matters of substance

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

November 2011

Shaken, not deterred

Despite the devastating Canterbury earthquakes, the small and unassuming Hepatitis C Community Clinic in Christchurch has successfully completed its 3-year pilot phase. But will its pioneering approach to this silent disease become a benchmark model for other cities?

www.drugfoundation.org.nz

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

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

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

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

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News

The Director's Cut

PRESIDENT Bill Clinton warned, "Never pick a fight with people who buy ink by the barrel". That's good advice; making an enemy of the media is not wise.

Nevertheless, I do think the media's treatment of the "Zac Guildford incident" deserves a brickbat, along with a challenge to deal with addiction and problematic alcohol/drug use better.

Walking into my dairy the other week I was confronted with roaring headlines from two major daily newspapers, one asking, "What will they do with the drunken player?" Other media revelled in the sordid details of Guildford's behaviour in Rarotonga, with some outlets dispatching journalists to the Cook Islands to gather more salacious stories, and others harassing Guildford's family and friends for an inside scoop.

The coverage demonstrated the worst side of our media: the gossipy, voyeuristic, scandal-loving, ugly side (the side we also saw with coverage of Milly Holmes). I thought at the time, if Guildford was someone with an alcohol dependency problem, that type of coverage would do little to help him. And more broadly, that type of coverage only served to reinforce the media's and the wider public's poor understanding about our country's alcohol and drug problems; addiction in particular.

I said as much at the time.

My message was clear: Your coverage isn't helping Guildford, and it isn't enlightening the public about the complex issues that might underpin Guildford's and other young New Zealanders' problems with alcohol and drugs; you have a responsibility to be more than a gossip rag.

I got a fair hearing, but most media weren't so keen on hearing that message, and continued to hunt down dirty details.

Some media tried their best and interviewed people who were able to say helpful things. Guildford's Crusaders coach, Todd Blackadder, especially deserves praise for his thoughtfulness and understanding of the wider issues. Colleagues from the sector also added more light than heat to the story.

Whether Guildford is just a young kiwi who drinks in very hazardous ways or someone with an alcohol dependency disorder is between him and the people providing him support. He deserves privacy on those matters.

But there are lessons for the media. You play an extremely important role in informing the public, but you need to get better informed on alcohol and drug matters. And when you cover problematic and dependent alcohol and drug use, please do so in a way that informs with compassion and without stigma. I hope you do better next time.

Happy reading, Ross Bell. ■

Key Events and Dates

Global Addiction Conference
5-7 December, Lisbon, Portugal
The inaugural Global Addiction 2011 Conference aims to cover all topics relating to the understanding and treatment of addictive disorders – from pre-clinical, neurophysiological mechanisms through diagnostic and treatment strategies to societal guidelines and health economics.
www.globaladdiction.org

Club Health 2011: The 7th International Conference on Nightlife, Substance Use and Related Health Issues
12-14 December, Prague, Czech Republic
Club Health 2011 will focus on the wide range of issues that affect the health of people in nightlife settings. This includes alcohol and drug use, sexual health, violence and anti-social behaviour, management and design of nightlife settings, late night transport, staff training, and international nightlife tourism.
www.clubhealthprague2011.com

FebFast
1-29 February, Nationwide, New Zealand
FebFast is an alcohol awareness campaign running for the second year in New Zealand. It challenges ordinary New Zealanders to forgo their alcohol consumption for a month to raise funds for programmes helping to reduce alcohol and other drug-related harms among young people. Sign up now!
www.febfast.org.nz

Global Alcohol Policy Conference
13-15 February, Bangkok, Thailand
The Global Alcohol Policy Conference will bring together leaders from all over the world who are committed to the development and implementation of effective alcohol policy, free from commercial influence. The conference will also be a platform for developing a truly global network and for discussing future efforts to reduce problems from alcohol globally.
www.gapc2011.com

4th International Gambling Conference
22-24 February, Auckland
The 4th International Gambling Conference will be hosted by the Problem Gambling Foundation of New Zealand, the Gambling and Addictions Research Centre of Auckland University of Technology (AUT)and Hapai Te Hauora Tapui Māori Public Health. This well established biennial event is one of the leading international conferences on problem gambling, attracting delegates from New Zealand and around the world.
www.pgfnz.org.nz

15th World Conference on Tobacco or Health
20-24 March, Singapore
This conference is held every 3 years and attracts thousands of academics, health professionals, non-government organisations and public officials from more than 100 countries. The theme 'Towards a tobacco-free world: planning globally, acting locally' encompasses a vision of a world that is free from the harmful effects of tobacco.
www.wctoh2012.org

5th National Biennial Conference on Adolescents and Adults with Fetal Alcohol Spectrum Disorder: It's a Matter of Justice
18-21 April, Vancouver, Canada
This conference is essential for those living or working with adults with FASD. It will also be of critical interest to those supporting adolescents with FASD and planning for their futures. The conference will provide a forum to share research, experience and practice to discuss how we can effectively sustain and enhance the lives of those with FASD, their families, service providers, and communities.
www.interprofessional.ubc.ca

International Society for the Study of Drug Policy Conference
30-31 May, Canterbury, United Kingdom
The 6th annual conference will discuss a wide range of drug policy issues, with a particular focus on how empirical studies can and do influence drug policy. Keynote speakers include Professor Thomas McLellan, University of Pennsylvania, and Dr Michel Kazatchkine, Executive Director of the Global Fund and member of the Global Commission on Drug Policy.
www.issdp.org/conferences.php

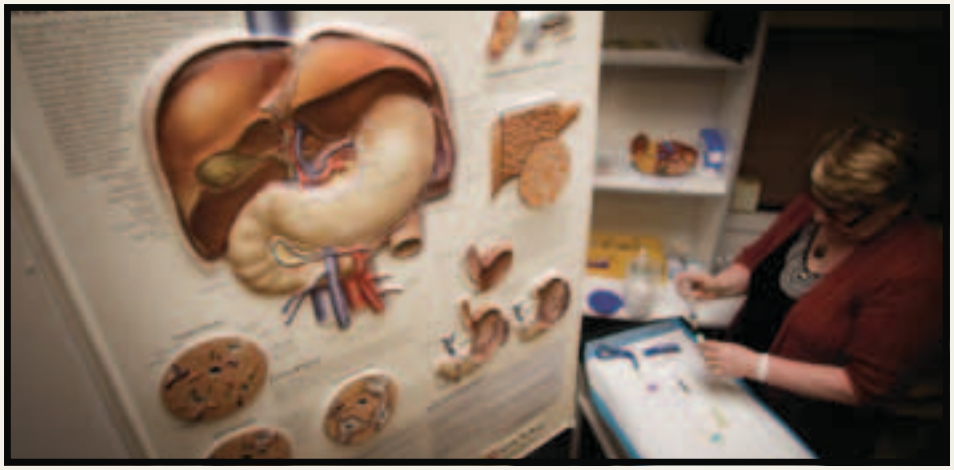
Beyond 2012: Leading the Way to Action
6-8 June, Fremantle, Western Australia
The National Indigenous Drug and Alcohol Committee (NIDAC) will host Australia's second national drug and alcohol conference. The conference will highlight how the sector can lead the way to action in addressing the harmful effects of alcohol and other drugs and their associated harms among indigenous Australians.
www.nidaconference.com.au

Safety 2012 World Conference
1-4 October, Wellington
The Safety 2012 World Conference is the 11th biennial international conference on injury prevention and safety promotion, co-sponsored by the World Health Organization. The conference will bring together the world's leading injury prevention and safety researchers, practitioners, policy makers and advocates, to debate, discuss and share information and experience.
www.conference.co.nz/worldsafety2012

Holding an event? Promote it here and on our website
www.drugfoundation.org.nz/events

The little community clinic that could

Hepatitis C has been called a silent killer. An individual can have the insidious virus for years without realising, until it starts to attack their liver with potentially deadly consequences. An estimated 50,000 people in New Zealand have hepatitis C, and the numbers are expected to increase dramatically.
A community clinic has been set up Christchurch as a pilot programme with the aim of tackling the disease head on. **Kelly Andrew** takes a look at its novel approach.



“Because it can be symptomless for many years, only about a quarter of people with hepatitis C are aware they are carrying the virus, with 20 percent diagnosed and only 5 percent accessing treatment.”

A SMALL yellow sign with CLINIC written in black type is the only clue to the new location of the Christchurch Hepatitis C Community Clinic. Uprooted from its former home in the central city by the February 2011 earthquake, the centre has been forced to set up in a temporary site in an industrial area on the city fringe where factories, panel beaters and fledgling businesses are the more usual tenants.

The front door is painted lilac, and inside, the waiting room comprises an old brown couch and a desk. A narrow stairwell leads to an office and small clinic room upstairs where blood tests can be taken. The basic surroundings, stocked with second-hand furniture found on Trade Me, have not stopped the clinic enrolling more than 530 clients since it opened its doors in January 2009. In fact, its laid-back informality, approachable staff and accessible community setting have been key components in its success.

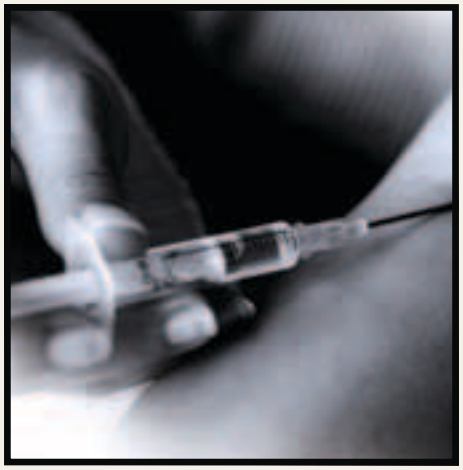
Clinical Nurse Manager Jenny Bourke believes the unique Christchurch service represents a benchmark model that could be adapted to suit other cities around the country to improve management of what is a highly debilitating and increasingly prevalent disease.

“It’s the only clinic of its kind in the country and the only one internationally that’s focused solely on management of hepatitis C. It integrates primary healthcare with secondary healthcare, and I think it has the potential to be transferred in some form to other regions. It could devolve some of the antiviral treatment from hospitals into the community setting, allowing better use of our health dollars.”

It’s estimated 50,000 New Zealanders are currently living with the hepatitis C virus, and this is predicted to increase by 50 percent in the next 10 years. What makes these figures of greater concern is that, because it can be symptomless for many years, only about a quarter of people with hepatitis C are aware they are carrying the virus, with 20 percent diagnosed and only 5 percent accessing treatment. The estimated cost to New Zealand if those infected do not receive treatment is $400 million annually by 2020.

While HIV and AIDS have had a much higher public profile than hepatitis C, internationally, there are about 200 million people with the disease and only 40 million with HIV. There is undoubtedly a need to ensure early diagnosis and improved access to treatment for people with hepatitis C. The vast majority of sufferers are either past or current injecting drug users, and Bourke says this group often feels stigmatised and discriminated against, making them difficult for mainstream health workers to reach.

Establishing a community-based clinic to provide testing, support and information to people with hepatitis C



“Christchurch has the largest population of injecting drug users in the country, with an estimated 10,000 currently in the Canterbury region.”

was first mooted back in 2002 by a group that included Charles Henderson, now National Director of the New Zealand Needle Exchange Programme. Locating such a clinic near a needle exchange and establishing a close relationship between the two organisations seemed like a “no brainer” to him, considering up to 90 percent of intravenous drug users will contract the disease through infected needles or syringes. Christchurch has the largest population of injecting drug users in the country, with an estimated 10,000 currently in the Canterbury region.

A proposal for a community clinic was presented to the Hepatitis C Treatment Advisory Group by Bourke as a result of a collaboration between three Christchurch-based organisations – the New Zealand Needle Exchange, the Rodger Wright Centre Needle Exchange and the Hepatitis C Resource Centre – and in 2008, the government gave the go-ahead for Health Ministry funding. The 3-year pilot was part of a package of funding for treatment programmes designed to help resolve the so-called bad blood scandal of the 1990s, which stemmed from delays in donated blood being screened for hepatitis C.

Sharing governance with the nearby Rodger Wright Centre, the Hepatitis C Community Clinic opened with the aim of increasing access to diagnosis and treatment, improving monitoring and prevention of the disease and helping people with the virus have a better

“While HIV and AIDS have had a much higher public profile than hepatitis C, internationally, there are about 200 million people with the disease and only 40 million with HIV.”

A client’s view of the Christchurch Hepatitis C Community Clinic

Richard* says he would not have found out he had hepatitis C if he hadn’t visited the Christchurch Hepatitis C Community Clinic last year.

A friend who worked at the Rodger Wright Centre Needle Exchange suggested he go to the community clinic and get checked out, and his test results came back positive. He was an injecting drug user about 20 years ago in Australia but wonders if he might have been infected by borrowing a friend’s disposable razor about 5 years ago.

Before his diagnosis, he had experienced headaches but no other symptoms that would have made him suspect he had hepatitis C. He had been a patient of the same GP for about 10 years and says, despite telling him he had the antibodies for hepatitis C, the doctor had not suggested further testing or treatment.

“He hadn’t really done anything. It’s not until I went to the hepatitis C clinic that things started happening. They gave me heaps of info and got me on the course [of treatment]. Otherwise, I wouldn’t have known I had it until it actually bowled me over… I can see why they call it the silent killer.”

Richard has been having antiviral treatment – a combination of pegylated interferon and ribavirin – for about 5 months and will find out in a few weeks if it has been successful.

He says testing should be more widely available so that people find out their hepatitis C status as early as possible. He highly recommends the community clinic to other people.

“They don’t look down their noses at you like a lot of people do. They take you for what you are, not what you’ve done. They can’t do enough for you, and they’ll make you a cup of coffee and put you at ease. It’s not like a hospital or a surgery. It’s a lot more informal.”

* Richard is not his real name.

“The more you know, the less you know; that’s what I find. I learn something new about [hepatitis C] every week, and I tell that to my patients. There are new inroads into treatment and new clinical trials all the time, things are always changing.”

Clinical Nurse Manager Jenny Bourke

quality of life. Bourke says it has quickly built a good rapport with its clients.

“The thing we’ve managed to do well is to get on side with the community we serve – they wouldn’t come if we didn’t serve them well.”

In a pioneering approach to a major public health issue, the clinic liaises with other local health agencies such as general practices, the Community Alcohol and Drug Service, the Christchurch Methadone Programme and Christchurch Hospital as well as needle exchange staff.

