained in Christchurch, and 1,986 assessments were completed out of a total of 27,272 detainees at Counties Manukau. The evaluation found the nurses were providing increased access to mental health services, better information about drug and alcohol services, referrals and reconnections with mental health and alcohol and drug services.

Thirty-eight percent of the Counties Manukau assessments and 11 percent of the Christchurch assessments resulted in referrals to treatment providers. Christchurch now has the nurses available 24 hours a day, while in Counties Manukau, they are at the watch-house part-time.

Canterbury District Health Board General Manager Mental Health Toni Gutschlag says the pilot demonstrated there are significant benefits in having mental health nurses based at watch-houses 24/7 and working closely with Police.

“It has resulted in lives being saved, and that’s something you can’t put a price on. It’s also strengthened our relationships with Police and their understanding of mental health issues in our community.”

Despite that, Canterbury is the only place to have nurses working in the watch-house at all times, and the scheme has not been rolled out to areas beyond the pilot regions.

The nurses in watch-houses scheme is not the only initiative Police are now using to tackle drugs more constructively. When they received intelligence in 2015 about a methamphetamine ring centred on Te Aroha, they tried a new approach to drug offending and set in motion an initiative that is now spreading around New Zealand.

The Police planned an undercover investigation, code-named Operation Daydream, involving officers from Te Aroha, Paeroa, Matamata and Waiuku.

Around the same time, a crime prevention co-ordinator position had been created on the Organised Crime Squad. Police accordingly decided to build crime prevention and reducing drug use into Operation Daydream.

Detective Ian Foster of Waikato Police says making contact with the people using the drugs became an integral part of planning for the operation.

“Previously, we would not have done that. We were also looking at community awareness. We realised that a lot of people know about meth but don’t know the signs and symptoms to look at for family and friends.”

Forty Police officers swooped on properties in the four towns, arresting eight people. A ninth, Anna Merrianne Muir, was picked up at a service station in Bombay, where drugs and cash were found in her car. She pleaded guilty to methamphetamine and cannabis offences and was sentenced to six years and two months’ jail.

The next phase of Operation Daydream then swung into action. Police spoke to the people whose names they’d gathered, organised a community talk in Te Aroha and used information obtained to assist the community in grappling with meth. They also produced a leaflet to hand out with information about support services relating to drugs and alcohol, fines, gambling, family violence, youth and parenting issues. Taking this approach

“Family and friends – they can deny it too, but they’re shocked when we turn up on their doorstep and say, ‘We know you’re using.’ We’re just the catalyst to push them in the right direction.”

DETECTIVE IAN FOSTER

also gave the Police insight into how some of them had started taking drugs and why they were using them.

Foster says Police were initially not sure how these people would react to being approached by Police but found most of the interactions constructive.

"The majority of people we spoke to were really positive. They spoke to us, and it was a really positive interaction – it surprised us."

Since then, Police have refined their approach. For example, they did not initially take support services staff with them when they approached users as they were concerned about risk.

There has also been a lot of interest in the approach from Police in other parts of the country, as well as from the Ministry of Health. A case study of Operation Daydream is being prepared, and Foster and Detective Scott Neilson gave a presentation about the exercise to other Police before winning an Excellence citation at the 2016 Problem-Oriented Policing Awards.

Foster says the key outcome has been a significant drop in crime in the area. Four months prior to the operation, crime was relatively high, but it fell markedly afterwards, and the crime statistics for the 2015/16 Christmas and holiday period were the lowest in three years.

Local councils are also supporting the initiative, which has been rolled out to as many as six communities in eastern Waikato.

"There's been huge positive feedback from the community," says Foster.

"We were really quite stunned by how successful it was. As Police, we have only a limited amount of time with these users, but sometimes we're the first people who can say to a person, 'We know you're using.' Family and friends – they can deny it, but they're shocked when we turn up on their doorstep and say, 'We know you're using.' We're just the catalyst to push them in the right direction."

In Wellington, Police adopted the new Daydream approach for Operation Oak, which ended in December 2016. It involved Police targeting a man they believed was dealing and culminated in the execution of 13 search warrants and the arrests of seven people. Around 50 grams of meth, $40,000 of cash and stolen property were recovered in the raids.

Detective Senior Sergeant Tim Leitch of the Wellington District Drugs and Organised Crime Team says that, over the past year, the Police have changed their mindset and started thinking about the people who buy drugs and about the families of suppliers – including the risks to children living where drugs are being bought and smoked.

"However, we also realise it is important to engage with those who are purchasing the drugs, as they will almost certainly have addiction issues, and their use will be having adverse impacts on their lives including their wider families' wellbeing."

DETECTIVE SENIOR SERGEANT TIM LEITCH

"We are still focusing on arresting and charging those who sell drugs like meth, as prosecution and imprisonment of these offenders leads to disruption of the supply chain and prevention of offending. However, we also realise it is important to engage with those who are purchasing the drugs, as they will almost certainly have addiction issues, and their use will be having adverse impacts on their lives including their wider families' wellbeing."

Leitch says Police during Operation Oak found that some of the meth purchasers were deeply affected by their use, and it was having significant impacts on their lives.

"[T]he interaction with the Police was the catalyst they needed to effect positive change. Others we spoke to refused to acknowledge that their drug use was a problem and did not want any support or advice. Even with these people, however, we hope that, simply by raising the issue with them and suggesting they make contact with support services, in time, it may be the catalyst they need to reconsider how their drug use might be impacting their lives."

Police identified the people buying meth and interviewed as many as possible. They found a number had significant methamphetamine problems they were hiding from their families. Families were struggling to pay for housing and other

Community Law Centres o Aotearoa CEO Liz Tennet.

Photo credit: supplied.

costs when several hundred dollars a week was going out of the budget to buy meth.

"That was quite an eye opener for us, but also for the families and partners. The partners might not have known about the meth use."

Police referred drug buyers to the Meth Helpline as well as to services dealing with family violence and child protection. People the Police were able to identify received personal visits to offer help. Leitch says about half of the 15 or so people visited reacted positively and appeared to want to address their issues.

Sixty more people were either not identifiable or not locatable. Those people were sent bulk text messages advising that the alleged supplier had been arrested and inviting them to contact the Police or support services if they had a meth problem.

Leitch says it is not yet clear whether support agencies have sufficient resources to cope if Police start referring more people to them. He acknowledges that such services generally struggle for funding and says Police need to talk to them about that.

However, he believes the new approach will pay dividends. Having been in his position for a number of years, he is used to seeing the same people repeatedly coming through the system. Addressing addiction issues will reduce recidivism and prevent crime and victimisation.

"I do expect it will spread across the country. It's the way of the future, really."

In Tairawhiti, the Police call the new initiative Policing, Rehabilitation and Offering an alternative (PRO). After witnessing the impact of meth on the community, Police in 2016 began co-operating with iwi and support services to provide help to drug users.

One operation in Tairawhiti involved prosecuting 48 people. Thirteen were remanded in custody or bailed to places outside the area, but the other 35 all took up PRO and completed counselling for drug depedency, and only three had reoffended by the end of the year. Police are now working closely with Te Rānanganui o Ngāti Porou, Te Whare Oranga and Te Kupenga addiction services.

Waitemata is also trying the approach. Following a meth operation, Police texted 140 suspected drug buyers and offered them a helpline, addiction services or contact with a detective. Officers were surprised when 20 people chose to contact Police directly asking for help.

The third strand of this breaking-the-cycle approach being adopted by the Police is marae justice panels.

Also called iwi or community justice panels, these have been piloted in several locations around the country. Roger Kemp of Canterbury Community Law was the project developer of the first panel.

Offenders who accept guilt in cases of low-level offending carrying jail sentences of six months or less may be referred to the panel at the discretion of the Police.

Three community representatives from fields such as schools, churches or sports clubs sit on the panels and meet with the offender for 30 minutes to discuss the crime and what is happening in the offender's life.

Offenders are asked about their addictions and referred to programmes or counselling. Participants might be required to research and write an essay about the long-term impact of cannabis on the brain and the implications of convictions for young people's futures.

Offenders sign contracts and, if they fail to comply, will be referred back to the Police for prosecution. Compliance runs at around 85 to 90 percent, compared with 30 percent for court orders.

Kemp says the Christchurch panel deals with offences for a cost of $350 to $400 each, compared with between $3,000 and $4,000 for a crime dealt with in the justice system. Recidivism is also markedly reduced.

Manukau Urban Māori Authority (MUMA) CEO Willie Jackson is enthusiastic about the benefits of the panels operating in his area. He says demand for them is huge, and if MUMA had more funding, they could be used far more frequently as a more constructive approach to offending.

"There's enough crime out there for us to be doing this every single day – twice a day. We do it a couple of times a week. We're not talking high-level crime. We've got qualified people, skilled people. It's a good response from our community."

Jackson says the panels "work a treat". "We want to keep people out of the justice system. The idea is to get them early. We believe in second, third, fourth chances. It just gives them an opportunity, and it's good for them to see that Police are not the enemy."

Community Law Centres o Aotearoa CEO Liz Tennet says the panels to date have been successful, and she would like to see a similar model run by iwi and rolled out nationwide. Community Law Centres have done detailed work about this proposal. They approached all iwi in New Zealand to consult them, leading to the *Community Justice Panels, Iwi & Marae Justice Panels – Consultation Project: Final Report* published in September 2016.

“We want to keep people out of the justice system. The idea is to get them early. We believe in second, third, fourth chances. It just gives them an opportunity, and it’s goodfor them to see that Police are not the enemy.”

WILLIE JACKSON

An evaluation of the Christchurch panel was completed in November 2012, and a report on the iwi panels piloted in the Hutt Valley, Gisborne and Manukau in 2014 and 2015 was released in June 2016.

The 2012 evaluation concluded that the Christchurch community justice panel was an effective alternative resolution method that contributed to reducing prosecutions for low-level offending. Seventy-nine percent of offenders fully met conditions set, while a further 10 percent complied at least partially.

The Christchurch panel generally set two or three conditions for offenders, with community service being the most common requirement for those not previously known to Police. Apologies were required in 69 percent of cases involving people with a prior offending history.

The evaluation noted that the panel approach had been tested on a small number of higher-threshold offences with some success but said the eligibility criterion of offences with a maximum of six months’ jail was to be retained for the foreseeable future.

The evaluation of the Hutt Valley, Gisborne and Manukau pilots identified three criteria as crucial to the success of iwi panels:

- The use of tikanga Māori to uphold the mana of those participating.
- Prominent iwi/Māori leadership being evident at each panel site to promote the panels both internally and to the community.
- The selection of experienced and skilled providers.

The paper said offenders interviewed for the evaluation were very satisfied with the process and the support from providers. However, few victims attended the panels, and limited information about the views of victims could therefore be obtained.

Police Deputy Chief Executive Superintendent Wally Haumaha says the evaluations showed the panels can help to identify factors associated with offending and assist offenders with the services and support they need to get their lives on a more positive path.

“These supports can also help achieve broader social sector outcomes for people, by helping people obtain driver’s licences, access treatment and support services, undertake volunteer work and engage in education or training programmes. Work is under way to consider future funding arrangements.”

Tennet says representations have been made to the Ministry of Justice about extending the panels, and the Police are strongly in favour of the initiative.

