Matters of Substance.
JULY 2019 | Volume 30 Issue No.2 | www.drugfoundation.org.nz
AT THE HEART OF THE MATTER, NZ DRUG FOUNDATION.
Te Tūāpapa Tarukino o Aotearoa

Hugs not drugs (or both)

The criminality of drugs fuels fears and doubly so for LGBTQ people. A growing body of research reveals a spectrum of use. In what ways can harm reduction better support this community?

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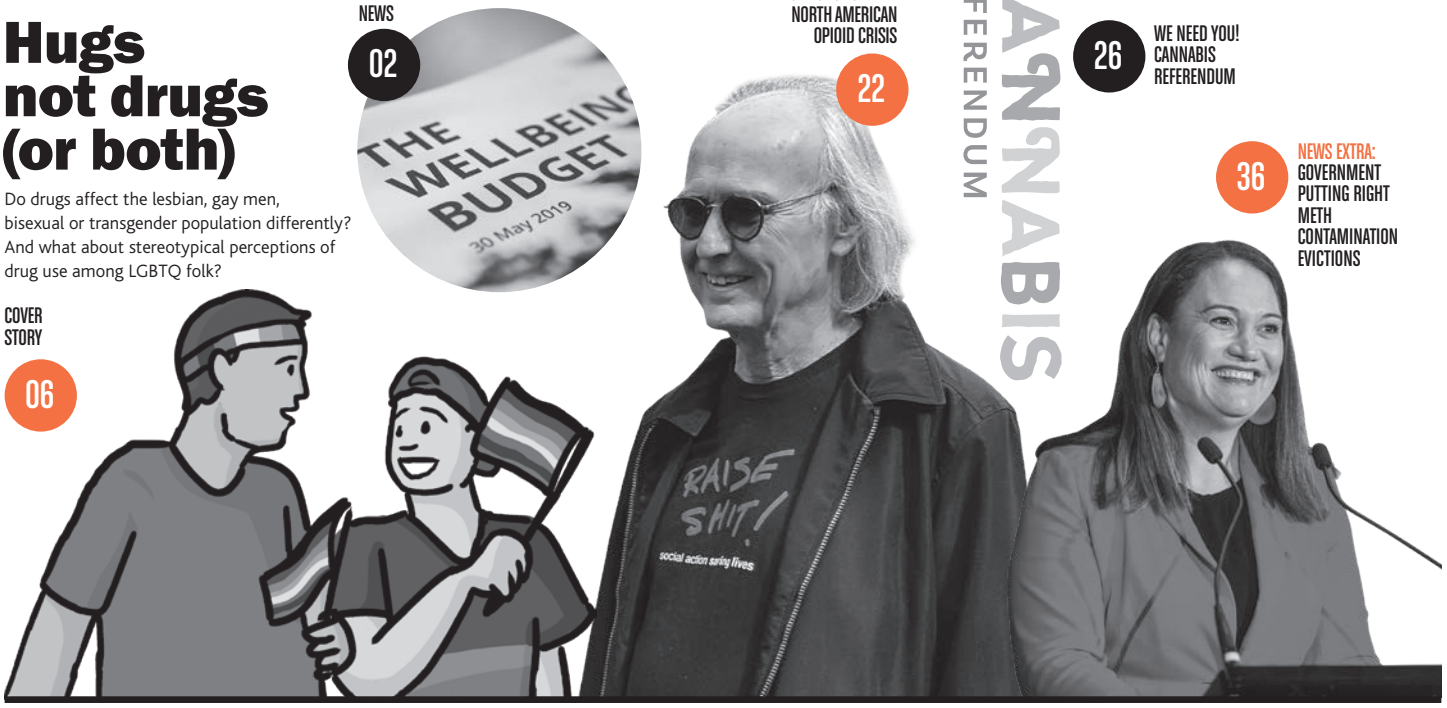

FEATURES

REGULARS

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

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

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

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MATTERS OF SUBSTANCE
July 2019
Vol 30 No. 2
ISSN 1177-200X

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THE DIRECTOR'S CUT

Debate about drug law can fall into a trap. The focus can too easily be abstract and academic or stray dangerously into ideology.

I was reminded of this when I watched the speech again that Tuari Potiki, our Board chair, gave at the UN three years ago. In his kōrero on ending the drug war, he invited nations to look at things afresh: "Remember that the people we're all here talking about are our sons, our daughters. And if you think just for a minute how would you want your son or daughter to be treated, then the way forward becomes very, very clear."

ROSS BELL
Executive Director

Let's imagine what the rewrite of our drug policies and laws looks like if we put our families front and centre.

I don't want my kids to use drugs (my eldest has just become a teenager), but I don't want their futures ruined with a criminal conviction if they do. I want them to receive high-quality drug education while at school and be equipped to live in a world where alcohol and other drugs exist.