The clinic’s 3-year pilot ended in October, and an evaluation has been carried out by the National Centre in HIV Social Research at the University of New South Wales. The results back up Bourke’s pride in the project. The report says the clinic’s model provides a continuum of care that improves the health of people with hepatitis C.

Clients expressed a high level of confidence in and satisfaction with the clinic – with 95 percent giving positive feedback. It was described as non-judgemental, non-threatening and holistic, with clients saying they felt more supported and less discriminated against by staff at the clinic compared with mainstream healthcare workers. The report says, overall, the centre is meeting its objectives in increasing knowledge of hepatitis C, enabling lifestyle modifications and increasing access to treatment for what can be a marginalised group.

A feedback form asking clients where they would go for help if the clinic was not available found 50 percent ticked “nowhere”, suggesting these people would not have received testing and management without its help. Through the clinic, 71 clients have so far been referred and supported through to antiviral therapy at Christchurch Hospital.

“To be open to anybody who has concerns I think is really important, and sowing the seeds early on is good for harm reduction and self-management.”

Clinical Nurse Manager Jenny Bourke

The evaluation also praises the clinic’s integrated model, saying that, by working in partnership with other agencies, it was able to act as a point of entry for people unwilling to directly access conventional healthcare providers. However, it recommends clinic staff work harder on improving their relationship and collaboration with PHOs and GPs.

Bourke, who has a friendly but firm manner, spent time training in Australia and New Zealand to become a specialist hepatitis C nurse in 2006 after developing an interest in the disease

while working in Christchurch as a home detox nurse – visiting people who had been through detoxification from alcohol or other drugs. She enjoys working with her clients, and she finds the hepatitis C virus fascinating, despite its highly damaging effects.

"The more you know, the less you know; that's what I find. I learn something new about it every week, and I tell that to my patients. There are new inroads into treatment and new clinical trials all the time, things are always changing."

Clinic data shows 22 percent of its clients are Māori and most are aged 35 to 49. Nearly three-quarters are on Work and Income benefits, a group most in need of more equitable access to healthcare.

Bourke says the clinic's approach is non-judgemental and based around asking each client what they want to do and then helping them achieve it. It provides completely free access to testing, social work and on-going information. It refers some patients to hospital-based treatment services, but others may choose not to have antiviral treatment, and they are offered information on ways to prevent their disease progressing, including healthy eating, quitting smoking and referral to the Community Alcohol and Drug Service. While the centre is nurse led, it also has a part-time GP, Mike Thwaites, to help with hepatitis C-related health concerns, and a part-time social worker, Marilyn Brown.

Earthquake shakes up community clinic

Until 22 February 2011, Christchurch's Hepatitis C Community Clinic was housed in a two-storey timber and roughcast building on Lichfield Street in the central city. When the huge earthquake struck, the old building partly collapsed, with one floor toppling one way and the ground floor slumping the other.

Fortunately, Clinical Nurse Manager Jenny Bourke and the clinic's social worker, Marilyn Brown, were attending a training course elsewhere, but there were two other people inside at the time – New Zealand Needle Exchange Programme receptionist Liz Neho, who worked upstairs, and the hepatitis C clinic's receptionist, Micky Ingram, on the ground floor.

Ingram remembers everything around him lurching sideways accompanied by the sound of timber in the building being ripped apart. He managed to wrench open the front door, which was leaning sideways at a surreal angle, and found himself kneeling on the street with Liz behind him. She had somehow bumped down the stairs and landed outside.

The badly damaged building had to be demolished, and for several months, the clinic operated temporarily from a Portacom on the empty site, with files stored in a staff member's living room. Bourke says the situation wasn't ideal, but despite the disruption, the number of clients has actually increased since the quake.

"Even though we lost our building, it was as if people's psyche was, 'We've survived this, we want to continue to survive,' and that seems to have kept going because we've had more and more new clients."

Despite the loss of important equipment, including computers, resources and some records, important patient files were able to be salvaged from the old building before it was knocked down. In October, Bourke managed to find a new short-term home for the clinic that is close to the central city. Posters at the Rodger Wright Centre Needle Exchange publicise the clinic's new location, and while walk-ins off the street are not as common, Bourke says most clients hear about it through word of mouth.

By the end of the year, the clinic will have a new central city location in a building on Cashel Street it will share with the Rodger Wright Centre Needle Exchange, which also lost its former home in the quake.

> **“… you’re doing a lot of good for a reasonable amount of dollars, so it’s a good investment.”**
>
> Charles Henderson

The clinic is open to anyone who believes they may have been exposed to hepatitis C, but with its close ties to the Rodger Wright Centre and an outreach clinic Bourke runs every Thursday at the Christchurch Methadone Programme, it particularly targets injecting drug users who are at highest risk.

“The affiliation with the Rodger Wright Centre and the Methadone Programme helps us find a great niche, because that is our target population,” Bourke says.

“But it’s really important that those who are not on methadone or are no longer using drugs also feel comfortable accessing the clinic.”

Proposed new premises in Cashel Street will see the community clinic sharing a building with the Rodger Wright Centre, but Bourke says separate access will be available for clinic clients.

People who are currently injecting drugs are generally excluded from treatment but Bourke says it is still important for them to be tested and find out their hepatitis C status so they can get information on the disease and their options for management and the treatment process.

“To be open to anybody who has concerns I think is really important, and sowing the seeds early on is good for harm reduction and self-management.”

Charles Henderson says hepatitis C is at “absolutely epidemic” levels and the situation is likely to get worse. Advanced drug treatment means people with HIV can maintain their quality of life for many years. But with hepatitis C, there’s a 50 to 80 percent chance that antiviral therapy will be a ‘cure’, preventing a patient’s progression to chronic liver disease. The success rate depends on what genotype (or strain) of the virus they have.

“The stats are clear; there are currently 32 liver transplants in New Zealand each year. That’s going to increase to 250 by 2030, and it will be predominantly due to hepatitis C infection. It’s such a nasty, pernicious virus. You might be largely asymptomatic, but a few years down the line, you could be cirrhotic and eventually need a liver transplant.”

Henderson strongly believes the Christchurch Hepatitis C Community Clinic is delivering a valuable service and says the trial has been a success despite huge disruption caused by two major earthquakes and the loss of its original building.

“By attaching a health clinic to a needle exchange and working with other agencies like GPs, the Community Alcohol and Drug Service and the hospital, you’re doing a lot of good for a reasonable amount of dollars, so it’s a good investment.”

However, the clinic – which won a second runner-up award in the community-based section of the Canterbury District Health Board’s

> **“It’s such a nasty, pernicious virus. You might be largely asymptomatic, but a few years down the line, you could be cirrhotic and eventually need a liver transplant.”**
>
> Charles Henderson

(CDHB’s) Quality Improvement and Innovation Awards last year – is only assured of CDHB funding for 1 more year, and its long-term future is unclear.

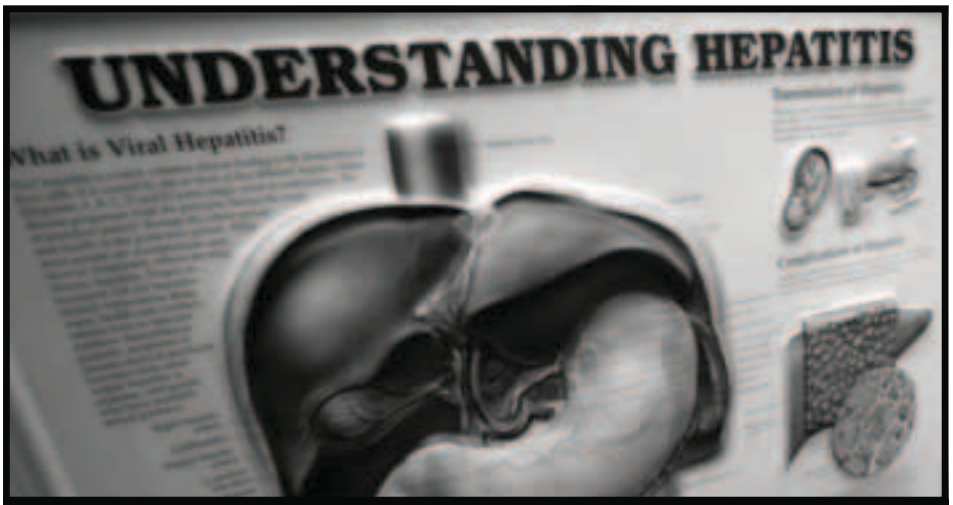
The Ministry of Health is currently investigating ways of improving hepatitis C services around the country, with a summary report due from the Hepatitis Foundation of New Zealand in March next year covering a wide range of hepatitis C issues. A Ministry spokesperson says it is reviewing the evaluation report of the Christchurch clinic by the National Centre in HIV Social Research, and the findings will feed into future planning for the provision of hepatitis C services.

But he says there is no expectation the hepatitis C clinic model piloted in Christchurch will be rolled out as a national solution for hepatitis C services in New Zealand.

Bourke says providing early diagnosis, management and the option for antiviral therapy is paramount in order to make headway in tackling this disease. She believes the community clinic provides the most effective model for Christchurch, but other centres may need to adapt to local circumstances.

“We’ve set up a benchmark model that can provide a framework for future improvements in hepatitis C services.” ■

Kelly Andrew is a writer based in Christchurch.



What is hepatitis C?

Hepatitis is inflammation of the liver caused by one of several viruses – hepatitis A, B, C, D or E. The hepatitis C virus is carried in the blood and can only be passed on through blood to blood contact – including sharing of needles and drug equipment during injecting drug use, non-sterile tattooing and body piercing equipment or at birth from a mother with hepatitis C.

It is estimated there are up to 50,000 New Zealanders infected with the virus, and only a quarter of these people are aware they are carrying the disease. It often progresses slowly over many years without noticeable symptoms, but common signs include fatigue, nausea and abdominal pain.

Chronic hepatitis C can lead to years of ill health and reduced quality of life. Left untreated, it can cause damage to the liver that may progress to cirrhosis and, in some cases, eventually lead to liver cancer or liver failure.

For people who are infected through injecting drug use, the risk of cirrhosis is 20 to 30 percent, and 5 to 10 percent of those will die or need a liver transplant for liver failure or liver cancer.

Liver cancer from hepatitis C is increasing rapidly in New Zealand, from one case in 1995 to 29 in 2007, and chronic hepatitis C is now the leading cause of liver transplant operations. The cost of a transplant is about 10 times the $25,000 cost of treating someone with hepatitis C.

An estimated 50 percent of all New Zealanders with chronic hepatitis C infection need to be treated, and 30 percent need to be cured to avoid the expected doubling in numbers of hepatitis C-related liver cancer and liver failure by 2030.

There is no vaccine for hepatitis C, but treatment with antiviral medication can help prevent progression to chronic liver disease.

More advanced drug treatment for the virus – called directly acting antiviral treatments (DAAs) – is expected to be available in New Zealand in 2015, although funding through Pharmac has not been confirmed. These drugs have higher cure rates and shorter treatment times than the antivirals currently used in combination – pegylated interferon and ribavirin.

Searching for solutions

An interview with Tom McLellan

In early September, Professor Tom McLellan was in New Zealand to speak at both the Cutting Edge Addiction Treatment Conference, and the Drug Policy Symposium organised by the Drug Foundation and the NZ Society on Alcohol and Drug Dependence.

UNTIL recently, Professor McLellan was the Deputy Director of the Office of National Drug Control Policy in the US and a primary advisor to the Obama administration on drug demand reduction. His long and distinguished career in addiction medicine, coupled with a tragic, personal loss to addiction within his own family, have made him one of the world's pre-eminent experts.

He graciously took time out of his busy schedule while here to share his thoughts with *Matters of Substance* on treatment and recovery, what works and why.

Matters of Substance: How does the patient model work in America?

Tom: I think most addicted people admit they have a disease, and that's a useful way for them to understand it. I like the 'client idea' where the individual to whom you are providing services has some say, but my experience is that's mostly lip service.

Matters of Substance: Do you think the state or funders agree when you start talking about addiction as a chronic illnesses?

Tom: No. In 2000, we published a paper that described a lot of that in the *Journal of the American Medical Administration.* That year, it got the most letters to the editor, and all of them were negative. Most began with: "How dare you? That addicted scum has nothing in common with my diabetes patients."

They think it can't be a disease because they brought it on themselves, and they absolutely did, but they forget that type 2 diabetes, most cardiovascular illness, tooth decay and so on are also brought on by personal behaviours.

Matters of Substance: Has the medical profession's attitude shifted since 2000 when you published in the journal?

Tom: No. In the US, there's only one college with a course in substance abuse. Most doctors see addicts at their worst in the emergency room, puking on their shoes, stealing things, raising hell. And they imagine they know about substance abuse disorders from that.

So when I say I want to help them screen for substance use disorders, they look at me like I have three eyes.

Matters of Substance: How do we overcome this?

Tom: Well, first of all, I really don't think it's sensible to think of primary care doctors treating addiction, nor is it sensible they treat terribly severe cases of diabetes or cardiovascular illness. That's why they make speciality care.

But unlike other illnesses, there's nobody doing prevention or early intervention. There's nobody trying to detect these lower-level, still very

“In the US we ask whether users think their use is problematic. Most do not. So to tell them they need a treatment programme and to be abstinent for the rest of their lives – one day at a time – is a no sale.”

manageable, cases of harmful use.

It’s like telling a GP he’s got to be aware of allergies. Most don’t want to be allergists, but they know they can’t prescribe something that will produce an allergic reaction. That makes sense to them, so they learn. And I think the same is true for substance use disorders.

Matters of Substance: How should we look at intervention and prevention?

Tom: It’s tough because addicts don’t generate a lot of sympathy. I think one of the reasons stigma surrounds them is because we fail to deliver a reasonable solution. There was stigma around tuberculosis, polio, AIDS, depression, erectile dysfunction – but when we started getting results, stigma disappeared.

The problem is those other conditions were understood as medical. Ours was always thought to be moral. Once we start delivering measurable results, I think the stigma’s going to disappear. Someone properly managed is going to have a great deal of drug-free time, fewer instances of public health and public safety annoyance, and the public will come to value that.

Matters of Substance: So the question really is how can we start to actually have an impact?