“I know the Ministry of Justice has done some work on it, but we think they could be doing a lot more. We would like to see them focus on this as a potential policy initiative.”

Tennet acknowledges that the panels require funding but says the model is very economical. Its other benefits are the community involvement and the mana and respect inherent in the process.

Justice Minister Amy Adams viewed the operation of the community justice panel in Christchurch, and Tennet says the Minister was very impressed. Kemp states that those involved with the pilots are wondering why nothing more appears to be happening. He says the massive cost savings demonstrated by the process mean that funding is not the issue.

“I just don’t know why the government’s taking the length of time it is to do this, because community justice panels tick every box.”

Kemp understands there might be progress in rolling out additional panels in 2018 but expects the government will change them significantly if it does create more. He has spoken about the Christchurch panel in other parts of the country and says there has been a lot of enthusiasm and that there would be enough community support now for panels in Hamilton, Rotorua, Central Auckland, Dunedin and Wellington.

Consultant Jane Troughton worked with Kemp on the core principles for the panels and was involved in consultations about the initiative around the country. She says the response was tremendous and, like others, she is puzzled about the current stalemate.

“I just don’t know why the government’s taking the length of time it is to do this, because community justice panels tick every box.”

ROGER KEMP

Troughton believes that, as well as offering cost savings, the panels change community dynamics because they enable the community to be involved in justice processes. New Zealand has a high imprisonment rate and a punitive approach to offending, and Troughton says the panels provide an opportunity for face-to-face resolution and a different approach.

Justice Minister Amy Adams did not respond to a request for comment about the future either of marae justice panels or of the Alcohol or Other Drug Treatment Courts. The latter, which have been running in Auckland and Waitakere since 2012, are nearing the end of their five-year pilots.

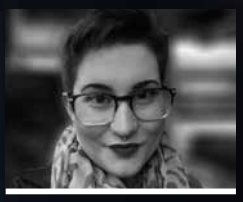
It is little surprise that more-constructive approaches have been initiated and piloted by those working on the ground, rather than by politicians or government ministries.

Anyone working in the legal system quickly becomes familiar with the sad parade of people who cycle regularly through the Police cells and the courts. In the past, the system spent vast amounts of money arresting and processing these people but did little about diagnosing the causes of their offending or supporting them to overcome their problems.

Referring anyone using drugs for help, posting nurses in watch-houses, marae justice panels and the Alcohol or Other Drug Treatment Courts are all efforts to adopt a more-effective approach and break the cycle of hopelessness and offending. What is needed now from the government is recognition of the demonstrated benefits of these initiatives, a long-term approach to solving rather than simply managing problems, and financial support. The programmes clearly ought to be rolled out nationwide, and it is up to the government to make that happen. ■

It's going to take more than silver linings...

KATIE BRUCE



LUCY MOSS-MASON

Hearing about these new pockets of humanity and hope in our justice system is refreshing. What a difference it makes when people care about the people they work with and make changes to better respond to people's needs. Good ideas, innovations and common sense often come from those working directly with people affected, as well as from those affected themselves. They are the witnesses and participants who see the effects our laws and policies have.

What the initiatives mentioned here have in common is that they look outside of the justice system for inspiration.

Bringing nurses into Police stations to increase the safety of detainees, for example, acknowledges that drug misuse is a health issue, although the setting is still custodial.

Looking outside of the justice system is also a recognition that addressing issues that can lead people to be in the justice system in the first place is more effective than punishment.

“While well intentioned, there is little scientific basis behind how illicit substances are categorised under the Misuse of Drugs Act, and research has continually demonstrated that alcohol is the most harmful drug.”

This is the logic behind the iwi or community justice panels, in which those who accept guilt of a low-level offence are asked about what is going on in their lives and are often referred to community health programmes. The Policing, Rehabilitation and Offering an alternative (PRO) initiative in Tairāwhiti similarly had great results for those who completed addiction counselling rather than custodial sentences, with an impressively low rate of reconviction.

What is most special about these initiatives, however, is that they are bucking the trend.

But at the very same time these promising initiatives are being trialled, our criminal justice system is becoming increasingly punitive. The Salvation Army’s 2017 State of the Nation report points to a record prison population, record rates of convictions leading to prison and record levels of spending on prisons – with an extra $2.5 billion pledged over the next five years. The report states that “despite the lesson that prisons breed more crime, there is no apparent end to our political ambitions of building more and larger prisons”.

How will communities flourish if they are stifled by a context of laws and policies that divert millions upon millions of taxpayers’ money into a punitive system that is only good at recycling people? The more time people spend in prison, the more likely they are to return.

Both National and Labour have pledged more Police in the lead-up to this year’s general election. A new $1 billion prison is on the horizon. Yet, just as important to note are the things we choose not to invest in. Iwi and community justice panels have not been rolled out. Legal aid services have been cut. Many community organisations and support services, such as Community Law, have not received increases in funding for a decade.

We can have hope about the silver linings in our justice system, but these local initiatives need to be backed by a government prepared to listen to what is working, extending initiatives beyond the pilot phase and reflecting on how national policies and legislation are taking us in the opposite direction.

This could not be clearer in relation to our drug laws and policies.

Aotearoa has one of the highest rates of recreational drug use in the developed world. Forty-nine percent of Kiwi adults aged 16–64 report they’ve used illicit drugs for recreational purposes at some point in their lives, and 14.6 percent report past-year cannabis use (Ministry of Health, 2010). The rationale behind our legislation, policy and practice is flawed. While well intentioned, there is little scientific basis behind how illicit substances are categorised under the Misuse of Drugs Act, and research has continually demonstrated that alcohol is the most harmful drug in terms of individual and societal harms.

Our nation continues to have a public conversation about how we manage drugs and the people who use them. This year marks 42 years since the passing of the Misuse of Drugs Act – Aotearoa’s primary drug legislation – four years since the introduction of the Psychoactive Substances Act, which has sought to further restrict trade and consumption of ‘legal highs’, and only a month since the requirement for ministerial approval of cannabis for medical use was shifted to the Ministry of Health.

While our drug legislation appears to be achieving little in preventing use of illicit substances, it is having profound effects on our criminal justice system. In December 2016, of the 10,000 people in our prisons, 13 percent were incarcerated for drug and/or anti-social offences as their most serious crime. That is a whopping 1,288 people who would almost fill the new planned prison, which has a capacity of 1,500 beds.

And while our drug legislation applies to all New Zealanders equally on paper, in policy and practice, the disparities between middle New Zealand and those most affected by the punitive arm of the criminal justice system are stark. Māori are about twice as likely to receive custodial sentences for drug offences, and the Māori prison population recently exceeded 5,000 for the first time.

It doesn’t have to be this way. There are alternatives to the criminal justice response we are so accustomed to.

In 2001, Portugal decriminalised all drugs for personal use. This decision has had wide-reaching consequences for the small European nation, with dramatic decreases in drug-related deaths and HIV infection rates. Drug use has also decreased, particularly among youth aged 15–24. A study published in the *British Journal of Criminology* in 2010 found that there has been an associated decline in levels of imprisonment for drug-related charges and an increase in the number of individuals voluntarily engaging in health initiatives to treat problematic drug use.

“Māori are around twice as likely to receive custodial sentences for drug offences, and the Māori prison population recently exceeded 5,000 for the first time.”

Other countries have made strides towards liberalising their drug policies over the past decade, and a number of American states have decriminalised cannabis for medical and recreational use.

Movement away from the criminal justice system towards a healthcare approach of compassion and humanity is not just possible – it is necessary.

Certainly, there are pockets of good practice in the formal approach to drug misuse in Aotearoa that are making a positive difference in our communities. Watch-house nurses are an example of those caring in a punitive environment where the flow of bodies through our prison pipeline is unceasing. But pockets of good practice and these silver linings do little to challenge the undeniable systemic harm caused to individuals, whānau and communities. In fact, initiatives that promote care in the context of punishment risk acting to legitimise punitive regimes, however well intentioned.

We need a bigger imagination than a paradigm of punishment in Aotearoa. When the silver linings in our justice system are those that draw inspiration from outside of it, we should question any further investment in growing our current punitive approach. ■

JustSpeak is a network of young people speaking out for evidence-based transformative change in our criminal justice system.

The myth: Methamphetamine and minors

The statistics say it, the kids say it, health workers say it – "So why won't society believe that meth dependence among Kiwi kids is rare?" asks **Keri Welham**

KERI WELHAM

> **“Police and health workers investigated – but found a total lack of evidence. A town meeting was arranged. A handful of people turned up, and no-one could pinpoint the source of their information.”**

> **“Meth has done its own PR – it’s an ugly drug with an ugly reputation – and many can’t be bothered.”**

Young people love to exaggerate – their achievements, their woes, the success or otherwise of their fledgling love lives. And drug use is no different.

But when it comes to methamphetamine, many young people don’t even bother talking it up. Meth has done its own PR – it’s an ugly drug with an ugly reputation – and many can’t be bothered.

“Meth has a bad reputation. They all know it’s a very intense drug to do, while they barely consider cannabis a drug,” says Auckland-based alcohol and other drug (AOD) specialist Farah Elnashi.

Meth is expensive, and that necessitates major lifestyle changes for users such as associating with those taking the drug regularly and/or the introduction or ramping up of criminal offending to have the money to buy it. Those working in youth AOD treatment say there are very few school-age young people dependent on the drug.

The Youth2000 survey results from 2012 showed less than 1 percent of students had ever used meth – and most of those had only used it once.

In more recent times, the Prime Minister’s Meth Action Plan revealed that, at the end of the 2015 financial year, a mere 1.3 percent of young people aged 18 to 24 surveyed had used meth.

And yet, there is almost an urban myth of its use among young people in New Zealand.

Youth AOD programme manager Caleb Putt tells an insightful story about attending a small town meeting to address the ‘meth scourge’ among children in the town. The media had been reporting the problem, the community had called for action and Police and health workers investigated – but found a total lack of evidence. A town meeting was arranged. A handful of people turned up, and no-one could pinpoint the source of their information. Caleb was grateful for the opportunity to connect with the community but says the lack of evidence on offer at the meeting seemed to back up his agency’s data – childhood meth use in this town was little more than a rumour.

Putt works for Sorted, a facility that co-exists within the Bay of Plenty’s Child and Adolescent Mental Health Service. It deals with alcohol and drug intervention for those aged 18 and under. Sorted sees 230 to 250 young people a year.

Client experiences can span from being caught smoking cannabis to suffering drug-induced psychosis. Most Sorted clients are referred because their drug use has brought them to the attention of their school or Police. The most common drug use pattern is cannabis use daily and alcohol once a week.

Only two or three young people a year present to Sorted with meth problems. A few others will have used it, but it won’t be the drug at the centre of their dependency.

Putt says people do not generally gain the networks or resources necessary to access meth until they’ve hit their late teens or early 20s.

“Obviously, we are [a service for people] under 18, and that has a huge bearing.”

Anecdotally, young people do not talk about meth use among their peers. They don’t mention using it or being approached by sellers of the drug. Putt says most teenagers aren’t actually interested anyway. Some may try it once but, like synthetic cannabis, it’s just not enough fun to be the drug of choice for most.