As they get older and go to parties and festivals, if they choose to use drugs, I want them to access harm-reduction services. I want them to get help easily if ever they have a problem. When they're adults, I don't want them buying cannabis from organised crime, who might rather sell them synnies or meth.

Like you, I want the best for my kids as they get older and the same for all young New Zealanders.

New Zealand's current drug law has failed to protect young people. We continue to have some of the highest cannabis use rates in the world, and organised crime groups have been enriched in the process. The 50-year experiment with cannabis prohibition has simply not worked to protect public health. We can't allow it to continue.

Legal regulation of cannabis gives us the tools to do better at keeping it out of the hands of young New Zealanders. After all, drug dealers don't check ID. Legal regulation provides safe access of potency-controlled products to adults who choose to use them. Legal regulation undermines the criminal black market and instead returns tax for spending on drug prevention, education and treatment.

For drugs other than cannabis, such as methamphetamine, the Portugal model also provides greater help for our families. Their model of decriminalisation, combined with treatment and social support pathways, has brought major public health gains. But most importantly it's shifted the way society views "the drug problem". It has removed the shame and stigma that people and their families often face with drug problems. People seek help without judgement, and it is available.

Amendments being made right now to our drug law, coupled with the massive new budget spending for mental health and addiction, puts New Zealand on a path towards showing compassion and kindness to our families affected by drugs. That makes me happy.

In drug policy debates you will often hear people say, "We need to think of the children!" Yes we do, which is why I advocate for reform.

SOCIAL

@DrMtyndall In the context of a mass drug poisoning epidemic #HarmReduction is absolutely necessary to save lives but is clearly insufficient as it cannot address structural violence - neglect, poverty, incarceration - and prohibition policies that "created" fentanyl. #SafeSupply is treatment ... JUL 3

@garthmullins Another bad day. Fentanyl & benzodiazepines sold as heroin / down. Ppl are right out of it. For several seconds, I thought a friend was dead. Long periods of unconsciousness. Memory loss. Naloxone don't work on the benzo part, only the fentanyl. Be careful who you score off. ... JUL 4

@sarahblyth 16 ODS in 2 days at @vancouverops I am so thankful for our amazing team, it's been really tough on everyone. ... JUL 6

@sarahblyth Norma saved 8 lives in 5 hrs at @vancouverops send her and the ppl she helped love ... JUL 7

@garthmullins "We learn from history that we do not learn from history."-Hegel.

- 1997: "China white" public health emergency declared.
- 2016: fentanyl public health emergency declared.
- 2019: benzos...

Only ending prohibition can avoid the next crisis. And the next. And the next ... JUL 8

@commonknow_nz Reading of the pain & suffering the war on drugs causes is pretty fricken heavy going. So, so much unnecessary pain. Good to know radical solutions are being discussed. Kia kaha!!! ... JUL 8

KEY EVENTS & DATES

18–21 SEP	**Cutting Edge 2019: looking back, moving forward, Auckland** **cuttingedgeconference.org.nz**
23–25 OCT	**Lisbon Addictions 2019 Lisbon, Portugal** **lisbonaddictions.eu**
6–9 NOV	**International Drug Policy Conference 2019, St Louis, USA**
25–27 NOV	**Issues of Substance, CCSA Ontario, Canada** **issuesofsubstance.ca**

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NZ.

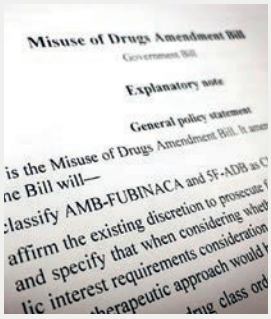
01 WELLBEING BUDGET A GAME-CHANGER

A $1.9b investment has put mental health and addiction firmly on the government's agenda.

The 2019 Wellbeing Budget took into account 38 of the Mental Health and Addiction Inquiry's 40 recommendations, promising a raft of new services and more support for existing ones. Funding is earmarked for front-line support in places such as GP clinics, Māori health centres, schools, hospital A&E departments and prisons.

The Drug Foundation has welcomed this compassionate approach, which will allow more people to access help sooner. Now it's time to translate the good ideas into action – which also means confronting society's attitudes towards criminalising and stigmatising people who use drugs.

02 MoDA amendment bill


Misuse of Drugs Amendment Bill
Explanatory note
General policy statement

RIGHT NOW, MPs are considering a significant change to our outdated drug law – the Misuse of Drugs Amendment Bill. The proposed new law will require Police to prosecute someone for drugs only if it's in the public interest and to consider whether a health-centred or therapeutic approach would be more beneficial. Two of the most dangerous synthetic drugs, AMB-FUBINACA and 5F-ADB, would be reclassified as Class A drugs.

A member's Bill by National MP Simeon Brown, which aimed to amend the Psychoactive Substances Act to impose harsher penalties on synthetic-drug dealers, was voted down.