Tom: In the US, we ask whether users think their use is problematic. Most do not. So to tell them they need a treatment programme and to be abstinent for the rest of their lives – one day at a time – is a no sale. So I think one of the really marketable interventions is going to be something that’s not really widely used but could be.

You know, something like a guy says, “Oh, I guess I was using too much. I’m going to reduce,” and they’re able to. Hooray! Or following that they say, “Well, I always thought I could stop, but I don’t seem to be able to.” That would also be positive. That’s somebody who gets an early indication that they’re going to need something else, but they can truly say they haven’t been in treatment. They’ve been in an extended preventive intervention.

Matters of Substance: And how do we decide how much should go to tertiary treatment, how much to early intervention and how much to prevention?

Tom: That’s an easy one. You want to put a lot of money into prevention because, if you get something that’s not quite out of control early, you have a lasting impact for a long period of time and a big economic return.

Matters of Substance: How did you get involved in this area? You were working with Vietnam vets?

Tom: Yeah. Like almost everybody else in the field, I totally fell into it. My thesis was on auto-shaping the brains of rats, pigeons, crayfish etc, and I was stunned to find nobody was walking up to me with $100,000 job offers. So I bought a farm in Pennsylvania. Then I literally drew a 25-mile circle around it, and the only damn thing that looked like it would give me any outcome was the Coatesville Veterans’ Administration Medical Centre.

I went down there and said, “I’m here, armed with my rat-running thesis.” I was equipped for nothing other than being a technician and an evaluator in a then very new substance abuse treatment programme.

Matters of Substance: So what do you confront them with when you’re working with these guys with very serious addictions?

Tom: Well, mainly empathy. These guys didn’t have the advantages I had, but they put their pants on the same way I did. I realised that, to understand addiction, you have to know a hell of a lot more than just the quantity and frequency of the drugs they were taking. You need to know about their medical problems, their employment and their family and stuff.

Matters of Substance: So what are some things that have impacted on you?

Tom: A surprising thing for me was that

the correlation between the severity of the drug problem area and other problem areas – employment, medical, psychological etc, was very poor.

The people with the most severe drug problems did not always have the most severe employment or the worst family. Sometimes, people with less severe use had awful psychiatric problems. That changed the way I was thinking despite what everybody knows about employment and crime problems being related to addiction.

At a personal level, when I was in the midst of a really booming career, winning awards and publishing stuff and going from assistant to associate professor and all that stuff, my own son became addicted.

Now you might say, "That's terrible, but if it has to happen to somebody, better it be you, because after all, you're an expert."

Well, I didn't know what the hell to do. I had no idea how to transfer any of what I thought I knew into something practical, where to send my kid, what kind of treatment he needed, and nobody I knew did either. If I don't know what the hell to do, what's the guy at the garage to do? What's the gal who's teaching in school do? And they need and deserve something tangible.

Matters of Substance: So what are some of those tangible, worthwhile things?

Tom: Well, we started something I've got great expectations for. We went and talked to the people who know more about evaluating and reporting back to the public – Consumer Reports. They were very gracious. They compare different refrigerators, colleges and cars and know what features the public is interested in. They present the information in a really good way, and we're going to do exactly the same thing with treatment programmes.

One sensible, unarguable measure of quality is what kind of features are in a treatment programme. There's a finite list of evidence-based practices, so stage one is developing a list of these and then deciding how to describe them to patients. Then we call up the treatment programme and ask how many of these things they have and how often they do them. Then we ask the patients there the same questions. At the end of the day, we have a nice list of what you get in the various treatment programmes.

"I am really disappointed in your government personnel I've heard speak. They have such an opportunity to do something different."

But there's also stuff that you really can't measure. If you're a 16-year-old girl and you're in groups with 40-year-old guys, that's not all that comfortable. So we find out about that and then make all this information available.

We hope it has two effects. First, it will help Mr and Mrs Jones in that very difficult decision – where to send Johnny. But second, we hope it begins to drive the providers. If Shady Acres is getting all the referrals because they have more to offer, the other programmes are going to get wise, and it should raise the standards of the industry.

Matters of Substance: How much are we running the risk of being non-punitive?

Tom: I don't want to avoid being punitive, but I think punishments have been done stupidly. In the US, they now have drug courts. They weren't invented by the treatment system but by judges who were sick of seeing the same offenders back – drunk driving or sticking up a bank for their cocaine money. And they created one of the most intelligent combinations of punishments and supports.

Now in the US, legislators make these rules about punishment. For hundreds of years, they've imagined that terrible long-term punishments will change behaviour. They do not. That is not my opinion, it's a simple fact.

Imagine if you said to your kid who is playing video games and you want him to do his homework, "Now, Johnny, if you don't stop that video game right now, there is a 30 percent chance that, sometime within the next 2 years, I am going to ground you for life." The kid will look at you strangely and resume his video game. What you say is, "Johnny, stop the video game or no TV tonight. Now!"

You need the stick and you need the carrot. In a person who's harmed society in some way – stuck up a bank, driven drunk into somebody and hurt them – I don't think you say, "Oh, he must have a terrible disease and we should love him." Well, we should, but we should also hold him accountable. I think drug courts have shown you can mix sensible sanctions with decent rewards and services in a way that benefits society.

In the US, there are very few things Republicans and Democrats agree on. Well, you've just stumbled on one. Democrats have never liked harsh sentencing practices around substance abuse. Now, Republicans who aren't all that against them in principle say, "Holy hell, we're spending a tremendous amount of money and we're not getting any return," because there's a 70 percent

“If I don’t know what the hell to do, what’s the guy at the garage to do? What’s the gal who’s teaching in school do?”

recidivism rate. So for wholly different reasons, they’re ready for a change.

Most people in jail in the US are there because they stuck up a bank or something and they got parole or probation. During probation, they have mandatory urine tests. When the urine comes up positive, it’s a parole violation. Bingo, 2 and a half years at $32,000 a year. Meanwhile, an outpatient treatment programme is terribly under-funded at about $4,000 a year per outpatient. So there’s a discrepancy there, and there’s an opportunity to do business.

You first say to the incarcerated individual, “Would you like to get out of jail? You have to sign up for 2 years of this probation, and we’ll start you out with a day a week of coming in for drug treatment and we’ll give you counselling and all kinds of services. If you have clean urines, we’ll make it 1 day every 2 weeks. If the urines are positive and you’re not able to control, we don’t send you back to jail, we increase the treatment. You come in three times a week now. If that doesn’t work, then we go to residential.

Well, we figured out that you could deliver a really thick treatment service with lots of monitoring – and I’m not going to apologise for the monitoring. Remember, the guy went from jail and you have an obligation to the community. So lots of monitoring and lots of services for about $18,000. The state wins, the treatment system wins, the guy wins. That’s another solution.

Matters of Substance: So you know what New Zealanders say when they pick up a tourist: “What do you think of our country?”

Tom: Well, let’s go down the list. First of all, the geography is astounding. I haven’t seen near enough, but what I’ve seen is truly beautiful. People are awfully friendly. I particularly like those Māori ceremonies. They really did make me feel welcome in a way you’re not going to get in New York. I find it charming.

Matters of Substance: So what are some things we could do?

Tom: I am really disappointed in your government personnel I’ve heard speak. They have such an opportunity to do something different. It was announced that there’s going to be a budget cut of up to 50 percent in some cases. That’s never pleasant, but it definitely allows you to say, “For God’s sake, you don’t expect me to do the same thing with half the money! I’m going to try things I never tried before. I’m going to do some pilot things, and if they work out, I’ll scale them when we do have money.” It’s disappointing, because there’s lots of opportunity out there and, I think, a very willing workforce.

Matters of Substance: So how does such a nice, erudite guy end up being an advisor in the lion’s den of politics?

Tom: Well, two things happened. About 11 months before I was called, I lost my youngest son to addiction. He died the day of his last exams, celebrating his graduation, and it was absolutely devastating.

The second thing was a call from Mr Biden who said, “What do you think? You could make a difference,” and all that. I said, “No”. They called back, and I had begun to think maybe I could turn this terrible personal tragedy into something positive. I was pretty reluctant because I don’t have much regard for politicians or political process. I was looking for the right thing to do, but the overriding thing was I had tremendous respect and still do for Mr Biden and Mr Obama, the whole administration.

And I thought, “I’ll give it a whack.” I’m glad I did, and I’m glad I got out. I think I was helpful, and I think I got to the end of what I could reasonably do, and I’m glad to be doing what I’m doing now. I’m searching for solutions.

Matters of Substance: It was an honour having you here.

Tom: It was an honour to be here. Thank you very much. ■

Watch Tom’s symposium presentation online at www.drugfoundation.org.nz/through-the-maze.

As seen on TV

Popular culture and the legalisation of drugs.

Just a few years ago, it was almost unthinkable that legalisation of drugs would become a mainstream debate. It has long been thought a political impossibility. Despite the arguments in favour and the continued failure of drug law enforcement policies, many in positions of power felt the public just wasn't ready for such a discussion. But if popular television shows are any form of public barometer, this may be beginning to change, writes **Hamish McKenzie**.

WELCOME to 2011. We have a drugs war in Mexico that has cost more than 40,000 lives in the past 5 years. Vicente Fox, the country's former President, has called for legalisation. Even more remarkably, his hardline successor Felipe Calderon – the man responsible for escalating a 'war on drugs' that is in part responsible for the out-of-control violence in Mexico – has called for the US to look for 'market alternatives' (aka legalisation) to reduce demand for drugs. Even a poll-stricken Don Brash has discovered decriminalising marijuana might not be such a bad idea.

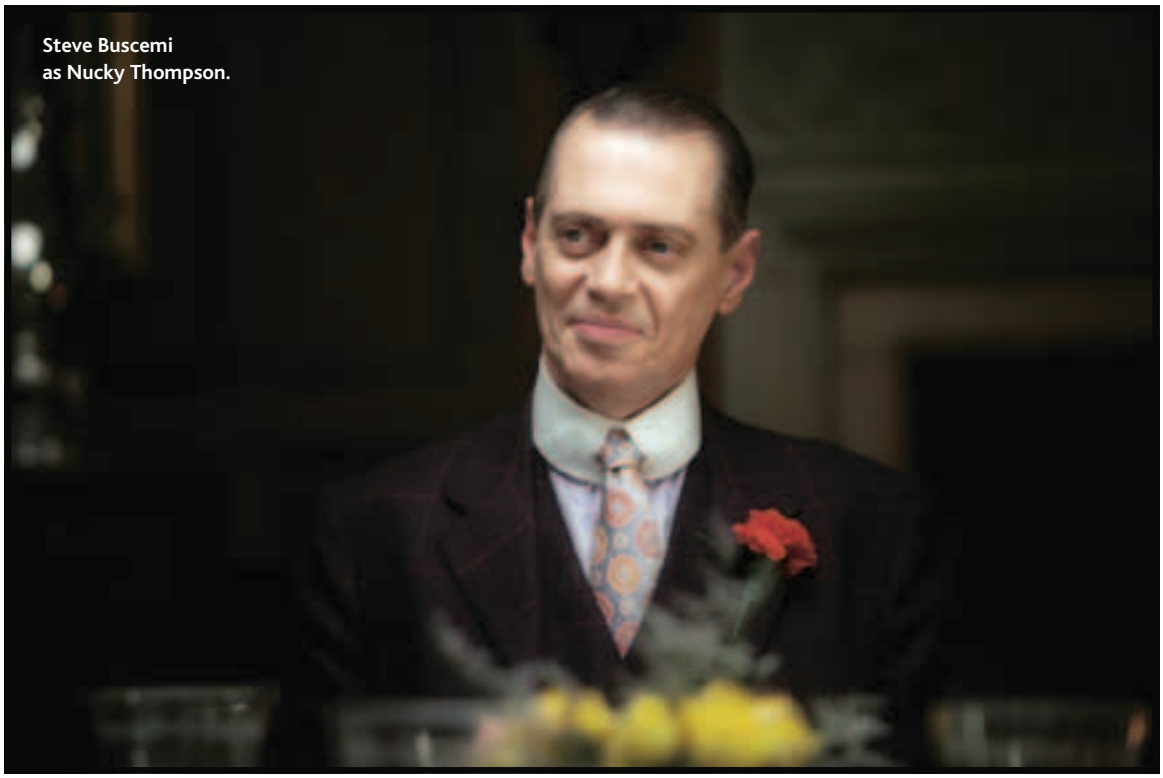
The public softening towards legalising drugs has probably been fuelled, to some extent, by popular culture. The critically lauded HBO show *The Wire*, for instance, highlighted the futility and counter-productive effects of the war on drugs and presented a nuanced portrait of the drug-related economy in Baltimore. The show ran for five seasons and elevated creator David Simon into super-celebrity status. He regularly holds forth in the media on the need to legalise drugs.

And now, another blockbuster TV show is all but openly advocating a by showing the utterly destructive effects of a government's last attempt at prohibition. *Boardwalk Empire* is HBO's latest hit – a show that pulls an average 10 million viewers per episode across all broadcast platforms, according to the cable TV network. In its debut season, it won two Golden Globes, including one for Steve Buscemi as best actor in a drama series, and was nominated for 18 Emmy Awards.

The show is set in 1920s Atlantic City, New Jersey, soon after Prohibition is enacted. It not only dramatises the rise of organised crime and the bootlegging economy, but it also spotlights corrupt politicians and the rise of modern America – a time when the United States was becoming the richest nation on Earth.

By design, the show touches on historic themes that have strong parallels with today, including the compromised political culture, inadequate treatment of war veterans and, most strikingly, the failure to control a popular substance that is ostensibly illegal. In the 1920s, that was alcohol. Today, it's everything

"The public softening towards legalising drugs has probably been fuelled, to some extent, by popular culture. The critically lauded HBO show The Wire, for instance, highlighted the futility and counter-productive effects of the war on drugs and presented a nuanced portrait of the drug-related economy in Baltimore."



Steve Buscemi as Nucky Thompson.

from cannabis up.

Boardwalk Empire's protagonist Nucky Thompson (played by Buscemi) sums it up in the first episode when he tells his fellow bootleggers, "We've got a product that man has to have!" Nucky – who is based on real-life businessman and Republican operative Enoch 'Nucky' Johnson – is part gangster, part politician; a county treasurer who uses his influence to get friends and associates elected to positions of power, and who uses money to solve problems. When money doesn't work, he turns to darker methods to get his way. Much of his income stems from controlling bootlegging operations in the city. Naturally, then, he sees only opportunity in Prohibition.