Farah Elnashi is clinical manager for Odyssey Auckland youth community team. A staff of 28 follows young people from assessment through to transition back into the community. The focus is on young people aged 13 to 18. At any one time, there are 13 young people in Odyssey’s residential facility. Odyssey holds the national meth contract for treatment of those up to age 24. Through this contract, priority for four of Odyssey’s residential beds is given to young people who have

"Only two or three young people a year present to Sorted with meth problems. A few others will have used it, but it won't be the drug at the centre of their dependency."

used meth. However, very few young people come to the programme because of a core dependency on it.

In the last year, Elnashi says there have been fewer than four young people – aged under 18 and hailing from across the country – who have been referred to Odyssey for help under the national contract because meth was the presenting issue.

"From what I can see, we have a lot of kids come through that have tried it once or twice."

It's not a total beat-up

Experts say there are definitely some issues of concern when it comes to young people and meth in New Zealand.

About 50 people arrived at Waitangi on 5 February as part of an anti-meth hīkoi from the Far North. Kaitaia anti-drug campaigner Reti Boynton told Radio New Zealand, "We're sick of it. Our kids are suffering."

He spoke not of children using meth but of their troubling proximity to the drug. "I've got reports of teachers finding it inside school lunchboxes. When the kids are asked what they're doing with it, they say mum or dad asked them to drop it off at uncle's place on the way home. Little kids like this are drug trafficking."

In recent months, Dunedin mums Rebecca Marechal and Jaz Hunter toured Otago towns to gauge the size of the meth issue in the region. *Stuff* reported that Marechal met many people who spoke of dealers targeting youth as potential customers. An Oamaru community worker claimed young people were offered "$5 tester bags" to help develop a habit.

Dunedin's Aroha Ki Te Tamariki Trust/Mirror Services supports young people aged 12 to 22. Director Deb Fraser says meth use seems to be a more significant problem in the Otago region than some other parts of New Zealand, although she is not convinced by reports that the region is "saturated" with the drug.

"It's here, and it's accessible," she says. Fraser knows of established networks that have offered 'first go free' to tertiary students in Dunedin and that The Octagon remains well known as a marketplace for the drug.

She says one-off opportunities such as 'tester packs' and 'first go free' deals play into the myth that meth is a drug that hooks people the very first time it's used. While she does not believe this, she is concerned that these attempts to attract new people make it very easy for those who enjoyed the taster to get deeper into the drug and potentially develop problematic or dependent meth use.

In some places, numbers are on the rise

Fraser says around 12 percent of all referrals to Aroha Ki Te Tamariki Trust/Mirror Services are for problematic or dependent meth use. She could not immediately measure this rate against previous years but said she knew this illustrated a significant increase in the profile of meth as the drug of concern for clients.

She is unequivocal about the reason behind the difference between her figures and those at Elnashi's Odyssey or Putt's Sorted. It's the age of the clients accessing their services.

"So we're seeing the group that's more likely to have exposure to meth use."

She says that, by their late teens and early 20s, people are much more likely to be associating with people who use or sell drugs, and they are more likely to be able to find a way to finance regular drug use.

Age may protect young New Zealanders for now, but the Australian experience sounds warning bells.

There is mounting evidence that meth – known there as ice or speed – is readily available to young Australians and is increasingly part of their drug-taking experience.

Research published by the *Medical Journal of Australia* found the percentage of young people in AOD treatment

programmes who had used meth doubled in the five years to 2014.

Researchers surveyed 865 adolescents (aged 14–18 years) who were in residential AOD drug treatment programmes between 2009 and 2014.

The Guardian reported that, in 2009, almost 11 percent of those surveyed believed meth was their drug of greatest concern. By 2014, that had jumped to more than 48 percent.

While those surveyed also recorded high levels of cannabis use (85 percent), tobacco use (73 percent) and alcohol use (64 percent), meth was the only drug to have shown a significant upward trend over the five-year study.

The research team, led by Dr Sally Nathan from the University of New South Wales School of Public Health and Community Medicine, found links between meth use and the number of places a young person had lived and their enrolment in a special class at school. This suggested those with learning difficulties or unstable accommodation might be at a higher risk of methamphetamine use – or that use may result in learning issues and unstable accommodation.

Mark Ferry, AOD treatment programme director at Australia's Ted Noffs Foundation, told *The Guardian* the increase in use was due to meth becoming more available as the price went down and its manufacture increased.

New Zealand could face the same market pressures and the same resultant rise in meth use among young people, but for now, meth use among New Zealand children aged 18 and under appears to be rare.

So what does it matter if society is overhyping meth use by Kiwi kids?

The biggest concern: distraction

The numbers in New Zealand may be small, but the impact for those battling dependency, and those around them, is mammoth.

"It's extremely addictive," Elnashi says.

She says meth changes the chemistry of the brain so a user no longer gets pleasure out of normal experiences. They will smoke to feel normal, then crash. It's extremely hard to come off, and the come down mirrors depression.

So it's a menacing drug – what's wrong with society reacting in a strong way to use of it?

Elnashi says one of the worst consequences of society believing there is a major problem with children and meth in New Zealand is that reactions to any use become hysterical and consequences can escalate very quickly.

"The problem Putt sees with the overblown hype around meth and young people is that society will take its eye off the true problem among those with dependencies: alcohol."

"People see a kid using meth at school, they're out."

Or parents send their child – who may have only used it once – straight to rehab, which disconnects them from the protective factor of their schooling, their family and those friends who are not using.

Elnashi feels young people could, in fact, be pushed further in the direction of the drug if they lose the foundations of their former lives, such as school. She says none of the young people presenting to Odyssey with a dependency on meth have school as a protective factor.

The problem Putt sees with the overblown hype around meth and young people is that society will take its eye off the true problem among those with dependencies: alcohol.

He is keen to remind that alcohol is still a significant factor in Police callouts involving young people and says cannabis and alcohol are much more accessible to teens than meth. Cannabis is very cheap, if they pay at all, and is widely available through teen networks. Alcohol is harder to procure, but older siblings will often buy it for those under 18.

Elnashi agrees she'd be scared to see the focus drift off alcohol.

"[Meth's] not the major problem. Let's talk about alcohol."

She says young people may try meth, but they rarely stick with it. They have easier access to cannabis and alcohol, and it's not as expensive. If anything, she believes meth use might be slightly on the wane. Young people have made assessments of the drug's pros and cons and decided it's not worth it.

"It's not an amazingly cool thing to do, unlike cannabis, which they think is so cool," she says. ■

QUOTES OF SUBSTANCE

"Premiers' offices should be moving with mainstream opinion and saying, 'Yes, a medically supervised injecting room should be given a broader mandate and there should be consultation with parents about the prospect of testing pills at music events'."

Former Victorian and NSW premier Bob Carr, at the recent launch of the Australia21 report which recommends decriminalisation of drug use in Australia.

"No matter what's happened, no matter what you've done, no matter how much damage is in your life … it can be fixed."

Janet Balcombe, author of Wild Side, a recently-released book about her recovery from methamphetamine dependency.

"There will be no alcohol consumption on the streets, squares and public places and that is final. Availability of alcohol during the tournament will commensurate with our customs and traditions. Personally, I'm against the provision of alcohol in stadiums."

Hassan Al-Thawadi, secretary-general of Qatar's Supreme Committee for Delivery and Legacy, speaking about the 2020 Football World Cup.

When grandparents must step up

Wide-ranging research has laid bare the experiences of grandparents stepping up to raise grandchildren due to their own child's battle with drugs. It places enormous financial, physical and emotional stress on grandparents at a time when they should be free to focus on retirement. **Matt Calman** delves into these findings and talks with some of the grandparents behind the data.

MATT CALMAN

Researcher, and former member of Parliament Dr Liz Gordon clutches the spiral-bound research to her chest. Pale-blue notes curl out from the edges of the thick document, marking pieces of precious information within. She says there has "never been a study like this in the world" on a trend that has been increasing worldwide in recent decades. None has offered such comprehensive information on what leads to children entering grandparental care or included such detailed accounts from the families involved. The research was commissioned by support and advocacy organisation Grandparents Raising Grandchildren (GRG) and funded by a $75,000 Lotteries Community Sector Research grant.

GRG Chief Executive Kate Bundle says the "incredibly rich data" will be a key lobbying tool to urge the government to provide more support for grandparents.

"We've always made a point to have accurate information and data to back up what we knew was happening on the ground."

The survey was completed by 850 grandparents. Of 1,300 grandchildren, 579 (43 percent) came into grandparental care due to drugs – the most common reason given. Revealingly, the only drug cited by grandparents was methamphetamine (meth). Most cited multiple factors including domestic violence (40 percent), family breakdown (39.8 percent), neglect (39.8 percent), parents being unable to cope (38 percent) and alcohol abuse (25 percent). Māori accounted for 36 percent of respondents.

GRG has approached organisations such as the New Zealand Drug Foundation and the Health Promotion Agency to fund further papers on specific parts of the research, such as alcohol, domestic violence and drugs. One paper will focus on whether the grandchildren's lives had improved in the care of their grandparents. Another will look at the experiences of Māori.

Gordon will drill deeper into issues such as the effects of parental separation, the significant drop in parent visits when drugs are involved, health issues arising from drugs and education outcomes (such as children with behavioural problems being stood down by schools).

Taking on the financial burden of grandchildren forces many grandparents below the poverty line. Many need to give up work, cut back hours or move. Many endure financially debilitating stand-down periods waiting to qualify for benefits.

"Taking on the financial burden of grandchildren forces many grandparents below the poverty line. Many need to give up work, cut back hours or move. Many endure financially debilitating stand-down periods waiting to qualify for benefits."

Photo credit: Matt Calman.

Kate Bundle – GRG Chief Executive

Photo credit: supplied.

Gordon cites the case of great grandparent Terry Kopu, who went public in September on the burden of raising her now nine-year-old great grandson, Kuldeep. Kopu gave up her job without notice in order to rescue baby Kuldeep from foster care and racked up credit card debt to buy him the essentials. She also faced a stand-down period for the Unsupported Child Benefit – of which about 70 percent of grandparents are eligible – because, to qualify, she needed to provide evidence she would have custody for at least 12 months.

"She should have been able to go in and get that ... but the 12-month thing is a terrible barrier," Gordon says.

Bundle says it is often difficult for grandparents to meet the 12-month criteria as it relies largely on how frontline Child, Youth and Family (CYF) staff interpret the situation. Grandparents have been denied the benefit only to gain it later and then be told they should have received it from the start, she says.

"That is a real hole. We've lobbied the government to ... have an exception to the 12-month rule in some situations, but we have not been successful."

GRG started in 1999 with just 10 members on Auckland's North Shore after founder Diane Vivian put an advertisement in a local paper. Membership has now mushroomed to more than 6,000 members.

The 2013 Census revealed there were 9,500 families where a grandparent was raising a grandchild. Bundle says Vivian fields calls during the week on GRG's 0800 line and is daily counselling "grandparents at the end of their tether".

Recently, Vivian had heard from grandparents who found their daughter smoking meth with her 11-week-old baby and three-year-old. In another case, a seven-year-old girl had been looking after three younger siblings while her mum smoked the drug and her father, who has a drug dependency, was at work. There are other stories of children's interests suffering as their parents put drug use first.