03 Harsh prison sentences under scrutiny

THE COURT OF APPEAL is considering a series of cases that question New Zealand's policy of harsh prison sentences for Class A drug supply.

Back in 2005, following some high-profile, violent crimes involving methamphetamine, the courts opted to use strict weight-based guidelines for sentencing. Currently, anyone caught supplying more than 500g of Class A drugs could face life imprisonment.

However, judges have since questioned the rigidity of this rule, which prevents them considering the individual's personal circumstances. The government's own expert witness, criminologist Simon McKenzie, told the court longer sentences are not an effective deterrent anyway.

A decision is expected later this year.

04 Cannabis referendum a yes/no question

AS NEW ZEALAND heads towards the 2020 cannabis referendum, the government has released details of the proposed legislation so people will know what they are voting for.

A Cabinet paper, released in May, sets out a health-focused plan for adults (over 20) to use and buy cannabis and to grow some plants at home.

Justice Minister Andrew Little said voters would choose between the draft legislation and the status quo. The government would abide by the voters' decision, and he hoped the National Party would too. If enacted, the Bill would then go to select committee. He said more details would be released in time.

Read more on page 26.

05 Straight up about drugs and alcohol

A RECENTLY released web series fronted by well-known celebrities aims to educate young New Zealanders about drugs and alcohol.

Launched in May by Villainess.com with support from the Drug Foundation, *The Real Drug Talk* combines humour and expert information to gain the trust of Kiwi teens – so they'll actually watch it.

Villainesse editor and Drug Foundation board member Lizzie Marvelly says the legal status of drugs makes people reluctant to talk openly about their experiences. However, following her previous series, *The Real Sex Talk*, young people told her they wanted to know more about drugs and alcohol and how to keep themselves and their friends safe.

06 Law hasn't stopped Kiwis using medicinal cannabis

NEW RESEARCH suggests tens of thousands of New Zealanders are breaking the law to use medicinal cannabis.

Medical Cannabis Awareness New Zealand (MCANZ) launched an online survey at the beginning of May and, by early June, there were 1,800 responses. It's the first piece of research dedicated to summarising usage trends in the illicit market to better inform prescribers and policy makers about barriers, usage and demographics.

Shane Le Brun from MCANZ says early results suggest people are using cannabis for multiple different medical conditions. Many are frustrated and feel they can't talk to their doctor about their use.

07 Kiwis drinking less – and more

KIWI MILLENNIALS have been credited with driving lower alcohol consumption rates in New Zealand, bucking the global trend, according to a recent study published in *The Lancet* medical journal.

However, although the younger generation may be opting for a healthier lifestyle, Kiwis still have a high rate of drinking overall, and one in three still binge drink regularly.

Figures show average consumption fell from 13.5 litres of pure alcohol a year to 10.8 litres a year – that's around three standard drinks a day. But while around 11% did not drink at all, 34% were drinking heavily at least once a month.

08 Small town topples the big guns

A SMALL CHRISTCHURCH community says it's beaten the "big boys" after blocking a Liquorland store from adding to the 16 off-licences already operating in the area.

Liquorland appealed the District Licensing Committee's decision to reject its application for a new store in Phillipstown, taking the case to the Alcohol Regulatory and Licensing Authority.

Police lent their weight to the opposition, saying Phillipstown was a "priority location" with a high level of alcohol-related harm. The Authority released its decision in May, agreeing with the Committee.

Delighted community advocates said the victory set a precedent for small communities.

09 Drug check-point ahead – proceed with caution

THE GOVERNMENT recently announced plans to consult with the public around roadside drug testing. However, the NZ Drug Foundation has advised caution.

Associate Transport Minister Julie Anne Genter admitted there were issues with the technology. She said saliva tests, such as those being used in Australia, are slow to process, do not establish impairment, are not 100% accurate and can only identify three substances – methamphetamine, MDMA and cannabis.

Drug Foundation Executive Director Ross Bell called for better use of "old-school" impairment tests, with training for frontline officers. Submissions closed on 28 June.

10 Synthetics report uncovers help-seeking issues

A REPORT into synthetic cannabinoid use in Maraenui found funding issues and a complicated referral system were causing long delays for people seeking help.

The report was commissioned after media attention highlighted problems with the drug in the small Napier suburb. It surveyed health practitioners, users and residents and found many people were unaware of the services available or how to access help. While some providers were stretched, others had spare capacity. Despite concerns, there were no wait lists for services. A more whānau-led approach was recommended to make services more culturally responsive.

World.

01 MEXICO PLANNING TO DECRIMINALISE ALL DRUGS

President Andrés Manuel López Obrador has announced plans to decriminalise illegal drugs in Mexico, where use has soared over past decades and thousands have been killed every year in drug-related murders.

He says the War on Drugs isn't working, and decriminalisation paired with rehabilitation programmes is the only feasible solution. A new five-year plan offers treatment instead of punishment by redirecting resources away from enforcement and into programmes of "reinsertion and detoxification".