"Mr Mayor, fellow members of the City Council," Nucky, dressed in a tuxedo and wearing a red carnation, announces during a raucous dinner party scene in the first episode. "In less than 2 hours, liquor will be declared illegal by decree of the distinguished gentlemen of our nation's Congress." Nucky pauses, raises his whisky glass and with a wry smile says, "To those beautiful, ignorant bastards!"

Cut to New York's Waldorf-Astoria hotel, where HBO has taken over a suite of rooms on the 29th floor. Buscemi is sitting at a round table and taking questions from a small group of reporters. With those famously droopy eyes looking a touch weary – perhaps because he only finished filming for *Boardwalk's* second season the night before – Buscemi puts Nucky's sometimes ruthless actions into perspective.

"Prohibition created an opportunity for a lot of people to make a lot of money," says Buscemi, who's dressed in a grey shirt that hangs loosely on his slight frame.

"It attracted a certain type of individual who maybe was comfortable not playing by the rules. If that's what you're interested in, you probably don't care so much about who gets hurt. I'm sure they didn't start out wanting to hurt somebody, but when there's that much money to be made, somebody's going to get hurt."

Sound familiar? It's intentional. *Boardwalk Empire's* creator Terence Winter says he always wanted the show to evoke comparisons with contemporary culture and particularly with the drugs trade.

"When I was developing it, even before it was *Boardwalk Empire*, even before it landed in 1920, I wanted whatever I did to hold a mirror up to society today," says Winter, whose previous gig was as a writer on *The Sopranos*.

"When I did the research on the Prohibition era, the more I learned about what was going on, really deep into the culture, it became almost eerie how similar things are: corruption in government, the way sexual mores were changing, Wall Street was a casino, not to mention Prohibition being an almost perfect overlap with the drug business and what's going on here in the United States and Mexico and really all over the world."

Asked if he has an opinion on drug legalisation, Winter responds, "I think it's pretty clear the war on drugs doesn't work, and I think if you take the profit motive out of being a drug dealer, maybe kids would want to do something else

Michael K Williams as Chalky White.

> **“Alcohol became more dangerous to consume; crime increased and became ‘organised’; the court and prison systems were stretched to the breaking point; and corruption of public officials was rampant.”**
>
> Mark Thornton

for a living. There are a lot of lessons to be learned from Prohibition, which I think was the single event that made organised crime possible. So, yeah, they should certainly explore the possibility of regulating and taxing drugs.”

While it was enacted with the best of intentions, Prohibition was a disaster. The law took effect in January 1920 and was a response to a strong temperance movement that sought to reduce crime, prevent abuse by alcoholic husbands and wipe out other negative social effects of excessive consumption. It didn’t go to plan.

“Although consumption of alcohol fell at the beginning of Prohibition, it subsequently increased,” wrote Mark Thornton, an Auburn University economics professor, in a report on Prohibition’s failure for the Cato Institute, a Washington DC-based think tank.

“Alcohol became more dangerous to consume; crime increased and became ‘organised’; the court and prison systems were stretched to the breaking point; and corruption of public officials was rampant.”

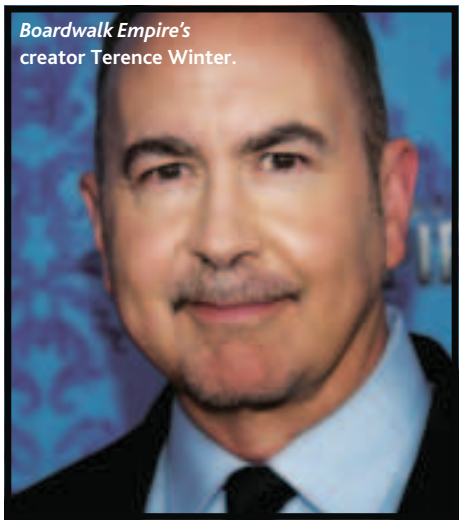
While funding for Prohibition enforcement increased from $4.4 million to $13.4 million in the 1920s (and that’s not counting the $13 million a year spent by the Coast Guard – big money in those days) – crime rates soared. The homicide rate alone increased by 78 percent compared to pre-Prohibition times, according to Thornton.

A good chunk of this crime could be attributed to gangsters, whose fortunes, thanks to Prohibition, were on the rise. Previously, mafia organisations in the US were restricted to controlling prostitution, gambling and theft. Bootlegging became a thriving new industry. By the end of the 1920s in Chicago, for instance, Kingpin Al Capone controlled all of the city’s speakeasies as well as bootlegging operations across the country, helping him net annual profits that registered in the tens of millions of dollars.

Organised crime centred around the trade of banned substances still exists. In New Zealand, the phenomenon is most visible in our gangs, while in the US, elaborate networks help themselves to enormous profits from the drugs trade – a point made well by *The Wire*. The violent cartels harvesting and manufacturing the drugs in countries such as Mexico and Colombia, meanwhile, make the mafias of the 1920s look tame.

“It is interesting to see things really haven’t changed,” says Buscemi.

“Today, the gangs are more vicious than ever – a lot more vicious than I think they were then. It’s all over something that’s illegal, and it makes you think, well, if it wasn’t illegal, would there be that much violence? Would the stakes be as high? The whole war on drugs I don’t think is working. It’s really a war on innocent people. That’s who’s really getting caught up in it.”



Boardwalk Empire's creator Terence Winter.

One man on the cast of *Boardwalk Empire* can speak with more authority than most on the ill effects of prohibition. Michael K Williams enjoys the distinction of playing a fan favourite on not only *Boardwalk Empire* – in which he plays Chalky White, a bootlegger and the de facto mayor of the African-American community in Atlantic City – but also on *The Wire*, for which he brought to life the unforgettable Omar Little, a vigilante stick-up artist who robbed drug dealers.

Williams dabbled with drugs as a teenager, got into trouble, went to mandatory rehab, got in a bar fight that left him with a scar that runs from the middle of his forehead down to the bottom of his right cheek bone and then went on to a successful career as a dancer in music videos and, ultimately, in acting. In the interview room, he is a friendly and warm presence, with none of the quiet menace that Omar exudes in *The Wire*.

Given his experiences and roles, he is asked, does he think the war on drugs is doomed to fail?

Williams raises his eyebrows, exhales a big breath and says, "Wow. Got a minute?"

The reporters laugh, before he continues. "I think that the whole title 'war on drugs' is total bullshit," he says. He points to season two of *The Wire*, which showed how vulnerable US ports were to the importation of drugs on a large scale. "How can you have a real war when you've got your ports wide open?" he asks. "It's just smoke and mirrors it seems to me."

He says that, just like during Prohibition, a lot of people make a lot of money from drugs – and it's not just the gangs. Lawyers, for instance, have plenty to earn from it, too. Williams bemoans the fact America could send a man to the moon, but it can't figure out how to stop drugs coming into the country. He also reckons the economy will have a large part to play in the ultimate fate of drug legalisation.

"If the country continues on the financial down spiral," he offers, "I think illegal drugs will become legal."

Of course, anyone who knows Omar knows that he must be listened to. After all, this is the man who brought us such words of wisdom as, "Money don't have owners – only spenders," and "It ain't what you takin', it's who you takin' from, ya feel me?"

The significant thing is that, thanks to shows like *The Wire* and *Boardwalk Empire*, it's not only people like Omar – the marginalised and down-trodden – who are giving voice and power to the drug legalisation movement. The very topic, once so incendiary, has become mainstream. It seems, finally, 9 decades on, we are starting to learn the lessons of Prohibition. ■

Hamish McKenzie is a writer based in the US.

Prohibition facts

- Alcohol consumption rose to record levels during Prohibition.
- **ALCOHOL CONSUMPTION AMONG WOMEN AND CHILDREN INCREASED DRAMATICALLY.**
- Because organised crime groups didn't pay taxes on their profits and didn't report production to the government, it's impossible to discern exact consumption figures during Prohibition – or how much money the gangs made.
- **ALCOHOL PRICES WENT UP STEEPLY, SO MANY PEOPLE MADE THEIR OWN BOOZE IN BATH TUBS.**
- In the second decade of the 1900s, the homicide rate in big cities was 8.4 per 100,000 people. During Prohibition, the rate increased to 10 per 100,000 people.
- Arrests for drunkenness and disorderly conduct increased 41 percent, while arrests for drunken driving increased 81 percent. (Note: Prohibition coincided with an explosion in private vehicle ownership.)
- **PROHIBITION LED TO AN EXPLOSION IN PRISON POPULATIONS, AND PRISONS BECAME OVER-CROWDED.**
- Prohibition led to a spike in corruption. According to Cato Institute scholar Mark Thornton, "Everyone from major politicians to the cop on the beat took bribes from bootleggers, moonshiners, crime bosses, and owners of speakeasies. The Bureau of Prohibition was particularly susceptible and had to be reorganised to reduce corruption."
- **PROHIBITION WAS REPEALED ON 5 DECEMBER**

1933.

- **ALCOHOLICS ANONYMOUS BEGAN IN**

1934.

A second look at Prohibition

Prohibition – the notorious "failed social experiment" to rid the US of alcohol – was on many in America's minds last month amid television broadcasts of director Ken Burns's highly acclaimed documentary series of the same name. But is the received wisdom on prohibition entirely accurate? Former Advisor to President Obama's Drug Czar **Kevin Sabet** suggests it might not be.

RECENT television shows about Prohibition have immediately been seized upon by drug legalisation advocates, who say they show that drug prohibition should be abandoned. But a closer look at what resulted from Prohibition and its relevance to today's anti-drug effort reveals a far more nuanced picture than the legalisation lobby might like to admit.

First, it is important to get the facts right about Prohibition, which lasted from 1920 to 1934. As ratified in the 18th Amendment, Prohibition banned the "manufacture, sale, or transportation of intoxicating liquors within, the importation thereof into, or the exportation thereof from the United States".

Many states – 36 of the 48 to be exact – had already banned liquor prior to the constitutional amendment. As argued by Harvard's Mark Moore and other astute policy observers, alcohol prohibition had beneficial effects along with the negative ones. Alcohol use plummeted among the general population. At the beginning of the 20th century, Americans drank 2.6 gallons of alcohol per person per year. By 1919, this amount dropped to 1.96 gallons per person.

In 1934, the first full year after repeal of Prohibition, alcohol use stood at 0.97 gallons per person. From then on, consumption rose steadily to its present level, approximately tripling from the time immediately after Prohibition. Furthermore, death rates from cirrhosis of the liver fell from 12 per 100,000 in 1916 to five per 100,000 in 1920 and remained at that level throughout Prohibition before rising sharply again after repeal.

Additionally, arrests for public drunkenness were cut in half. Yes, organised crime was emboldened, but the mob was already powerful before Prohibition, and it continued to be long after. In fact, the homicide rate grew faster in the decade before Prohibition, according to a National Academies of Science report.

Even with these statistics, no one is suggesting alcohol prohibition should be reinstated. Americans have concluded that the right to drink outweighs its public health and safety consequences. But it is important to remember that the policy was not the complete failure that most think it was, so we should be wary of misapplying its lessons.

If our experience with prohibition was a nuanced one, then it is surely a stretch to apply the so-called conventional wisdom associated with it to help us shape policies on other intoxicants today.

Still, a favourite argument of legalisation supporters is that, since "we all know" alcohol prohibition failed, drug prohibition is destined to fail, too. Given modern America's thirst for liquor, it is a clever political manoeuvre to link the two policies in this way. But notwithstanding one's position on the success or failure of alcohol prohibition, there are key differences between that policy and modern day drug enforcement that render a comparison almost useless for serious policy analysis.

First, it should be remembered that, unlike illegal drugs today, alcohol was never really prohibited altogether. Laws forbade the sale and distribution of liquor, but personal use was not against the law. Second, alcohol prohibition was not enforced in the way today's drug laws are. Congress and the executive branch were uninterested in enforcing the law. Even many prohibitionists felt the law was so effective it did not need enforcement. Police, prosecutors, judges and juries frequently refused to use the powers the law gave them. In 1927, only 18 of the 48 states even budgeted money for the enforcement of Prohibition, and some states openly defied the law.

The key difference between alcohol and drug prohibition, however, lies in the substance itself. Alcohol – unlike

THE AMERICAN ISSUE

A Sabbathless Nation and a Stainless Flag

U.S. IS VOTED DRY

36th STATE RATIFIES DRY AMENDMENT JAN. 16

Nebraska Noses Out Missouri for Honor of Completing Job of Writing Dry Act Into the Constitution; Wyoming, Wisconsin and Minnesota Right on Their Heels

JANUARY 16, 1919, MOMENTOUS DAY IN WORLD'S HISTORY

“Alcohol – unlike illegal drugs – has a long history of widespread accepted use in our society, dating back to before biblical times. Illegal drugs cannot claim such pervasive use by the majority of the planet’s population over such a long period of time.”

illegal drugs – has a long history of widespread accepted use in our society, dating back to before biblical times. Illegal drugs cannot claim such pervasive use by the majority of the planet’s population over such a long period of time. Of course, cannabis *has been used* for thousands of years, and other mind-altering substances have their place in *certain cultures during specific periods of time*, but no substance other than alcohol can claim such widespread approval, use and influence.

So what lessons should policy makers take from America’s experiment with alcohol prohibition to inform drug policies? One is that, when a substance is legal, powerful business interests have an incentive to encourage heavy use by keeping prices low. Heavier use, in turn, means heavier social costs. For example, alcohol is the cause of a million more arrests annually than are all illegal drugs combined. Indeed, alcohol use leads to $180 billion in costs associated with healthcare, the criminal justice system and lost productivity; alcohol taxes on the other hand – kept outrageously low by a powerful lobby – generate revenue amounting to less than a tenth of these costs.

Even so, legalisation advocates try to capitalise on today’s global economic woes and use the potential for new tax revenues as a key argument in favour of repealing drug laws. But as author Daniel Okrent, whose research into Prohibition inspired Burns’s series, wrote last year, “The history of the intimate relationship between drinking and taxing suggests … that … [people] are indulging a fantasy of income tax relief emerging from a cloud of legalised marijuana smoke should realise it is likely only a pipe dream.”