Bundle says, "These kids are sick, their dogs are sick, and mum and dad just descend into this meth hell and they just lose the ability to be parents. And it is grandparents who are picking up the pieces."

For 56-year-old solo-grandmother Jane (not her real name), the care and protection of vulnerable children is a common part of her job as a social worker. She stepped in to care for her two granddaughters, now both teenagers, after they were removed from her daughter and son-in-law who were dependent on methamphetamine.

Before Police and CYF intervened, she had suspected drugs were in the picture. Visits from her daughter dwindled,

"Once they've got them in a place of safety, they're technically no longer in need of care and protection. But there's a gap there in terms of actually supporting those caregivers."

KATE BUNDLE

Dr Liz Gordon.

Photo credit: Matt Calman.

“The girls’ trauma left them afraid of the dark and suffering frequent nightmares and they were “incredibly angry and nasty” when they arrived.”

and the girls’ schools had started calling about regular absences.

“[My daughter] was going downhill rapidly, and the girls were starting to go downhill rapidly,” Jane recalls. “I’d go around to the house, and they were in a pitiful state.”

Methamphetamine use had left her daughter incredibly skinny, riddled with head lice and with pipe burns on her face. Her daughter remains angry and resentful, and they have become estranged.

At the end of last year, Jane’s youngest granddaughter began running back to her parents, which she says the authorities condoned.

She called CYF daily to plead with them to enforce custody rights she had gained in Family Court, but “they just kept fobbing me off”. With no back-up from the state and no practical way of preventing her granddaughter “voting with her feet”, Jane baulked at the $50,000 lawyer’s costs to return to court to enforce her custody rights. She has become disillusioned with CYF.

“They didn’t do their job. It’s OK for you to take over and look after your own ... but when you put your hand up to say I need some help, they’re not there for you. It’s on you.”

Bundle says the trend over recent decades had been an urgency to place children with family members to ensure their care and protection. After that, it was deemed the state’s job had been done.

“You’ve got a desire to place children quickly and to limit the financial burden on the state. Once they’ve got them in a place of safety, they’re technically no longer in need of care and protection. But there’s a gap there in terms of actually supporting those caregivers.”

One of Jane’s “greatest struggles” has been finding adequate counselling for the girls. Lack of treatment is often in the media, but a dearth of specialist support services for families is sadly “further off the government radar”, Jane says. One counsellor she took them to was visibly “stunned” by the girls’ stories. After the session, the girls did not want to go back.

“They need someone who’s not going to be surprised and shocked by their story. They just didn’t know how to deal with these girls.”

During her time as a Family Court lawyer, Bundle represented many grandparents who had to spend their retirement savings or sell houses to pay for legal fees. For those who qualified for legal aid, the charges were often attached to their homes.

“That’s been a big issue for many of our grandparents. It’s really, really tough for them.”

Jane has had to move twice since gaining custody and had to wait months before qualifying for a benefit. However, due to the age of her granddaughters, she has been able to continue full-time work. The girls' trauma left them afraid of the dark and suffering frequent nightmares, and they were "incredibly angry and nasty" when they arrived. Late last year, "it just got so hideous and hard to manage" she considered giving them both up.

"Their behaviours were out of control. All their anger was aimed at me, and I was to blame for everything."

This year, with just her eldest granddaughter remaining, things have started to settle down. School is going better, and her granddaughter has "hopes and dreams" of studying medicine or becoming a te reo teacher.

"She's wanting to do the right thing. I do have some sense of hope for her."

Bundle says she has seen many examples of grandchildren who, despite traumatic beginnings, have blossomed into the "most wonderful young men and women".

"We know that grandparent care can work if it's well supported. It's now or never really, because we've got to get this right."

The same problems are happening in the US. Late last year, PBS NewsHour reported there were 2.9 million children there living with grandparents in 2015, up from 2.5 million in 2005. Maria Moissades of the Office of the Child Advocate Massachusetts puts it down to the "current national opioid epidemic".

"You've got grandparents who thought they were going to spend their retirement fishing and travelling. Now they're raising [as many as] five grandkids."

Gordon's research revealed grandparents battling health problems – some were dying of cancer – and many of the grandchildren had significant behavioural problems or were suffering trauma and anxiety. Some children displayed symptoms of foetal alcohol syndrome or drug-related symptoms from their mother's drug-use during pregnancy.

"The poor grandparents get left with a really enormous burden at an age and a time often ... that they're not able to cope all that well," Gordon says.

West Coast-based midwife Olivia (not her real name) is a solo-carer to her daughter's two-and-a-half-year-old son. He attends kindergarten every day, and she has found a reliable babysitter who helps when she is called to work after hours. The 53-year-old, who is of Ngāi Tahu descent, once again finds herself juggling full-time work and childcare.

"I've been there and done it, and I'm tired," she says. "There's only me, and I'm on call. But love for him is too deep, so I have to deal with that. I love him to pieces."

When Olivia's daughter tested positive for meth during pregnancy, CYF became involved, and the prospect of foster care loomed. Olivia persuaded CYF to allow the baby to stay with her daughter under her guidance, but when her daughter relapsed (and was later violently assaulted by her new partner), Olivia took full custody of her then eighth-month-old grandson. It had been an "ugly" and difficult time for Olivia, who had just been made redundant, and at one point lived $400 below the poverty line. She soon gained a new job and has made ends meet with help from a weekly benefit of between $146 and $240.

Olivia says her daughter seems to be doing better and visits occasionally. However, the "dysfunctional life of a drug user" means she cannot cope with full-time parenting. Having her grandson is the best way of supporting her daughter.

Olivia says her grandson is an absolute joy when he is happy, but his behaviour is frequently hard to manage. Even getting through breakfast, dressing him and getting him into the car can be exhausting.

"You've got grandparents who thought they were going to spend their retirement fishing and travelling. Now they're raising [as many as] five grandkids."

MARIA MOISSADES

Occasionally, she would love the respite of somewhere she could drop her grandson or someone to cook her dinner.

"It's full on. He just fights me all the time. Sometimes I feel like I've done a marathon before I've even got to kindy. I can't go to the wharepaku (toilet) by myself. I can't do anything on my own. I don't have any social life."

Despite the hardships, she regards taking custody of her grandson as her responsibility. Looking after whānau members is also an important part of her culture.

"It's just what happens. It's part of who you are [as Māori]. I did have my life mapped out. I certainly never expected to get this, but what do you do? If they defer on their responsibilities, who else is going to pick up the pieces?" ■

USA drug policy in the early days of Trump

We're just a few months into the new Trump-led America, and while some of his initial appointments are troubling, there's no clear indication yet as to where his administration will stand on drug law reform. **David Young** looks at where the chips are starting to fall and whether the indications are that reform will continue or that years of slow and steady progress will be rapidly undone.

DAVID YOUNG

A unique aspect of Donald Trump's presidency is that, weeks after inauguration, nobody is any the wiser about what many of his actual policies might look like.

That's true even for those who would typically be delighted by the election of a Republican president and who support a firmer line on drug policy.

"Nobody really knows what to expect," says Kevin Sabet, co-founder of anti-legalisation group Smart Approaches to Marijuana (SAM).

"I think they are still trying to figure it out. But I wouldn't be putting money into the marijuana industry right now."

Supporters of drug reform are looking at Trump's early personnel picks and expressing alarm. The Drug Policy Alliance is highlighting an early Trump decision – the appointment of Jeff Sessions – in online fundraising advertisements asking supporters for help to challenge the new Attorney General's "every step".

"We're very concerned," says Drug Policy Alliance Deputy Director Michael Collins.

"This is the guy I would have named if you had asked me a year ago who would be the worst pick for Attorney General. He was the worst senator on these issues, and now that he's the top cop, it's going to be very challenging."

Sessions is a hardliner on drug enforcement, sentencing reform and forfeiture. Last April, he summed up his views on cannabis at a Senate hearing.

"We need grown-ups in charge in Washington saying marijuana is not the kind of thing that ought to be legalised, it ought to be minimised, that it is in fact a very real danger," he said.

Sessions blocked sentencing reform legislation that was supported by his own party and supports the use of 'civil asset forfeiture', which allows Police to confiscate property from people who may not be accused of a crime. Drug convictions made up 40 percent of convictions when Sessions served as US Attorney for the Southern District of Alabama – double the rate of other Alabama federal prosecutors. In the 1980s, he famously said he thought the Ku Klux Klan "were OK until I found out they smoked pot".

Sessions' confirmation hearings saw him largely avoid questions on legal cannabis. But the very fact he was asked them is important, says Collins.

"We have gone from two states legalising to basically seven, so we now see additional support. A number of senators asked Sessions about recreational marijuana and gave remarks about their

> **There is a strong political argument against clamping down on legalised cannabis: politically, pot is more popular than Trump.**

concern. It's quite telling about where the political winds are."

Sessions was confirmed by 52 votes to 47 at the end of a bitter nomination process.

But Institute for Policy Studies Fellow and Drug Policy Project Director Sanho Tree says the problem isn't just with Sessions.

"The whole new Cabinet is incredibly backwards," he says, pointing to Health and Human Services (HHS) Secretary Tom Price, who voted against virtually every drug policy reform bill, including medical cannabis provisions supported by other Republicans.

Although federal regulation of illicit drugs rests primarily with Sessions' Justice Department, drug reform advocates fear Price could use his powers to penalise doctors or take legal action against sellers working with medical cannabis.

One of the most far-reaching drug policy decisions for the new administration will be on the 'Cole memo', which has broadly protected states that have legalised cannabis from federal intervention.

Under federal law, cannabis remains a Schedule 1 drug just like heroin, meaning it has no medical value, has high potential for abuse and there is no accepted safe use, even under medical supervision.

The non-legally binding memo was drafted by the Deputy Attorney General in 2013 to advise federal law enforcement agencies on how to approach states that have legalised cannabis.

The memo suggests US attorneys not bring federal prosecution against individuals or business that are compliant with the cannabis regulations of their states – unless their behaviour violates particular federal priorities that include preventing the distribution of cannabis to minors and preventing revenue from going to criminal enterprises.

Trump's administration has four choices. The first is to maintain the status quo – "keep the memo in place, focus on other things and not make this an issue," as SAM's Sabet puts it.

"I don't think that's going to happen."

The Trump administration could rip up the memo and enforce federal law,

> **The whole new Cabinet is incredibly backwards.**
>
> SANHO TREE

possibly warning states that they could lose federal funding.

At the other extreme, it could pass a 'states' rights' law that allows cannabis to be legalised.

Or it could 'enforce' the Cole memo, meaning the federal government would determine whether states have violated its terms.

"Monitoring has never been done," argues Sabet.

There is a strong political argument against clamping down on legalised cannabis: politically, pot is more popular than Trump.

"Basically, it beats all politicians in popularity, so it's not a smart move in that sense," says Tree.

It would also risk upsetting states' rights advocates – traditionally Republicans.

While nobody can confidently make any predictions about the future of the Cole memo, one ostensibly drug-related policy has been made very clear: President Trump will build a Mexican border 'wall' to stop the flow of "bad dudes" and contraband – although it is not expected to impact the flow of drugs.

"Walls are essentially a Bronze Age technology," says Tree. "Humans have had thousands of years to develop countermeasures."