Obrador has called on the United Nations and the US to follow suit. An estimated $19–29 billion worth of Mexican cartel drugs are sold every year in the US.

02 Canada considering amended pardons Bill

CANADA'S PUBLIC Safety committee has accepted 11 new amendments to a Bill that would pardon – but not expunge – previous minor cannabis convictions (under 30g).

The proposed Bill would still allow people with other convictions, lost records or outstanding fines to apply. Past pardons would no longer be revoked by a later cannabis conviction. The $631 application fee was waived, but a five-year waiting period stands.

A last-ditch effort to replace pardons with expungements and for the process to be automatic was voted down. Critics have called the Bill a "token gesture", arguing it's too restrictive and could still result in people being barred from the US and other countries.

03 Historic US trial seeks damages for opioid crisis

A FOOTBALL player's father was among those giving evidence in an ongoing trial that seeks to hold drug makers accountable for the US opioid crisis.

In the first of nearly 2,000 cases, Oklahoma's Attorney General accused Johnson & Johnson and subsidiaries of a "cynical, deceitful, multimillion-dollar brainwashing campaign" in the interest of competition and greed.

State prosecutors allege the companies created a public nuisance and cost the state billions of dollars, destroying thousands of lives in the process. Johnson & Johnson has vehemently denied the allegations, saying the public nuisance accusation is being misused, and all drugs were clearly labelled.

04 Denver loosens up on magic mushrooms

DENVER, COLORADO, has become the first US city to decriminalise magic mushrooms or psilocybin.

Initiative 301 was narrowly passed last month, making use and possession of psilocybin for over-21s the "lowest possible law enforcement priority". It prohibits any resources being spent on pursuing criminal penalties for use or possession.

The drug was not a high priority anyway – approximately 50 people a year are arrested for possession or sale, and 11 of them prosecuted. However, it recognises a growing underground industry of professionals treating depression, anxiety, addiction or post-traumatic stress via guided hallucinogenic experiences.

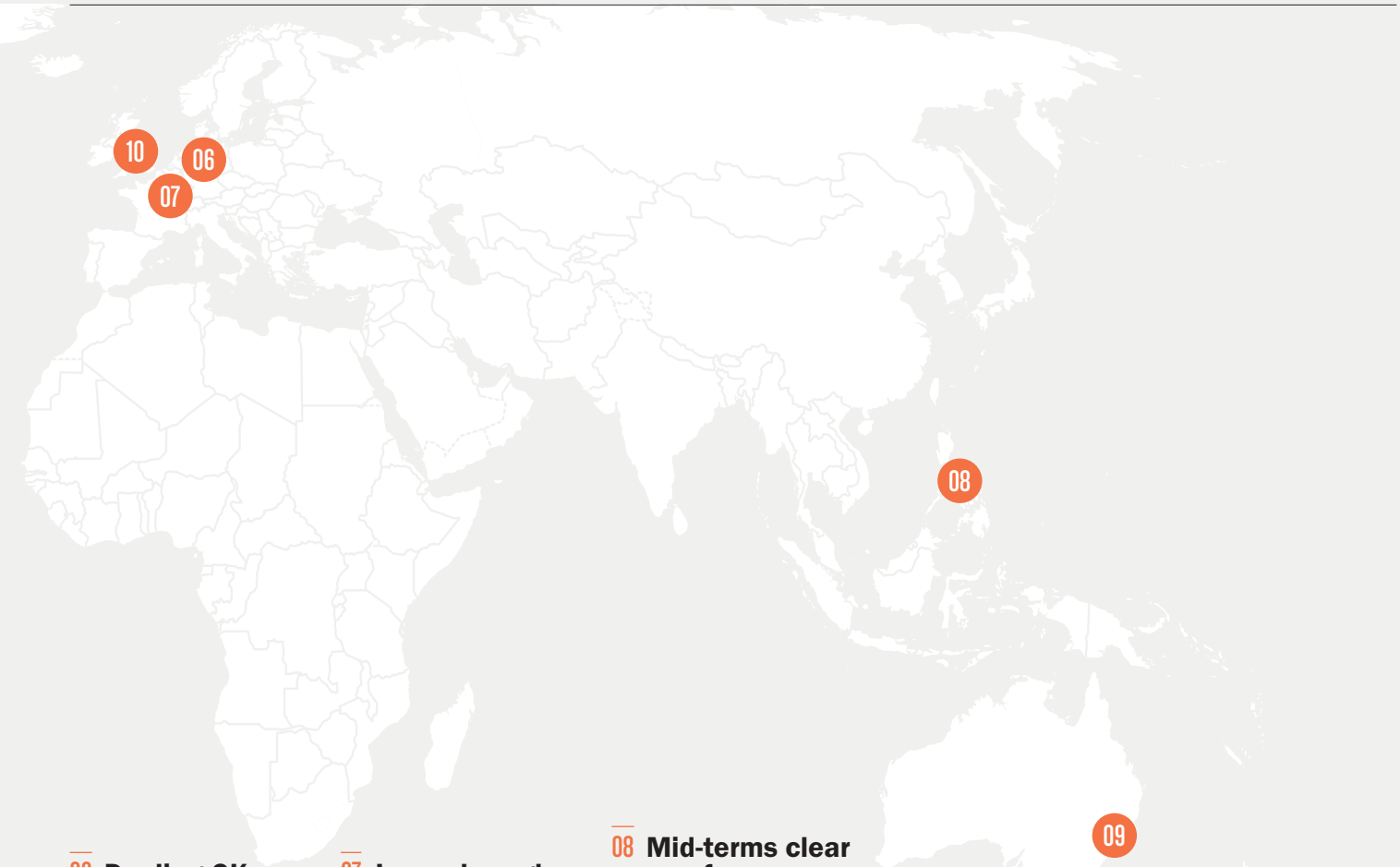
The initiative applies only to Denver. A review panel will report back on the outcomes.