If our experience with legal alcohol provides us with any lessons for drug policy, it is this: we have little reason to believe the benefits of drug legalisation would outweigh its costs.

But that doesn’t mean we need to be severe and punitive in our drug enforcement either. People in recovery from alcohol and other drug addictions should be entitled to social benefits, including access to education, housing and employment opportunities, despite their past drug use.

We should think seriously about the rationale and effectiveness of imposing harsh mandatory minimum sentences for simple drug possession. And no one can credibly argue we have enough treatment slots for everyone who needs them or that we have an adequate supply of evidence-based drug prevention for every school kid, regardless of background. Indeed, our current drug policy leaves something to be desired, and like most policies, it needs constant refinement.

Still, it is wrong-headed to think the only choices we have in drug policy are a punitive approach centred exclusively on enforcement or one based on careless legalisation. Neither has ever worked particularly well. ■

Kevin A Sabet PhD stepped down last September as Senior Policy Advisor to President Obama’s Drug Czar. He is currently a consultant through www.kevinsabet.com and a Fellow at the Center for Substance Abuse Solutions at the University of Pennsylvania. Follow him @kevinsabet.

Let's get serious

When drug addiction hits the news, it's usually for the wrong reasons. Charlie Sheen trashed a hotel room. Lindsay Lohan's back in rehab. Sly Stone, at 68, still uses cocaine and lives in a van. Amy Winehouse must have died of an overdose. Clearly something is awry when, instead of discussions about how to address addiction and treat people suffering from it, the media overwhelmingly favours a voyeuristic approach that caricatures the problem as the domain of out-of-control celebrities. But, writes **Hamish McKenzie**, the UN's new Addiction Ambassador wants to move drug dependency issues out of the tabloid gutter.

ACTOR AND author Christopher Kennedy Lawford was appointed UN Addiction Ambassador in March (full title: Goodwill Ambassador on Drug Dependence, Treatment and Care.)

He's well qualified for the role. After growing up in the famous Kennedy family – JFK was his uncle – and doing "enough drugs and alcohol for a lifetime," he wrote a best-selling memoir, *Symptoms of Withdrawal*, which chronicled his long struggle with dependency. He followed that up with *Moments of Clarity*, a book of essays by public figures who have overcome the same demon.

As an actor, he has appeared in films such as *Exit Wounds* and *The World's Fastest Indian*, which brought him to New Zealand, a country for which he has developed an enduring attachment. ("I loved New Zealand," he says at the end of our interview, "and any opportunity to go back, I'm shamelessly available.")

Over the phone from his home in Hawaii, he says he wants to elevate the 'addiction as an illness' discussion into the mainstream and give it a legitimacy he thinks it currently lacks.

"Too often in the institutional, governmental and even in the non-profit world, people look towards celebrity or visibility as the be-all and end-all of what you need to do," he says in a hoarse voice that brims with passion.

Throughout our conversation, he exhibits a tendency for long, breathless sentences that somehow morph into complete paragraphs. On several occasions, his rasp rises to a shout as he gets himself worked up about issues that touch his hot points: individual responsibility; the tawdry media focus on celebrity; and patronising approaches to addicts (to name a few).

In this case, after half a beat, he continues by saying celebrity endorsement is not enough. "With HIV, there were a lot of celebrities that came on board and did some advocacy, but there was an infrastructure of people who were dedicated, who were the afflicted and also the loved ones of the afflicted, who knew how to make the system respond."

When it comes to drug dependency issues, Lawford says, the sort of infrastructure that can be coupled with good information to change policy and perception doesn't yet fully exist – "but we're getting there".

The science is changing, we're starting to get great information on the brain, and the treatment industry is growing up – especially in the US, where the White House has shifted its drug policy emphasis from source eradication to demand reduction. In the meantime, however, other drug issues are hogging all the air time. Drug treatment and recovery, it turns out, is a less sexy topic than, say, legalisation.

Many think treatment is hopeless, even though there has been some great success, especially in the US, says Lawford. It's a view that is fed by the media's obsession with Charlie Sheen and Lindsay Lohan at the expense of coverage about scientific and treatment breakthroughs. It doesn't help that there's a lack of understanding about the plights of addicts and a pervasive sense that relapses shouldn't be tolerated.

"If somebody with diabetes goes off their insulin and binges on Dunkin' Donuts, nobody's jumping up and down and screaming they shouldn't get services or any of that stuff," he says.

"If an alcoholic falls off the wagon, or a drug addict, then they go, 'You know, they deserve what they get, and they shouldn't get any more services'."

The distinction clearly bugs him. "There's no difference between the diseases!"

It's also much easier to talk about the likes of legalisation – especially when your money's involved. Treatment and recovery, on the other hand, are complicated issues most people don't want to deal with.

"It's a difficult fix. This is not a thing you can just take a pill for or throw a bunch of money at. This is going to take some thought. There are lots of moving parts to solving a chemical dependency problem or a process addiction problem. There's the family, there's the individual, there's the life issues,

"Many think treatment is hopeless, even though there has been some great success, especially in the US … It's a view that is fed by the media's obsession with Charlie Sheen and Lindsay Lohan at the expense of coverage about scientific and treatment breakthroughs … there's a lack of understanding about the plights of addicts and a pervasive sense that relapses shouldn't be tolerated."

Christopher Kennedy Lawford

Kennedy Lawford as Jim Moffet in Roger Donaldson's *The World's Fastest Indian.*

whatever their job situation is and all those kinds of things."

David Carr, meanwhile, has a unique perspective on addiction and the media. He's a prominent columnist for the *New York Times*, but he has also written a best-selling memoir, *Night of the Gun*, about his past life as an addict. A recently released documentary called *Page One* depicts Carr as one of the newspaper's star reporters and repeatedly refers to him as a "former crackhead".

"That's certainly the most interesting thing about me," he says with wry humour over the phone from his home in Montclair, New Jersey, "but it's not the only thing about me. I was a single parent for 8 years, I ran newspapers, I've done some stories along the way, I've written a book. But it's just a way of saying who I am in a very quick, short form, and crackhead's a very powerful word. It happens to be true, too."

Carr is in the middle of expressing his disdain about the coverage of Amy Winehouse's death and how "the nature of celebrity coverage requires that human beings be reduced to tropes".

"When Amy Winehouse died," he says, "it was just like, 'Well, she was on a tear and she ended up overwhelmed on chemicals'."

He found it appalling the singer was written off as some kind of joke.

"I realise there's video tape of her acting like a knucklehead, but who among us hasn't acted stupid?" he says.

"I'm not suggesting she didn't have problems with chemicals, but she was a significant artist and a person who was by all accounts a decent human. Yeah, she could become abusive when she was doing chemicals, but that was not the end of the story with her."

Carr says the consequences of dependency are a "meme" of celebrity coverage.

"It's become a bit of a cliché. What doesn't get covered a lot is recovery. People focus on the fact that Charlie Sheen seems to be driven by chemicals to do really stupid things, but they ignore the fact that his dad, who had very significant issues with substances, straightened up and ended up in recovery."

"Recovery's not as interesting as active addiction. It's covered in cartoonish ways, and that's as much as people really want to know about it."

Carr knows Lawford personally and supports his appointment as a UN ambassador, even while pointing out that – with genocide, manipulation of food supplies and systematic rape – the UN has larger priorities than addiction on its plate.

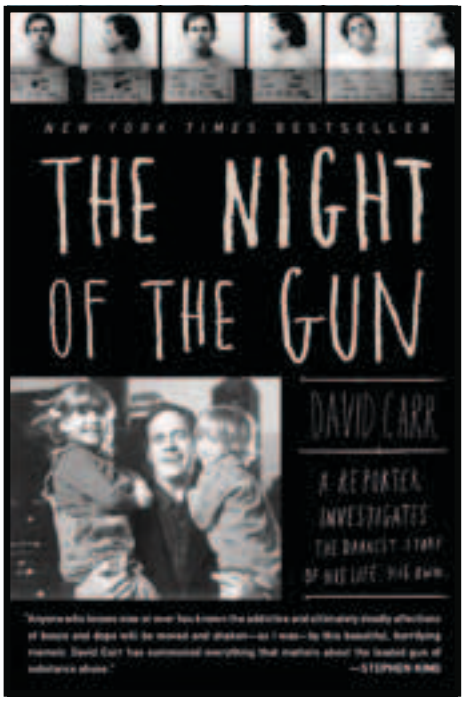
"He's a smart guy, and he's a powerful spokesman, and he's got very significant global connections," says Carr of Lawford.

"He has the ability to generate awareness and a little bit more complicated thinking about addiction issues – nothing about that can be bad."

While he may be a product of Hollywood, the most famous setting for chemical dependency, Lawford's world view stretches far beyond US borders. In fact, much of his focus is on the poorer countries.

"I'm much more interested in the developing world and low and middle-income countries, because they need the most help," he says.

"I'm not going to try and deal with heroin addicts in Berlin or Chicago, necessarily, although I think those people deserve a shot at this too, but there are a lot of people that just don't have anything going for them, and a little bit of money and a little bit of resource will go a long way in those places."



“It’s become a bit of a cliché. What doesn’t get covered a lot is recovery. People focus on the fact that Charlie Sheen seems to be driven by chemicals to do really stupid things, but they ignore the fact that his dad, who had very significant issues with substances, straightened up and ended up in recovery.”

New York Times columnist David Carr

He brings up a new trafficking route in which smugglers move drugs from South America to West Africa and then into Europe.

“Those people over there never saw cocaine,” he says of the West Africans.

“They have now. They have no infrastructure to deal with that. And the collateral damage is unbelievable because these motherfuckers go up West Africa and they pay for everything with cocaine. They habituate an entire generation of West Africans who did nothing except grow up wherever they were, and suddenly some guy in a truck comes along and they get white powder, and what do they know?”

This is one of those times when Lawford works himself into a rhetorical lather. He continues to rail about drug problems in the Third World and the rest of the world’s apparent blindness to them.

“Americans don’t know that, in Afghanistan, there are 5-year-old kids getting addicted to opium, because there’s no health infrastructure and because that’s the way it is and opium is the only thing that kills the pain over there. They have no idea what the face of this illness looks like in Bangladesh, where kids work on boats 16 hours a day and are addicted to speed, not because they like the speed or it helps them work, but because they don’t make enough money to buy *food*.”

Lawford isn’t concerned with the Parisian lawyer who wants to legalise cocaine so he can have fun with his girlfriend on the weekend – he’s more worried about the hundreds of millions of people already living under very difficult circumstances, “and then you put drugs on top of it”.

“You’ve got to be a dead person not to have some feeling about that,” he says.

“I’m a drug addict, I’m one of the lucky drug addicts. I’m a First World drug addict. There’s a lot of folks that didn’t have the opportunity I did.”

He highlights his experiences with methadone – a pain reliever used as a substitute for heroin to counter withdrawal symptoms – as an example.

“I’ve been on methadone in New York City, and I never had the problem of showing up at the methadone clinic and it being closed – because if you show up at the methadone clinic and it’s closed, you’re in for a hell of a weekend. And that happens all the time in Eastern Europe, for whatever reason.”

As far as ambassadorial roles go, Lawford’s is an interesting one. Just listening to him speak, you get a sense of what a vast and complicated a job it is. From getting the media to talk constructively about recovery to addressing emerging addiction problems in the developing world, the only thing that is certain is that there will be no easy solutions. Lawford is operating on ground that is constantly shifting and on a global scale. On top of that, he’s operating out of the US where, if you don’t have money or political connections, it’s difficult to get anything done.

“As a movement, we have nothing,” says Lawford. “We have very little advocacy – it’s in its infancy now.”

He does, however, see potential in the 12-steps programmes operating out of church basements around the world. If they went public with their addiction knowledge and experience, the job might be a little easier.

“Those people could be the backbone of a recovery movement if they wanted. They just have to get the information out.”

The question is, how is that going to happen? Discovering how is just one of the many challenges Lawford faces. ■

Hamish McKenzie is a writer based in the US.

Stop Press

IN FEBRUARY 2012, Chris will be visiting New Zealand as UNODC Goodwill Ambassador and as a guest of the Drug Foundation.

Where everybody knows you're nameless

A history of Narcotics Anonymous in New Zealand

Every evening, in community centres and church halls around New Zealand, recovering addicts attend Narcotics Anonymous meetings. Janet C brought the concept home with her from Australia almost 30 years ago. She still attends a meeting once a week and confronts her condition with the words: "Hi, my name is Janet, and I'm an addict."

By Keri Welham.

JANET C is 56 and has been in recovery for 32 years. She began using drugs in her early teens and had been addicted for a decade by the time she began treatment at 23.

"I was a teenager in the 60s. In those days, it was peace and love and marijuana and LSD …"

Janet C's drugs of preference were heroin and cocaine.

"In reality, I've used everything."

And that's about as much as you'll ever hear her relive from those days of addiction. No salacious tales of dealer boyfriends, horror trips, wasted weeks that turned into years.

She says it's too tempting for a person dependent on drugs to divert attention away from their disease by weaving a rollicking yarn about their years of excess and damage.

And so, at Narcotics Anonymous, the fellowship Janet C is credited with establishing here in the early 1980s, the focus is purposefully sharp. The topic on the table is recovery.

Narcotics Anonymous (NA) is an adaption of the Alcoholics Anonymous (AA) 12-step programme. It is the largest 12-step programme after AA, and 2010 statistics from Narcotics Anonymous World Service show there were 58,000 weekly meetings across 131 countries.

In a legal sense, a narcotic is a drug that is prohibited, but NA welcomes anyone for whom legal or illegal substances have become a major problem. Some NA attendees are people dependent on alcohol who, for whatever reason, feel better served by NA than other fellowships.

There are no fees, but people give a koha, and this covers the rent of meeting venues and literature. It is one of the 12 traditions on which NA is built that the fellowships be self-sustaining so they are not beholden to any outside influence.

NA was born in the US in the 1950s, but really took off in the 1960s. New Zealand's flirtation with the movement in the 1960s failed despite the dogged efforts and sparkle of a celebrated Kiwi poet.

James K Baxter, known in AA as Jim B, was a driving force behind the fledgling fellowship that first met in a Quaker hall in Mt Eden in 1969. He wanted to call the group the Fellowship of Love and Self-Help (FLASH).