Tree expects international counter-narcotics measures to be strengthened.

"It's about posturing and looking tough. People who pay a price are overseas with no lobbies here to protect them."

At least one key player in drug policy is yet to be announced: the so-called 'Drug Czar' or Director of the Office of National Drug Control Policy. Florida Attorney General and Trump transition team member Pam Bondi was seen as an early contender. Bondi opposed Florida's medical cannabis ballot measures in 2014 and 2016. Frank Guinta, a former New Hampshire lawmaker, has also discussed the role with Trump's team. The former congressman made the opioid crisis a central focus in his most recent term, advocating for legislation that passed last year aimed at countering the epidemic of addiction to painkillers, as well as accompanying funding.

> **When the administration does start rolling out pilot initiatives, in any normal administration, that will require months of work and a long process of inter-agency communication, fighting over every comma ... Trump can destroy all of that in one 3am tweet. That's the wild card.**
>
> SANHO TREE

As Trump settles in to the White House, those on both sides of drug policy reform are reflecting on the legacy of his predecessor.

"It's one of those things where you don't always appreciate what you have at the time," says Collins.

"The former administration doesn't get an A+ grade, but it did a lot to move rhetorically from the War on Drugs, [and] the President's clemencies [given to prisoners on drugs charges], a lot of work on treatment instead of incarceration [and] a Drug Czar who is in recovery were symbolically important."

Tree adds, "Obama's Drug Czar did a lot of good on harm reduction. In that sense, it's going to be hard to see how Trump does any better."

Unsurprisingly, anti-legalisation group SAM has a different view.

Kevin Sabet says, "Unfortunately, in the last four years, you've seen this massive proliferation of Big Marijuana, which makes massive money off of heavy use especially among college students."

It remains to be seen whether anti-legalisation advocates like SAM end up any happier about the new administration's policy direction.

The biggest unknown factor is possibly the impetuous President himself. Trump is a teetotaller who has expressed just about every imaginable position on drug legalisation.

"When the administration does start rolling out pilot initiatives, in any normal administration, that will require months of work and a long process of inter-agency communication, fighting over every comma," says Tree.

"Trump can destroy all of that in one 3am tweet. That's the wild card." ■

David Young is a journalist based in Washington DC, USA.

Population 2016:

24.2m

The sky hasn't fallen on: Australia

In this third instalment of our series on innovative drug policies in different countries, we look to our neighbours across the Tasman. We discover that, even though some states in Australia removed criminal penalties for drug use and possession more than a quarter of a century ago, you have to work pretty hard to find any evidence of anything much bad happening as a result.

What is the law in Australia?

Australia has had cannabis and other drug decriminalisation policies in place for over 25 years, though each state or territory takes its own, quite different, approach. South Australia, Northern Territories and Australian Capital Territory have decriminalised cannabis possession de jure (in law). This means that, rather than a criminal charge, cannabis users get a civil penalty, such as a fine. The flip side of this is that people still end up with a criminal conviction if they don't pay their civil fines (which seems to happen quite a bit).

Western Australia also adopted a civil penalties scheme in 2004 but then returned to a criminal model in 2011, for political reasons. Instead, Western Australia and the remaining states and territories have de facto decriminalisation. This means that, while use and possession remain a crime, Police will usually refer users to education and treatment rather than prosecuting. In most states, de facto decriminalisation applies to possession and use of all illicit drugs, not just cannabis (see table opposite).

So how has decriminalisation impacted on cannabis use?

Most of the research appears to show that the various decriminalisation and depenalisation policies in Australia have had very little or no impact on people's decision to use cannabis or other drugs. Some studies have found a slight increase in usage, but most have not. Research is made difficult though by the fact that states and territories have a mixture of de facto and de jure decriminalisation for cannabis and for other drugs and that these policies have developed and been tweaked over a long period (back to a time when we were not so good at keeping statistics on everything). In addition, some of the states that have not decriminalised actually have less strict rules and prosecute fewer people than those that have, meaning that comparisons between the states are difficult.

How about the effect on crime?

One illuminating recent Australia-wide study compared the cost-effectiveness of arresting minor cannabis offenders versus cautioning and then diverting them into education or treatment programmes. The results were unequivocal: arrest was a lot more expensive and no more effective in deterring the usage of those caught.

Decriminalisation in Australia by legal model, drug and state/ territory, for people aged 18 and over

	DE JURE REFORM		DE FACTO REFORM	
State/Territory	Cannabis	Other illicit drugs	Cannabis	Other illicit drugs
NSW			✓	
QLD			✓	
VIC			✓	✓
SA	✓			✓
WA			✓	✓
TAS			✓	✓
ACT	✓		✓	✓
NT	✓			✓

Source: Decriminalisation of drug use and possession in Australia (2016) – Drug Policy Modelling Program, NDARC, UNSW Australia

Cost of caution, plus education/treatment	A$388
Cost of arrest	A$733

In terms of the effect on cannabis consumption after arrest or caution, there was no statistically significant difference between the two approaches (in both cases, usage barely changed at all).

Some opponents of drug law reform worry that decriminalisation might lead to an increase in crime as people perceive laws to be weaker. This isn't borne up by the evidence in Australia, where they have found that people who do not receive a criminal record are much less likely to engage in future crime or have contact with the criminal justice system, even when you take into account their previous offending history. There is also no evidence from Australia that decriminalisation has led to a rise in other types of crime.

So have there been any significant negative effects?

Yes – "net widening". In some states, more people were sanctioned after reform than before, simply because it had become easier for Police to process minor drug offences than it was before. If we were to decriminalise in New Zealand, this effect should be avoidable by tweaking the policy design.

Our overall conclusion?

Moving to a decriminalisation model has not caused the sky to fall in on Australia. ■

"The fact is that, today, fewer young people are smoking tobacco, using drugs or consuming alcohol than their parents' generation did."

STEFAN GRUENERT, CHIEF EXECUTIVE OF ODYSSEY HOUSE VICTORIA

Medicinal cannabis

As of late 2016, Australian businesses can now apply for a licence to cultivate cannabis for medicinal use or to conduct research. Individual states will decide whether the use of medicinal cannabis will be allowed and by whom, at what dosage and who will dispense it.

So far, states and territories are taking a range of approaches to the use of medicinal cannabis. In Queensland, specialists will be able to prescribe medicinal cannabis to treat illnesses including MS, epilepsy, cancer and HIV/AIDS. In New South Wales, cannabis will be available for end-of-life illnesses, and in Victoria, for children with severe epilepsy.

Cannabis use patterns

Cannabis is the most common illicit drug in Australia.

34.8% of Australians aged 14 years and over have used cannabis one or more times in their life

10.2% have used it in the previous 12 months

National Drug Strategy Household Survey 2013

How does this compare with NZ?

42.0% aged 15 years and above have tried cannabis, and 11% used it in the last year (2012/13)

"I have enjoyed the many blessings that cannabis can bestow for a lot of my adult life and have not lost my mind or become a serial killer."

FIONA PATTEN, A VICTORIAN UPPER HOUSE MEMBER

Drug use patterns

ALCOHOL IS THE MOST WIDELY USED DRUG IN AUSTRALIA.

18.2% **Around 1 in 5** Australians over 14 drink at levels that put them at risk of alcohol-related harm over their lifetime

41.8% of Australians aged 14 years and over have used illicit drugs in their lifetime

National Drug Strategy Household Survey 2013

Jail time for illicit drug offences

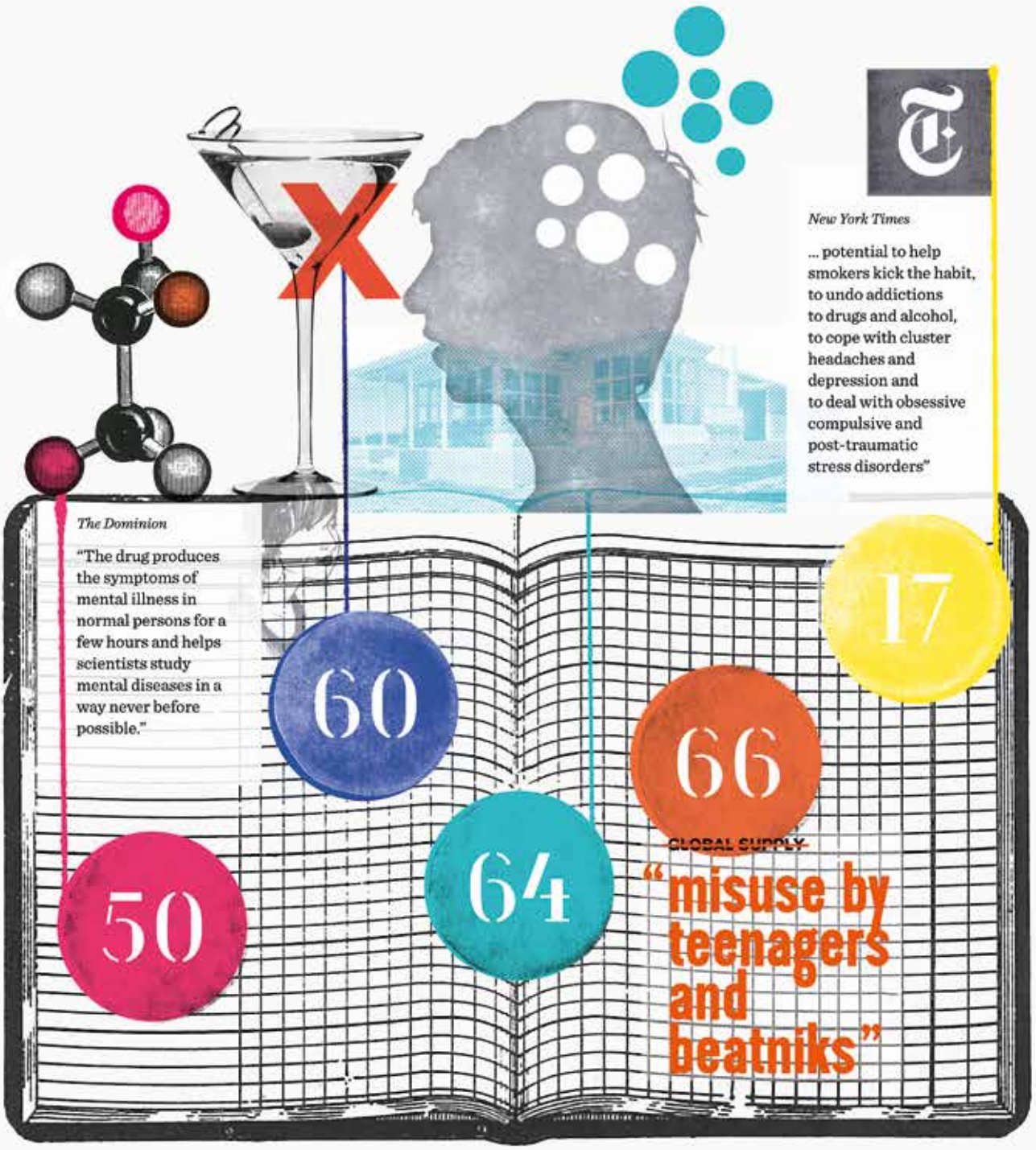
4,700 people in jail for illicit drug offences at June 2015

13% of 36,100 prisoners in Australia

Australian Bureau of Statistics

"... decriminalisation has not resulted in the catastrophic explosion in cannabis use many predicted as a result of decriminalisation."