05 Ancient religious hallucinogens

SCIENTISTS THINK an ancient fox-snout pouch containing traces of powerful hallucinogenic drugs, found in southwestern Bolivia, may have been blended by a pre-Inca Tiwanaku shaman a thousand years ago.

The pouch, found by anthropologists in 2010, has since been analysed and found to contain multiple substances including cocaine, bufotenine (a psychedelic snuff) and psilocin – similar ingredients to the psychoactive drink ayahuasca, still used for religious ceremonies in some parts of the Amazon.

The rare find suggests a sophisticated plant knowledge of psychedelic plant interactions, with clear evidence of experimentation to give lengthier and more powerful hallucinations.



06 Dealing OK – but keep to the pink zones

PARK OFFICIALS have taken the unusual step of allowing drug transactions in designated "pink zone" areas of Berlin's Görlitzer Park to stop dealers intimidating visitors.

The park is a popular meeting place in the trendy district of Kreuzberg, but known dealers were regularly crowding the entrance, deterring visitors. After repeated attempts by Police to clear them away failed, the park manager found a creative solution – allow them to trade in designated areas, identified by spray-painted pink boxes.

While Police were strongly critical, officials and some members of the public claimed that "zero tolerance" measures did nothing to deter the men, who are said to be mainly asylum seekers unable to work while they wait for permits.

07 Luxembourg's legal cannabis regulations"

LUXEMBOURG'S POLITICIANS are fleshing out recreational cannabis legislation after the country voted to legalise last November.

Following a research trip to Canada, ministers announced plans to set a minimum age of 18 for possession of up to 30 grams in public. Minors would not be criminalised for possessing less than 5g, and THC levels would be strictly limited. Regulations around sale and cultivation have yet to be decided. However, "harsh penalties" would be imposed for operating outside the legal framework.

Only Luxembourg residents would be permitted to purchase cannabis, following concern from neighbouring France and Germany. Parliament will vote on the Bill later this year.

08 Mid-terms clear way for more extreme drug policies

PHILIPPINES PRESIDENT Rodrigo Duterte gained resounding support in last month's mid-term elections, winning more power to continue his brutal drug war.

Despite international criticism, the President remains popular within the Philippines. His allies now control the senate, which until now had blocked his more controversial policies. Those include reintroducing the death penalty and lowering the age of criminal liability to 12.

Among newly elected officials is former Police chief Roland dela Rosa, who oversaw killings of thousands of people suspected of drug crimes. Police claim self-defence, but the Supreme Court has ordered the release of official documents, which human rights groups hope will reveal more.

09 Pill testing inquiry resists state opposition

THE HEAD of a special inquiry into drug use in NSW is pressing on with plans to test the effectiveness of pill testing, despite opposition from the state government.

Originally set up to look into methamphetamine use, the inquiry was expanded to include other stimulant drugs and also pill testing, after a spate of drug-related deaths and incidents at music festivals.

The Royal Australasian College of Physicians, the Australian Medical Association and former Australian Federal Police Commissioner Mick Palmer have all backed pill testing. However, NSW Premier Gladys Berejiklian continues to reject the evidence.

10 Green light for licensed drug-testing clinic

ENGLAND'S FIRST-EVER licensed drug-testing clinic could be rolled out nationally if it's shown to save lives. The pilot project, small Somerset town near Glastonbury, allows anyone over 18 to have drugs tested while they complete a short questionnaire aimed at delivering targeted harm-reduction advice.

The launch comes amid rising concerns about black market drugs containing toxic or more potent substances, such as cocaine laced with fentanyl and super-strength ecstasy. Addaction, the charity running the clinic, has an agreement with local Police that people will not be stopped or searched on their way in or out.