In a published history of NA, *Keeping New Zealand Clean*, Peter O recalls, "We overestimated the problem, and the people who really needed to be there didn't want to come. We ended up just talking about drugs … We were all just pillheads."

Undeterred, Jim B persevered with a community in a squalid house in Grafton where he and a small band of supporters dished out bear hugs, mattresses on the floor, food and compassion. It was to be run according to NA principles, but the central philosophy of anonymity was never a major priority in Jim B's well meaning but at times misguided efforts to help addicts. Reporters were invited along to NA meetings and wrote all about James K Baxter and his hope for this new fellowship.

Peter O suggests in *Keeping New Zealand Clean* that Jim B's

“The Auckland addicts feared the police would keep a close watch on the meetings to find out the names and descriptions of its members and prescribe something a little heavier than a helping hand.”

Peter O

incarnation of NA suffered because the potential for Police surveillance frightened users.

“The Auckland addicts feared the police would keep a close watch on the meetings to find out the names and descriptions of its members and prescribe something a little heavier than a helping hand.”

The surveillance issue never really died. Unlike AA, those attending an NA meeting could be assumed to have, at some stage, cultivated, bought or sold illegal drugs. Obviously, they had also been using them – and they may still be doing so.

When Janet C and a band of dedicated supporters successfully relaunched NA in the 1980s, they were careful to assure potential attendees that this was a safe environment in which to battle their addiction.

A flyer from January 1983 states, “We are not affiliated with any other organisations, charge no dues or fees for our service and are under no surveillance at any time.”

In the late 1970s, Janet C turned up at what she thought was a detox clinic in Australia with her nightwear, make-up and heated rollers.

“I chose it (the clinic) because they gave large amounts of medications.”

She thought she’d be there 1 week. But she’d actually checked in to an addiction treatment centre and she emerged 18 months later – in recovery, regularly attending NA meetings and keen to return to New Zealand. She says one phrase from that time resonated and drove her recovery: “I wasn’t responsible for my disease, but I was responsible for my recovery. Before that, it was always someone else’s fault.”

Janet C’s first drug-free day was 3 April 1979. When she left the treatment facility, it became clear she had very few friends or acquaintances who were living drug-free. She needed support and was encouraged by friends she’d met in treatment to re-establish NA in New Zealand.

The first meeting of the second attempt at establishing NA in New Zealand was held in September 1982 in View Road, Mt Eden. Three AA members helped Janet’s group adapt AA’s philosophies and structure for their needs. The first meeting, with just a handful of attendees, was dubbed New View.

Later NA meetings were held at the St James Centre on Beresford St in central Auckland. Attendees recall stepping over a drunk in the doorway, a freezing room, filthy cups, a fug of cigarette smoke, and if the chairperson didn’t turn up, they’d just relocate to someone’s house. The meetings went for 2 hours and were rambling affairs where people talked about everything from their specific drug use to politics, read poems and received feedback from the chair.

Janet C says there was “not a lot of health” in those early NA meetings. The majority of people were still on drugs, and many turned up high.

It was hard to offer addicts an encouraging story of recovery when few in the room were not using.

“There was often controversy, physical fights, and most people were using and dealing.”

But when Janet C went to the US, she attended well established NA meetings and brought home a more structured, better focused, apolitical and strictly anonymous approach to recovery.

Today, there are well over 100 NA meetings held in New Zealand every week.

The meetings are typically swift 1 hour long gatherings, and the politics stay at the door. In Auckland, attendees usually sit in a circle and start with the serenity prayer. As the donation basket is passed around, people introduce themselves by their first name and say how long they’ve not used drugs. Significant drug-free milestones – from 1 day to multiple decades – are recognised with an NA keytag or medallion.

Napier has New Zealand’s second-oldest NA community, with meetings dating back to 1984. By 1985, there were meetings under way in Ashburton, Auckland, Christchurch, Hanmer Springs, Napier, Palmerston North and Wellington.

These days, there are meetings in the larger cities that cater for common needs, such as Māori, gay, lesbian, bisexual, transgendered, women, young people. In the smaller centres – Waimate, Waihī, Hokitika – numbers might be modest, but the group culture is often strong and determined.

Janet C says in the early days, some particularly resolute NA members in small towns arranged to hire a venue, opened the doors and sat there alone once a week reading through the literature and committing themselves to another drug-free 7 days. It could be

“The whole aim is for you to talk about yourself. It’s not to talk about particular drugs, but about addiction, how it manifests in your life and what you can do about it. The primary message of a meeting is to offer hope and a way out.”

months before another person turned up to join them.

Those small and potentially lonely fellowships might be somewhat buoyed by the unique and highly prized aroha that is said to imbue NA meetings here with a particular feeling of warmth and humanity. This is a character for which Jim B is credited.

Most meetings – worldwide and in New Zealand – take place in public buildings, such as libraries, marae and council buildings.

After the Christchurch earthquakes, particularly the deadly shake on 22 February this year, many of the Garden City’s church halls and council-owned community centres were destroyed. Many NA meetings in Christchurch have been rescheduled and venues altered as a result.

Janet C says, these days, there are still those who are high at meetings, especially first-timers who are desperate for the courage to turn up, but they are often outnumbered 50 to one. NA insists the only requirement for membership is a desire to stop using, so those who are high are only turned away if they are disruptive.

Janet C says some newcomers fall swiftly into relationships with other people in recovery. This is discouraged – it is seen as another drug, a form of avoidance or dependency.

NA encourages sponsorship – where senior members mentor those less experienced with living a drug-free life. They speak on the phone daily, weekly or monthly depending on need, and more than 70 percent of NA members use sponsors. Janet C says the relationship with a sponsor is an integral part of the 12-step programme, guiding those new to recovery through the steps.

A November 2004 survey of 82 meetings attracted 475 responses. The survey found respondents had an average age of 35, were predominantly city-based and of European ancestry and attended up to three meetings a week. Of respondents, 56 percent had convictions as a result of drug use.

Addicts are masters of deflection, Janet C says, so the 12 traditions clearly insist that those who take the floor must talk about themselves, the nature of their disease and their road to recovery – in their own words.

“The whole aim is for you to talk about yourself. It’s not to talk about particular drugs, but about addiction, how it manifests in your life and what you can do about it. The primary message of a meeting is to offer hope and a way out.”

Attendees can choose whether to speak at a meeting, but it is seen as a milestone when they take the floor for the first time and name their disease in the format made famous by 12-step programmes worldwide.

Janet C is happy to tell her story but insists on the anonymity at the core of her 32 years of successful recovery.

While she believes people benefit from hearing the stories of someone else’s addiction and recovery, that can be achieved without breaking anonymity. In the case of celebrities who go public about their addiction, she believes their stories can attract attention that makes their own continued recovery more difficult.

The 12th NA tradition states: “Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.”

Adding to this, Janet C believes media reporting of addiction is weighted too heavily towards the titillating details of the disease rather than the story of recovery.

Janet C has a 20-year-old son who attended many meetings with her as a baby. She also has a partner of 25 years who is now well versed in the nature of addiction and recovery and sometimes even finds himself acting as a back-up sponsor when Janet C is unable to get to the phone.

After 32 years of NA meetings, Janet C still says she’s in recovery.

She has had times when she has gone as long as a month without attending a meeting. She gets “relapse warning signs” – anxiety, irritability, anger, intolerance.

“What’s the point of being in recovery if you’re not living at ease and happy with your life?”

“I still need to go to meetings and practise the programme principles. Recovery is a process, not an event. It is exciting, expansive and on-going – 1 day at a time.” ■

A new language for the children of the drug wars

For decades, governments have used the rhetoric of war to describe their drug control efforts and rally their populations behind hardline policies they say will help protect children. However, **Nayeli Urquiza** argues it's this very terminology that encourages the abuse of children by turning them into enemies of the state.

BENJAMIN Santos Montoya was only 16 when he died in April 2011, after being tortured during an interrogation by the army in the northern state of Coahuila, Mexico. He had been arrested, along with other four minors, for alleged links to organised crime.

It's not clear whether this was an isolated case of the Mexican army torturing minors, but Benjamin's story is typical of the violence engulfing young people in the context of the war on drugs. According to the Network for Children's Rights, at least 1,300 children have died since 2006 while 30,000 have been recruited into various activities within the country's drug economy.

Mexico may be a headline-grabbing hotspot for gruesome news, but the drug war is not just a Mexican problem. It affects young people all over the world. Levels of drug criminalisation may vary, but there is no continent untouched by the punitive approach to drug control.

While the rhetoric of war is not officially used in political discourse, cases like Benjamin's demonstrate how drug control policies can produce victims of violence. Furthermore, the preamble of the Single Convention on Narcotic Drugs 1961 characterises people involved in the drug trade as "evil". It could be argued this creates a foundation for the bellicose language in drug control policies by setting off the Manichean concepts in our shared consciousness on war. It invokes Christian theories on the just causes of war that allow for the redemption of sins, even if it is done through violence. In this way, it becomes morally right to apply the full force of the state in order to protect us from drugs.

This is even more evident when justifying the war on drugs in the name of children. What parent would not want policies that promise to protect children from the harms of drugs? However, some now recognise that these policies cannot deliver.

Gretchen Burns Bergman describes watching her two children develop heroin dependency. Now executive director of A New PATH (Parents for Addiction Treatment and Healing) in the US, she understands intimately the danger and pain addiction causes individuals and families. Yet Ms Burns Bergman saw deep flaws in the way the state claimed to protect her sons by criminalising them and by allowing addiction to be handled by a criminal justice system that seemed totally incapable of understanding the intricacies of the disease.

"People who do not have addictive illness cannot understand why an addict does not stop the destruction of their disease," she writes in a chapter in the new book *Children of the Drug War: Perspectives on the Impact of Drug Policies on Young People*.

"What we do not understand, we fear, and what we fear, we hate. This is how prejudice is nurtured and why the war on drugs became such a lethal plague to our society, a constant and continuing battle that does worse damage to children and their families than the drug abuse."

Children of the Drug War interrogates this counter-intuitive logic of the protector state, by which the "best interest of the child" is obliterated by the very methods used to achieve this goal.

Cast as a "danger of incalculable gravity" in the UN Convention Against the Illicit Traffic of Narcotic Drugs and Psychotropic Substances 1988, parents have told their children to "just say no to drugs" and have supported any policy aimed at prevention and early identification of problematic drug use.

Children playing in La Paz, Bolivia's San Pedro Prison.

But the methods adopted by the government seem to be having no effect on teens, according to a 2010 US Department of Education survey, *The Effectiveness of Mandatory-Random Student Drug Testing*. Moreover, some of these policies actually do more harm than good. In another chapter of *Children of the Drug War*, Adam Fletcher identifies practices that lead to exclusion, expulsion and stigmatisation of children such as the deplorable 'naming and shaming' of students through compulsory drug testing.

More worryingly, a Human Rights Watch report last September revealed Vietnamese authorities have institutionalised compulsory drug rehabilitation centres where young people are being tortured and exploited to manufacture cashews for the food industry. 'Protecting' young people from themselves gave the Vietnamese government a smoke screen for institutionalised forced labour and, in doing so, could be said to be indirectly profiting from the illegal drug market. These kinds of human rights violations show the need for stricter scrutiny of the methods used by governments to reduce drug use.

Elsewhere, for some mothers serving sentences for drug possession or trafficking, raising their children in prison is the only choice they have.

"For many of these women, the only other option was to leave their children in the streets," write Jennifer Fleetwood and Andreina Torres in *Children of the Drug War*.

"If we start changing the discourse from one of war into one of policies, strategies and best practices, we might be able to explore options that actually do result in the best interest of children."

While they could be seen as 'collateral damage' of the war on drugs, Fleetwood and Torres argue that women are intentionally targeted as the need to fill quotas for US aid pushes the focus down to the most vulnerable people in the value chain. Mandatory minimum sentences for drug possession, which have led to the dramatic rise of women in prison in the US and Ecuador, only exacerbate the problem.

These glaring examples reveal that, in protecting children from drugs, governments have established policies that do more harm than good. This reversal of the government's role – from protector to abuser – might not be deliberate, but its consequences have had severe implications for families all over the world. Like drums on a battlefield, the bellicose discourse of drug control helps secure popular support. In Mexico, for example, a 2011 poll found 72 percent of the population supported President Calderon's battle against organised crime, despite evidence that the increased militarisation has only intensified violence.

In other, more formal fields of battle, ignorance of the socio-economic complexities in Afghanistan has increased the number of women and girls bartered to repay opium debts. Gender discrimination has loomed over Afghan politics since the beginning of the War on Terror.

Children as young as 7 years old continue to be incarcerated and suffer in the prisons in Pakistan.

In the face of hunger, debts to local drug lords and opium eradication policies, parents sacrifice their daughters so the rest of the family can survive. To western eyes, this objectification of women is reprehensible and characteristic of backward paternalist societies. But this is an oversimplification of the economic reality of farming families, caused partly by the war and the poppy eradication programmes. The fact is, repaying debts with an arranged marriage is condemned by local communities, and farmers who do it are looked down upon as being unable to provide for their families.

With an illicit drug market valued at 13 billion dollars, there is now a dizzying array of material interests engaged in the drug war (though significant shares of these profits are rarely enjoyed by farmers or drug mules). But this lofty figure does not include investment in militaries and civilian private security. The US alone has spent $7.3 billion on training and other forms of assistance to the Colombian military for counter-narcotics and counter-insurgency activities and $1.1 billion in Mexico and Central America. Meanwhile, civilian private security services outnumber state police forces in countries like Honduras, South Africa and the US.

The morally laden idioms in drug policy may push forward money and militaristic responses to control drug abuse and trafficking, and calling these children "war casualties" or "collateral damage" only reifies the existence of this 'war'. But they are not war victims or prisoners of war or child soldiers. Instead, they are a vulnerable group who have been subjected to grave violations to their human rights at the hands of criminal organisations and the state – or they have been neglected as governments have privileged drug control over social, economic and human rights.

Attempting to balance the need to protect children and young people from drug abuse and the negative consequences of drug policies underpinned by existential rhetoric, Steve Rolles puts forward possible regulatory options in another chapter of *Children of the Drug War*. He draws on health policy perspectives and market regulations with strict age controls. In this way, preventing drug use among young populations would be more manageable and targeted and less onerous to a government's budget.

If we start changing the discourse from one of war into one of policies, strategies and best practices, we might be able to explore options that actually do result in the best interest of children. Without minimising the harm of drugs, such a blueprint would place pragmatism and human rights at the centre of drug debates.