EASTWOOD, FOX & ROSMARIN: *A QUIET REVOLUTION : DRUG DECRIMINALISATION ACROSS THE GLOBE*, MARCH 2016


New York Times
... potential to help smokers kick the habit, to undo addictions to drugs and alcohol, to cope with cluster headaches and depression and to deal with obsessive compulsive and post-traumatic stress disorders"
The Dominion
"The drug produces the symptoms of mental illness in normal persons for a few hours and helps scientists study mental diseases in a way never before possible."
60
17
66
64
50
GLOBAL SUPPLY
"misuse by teenagers and beatniks"

REDMER YSKA

ARTICLE 04

LSD:

New Zealand's LSD history

Redmer Yska tells how LSD rose, fell and is maybe rising again for both recreational and therapeutic uses.

It's half a century this year since New Zealand followed Britain and the USA in outlawing the mind-bending compound LSD. Less well recorded are the scores of 'acid tests' legally performed to treat mental illness here.

Lysergic acid was criminalised on 7 July 1967, the same day TVNZ screened a documentary describing the widespread use of pure Swiss LSD (Delysid) in local therapeutic settings, especially in Dunedin and Christchurch.

Police later arrested a Parnell writer and contributor to the *Compass* programme for possessing the "nefariously evil drug" impregnated into sheets of blotting paper. His lawyer, complaining of a witch hunt, assured an Auckland magistrate, "there's no evidence that the youth of this country is being ruined by drugs; there is no evidence that a large proportion of people are taking LSD and cannabis".

By 1967, LSD was an incendiary topic, already the most famous illegal compound in the world, trumpeted on the cover of the American weekly *Time* magazine. It was blamed for spawning a counter culture of "turned on" acolytes, a tie-dyed global "underground" with its own newspapers, paintings and posters, nightclubs and fashions, movies and theatre, literature and especially music.

According to American writer Jay Stevens, aficionados named it acid "partially on account of its usefulness in burning off that Greco-Judaic-Christian patina, but mostly because the drug's technical name was D-lysergic acid diethylamide."

So what led it to be used so widely in Kiwi psychiatry? The first local reports about "the drug that produces madness" turn up in the mid-1950s, a decade after Swiss chemist Albert Hoffman accidentally discovered its psychoactive properties. *The Dominion* noted, "The drug produces the symptoms of mental illness in normal persons for a few hours and helps scientists study mental diseases in a way never before possible."

By 1960, LSD's potential in treating addiction was widely acknowledged. In 1962, a TVNZ programme showed a Canadian woman taking it to help cure herself of alcoholism. As a storm of criticism blew up, Health Department official Dr Geoffrey Blake Palmer assured viewers that lysergic acid "is most definitely not a drug for general use".

Dr Blake Palmer, who would later chair major inquiries into illegal drug use in New Zealand (including LSD), suggested local psychiatrists, however, were eyeing it up as a useful tool in therapy. A colleague added, "It is unlikely any ordinary person would be able to gain access easily to such a drug in New Zealand."

In the USA, misuse of legal LSD was skyrocketing. Auckland folk singer Bryce Peterson was among a handful of locals to privately experiment with it. He'd write a song about his experience, memorably entitled *Slightly-Delic*. Recorded with his band House of Nimrod, it remains a rare classic of Kiwi psychedelic pop.

By 1964, 'acid tests' in therapeutic settings were commonplace in New Zealand. Records show psychiatrists were administering ampoules of Delysid, provided free by Swiss manufacturer Sandoz, to scores of consenting patients. The drug appears to have been in common use across Dunedin – at Cherry Farm, in the psychiatric department at Waikari Hospital and at Ashburn Hall.

The global criminalisation of LSD both demonised the drug and ended this research phase. In May 1966, Sandoz announced it would no longer supply the drug globally because of "misuse by teenagers and beatniks". The local branch of the Royal Australian and New Zealand College of Psychiatrists complained that "the drug had been found useful and that it was desirable that supplies be continued".

But only under therapeutic supervision. An unnamed Dunedin psychiatrist, said to have been using LSD in conjunction with psychotherapy, commented, "It would be deplorable if the availability of drugs is dictated by delinquents and hooligans."

In October 1966, the *New Zealand Medical Journal* issued the first dispatch from the frontlines of the legal Kiwi 'acid tests'. Dr David Livingstone's article 'Some Observations on the Usefulness of Lysergic Acid in Psychiatry' showed that, over two years, this Christchurch psychiatrist had administered LSD to 55 consenting patients in 131 closely supervised sessions, each lasting up to eight hours.

In colourful language, Livingstone noted how LSD had attracted "fascinated curiosity, fearful repugnance, reasonable healthy scepticism, and the tender hope of acclaiming an instrument which may make for a major breakthrough in understanding and treating mental and personality disorders".

He praised "the penetratively healing properties of this psychedelic drug … an agent of major therapeutic capability, facilitating personality change, and of help in resolving those disorders of the mind and personality which are deep rooted in the life experience of the human being".

At the same time, he underlined the need to restrict its use to therapeutic settings, warning of the "life threatening personality disintegrating propensities in the hands of unskilled experimenters", likening it to "making hand grenades available to delinquent youths".

The article indicates that Livingstone's sessions at Calvary Private Hospital in Christchurch chiefly involved 100 micrograms of LSD, a relatively small dose. He was prepared for panic attacks, with a cocktail of barbiturates and even methamphetamine on hand to calm participants down.

Within a few months of the government's decision to ban LSD, a local psychiatrist said the drug was still available for limited study, but its use in therapeutic settings was tailing off. By this time, headlines were telling of suicides, murders and all kinds of dangerous activity linked to the substance.

Half a century on, research shows that the "life threatening personality disintegrating propensities" described by Dr Livingstone were restricted to a relatively small percentage of LSD users.

And as the *New York Times* reported recently, increasing numbers of scientists are meanwhile revisiting lysergic acid, half a century after its spectacular international fall from grace.

"They are studying hallucinogens' potential to help smokers kick the habit, to undo addictions to drugs and alcohol, to cope with cluster headaches and depression and to deal with obsessive-compulsive and post-traumatic stress disorders," the newspaper said.

How long will it be before New Zealand researchers join those in renowned institutes including those in New York, Los Angeles, Zurich and London? ■

New tech for drug detection

It's almost the stuff of science fiction. Will trending new handheld devices for identifying substances become an important and useful detection tool, or are they unnecessary and a potential further intrusion on our civil liberties?

Late last year, New Zealand Customs announced it was expanding the use of FirstDefender handheld chemical analysers to a dozen locations around the country after a successful trial with a single device purchased for use at the International Mail Centre in Auckland in 2014.

Like the first devices, the 14 new ones were purchased with funding from the Criminal Proceeds (Recovery) Act, at a cost of nearly a million dollars. Customs Minister Nicky Wagner said they were being deployed to Customs posts in Opua, Auckland, Tauranga, Napier, New Plymouth, Wellington, Nelson, Christchurch, Timaru, Dunedin, Queenstown and Bluff.

So what are these things?

Remember the tricorders in *Star Trek*, which could analyse the contents of anything they were pointed at? A FirstDefender is a little like that. It uses Raman spectroscopy to quickly identify molecules by shining a laser light on them.

Each molecule has a specific spectral 'fingerprint' – defined by the position and relative intensity of a peak along a wavelength axis that can be matched against a library of reference profiles available to the device. That library can be updated as new drugs appear, and inconclusive results can be referred to a full-scale lab.

Inside the laboratory, these techniques have been commonly used for three or four decades, but in the past 10 years, Raman devices have become progressively more portable and, now, handheld.

The key practical advantage of Raman spectroscopy for field use is that it requires very little surface preparation, so the device can simply be pointed at a suspect substance, even through translucent packaging. (Alternatively, the substance being investigated can be placed in a vial that fits into the FirstDefender.) It is non-destructive and can also identify chemicals dissolved in water or alcohol. It's 'point and shoot', and results are shown within minutes or even seconds.

Although the FirstDefender devices, made by Thermo Scientific, can be used to identify any chemical substance, including explosives, Wagner emphasised their role in making drug identification faster, safer and more efficient for frontline officers.

"These devices will be a fundamental piece of equipment … making drug identification quicker, safer and more efficient. They are portable and easy to use, making it ideal for district ports and can be used for Customs' search warrants or taken on board vessels that are searched."

Customs says that, in Auckland, powders, crystals, liquids, creams, gels, tablets, capsules and paper tabs have all been successfully tested. Customs also reports successful testing on plant material. (While cannabis itself is hard to test for in the field because it fluoresces under laser light, drowning the Raman spectrum, synthetic cannabinoids sprayed onto plant matter can be reliably identified.)

Thermo Scientific says its "sophisticated algorithms" automatically determine the presence of mixed and contaminated chemicals. Other scientists note the relatively poor detection limits offered by the technique and the difficulty of identifying multiple chemicals in one sample, which may mask each other.

"Remember the tricorders in *Star Trek*, which could analyse the contents of anything they were pointed at? A FirstDefender is a little like that."

We were told by one scientist, "As you can imagine, when you overlay one fingerprint (compound A) over the top of another (compound B), there is no immediate way of telling or proving which peak belonged to which compound in the resulting sample spectrum. The computer has the advantage of being able to determine whether the sample spectrum is consistent with any specific two of the library spectra being overlayed on top of each other. As the number of components gets larger, this matching will get harder."

A 2011 review of Raman spectrometry in drug detection from Kent University in the UK correctly predicted it would increasingly "move out of the specialised laboratory and into the field with the use of portable systems". It also noted evidence that Raman spectroscopy is capable of being used to identify drug traces on fingers, clothes and even fingerprints, although not in the field.

Should we be concerned?

YES

These devices are appropriate as screening tools only. They don't provide definitive answers at an evidential level, and even a trained Customs officer would be unlikely to be recognised as a court room expert in chemical analysis. It would be a concern if evidential standards were lowered to allow that – but that's exactly what US Police forces already using the devices are calling for.

(The issues are similar to those in fingerprint identification, where computers can find a few apparent matching prints, but the expert fingerprint examiner needs to review those hits and form their own view about a probable match.)

While Customs is using the devices appropriately at the moment, manufacturers continue to promote uses at the edge of their capabilities. Again, we should be wary of them becoming a cheap 'point and click' way of performing tasks that should really require a definitive result from a lab-based mass spectrometer – especially if that involves detecting traces on personal effects.

If these devices – which currently cost tens of thousands of dollars each – are taken up by Police, as they have been in other jurisdictions, will there be pressure to justify the investment, perhaps by pursuing prosecutions in a way that might not have been the case before?

And if they get cheaper and more widely available – perhaps as add-ons on smartphones – what are the implications? More intrusive practices in workplaces? Drug dealers buying them to validate their own goods?

Further, why is it that only Customs has access to this technology? For emergency doctors, being able to positively identify the contents of a powder or pill that comes in with a patient may be a matter of life or death. Are the results being shared by Customs in a timely and useful manner? ■

NO

This is a fast and reliable technique that lets Customs officers know what they're dealing with without recourse to a laboratory. They then know whether to investigate further – and whether to take safety precautions in handling the material.