Hugs not drugs (or both)

Not everybody uses drugs in the same ways and this is especially true for the LGBTQ community. Are different approaches to harm reduction needed?

DEJAN JOTANOVIC
(AUTHOR)

SAM ORCHARD
(ILLUSTRATOR)


PROTECT
MY GENDER IS NOT A DISORDER
BODY CHOICE
WE HAVE ALWAYS BEEN HERE

Sex. Drugs. Carly Rae Jepsen. This is the iconography that tends to be massaged into mainstream conceptions of gay culture. Depictions in TV/film see us railing lines of MDMA and sniffing poppers at our Kiki clubs. The more grim scenes – always accompanied by a harrowing score – might show us smoking meth and dosing GHB at the neighbourly chemsex soirée (who's bringing the brie?).

Stereotypes are little things. They help confirm the biases we want to see in the world and make it difficult to consider that behind every trope is a real person with an individual set of values, histories and behaviours.

But they must tap into something. For example, it is a truth universally acknowledged that a gay person walks at a furious speed. While it's certainly true that while some stereotypes are funny and mostly harmless (gays are speedy walkers, love iced coffee, can't drive), others can be pretty dangerous.

The dangerous ones exploit already deeply set judgements and cast a sinister shadow over our community, sweeping us further into society's margins. This practice is called stigma: the process by which we make people feel bad, unwanted, disgusting for their behaviours and values. Over time this stigma stews inside of us until it becomes shame. And shame can be a real killer.

Why *do* gays walk so quickly?

My guess is it's a hangover from our days of stealthily walking away from our bullies after intermediate school. Others argue it's our most widely used mode of transport (we can't drive). One hypothesis theorised that "we constantly have 'Toxic' by Britney Spears (143 bpm) playing in our heads whereas straight people have 'Closer' by the Chainsmokers (95 bpm)". A symptom of all that iced coffee?

Then again, it could be the drugs.

DRUGS

There will always be questions when a topic is taboo – people are often most curious when something carries stigma. Immediately we're seduced by those prickly stereotypes. Why is this trope of drug use in the Rainbow community so popular and visible? Is it just gay men, or does it extend to the broader community? Which drugs are we using? Is there anything specific about our culture in Aotearoa?

Let's start with some data (although it's far from complete).

A 2012 analysis of global trends of "drug use among men who have sex with men". It noted an overall higher prevalence for illicit drug use. And there were key patterns within that use: most drug use was episodic (weekly/monthly) as opposed to daily; gay men are not a "homogenous group" as prevalence was even higher in further marginalised groups (e.g. ethnic minority men); drug use tended to be higher in larger urban centres as opposed to rural areas; and the prevalence of injecting drug users (IDU) was typically low (rarely climbing over 5%).

Locally, a 2017 study led by Dr Peter Saxton from the University of Auckland found persistently high drug use with gay and bisexual men in New Zealand. The dataset of 3211 participants – collected from a 2006 community-based Gay Auckland Periodic Sex Survey and a web-based Gay Online Sex Survey – presented a number of key findings. Over half of the participants (55.8%) reported

> **"I look myself in the eye and wonder when am I getting it together**
> **Lord it's been forever since it felt right."**
>
> BRENDAN MACLEAN, *HUGS NOT DRUGS (OR BOTH)*

drug use within the last six months (the base male population of NZ sits at around 23%). Cannabis was most favoured (37.9%), followed by poppers (36.7%), ecstasy (16.5%), amphetamine (10.5%), methamphetamine (7.4%), LSD (6.6%), cocaine (6.1%), GHB (5.3%) and ketamine (4.4%). Partially consistent with global findings, prevalence was higher for men living in urban centres (Auckland, Wellington, Christchurch), those living with HIV, and those who identified as Māori (though use was less common in Asian-identified ethnicities).

While the study provides a vital backbone, a lot has happened in the 13 years since the data was collected. Australian research has shown that drug use between 2006 and 2011 had fallen by about 8% – with a noted 30% decline for club drugs such as ecstasy, speed, crystal meth and ketamine. Cocaine, GHB and the use of erectile dysfunction medications (EDM) have, however, noted a sharp increase. Still, drug use is clearly higher than the base population group.

Data is currently being prepared by Saxton to give a more up-to-date snapshot. It's already been done in Australia where the 2016 Australian *Following Lives Undergoing Change* study observed that 17.3% of adult men had used any illicit drugs (2.5% for crystal methamphetamine), while 50.5% of adult gay/bisexual men in the study reported drug use in the last six months (12% for crystal methamphetamine).

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While drug use data on gay and bisexual men continues to increase, research on lesbian and bisexual women is less available. Men have historically been the focus of research due to other health-related issues such as HIV, meaning more have entered academic institutions with greater understanding and specialisation in gay/bisexual men's activities. And women have largely been neglected in data collection and analysis. In her book *Invisible Women: Exposing Data Bias in a World Designed for Men*, Caroline Criado Perez examines the deep effects of the absence of women in the creation of most societal norms.