But we won't be able to explore these options, through reasoned arguments and results-oriented case studies, until we get rid of the metaphor of war that turns children and their families into the enemies of the state and social order. ■

Nayeli Urquiza works at Harm Reduction International promoting the book *Children of the Drug War*. Read the book online or download a copy at www.childrenofthedrugwar.org.

Should Māori wardens have special powers to remove drunk Māori from bars?

Police caused a brouhaha earlier this year when they announced they'd use Māori wardens in Wellington during the World Cup to help keep the peace. Opponents say the Act is archaic and that it's racist to specifically target Māori. Supporters applaud such work by Māori wardens and say they were established by Māori to make a positive difference for Māori.

In this edition of Viewpoints we provide the arguments for and against Māori wardens' ability to intervene in specifically Māori cases of drunk and disorderliness.

The case against

PRIME MINISTER John Key was right when he weighed in on the Act's removal provisions saying they "felt racist". At the end of the day, he pointed out, if someone is removed from a bar, it should be because they're underage or they're intoxicated. Ethnicity has nothing to do with it.

Nice one, John. We don't have special 'drunk police' for any other ethnic group, and nor should we, because it implies the group has a worse problem with alcohol than other groups or that individuals within that group have some sort of genetic propensity towards drunkenness. This is implicitly racist and ostensibly untrue.

Secondly, these sorts of laws do nothing for New Zealand's race relations. Employing people to act solely on the basis of race is condescending separatism. What message do we send to the world, to our children and to each other when one drunk is hauled out of a bar because of the colour of his skin while his white mate is left alone? If New Zealand has a deepening racial divide, as some people claim, then laws like this are part of the reason why.

Lastly, there's absolutely no legal necessity to give Māori wardens these special powers. Under the Sale of Liquor Act 1989, it is already an offence to allow any person who is intoxicated or disorderly to remain on premises or to serve them alcohol. As such, any Māori warden carrying out these duties will be doing so in a bar that is breaching its legal obligations by not removing said drunk persons in the first place. If bar owners actually comply with current legislation, there will be no need to enforce the law using this antiquated system.

We're all for the idea of wardens patrolling to help police and head off trouble before it starts, but they should be made up of any or all races and should intervene whenever there's trouble with alcohol – not just when it involves Māori.

The Māori Community Development Act 1962 gives Māori wardens the power to tell bar staff to "abstain from selling or supplying liquor to any Māori who in the opinion of the warden is in a state of intoxication, or is violent, quarrelsome, or disorderly, or is likely to become so, whether intoxicated or not". It also allows them to remove the person from licensed premises and even to confiscate their car keys.

The case for

THOSE ARGUING against Māori wardens' special removal powers often don't fully understand why or how they do their job. They seem to think the wardens gleefully target drunk Māori in bars and then make a big show of hauling them out into the street while they ignore all the 'whiteys' making nuisances of themselves.

As Māori Party leader Pita Sharples pointed out when this made news, Māori wardens are a symbol of peace, "like a sort of security". They don't act like police, they don't make arrests, they simply are there as a mediator.

That's important because it is their non-confrontational methods that work so well. Senior Auckland warden Junette Rielly says Māori wardens focus on making sure young people keep safe while enjoying themselves on a night out, which could include offering rides home, assisting those in trouble and calming situations when needed. As such, they provide a reassuring public presence – and that's often not the case with the police.

The wardens have always held significant mana among Māori. Traditionally, they have a reputation as being 'old school', strong and wise, commanding deep respect. This is why Māori wardens are often able to calm a situation or prevent one from arising where pākehā or police authorities might have just the opposite effect.

But that they're just there for Māori is also a fallacy. Police Superintendent Wally Haumaha, who has overseen police/warden engagement since 2007, says he's never heard of targeted racism and that they'll actually intervene wherever required and whoever is involved. He describes the work they're doing as "bloody extraordinary".

Lastly, it's a bit rich to be slapping the old racist label on the special powers of Māori wardens. Māori cop a lot of flak for their higher representation in crime figures and incarcerations. Now, when they step up and do something to make a difference in a genuinely effective way, it's called racism. Damned if you do, damned if you don't.

We can all be really grateful for Māori wardens, because we're all better off for the terrific job they do. And if we're going to be critical of that, then let's at least get our facts straight first. ■

You decide

Should Māori wardens have special powers to remove drunk Māori from bars?

Vote now at www.drugfoundation.org.nz/viewpoints.

Quotes of Substance

“I got the terrible impression they just threw the gangplank down, and they went scampering off the ship like rats.”

An **unnamed** member of the New Zealand Defence Force, who witnessed the drunken behaviour of members of the Navy in Vanuatu, speaks out against the poor leadership shown by commanding officers.

“Where’s the weed?”

While still trapped in his car, **Danny Emms**, over three times the legal alcohol limit, asks the occupants of the house he crashed into to hide his cannabis stash before the police arrive.

“ALAC thinks the decision and the persistence in continuing with the plans for alcohol to be made available in cans is a mistake, and we suggest it is not too late to put this right.”

ALAC’s Environments and Settings Manager **Andrew Galloway** urges Rugby World Cup organisers to reconsider the decision to supply beer in cans at venues. Dutch brewers Heineken had official beer rights at World Cup venues but don’t produce their beer in plastic bottles.

continued on page 33 ▶

New Zealand News

$500 for black market tobacco

BLACK market prices for tobacco in prisons have hit $500 for a 30g pouch – five times the price of the most prized caviar available in New Zealand. The *Herald on Sunday* reported prisoners at Mt Eden Prison were paying up to $15 for a single roll-up cigarette.

In July and August, 353 contraband items were found in prisons and 31 prisoners were caught smoking. Despite this, Corrections says the smoking ban introduced on 1 July was a success.

Recently, staff at Christchurch Women’s Prison noticed a pair of slippers were unusually heavy, felt hard and had a strange smell. On opening the lining, staff found approximately 50g of tobacco in each slipper plus packs of tissues.

In another case, a 20-year-old man was caught trying to lob a sock full of cannabis, tobacco, lighters and lollies over a fence at New Plymouth Prison.

Cannabinoid tests $5,000 a pop

THIS year, 16 synthetic cannabinoids were made illegal and listed as Class C1 drugs.

Enforcing the change is the Temporary Drug Class Notices regime, which will be replaced next year by a permanent law requiring manufacturers of legal highs to prove the safety of their products.

Currently, the government pays around $5,000 to test each product it suspects may be synthetic cannabis – a cost Associate Health Minister Peter Dunne says it is “prepared to bear”.

Enjoi Products, makers of legal highs and party pills, recently released a repackaged and modified version of its synthetic cannabis to convenience stores across Auckland. However, the Ministry of Health confirmed the product contained a banned cannabinoid. The product was recalled and taken off shelves.

The *New Zealand Herald* reported at least one synthetic cannabis product, labelled “herbal tea”, has been sold since the day after the bans in August.

Mr Dunne said officials checked out such “rumours” and acted on them if they were substantiated.

Drug court pilot announced for Auckland

THE government has agreed to establish a drug court pilot in Auckland to deal with offenders with severe alcohol and drug dependencies, following recommendations from the Law Commission’s review of the Misuse of Drugs Act.

The drug court will try offenders with severe addiction problems who require intensive treatment to help break the cycle of their substance abuse.

The 5-year pilot will deal with approximately 100 offenders a year at treatment-related costs of $2 million.

Justice Minister Simon Power said the court is expected to be up and running from the second half of next year. It has not been decided where in Auckland it will sit.

“Establishing a drug court delivers on priorities under the government’s Drivers of Crime work programme, which includes reducing alcohol-related harm and improving the availability and accessibility of alcohol and drug treatment services,” he said.

Wine drinkers may be imbibing fantasy

DRINKERS of wine, sherry and port in New Zealand may be unknowingly breaking the law and consuming small doses of the party drug fantasy, an illegal Class B drug. The revelation has brought calls for wine to be tested to see if there are traces of gamma-hydroxybutyric acid (GHB) or its precursor gamma-butyrolactone (GBL) – the active ingredient in fantasy.

National Addiction Centre Director Doug Sellman said it seemed likely some wine contained GHB and called for more research.

“It raises the bizarre conclusion that many wines in New Zealand may, in fact, be technically illegal,” he said.

“There’s been no research done on New Zealand wines, and only one article in 2005 in the international literature.

We're not talking about trace amounts. If you drank a bottle of wine, a small but significant part of the intoxication will be from fantasy."

The article found GHB or GBL occurred naturally in fermenting grapes.

It looked at 50 beverages in Britain and found the ingredient in vermouth, sherry, port, red wine and white wine. The concentration of GHB ranged from 4.1–21.4mg per litre, with the greatest concentration found in red wine. Doses as a recreational drug are usually between 500mg and 3,000mg.

But Dr Keith Bedford, general manager of forensics at Environmental Science Research, said the level of GHB in wine was virtually meaningless.

"You can consider the effects as being very similar to alcohol. Compared to the amount of alcohol in alcoholic drinks, what we're talking about is trivial."

Thousands to benefit from $10m for alcohol, drug treatment

A $10 MILLION investment package designed to assist thousands of people with alcohol and drug-related issues of all severities has been announced by Justice Minister Simon Power and Health Minister Tony Ryall.

The funding, which comes out of alcohol excise revenue, is on top of the approximately $120 million spent on specialist alcohol and drug treatment services each year to reduce harm from alcohol and drug abuse.

The package complements the government's work to strengthen the regulation of alcohol through the Alcohol Reform Bill and delivers on the priority to reduce alcohol-related harm under the government's Drivers of Crime programme.

"Alcohol and drug abuse are major drivers of crime, with two-thirds of offenders who enter prison having dependency issues," Mr Power said.

Cannabis club founder's sentence doubled

DAKTA Green, the founder of New Zealand's first cannabis club, has had his jail sentence more than doubled following an appeal by the Solicitor-General.

Green, 61, who ran The Daktory in New Lynn, Auckland, for more than 30 months, had been sentenced to 8 months jail for selling cannabis, possession of cannabis and allowing a premises to be used for commission of a crime against the Misuse of Drugs Act.

However, the Solicitor-General appealed the sentence, arguing that the judge gave him too much of a discounted sentence. The Court of Appeal then quashed Green's original sentence and increased his jail term to 23 months.

Green had originally been given a lighter sentence because the sentencing judge considered Green's case was different because Green wasn't selling cannabis covertly or for personal gain, rather to maintain The Daktory.

The Daktory, although now closed for business, is still the headquarters of the Aotearoa Legalise Cannabis Party.

Mehrtens accused of being drunk on TV

ACCUSATIONS that All Blacks legend Andrew Mehrtens appeared on live television while drunk were raised twice during the Rugby World Cup.

The former Canterbury player, now living in France, appeared on the TV3 rugby panel show *Cup Talk* with glazed eyes and slurred speech, slugging back water during the 30-minute late-night show.

After an ad break, one of the hosts mentioned an incident had just occurred but refrained from giving details to viewers.

Claims of Mehrtens drinking before going on TV were also made after an earlier *Cup Talk* show aired on 12 September.

TV3 bosses sidestepped the allegations and put his behaviour down to jet lag, though he had arrived in the country 6 days earlier.

A TV3 spokesperson declined to comment on the allegations, but said they were "thrilled" with Mehrtens's performance on the late-night show.

Wellington media lawyer Steven Price said there were no Broadcasting Standards Authority guidelines about intoxicated presenters appearing on television, though grounds could be found for a complaint, depending on the circumstances. ■

Quotes of Substance

"Now that I'm gone, I tell you: don't smoke. Whatever you do, don't smoke."

Russian actor **Yul Brynner**, after finding out he was dying from lung cancer, wanted to create an anti-smoking commercial, which was released after his death by the American Cancer Society.

"I took more hell f or being fat than I did for being an absolute raging drug addict. I will never understand that!"

Kelly Osbourne takes serious offence from being derided for her once voluptuous frame and wonders why her weight, not her addiction, got the most attention.

"I behaved like a prat."

Criminal lawyer **Doug Taffs** regrets trying to escape police custody and vandalising a breath-testing machine after being pulled over for drink driving.

"I dunno what's worse for my brain, drugs or reality TV. I don't want to do either. But my wife makes me watch, which makes me want to do drugs."

Joel Madden of Good Charlotte fame compares reality TV to drugs.

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Quotes of Substance

“The situation will reach ‘crisis’ level within 30 days.”

The Patong Entertainment Business Association’s **Weerawit Kurasombat** tells the *Phuket News* there will be dire consequences if steps are not taken to bring booze back to Phuket’s party town after the Bangkok floods. Stocks of the precious beverage are running dangerously low. He said between 20 and 30 percent of the income generated by entertainment businesses in Patong is from alcohol sales. Of that income, 60 percent is from beer, 30 percent from whisky and wine, and the remaining 10 percent is from cocktails.

“Amy didn’t like to talk about her addiction, but it was there for all the world to see. To everyone else, it was Amy Winehouse, but all I could think was: ‘That’s my baby’.”

Janis Winehouse on the death of her daughter.

“We are concerned for the kid’s future. He’s missing school, right?”

Lead prosecutor **Gusti Gede Putu Atmaja** expresses concern for a 14-year-old Australian boy facing drugs charges in Bali.

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World News

CIA presence puts the wind up

CONTROVERSY has arisen in Mexico after a *New York Times* article revealed the CIA and the US Drug Enforcement Agency (DEA) are operating inside Mexico with the full cooperation of the right-wing government of President Felipe Calderon.

The CIA and DEA agents are supposedly assigned to help the Calderon government in its bloody war against drug cartels. However, many Mexicans remember the CIA’s anti-communist government interference in Mexico and suspect the presence of the CIA has political purposes.

Many recall the CIA’s Mexican presence during the 50s and 60s, which, coupled with recent allegations of the CIA infiltrating the Mexican government, leads people to believe the CIA’s involvement is to keep the right wing in power beyond the 2012 general elections.

The CIA and DEA have long supported Mexico’s war against drug and crime cartels, which intensified after Calderon was declared president in the wake of the much criticised 2006 elections. Calderon’s military policy towards the cartels has been violent, with over 40,000 drug-related deaths reported since he came into power.