By contrast, the usual method of indicative testing, with 'wet chemistry' kits, means packaging has to be broken, exposing staff to potentially dangerous chemicals – or perhaps spoiling the contents of an entirely benign package. It's also highly subjective when it comes to analysis and subject to false negatives and positives. Raman spectroscopy is quicker, safer and vastly more accurate.

The use of FirstDefender should also avoid wasted time in lab-testing suspicious samples that turn out to be benign. In six months' testing in Auckland last year, just over half of the substances tested for the presence of drugs turned out not to be controlled drugs and could be quickly released. Customs gives the example of a bag of suspect white powder that took hours to deliver to and urgently analyse in a lab last year but turned out to be PVC, or plastic. FirstDefender could have cleared it on the spot.

As the devices' ability to identify multiple chemicals in a sample improves, they will provide intelligence on what mixtures are entering the market – and, with further analysis, allow assumptions to be made about lines of supply and manufacture. Indeed, some Police forces using them in the US already report being able to trace drug batches to the actual dealer.

The results may not be 100 percent perfect, but repeated trials have indicated that errors, accounting for 3–5 percent of tests conducted, are typically false negatives rather than false positives. This seems a big improvement on reagent-based field test kits – which, in the US, have seen many innocent people arrested and placed under charge for months, only for the presumptive test to be overturned by proper lab analysis.

Will the use of portable Raman spectrometers expand? If the price falls as expected, quite probably – and that's largely a good thing. They could provide a non-destructive means of analysing food and drink or have a role in detecting fake pharmaceutical drugs. And, of course, they could contribute greatly to harm-reduction efforts at clubs and festivals.

Really, there's nothing to worry about here. ■

→ INTELLIGENT FINGERPRINTING

Picture a crime scene. The only lead is a single fingerprint, for which Police can find no match. And yet investigating officers can tell the suspect's gender, his grooming habits – and that he uses marijuana and methamphetamine.

That's the promise of a new technique presented in 2015 by researchers at Britain's Sheffield Hallam University and the Netherlands Forensic Institute. They were able to inspect traces of sweat in fingerprints with a technique called MALDI imaging mass spectrometry (MALDI-IMS) and detect a range of drugs and their metabolites.

The research has been funded by the UK Home Office since 2011 and has been trialled by Police at crime scenes. And the technique is about to go commercial.

Intelligent Fingerprinting, a company spun off from work at the University of East Anglia, says it is nearing launch of the "world's first handheld fingerprint drug-testing device". Pictures on the company's website show a disposable cartridge that is used to collect the fingerprint sample and then inserted in a 'reader' that delivers a result within 10 minutes.

The fact that metabolites are detectable should mean that drug use can be distinguished from mere contact with a contaminated surface. And, of course, it has the additional benefit of capturing a unique identifier of each subject – the fingerprint itself.

Intelligent Fingerprinting recently completed a two-year study of its technology in a Finnish drug rehab centre, and at last year's Global Addiction Conference, the company's Business Development Officer Dr Paul Yates billed it as "a more effective and compassionate approach to drug screening" than urine tests.

But the company is also promoting its use in other settings, including workplaces. Will it make workplace drug testing more acceptable and harder to refuse? And what are the implications of its use in border-control environments, where fingerprints may already be taken? Will countries such as Singapore, which prosecutes drug consumption by citizens even beyond its borders, have a powerful new tool?

Dear politicians: drug policy matters in election year

In this message to New Zealand politicians, **Kali Mercier**, the Drug Foundation's Senior Advocacy and Policy Adviser, explains why drug law reform should be an important election issue this year and why politicians need no longer fear that supporting change will lose them political traction.

KALI MERCIER

There is no denying the topic of drugs can bring out strong feelings. For some, drugs are a moral issue. Words like 'evil', 'scourge' and 'War on Drugs' are bandied around by our media, and there's always someone calling on the government to 'come down hard' on dealers. In a recent outburst, one TV commentator even called for methamphetamine manufacturers to be shot in the back of the head.

That may be why most New Zealand politicians seem keen to avoid rethinking our drug legislation. Perhaps they see the issue as too contentious, too 'fringe', too polarising – especially with an election fast approaching. Better to stick to the mainstream issues, such as housing, education and the economy, and try to ignore marginal issues like drugs ... right?

Actually, we argue that the wide-ranging negative effects of our outmoded drug law make this issue anything but marginal. Drug harms, and how we deal with them, feed into so many of the core issues politicians grapple with, including poverty, crime, Police numbers, overfilled prisons, housing insecurity, poor outcomes in social development, health, mental health and education. And it costs a lot. The New Zealand Drug Harm Index estimated the total social cost of illicit drug-related harms and intervention at a whopping $1.8 billion in the 2014/15 year.

Our drug law is simply not fit for purpose. The criminal model both stigmatises drug users and is a barrier for people seeking the help they need. And because drugs are illegal, we can't have the kind of sensible public debate about their impact that we need. Instead, public discourse is side tracked by sensationalist scare mongering about crime waves and drug epidemics.

Drug addiction tears apart families – but so does our drug law, which not only fails to protect people from harm, but adds to it by introducing people into the criminal justice system. As of December last year, 13 percent of our prisoners – around 1,300 people – were incarcerated primarily for 'drugs and anti-social offences'. In 2015, 1,726 people were convicted for cannabis possession or use. Having a conviction has many negative impacts on an individual's life and earnings. And, sadly, we know a parent having a conviction correlates with a decrease in their children's life outcomes.

So our next question to our politicians is: in 2017, is drug law reform really as contentious as you think? In a survey commissioned by the Drug Foundation in August last year, 64 percent of respondents agreed that possessing a small amount of cannabis for personal use should be either legal (33 percent) or decriminalised (31 percent). To repeat: two-thirds of New Zealanders are totally up for cannabis law reform. That doesn't sound particularly contentious.

In fact, having a major party come out strongly in favour of cannabis law reform could be galvanising for voters. This is what happened in Canada, where Prime Minister Justin Trudeau sailed to power on a ticket that included a commitment to legalise cannabis. And do New Zealanders in the Age of Trump need some visionary policy to get behind? We would say, "definitely".

Drug law reform is also gathering steam in the rest of the world, so if we changed our drug law, we would not be doing anything particularly 'out there' on a world scale. Recreational cannabis is now legal in eight US states and has been decriminalised in 18 more. In Chile and Jamaica, it's legal to grow it. In Spain, it's legal to smoke at home, and if you smoke in public, you'll get a fine, not a conviction.

> **“It’s worth underscoring here that we want to see reform not because drugs are safe but precisely because they can be very harmful.”**

> **“There’s now plenty of evidence that decriminalising or legalising drug possession does not lead to social breakdown or dramatic uptakes in youth drug use.”**

> **“The Drug Foundation would like to see a public health approach to drug regulation focused on minimising harm.”**

In Uruguay, you can possess, cultivate and sell cannabis completely legally. And cannabis has been decriminalised in a host of other countries.

There’s now plenty of evidence that decriminalising or legalising drug possession does not lead to social breakdown or dramatic uptakes in youth drug use. Countries that have decriminalised on the whole do not appear to have seen increases in health harms or drug use – though much depends on policy decisions around marketing and price and how much money is invested in treatment and prevention. As added bonuses, dropping criminal penalties saves vast sums on enforcement costs, and regulation could significantly increase tax revenue.

So what do MPs say about drug law?

Prime Minister Bill English is not a big fan of medical cannabis, and it’s certainly unlikely he will propose legalising recreational cannabis any time soon. Labour leader Andrew Little is reticent too, reportedly saying he doesn’t think decriminalisation would work as a policy and legalisation is not an option for Labour.

Amongst the smaller parties, there is more flexibility. United Future’s Peter Dunne (Associate Minister of Health) is keen to be involved in a review of the legal penalties for drug possession later this year. Asked whether he might favour replacing criminal penalties with civil, Dunne reportedly said it was premature to speculate, “but any review opens up a range of possibilities”.

NZ First would like a referendum on cannabis legalisation. Act leader David Seymour does not come out directly in favour of decriminalisation, but he’s very sceptical about the benefits of the status quo. Māori Party co-leader Marama Fox supports broadening access to medical cannabis and would like a “wider debate” on decriminalisation.

So far, the Green Party is alone in publicly supporting regulation for both recreational and medical cannabis use. Its recent policy also calls for increased prioritisation of drug education, treatment and intervention.

So what model of law reform do we propose?

The Drug Foundation would like to see a public health approach to drug regulation focused on minimising harm. For us, this means removing criminal penalties for all drug use, possession and social supply and exploring different options to reduce the harm arising from both current law and from the drugs themselves.

We’d also like to see a strictly regulated legal cannabis market. The word ‘regulated’ is key here. As with alcohol, communities need a say over where and how cannabis is sold and consumed, and there should be strict controls over price, potency, marketing and type of products available. We don’t particularly want to see cannabis lip gloss and jellybeans on sale, for example. Policy should be designed with health and other social impacts first and foremost, and these decisions should not be industry led. We’re definitely not advocating a profit-driven model in which ‘Big Cannabis’ joins the table with ‘Big Tobacco’ and ‘Big Alcohol’.

Canada could be a valuable guide for us here. Its government taskforce released a cannabis policy framework in November last year, designed specifically to protect young people from harm and to keep profits out of the hands of criminals.

It’s worth underscoring here that we want to see reform not because drugs are safe but precisely because they can be very harmful. It is crucial that any law reform includes greater resourcing for prevention, education and treatment. Any revenue gathered through taxation should be ear marked for those purposes.

So what would we like to see from you this year, MPs?

A good start would be recognition that taking a positive stance on this issue is likely to gain you support, not lose it, because most New Zealanders stand behind cannabis reform. Taking an evidence-based approach to drug law is now a real option for any MP who cares about crime, justice, healthcare and saving the taxpayer money.

So what are you waiting for, MPs? ■

Talking with Kiwis about drug reform

As part of our effort to ensure drug reform is a key election issue, the Drug Foundation is planning to bring as many voices as possible together this year to see whether we can develop some consensus around what specific legal model might work best in Aotearoa. We’ll be holding community hui and talking to iwi, politicians, school principals, young people, drug users and many others. Watch this space if you would like to be involved.

Putting anti-drug rhetoric on ice

There has been a proliferation of anti-meth approaches across the Antipodes based more on fear than facts. **Nicole Lee** uncovers some of the false rhetoric and looks more closely at what actually does work to reduce meth use.

NICOLE LEE

It is clear that crystal methamphetamine (or ice as it's known in Australia) is capable of causing significant harm, but when facts are distorted to create fear and stigma, it really helps no one. People who use meth and their families suffer, and it puts up walls that make the work of the health and law enforcement professionals responding to people who use meth and their families incredibly difficult.

As one former meth user said to me recently, "The biggest barrier to recovery is how badly other people treat you, you start to feel like you're not worth helping."

In Australia, and perhaps in New Zealand too, we've seen an onslaught of unhelpful exaggerated media reporting on ice, culminating this month with a sensationalist documentary on the ABC called *Ice Wars*.