While literature on illicit drug use for lesbian/bisexual women is scarce, a report by the Alcohol Healthwatch NZ, *Women and Alcohol in Aotearoa/New Zealand*, showed key differences within drinking. The review – which included focus groups and interviews with 41 women's health and welfare providers – concluded that lesbian/queer women were more likely to drink (at least weekly) than their hetero counterparts. This is in line with data provided by the 2015/2016 New Zealand Health Survey (NZHS): prevalence for heterosexual women sat at 76.5% but was much higher for women identifying as lesbian and bisexual (91% and 89.5%, respectively). (It's interesting to note that prevalence rates for heterosexual [84.2%], gay [84.1%] and bisexual [80.1%] men were all roughly similar.)

> **"We grow up fearing and stigmatising drug users because of the law's heavy hand, blind to nuance, critique and deeper interrogation."**

When thinking through drinking norms, Alcohol Healthwatch maintained that "lesbian and queer women's communities have grown around alcohol venues, and alcohol often plays a role in coming out". Their assessment of "hazardous drinking" pointed towards housing, violence, and employment – variables that catalyse problematic drinking, make seeking treatment more difficult, and are further weighted for lesbian/queer women when accounting for higher levels of discrimination. The review advised a need for targeted,

identity-specific programmes to help support women through problem drinking.

The review also reiterated that no data was found on transgender women's drinking or substance use in New Zealand. In fact, very little research has looked at health issues pertaining to transgender, intersex or gender-diverse populations at all. This is disappointing, but, honestly, unsurprising: little oxygen is given to Rainbow community members outside of gay, cisgendered (more often than not) white men. Much can be explained by the relative privilege that gay cis white men have over others in the community, amplifying their experiences and narratives. But pedestaling their voices as if they're representative of the entire community does a massive disservice to the unique experiences (and specific health-related issues) of those who aren't cisgender, male or white.

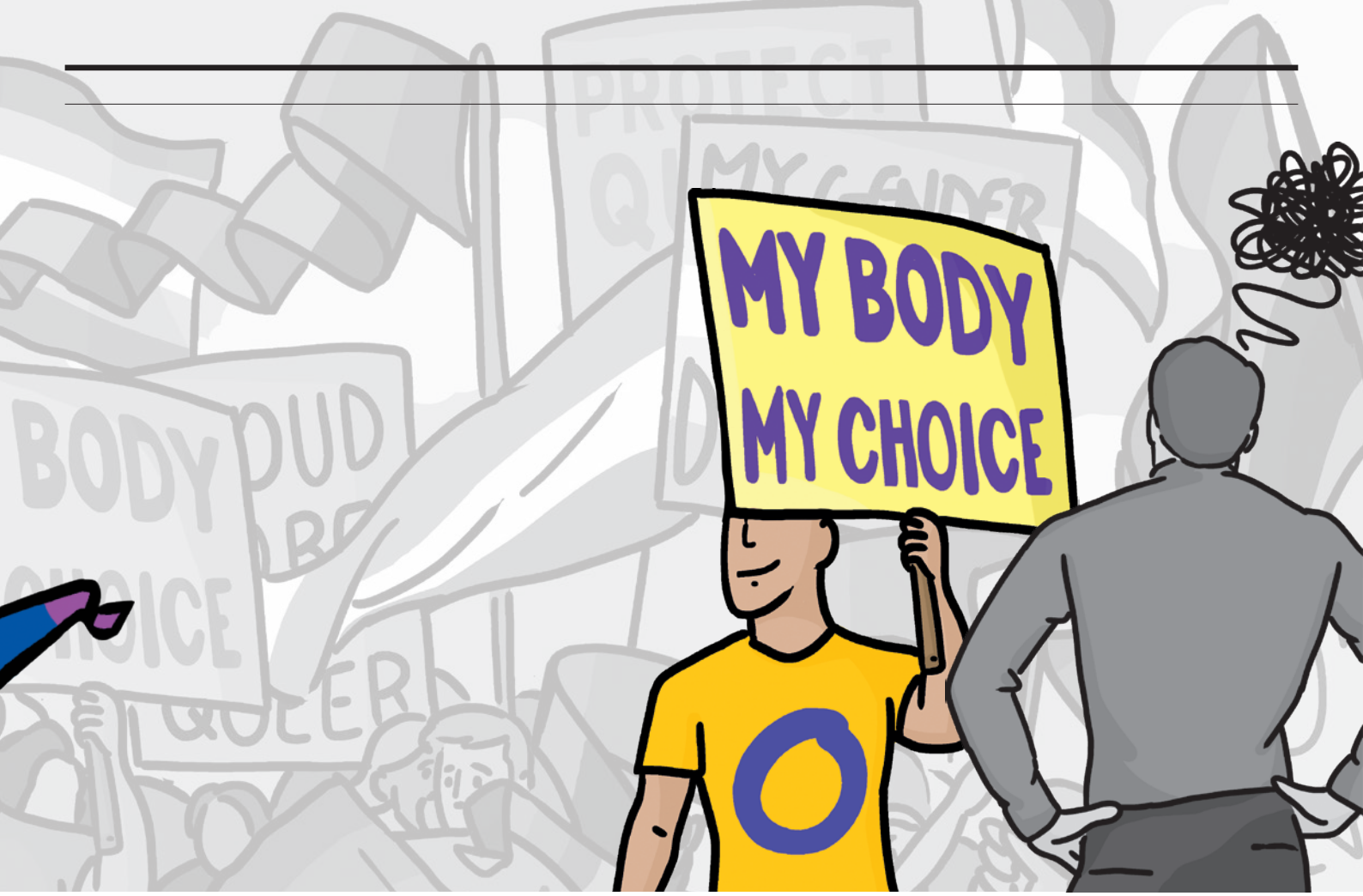
We've gotta do better. We must stop siloing our Rainbow identities and start learning from each other's experiences. The next step is to champion the work of those committed to making a difference for the subset of their own community.