Full frontal coca fight

UNITED States officials were surprised and concerned to hear Peru’s new government has temporarily suspended the eradication of coca plants. Coca is the base ingredient of cocaine, and the US has been trying for years to limit the production of coca in Peru as part of a broader war on drugs in the region.

Peruvian Interior Minister Oscar Valdes said eradication would resume “very soon” but added the government wanted to focus more on catching major traffickers and cutting off access to supplies, such as kerosene used to refine coca into cocaine.

“The public must understand that the reduction of illicit crops will continue, and there will be a frontal fight against drug trafficking,” Valdes said. “We are working on how to redirect efforts.”

According to the United Nations, Peru is the world’s leading grower of coca and is set to overtake Colombia as the top cocaine producer.

The coca plant has many medicinal and traditional uses in Peru and other Andean nations, but supporters of eradication say most of the crop is cultivated for the cocaine industry.

Drinking your way up the corporate ladder

BINGE drinking is becoming increasingly popular in China to the point firms are seeking employees who can handle copious amounts of alcohol. Drinking to develop work relationships in China has a long history, but the amounts of alcohol being consumed are increasing, and many employees feel they have to binge if they want to progress their careers.

Peter Chi, from China’s north-eastern Liaoning province, is not an alcoholic but regularly binges and spends many nights a week passed out on a table. He has been hospitalised for his drinking but says, as a respectable head teacher in his 40s, he feels he has little choice but to indulge – or risk harming his career

“No one likes binge drinking, but it’s not under your control,” he said. “Of course, I don’t like it, but there’s nothing I can do.

“If I don’t drink, it’s less likely I will be promoted, so I must drink, even if it’s not pleasant at all. People want to show they are forthright and try to get along with others … It’s very normal to get an order to drink from bosses.”

In fact, some job adverts explicitly demand applicants who can hold their alcohol. “Candidates with good drinking capacity will be prioritised,” says one advert seeking a business manager.

Treatment staff in job centres modestly increase access

THE UK GOVERNMENT has recently become more concerned that too few unemployed people with problematic drug use are being referred to treatment.

Recent figures revealed that, in 2006, over 30,000 users of heroin or crack cocaine in England were not in treatment for their drug use problems and were currently on an unemployment benefit. In 2009, even fewer people with drug issues were being identified

and referred for treatment.

Minister of Employment Chris Grayling trialled a programme where drug-treatment staff were placed in three job centres in high drug-use urban areas to facilitate the referral of unemployed users into treatment.

The programme saw an increase in the number of users being referred. In the month prior to the trial, just 13 users were identified. In the month where drug-treatment staff were present at the job centres, 57 users were identified and referred for treatment.

However, according to Grayling, the increase was not enough to warrant a national roll-out.

ELKaholic moose

A SWEDISH man was stunned to discover the roaring noise coming from his neighbour's front garden was an intoxicated moose stuck in an apple tree.

Per Johansson went to investigate an unusual noise late one night and found the female moose kicking about in the tree. The moose had been spotted sneaking around the neighbourhood for days and was drunk from eating fermented apples.

He was eventually able to free the animal with the help of police and rescue services by sawing off tree branches. However, the moose followed him home and slept off the hangover in his front garden for the next 2 days.

A heck of a way to harvest your dak

DRUG officials from Kyrgyzstan announced in August they had confiscated 4.5 tonnes of cannabis from illegal drug traffickers in just 7 days. Special mention was made that the cannabis was grown in the northern Chui Valley.

August is the month for cannabis harvesting in this particular region, as it is when it starts producing the narcotic resin.

However, the way the most concentrated and popular form of cannabis is harvested and produced has not changed for centuries. It begins with a freshly showered person riding naked for hours on a clean, washed horse inside a 2-metre high "forest" of cannabis.

Afterwards, the human body and the horse are covered with a thick brown layer of resin mixed with sweat. This is then thoroughly scraped off the human's and horse's bodies, and the mixture is subsequently pressed, moulded into bars and dried. Only a couple of pinheads in a cigarette are all that is needed for the user to get high.

Cannabis arrests cost more than they're worth

TWO reports from the United States have highlighted that a hardline stance on small-time possession costs more than it is worth and can cause more harm to communities.

A New York study revealed over 60,000 (mostly black and Latino male) New Yorkers will be arrested this year for small levels of cannabis possession, at an estimated cost to the city at $75 million a year.

A similar RAND report from Los Angeles, where medicinal cannabis is legal, has shown crime is higher in neighbourhoods where cannabis dispensaries have been closed. The report claims crime was as much as 60 percent greater around medical cannabis dispensaries that had been shut down by the City of Los Angeles compared to those areas with open dispensaries.

What's obvious from this information is, regardless of the waste of human lives cannabis arrests cost New York or Los Angeles, they are extremely expensive for both cities, save neither one money, and don't reduce crime.

Would you like fries with your syringe?

A BURGER franchise next door to a homeless shelter in Brisbane is sending out 20,000 pens that look like blood-filled syringes to appeal to the drug users who frequent the accommodation.

A local social service made complaints about the marketing gimmick by Burger Urge, which is using the syringes to promote its new menu, featuring options including "Lamb Phetamine" and "Beef Injection".

Rod Kelly, General Manager of the 139 Club homeless shelter next door, said it is using the promotional tools "without any thought of moral and community responsibility" and has urged people to strongly reconsider making purchases from the outlet.

Kelly is in charge of Queensland's biggest homeless day centre, which supports up to 70,000 people each year, many of whom are battling drug and alcohol addiction.

"I'm an ex-intravenous drug user, and in the early days when I was getting clean, if I saw that in my letterbox, it would have made me want to start using again," he said.

The *Courier-Mail* questioned Burger Urge co-owner Sean Carthew over the move, asking if he was comfortable about using drug addiction to sell burgers to people suffering physical and mental illness caused by drug use.

"Yeah, that's a fair comment," he responded.

Dutch getting hard on drugs?

THE DUTCH government has announced a move to classify high-potency cannabis alongside hard drugs such as cocaine and ecstasy, the latest step in the country's on-going reversal of its famed tolerance policies.

Dutch Economic Affairs Minister Maxime Verhagen said weed containing more than 15 percent of its main active chemical tetrahydrocannabinol is so much stronger than what was common a generation ago that it should be considered a different drug entirely.

The high-potency weed has "played a role in increasing public health damage," he said at a press conference in The Hague.

The decision means most of the cannabis now sold in the

Quotes of Substance

“No other New Zealand citizens are subject to the same intrusive search criteria.”

Civil liberties lawyer **Michael Bott** talks about drug dog searches in New Zealand secondary schools. Some police are refusing to carry out the random sniffer-dog drug searches amid claims they are breaching pupils’ civil rights. The move follows legal advice from police lawyers, but principals say this means they’ve lost a vital tool in the fight against drugs.

“He was having trouble functioning in everyday life.”

Doctors from London University have revealed details of what they believe is the largest amount of ecstasy ever consumed by a single person. Consultants from St George’s Medical School in London have published a report of a British man estimated to have taken around 40,000 ecstasy pills over 9 years. Though the man, who is now 37, stopped taking the drug 7 years ago, he still suffers from severe physical and mental health side-effects, including extreme memory problems, paranoia, hallucinations and depression. ■

Netherlands’ weed cafes would have to be replaced by milder variants. But sceptics said the move would be difficult to enforce, and it could simply lead many users to smoke more of the less potent weed.

Possession of cannabis is technically illegal in the Netherlands, but police do not prosecute people for possession of small amounts, and it is sold openly in designated cafes.

Conspiracy charges for discussing drugs

THE HOUSE Judiciary Committee of the United States has passed a bill that makes it a federal crime for US residents to discuss or plan activities on foreign soil that would violate the Controlled Substances Act (CSA), even if the planned activities are legal in the countries where they are to be carried out.

The bill allows prosecutors to bring conspiracy charges against anyone who discusses, plans or advises someone else to engage in any activity that violates the CSA, the massive federal law that prohibits drugs like cannabis and strictly regulates prescription drugs.

The law could also potentially affect academics and medical professionals. A doctor who works with overseas government officials on needle exchange programmes could be subject to criminal prosecution. If interpreted broadly, a prosecutor could possibly even charge doctors, academics and policy makers for contributing their expertise to experiments overseas.

Civil libertarian attorney and author Harvey Silverglate says the bill raises several concerns.

“Just when you think you can’t get any more cynical, a bill like this comes along. I mean, it just sounds like an abomination. First, there’s no intuitive reason for an American to think that planning an activity that’s perfectly legal in another country would have any effect on America. Second, this is just an act of shameless cultural and legal imperialism. It’s just outrageous.”

More beer consumed at Oktoberfest

A NEW record was set at this year’s Oktoberfest, the world’s largest folk festival, after revellers consumed 7.5 million litres of beer. The 17-day party ended in blazing sunshine, a contrast to the obvious gloom in Germany about the spiralling debt crisis, and drew some 6.9 million visitors, many clad in traditional Bavarian lederhosen or dirndls.

Most visitors came from Bavaria, the home of Oktoberfest, but more than a million travelled to Munich from abroad, mostly from Italy, the United States and Australia.

More than 118 oxen and 53 calves were consumed to the rousing strains of oompah bands, but the real foods of choice to help soak up the beer were roast chicken and pork sausages, with hundreds of thousands of each cooked up and dished out.

“The atmosphere at the Oktoberfest was, until the last day, absolutely excellent,” said Munich mayor Christian Ude, who described it as a “Dream Oktoberfest”.

The organisers were particularly pleased there were only 58 brawls in which drinkers used their “masskrug” or heavy litre beer mug as a weapon, said police.

Elvis-crooning Chile miner fights demons

IN ADDICTION treatment after an agonising 2 months trapped in the bowels of the earth, the Chilean miner who won America’s heart by crooning Elvis Presley hits is still wrestling with his dark side a year on from his rescue.

As most of the 33 miners celebrated the anniversary of a spectacular rescue that transfixed hundreds of millions of viewers across the globe and made them stars, Edison Pena was hundreds of miles away in therapy.

Pena was the miner who drew most attention and was feted with trips to run marathons in New York and Japan, sing Elvis Presley hits on the *Late Show with David Letterman* and even visit Graceland.

But Pena gave in to cocaine and alcohol and slipped into an alternate reality he says he yearns to shake off.

“They were like sedatives for adrenaline,” he told Reuters in an interview in the capital Santiago after a session with his therapist, sipping at an instant coffee. “It was like I was travelling in a car that only had an accelerator.” ■

Substance and Substantiation

Death by withdrawal?

Can a person chronically dependent on alcohol really die if they abruptly stop drinking? Or is this just another clever excuse not to part with their drug of choice?

Mythbusters investigates …

WHEN Amy Winehouse was found dead in her London home earlier this year, many assumed the cause of death was overdose. The only question on everyone's minds was what she'd overdosed on. Was it heroin? Was it barbiturates? Few would have suspected she'd died of alcohol withdrawal, but her family were certain this was the means of her demise.

Pam Corkery, journalist, broadcaster and former politician, has recently celebrated a year without drinking. She told the *New Zealand Herald* her decision to get on the wagon began with a call to an alcohol helpline. She was advised to go to a hospital, but she declined, saying she didn't want her family to know the extent of her addiction. So instead, they suggested she keep on drinking, just as a "maintenance arrangement", until she could come and see them. She was told this would prevent withdrawal convulsions.

There are inherent difficulties and hazards involved with empirically testing the serious hazards of alcohol withdrawal, so Mythbusters consulted Dr Doug Sellman, Professor of Psychiatry and Addiction Medicine at the University of Otago. He agreed there can indeed be very real dangers when an alcoholic goes cold turkey.

"Addiction involves a hijacking of the survival mechanisms in the brain. People with drug addiction continue to use the drug as if their lives depend upon it. Body and brain get their wires crossed, so people in withdrawal can certainly feel like they are going to die if they don't get enough of the drug they 'need'."

Withdrawal in someone with alcohol addiction itself is not life threatening, but there are complications that can lead to death, such as convulsions, where the person has an epileptic seizure, and cardiac arrhythmias, where the heart goes into a spasm and doesn't pump blood efficiently. Other common symptoms include nausea, sweating and dysphoria (anxiety and restlessness).

And we've all heard of the delirium tremens or 'the DTs'. Having the DTs is like being in a constant state of confusion and hyperactivity, and symptoms includes disorientation, hallucinations and vomiting. If the pink elephants aren't bad enough, an alcoholic experiencing the DTs is susceptible to grand mal seizures, heart attacks and stroke.

"Withdrawal in someone with alcohol addiction itself is not life threatening, but there are complications that can lead to death …"

Alcohol withdrawal symptoms are caused when prolonged periods of excessive alcohol intake are reduced or stopped abruptly. Alcohol, like many other drugs, is a sedative. Generally, it relaxes the body and induces calm. Over time, the brain adapts to frequent heavy doses. Its neurotransmitter system recognises the sedation and goes into a hyperactive state to overcome the effects of the alcohol so it can continue to function at normal levels. But when the body suddenly stops its intake of alcohol, the neurotransmitter system continues working in overdrive. This 'neurotransmitter rebound' can lead to all the problems we've discussed above.

It's a bit like two equally balanced people playing tug of war and one person suddenly drops the rope and the other is sent flying.

And that's why Dr Sellman agrees the chronic severe alcoholic should probably continue drinking if immediate help is not available. It's not just an excuse.

"It is easier on the body to reduce down over days or even weeks before stopping altogether. Another day of heavy drinking to prevent severe withdrawal symptoms while the person finds help is not going to make any appreciable difference to their health in the context of the thousands of heavy drinking days in their life."

So Mythbusters' conclusion is yes, you can die from alcohol withdrawal – not because stopping drinking is bad, but because your body has become convinced it needs alcohol to survive, and it just might kill you if it doesn't get it.

And what about Amy? Just as we go to press, a coroner has announced she was more than five times over the British drink-drive limit when she died. So it seems withdrawal was not the problem in her particular case. However, on the basis of what we knew before the inquest into her death, it was a feasible scenario. ■

For a full list of references, visit www.drugfoundation.org.nz/mythbusters.

press

Do yourself a favour, take a moment to consider what a pause of 29 alcohol-free days could do for you, for your liver, for society and for young people impacted by alcohol and other drugs. You can sign-up for FebFast 2012 at www.febfast.org.nz from 12 December.

febfast.org.nz

a pause for the better

febfast