We are not at war with ice. There's no ice epidemic, but there's certainly been a media epidemic. Careless language and exaggerated images create unnecessary community fear that can lead to knee-jerk policy responses and the stigmatisation of people who use drugs. Sometimes, responses to drug use problems seem counter-intuitive, but to effectively resolve this issue, we need to understand the drug and the people who use it based on what we know works.

This is not to suggest there is no problem here. It's just not the problem we've been led to believe. So what's really going on with this drug?

What is meth?

Methamphetamine is a strong synthetic stimulant that comes in two main forms: crystal (called ice in Australia) and powder (called speed in Australia). The crystal form is much stronger than the powder form, but the basic chemical makeup and the effects of both forms are the same. An analogy is light beer and vodka – they are manufactured using different methods but are both alcohol, and you only need 30ml of vodka to get the same effect as 375ml of light beer.

What happens when someone takes meth?

Meth in both crystal and powder forms works mainly by releasing dopamine. Dopamine is the pleasure chemical in the brain. Any time we do anything pleasant – eat a nice meal, watch a sunset, have sex, take drugs – we get a little burst of dopamine that makes us feel good. It reminds us we should do that again.

At low levels, meth increases feelings of wellbeing and confidence because of the increase in dopamine, but large amounts of methamphetamine can increase dopamine by up to 1,200 percent over baseline levels. Excess dopamine in the brain is associated with psychotic symptoms, like paranoia and hallucinations, but the suggestion that everyone who uses meth becomes psychotic is just ridiculous. Around 25 percent of people who use meth have experienced a psychotic symptom at some point – 75 percent never do.

When meth causes the release of excessive amounts of dopamine,

Some of the stories that do the rounds revel in bizarre behaviour, when this is rare.

eventually the brain runs out. Low levels of dopamine are associated with symptoms of depression. Many people feel flat and unmotivated for a day or two after using methamphetamine and about 80 percent of people who use monthly or more experience ongoing symptoms of depression.

Meth also increases noradrenaline, which switches on our fight or flight system, so people taking meth can be 'switched on' and over-alert to threat situations, increasing the risk of aggression. But not everyone who uses meth is aggressive – again, around 25 percent.

The problem is that we don't know who will and won't experience psychosis, who will and won't become aggressive and who will and won't get dependent when they use meth.

Who uses it?

The good news is fewer teenagers and young people are drinking and using drugs than in the past. This is a trend right across the developed world. Those who are drinking and taking drugs do so less often than in previous years. Meth seems to be following the same trends.

According to the latest available data, 1.1 percent of New Zealanders 16 years and over have used the drug in the past year. Those aged 18–34 year olds are the group with the most people who have used this drug, but drug use in this group is declining. Most young people who are offered drugs, including meth, don't try them.

So only a small percentage of the population use meth regularly, and there's fewer that use than a decade ago.

Not everyone who uses meth experiences problems with it. Around 70 percent of people who use meth take it less than 12 times a year and typically use for a short period in their life before they stop completely. This group will probably never need treatment but will benefit from harm-reduction strategies until they decide to quit.

Drug *use* doesn't necessarily mean drug *dependence* (sometimes referred to as 'addiction'). The biggest risk is using more than weekly. Around 15 percent of people use meth at least weekly and are at high risk of dependence and other harms like overdose, injury and poor health. This is just a little higher than for other drugs like cannabis where around 10 percent of people who use are dependent.

What if there is a problem?

Addiction to any drug develops over time. It is not possible to become dependent on any drug after one use, but some people might like it so much the first time they use that they keep using and their body adapts and they become dependent. But many people who use regularly don't become dependent.

Although there is no medication that is effective in treating meth dependence, there are very good psychological treatments available. People who use meth do as well as other people who use drugs when they get treatment, although the relapse rate from treatment is very high, so providing support once treatment is finished is very important.

Even just two sessions of specialised counselling can lead to abstinence. Residential treatment is an option, usually reserved for the most severe and complex cases, but is not the only (or even the first) option for people who use meth.

Preventing meth problems in our kids

Parental influences on drug use

Kids are strongly influenced by their parents' attitudes – in many ways, more

ABC TV's "Ice Wars" was criticised for exploiting people's misery.

than by their peers – so there are things parents can do to reduce the risk of their kids using drugs. Kids are less likely to use alcohol and other drugs, including meth, if their parents delay alcohol and drug use as long as possible, have clear rules about behaviour in general and supervise them closely, do not use alcohol or other drugs in front of them and communicate their values about drugs early.

School-based drug education

School-based drug education can be effective in preventing drug use, but not all programmes in schools reduce the likelihood of alcohol or drug use. Some even increase kids' interest in using drugs.

One popular programme in the US that has been imported to some parts of Australia and New Zealand, for example, involves ex-users showing confronting images of the negative effects of meth and sharing personal stories of suicide attempts, mental health problems and deaths from meth.

It seems logical that this might dissuade young people from experimenting if they can see the dark side of drug use, but young people think about the world differently to adults, and research has shown that it actually normalises drug use and increases the risk that young people become interested in using meth.

We know that unstructured chat sessions, lecturing and use of former drug users or Police to deliver prevention messages doesn't work. Schools, parents and governments shouldn't be allowing these methods in schools at all.

What can families do when there's a problem?

Families often suffer a great deal when a relative develops a problem with meth. There's no right or wrong way of responding, but when family members have vastly different responses or change the way they cope in unpredictable ways, conflict in the family can result. Agree on boundaries and responses, and stick to these as much as possible. It can help family members to get support from a therapist who specialises in alcohol or other drug problems in the family or from one of the many support groups available.

Families can encourage the person who uses drugs to seek help from a number of sources if they're ready. When families are involved in an effective way, the person using drugs is more likely to engage in treatment and outcomes are better. If the person isn't ready to seek treatment, talk to a family specialist who can explore options for encouraging someone into treatment.

American TV-style 'family interventions' or *South Park* 'fat camp' style interventions are unhelpful. They work on the premise that the person using is in denial about their drug use and how it affects others. They are designed to force the person to see those connections. However, confrontation is unlikely to

"Families can encourage the person who uses drugs to seek help from a number of sources if they're ready."

end in great insight, and it's often distressing for all involved. People who are 'encouraged' into treatment through 'family interventions' are less likely to stay in treatment and more likely to relapse.

There is also no evidence that forcing people into treatment works to reduce drug use in the long run. It may even backfire, creating more resistance to treatment. Even if you could force someone into treatment, you can't force them to make changes. As the saying goes: You can lead a horse to water but you can't make it drink.

So what should we do?

So if confrontation, scare campaigns and misinformation are not solutions, what should we do? Here are the most important things to focus on.

- Accurate education and early discussions about alcohol and other drugs can prevent or delay kids taking up drugs. Parents should communicate their values to their kids from an early age, and schools should only use programmes that are proven effective in reducing interest in alcohol and other drugs
- It's not possible to eliminate drug use, and there will always be some who want to experiment with drugs. The best response is to introduce programmes that reduce harms, with the knowledge that most people who use meth don't become dependent and will eventually stop
- Ensuring the availability of a range of treatment options has been shown to be effective. Confrontation and forced treatment can backfire and make the situation worse.

Drug and alcohol responses can sometimes be counter-intuitive but if we stick with what we know what works rather than what we think might be helpful, we can effectively tackle the problem of meth use in the community. ■

Nicole Lee is Professor at the National Drug Research Institute, Curtin University in Perth, Western Australia, and Director at 360Edge, Australia's leading alcohol and other drug specialist consultancy.

Photo credit:

Dr Huhana Hickey

Dr Huhana Hickey (Ngāti Tahinga, Whakatōhea) is a research fellow at the Auckland University of Technology and an outspoken medical cannabis law reform campaigner. She has been in a wheelchair since 1996 but was only formally diagnosed with primary progressive multiple sclerosis in 2010. It's a rare form of the disease that never goes into remission.

Q How did you come to be speaking up for improved access to medical cannabis?

A Well, basically it was pain. I got very tired of the morphine, the tramadol, the gabapentin, the codeine and all the damage they caused. I started doing some research into alternatives and came across trials of medical cannabis.

I'd tried cannabis as a teenager, and while it made me feel pretty good, I don't drink or do drugs now so I was a bit hesitant. I didn't want to end up being stoned or unmotivated all day.

I'd heard about Sativex and found a pain specialist who was able to help me apply for it. It took 10 days before it began to work and then the difference was amazing. Even my boss commented on how focused and better functioning I had become.

Anyway, I have a history of advocacy and was the first-ever solicitor for Auckland Disability Law in 2008, so it's natural for me to speak up.

Q You're moving from Sativex to the new Tilray medication. What's behind that change?

A Tilray is a more natural product. What I hate about Sativex is the peppermint, which actually adds to your spasms, and that it's alcohol-based. I really don't like alcohol or that Sativex makes me smell like a brewery. Tilray is based on coconut oil and cannabis oil, and I'm hoping it works as well as Sativex.

Q What do you see as the main barriers to improved access to medical cannabis?

A Cost and attitude, but cost is the big one. We need to make it more affordable than $1,200 or even $700 a month. It's destroying me financially.

So do I keep going down the expensive legal route or do I take the risk and access my meds underground like so many others? I want a doctor's support in monitoring my condition and my wellbeing. You don't get that if you go illegal. If you get caught and the Police decide to prosecute, not only will you go to jail, but you'll end up back on those nasty drugs, unable to be well.

After cost, the biggest thing is the irrational opposition of PHARMAC's board towards medical cannabis products. There are a lot of products containing cannabis that could help with a lot of conditions, and they can't be smoked or misused, such as balms, so what's the harm in them?

The system itself isn't such a big barrier. If you meet the criteria, you can get medical cannabis products. But I think doctors need education around it so they're aware of what's available and what it can do. A lot of them aren't.

Q Why do so many people get wound up by the idea that cannabis can be a medicine?

A Many people are against it because they assume you get stoned – which you don't.

You know, cannabis used to be routinely used as a medicine up to the 1930s and before the Reefer Madness propaganda, so it's not like we haven't had it before. But there's still a lot of stigma around it, particularly aimed at the poor and people of colour. So if we decriminalised it, what we'd be doing is not criminalising Māori and Pacific Islanders or people who have disabilities or who are chronically ill.

But there are also a lot of recreational users who do not like medical cannabis campaigners like myself because I don't support recreational use. Unless we put in place education, health services and support, it will be full of problems.

Q How much will change now that ministerial approval has been removed as a requirement?

A Not much. We still have to go through the Ministry of Health, which is a hassle. We've only got Sativex and now Tilray, but as I said, there are a whole lot of other products and variants that could do some good – but the government has said no. So we're still having to battle with policy, and we still have to get ministerial approval for non-approved products.

Q Where would you like things to head in terms of a medical cannabis regime?

A We need to stop mucking around and start getting real. In New Zealand, we have the most amazing climate and the ability to make these products and even distribute them overseas ourselves.

We also need to be honest. It can cause harm to a small number of people, and children should not have access to any cannabis unless they have a real medical need. But I have seen many children benefit and improve on medical cannabis, and it would be cruel not to have it available to them.

We need to have a good common-sense approach. That's going to require education, health support, good doctor support and much less Ministry involvement. ■

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