There is good news. Survey data is currently being collected by Dr Jaimie Veale (senior lecturer in psychology at the University of Waikato) and Jack Byrne (a health and human rights researcher based in Auckland). The Counting Ourselves project is "an anonymous community-led health survey for trans and non-binary people living in Aotearoa New Zealand". Information from the survey helps illuminate any differences in mental and physical health (including substance use), as well as depicting diverse experiences towards stigma, discrimination, violence and access to healthcare. These results will help to create a more gender-affirming healthcare system.

The other important data gap is with Takatāpui – Rainbow Māori. Led by associate professor Leonie Pihama, the Honour Project Aotearoa will "investigate the life experiences of Takatāpui to gain insight into understandings of health and wellbeing and investigate issues of access, provision and appropriateness of the health care services to this specific Māori community". Research from this project will give a better understanding of substance use, prevalence rates and motivations to better inform the public health sector.

> **"The fear of being judged or misunderstood can stop someone seeking help in the tracks."**
>
> NZ AIDS FOUNDATION COMMUNITY ENGAGEMENT MANAGER SEB STEWART

A number of theories have attempted to explain why drug use tends to be higher in Rainbow communities (again, attention is paid to gay/bisexual men). The most popular – or perhaps, digestible – places emphasis on minority stress: we're more likely to experience discrimination, bullying, stigma, shame, so we're prone to use drugs as self-medication. This maps neatly onto partnering statistics that



spotlight higher rates of depression and anxieties within the community.

Another thesis is "cognitive escape", momentary disengagement from everyday stressors in search of chemical bliss, and "combating loneliness" – drugs make us feel more connected, our relationships more intimate.

Much of our culture is centred on the bar and the club for community and pleasure. A 2013 Australian study noticed that the link between minority stress and substance use wasn't as consistent as first hypothesised: young people who face lower levels of stigma and internalised homophobia were more likely to drink and take club drugs. They reasoned that lessened stigma/homophobia allowed the sample to engage in more community activities – the gay bar – which normalises their substance use.

It's also worth remembering that some of us drink and take drugs because… drinking and taking drugs is really fun. It's admittedly enjoyable to lose yourself a little, see the world in a brand new way, heighten your physical and emotional experiences. People have done it for hundreds of years.

This fun is also political. Kane Race, professor of gender and cultural studies, argues in his 'Party Animals' his chapter in *The Drug Effect: Health, Crime and Society*, that dance drugs have a rich history in the collective gay identity as a mode of "urban belonging".

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Then there's chemsex. Party 'n' play feat Tina and Gina. Some of us take drugs (typically methamphetamine and GHB) because they enhance sexual pleasure.

Samuel Andrews works at the NZ Drug Foundation as harm reduction projects adviser and is completing a masters of health science with a focus on reducing drug-related harm within the gay community. He's currently researching the chemsex scene in New Zealand. "The current thinking is that there's a lower prevalence than Australia and the UK as drugs are less available and more expensive," he says, noting there are also fewer gay-friendly urban locations. Berlin, London and Sydney – places where chemsex largely occurs – have more dense gay populations.

This might be where many of you stop reading – shake their heads, scoff, cast judgement. Because what's more taboo and terrifying than a whole lot of gay orgy sex fuelled by a cabinet of Class As?

I'm sorry to say that's a big part of the problem. Because judgement prevents understanding, which is a barrier to preventing unsafe behaviour.

Chemsex carries risk. There are higher incidences of STIs and higher risks of exposure to HIV. But much of this could be mitigated if we treated issues with substances through a health model – harm minimisation – instead of following the same tired recipe we have for centuries: judge and jail.

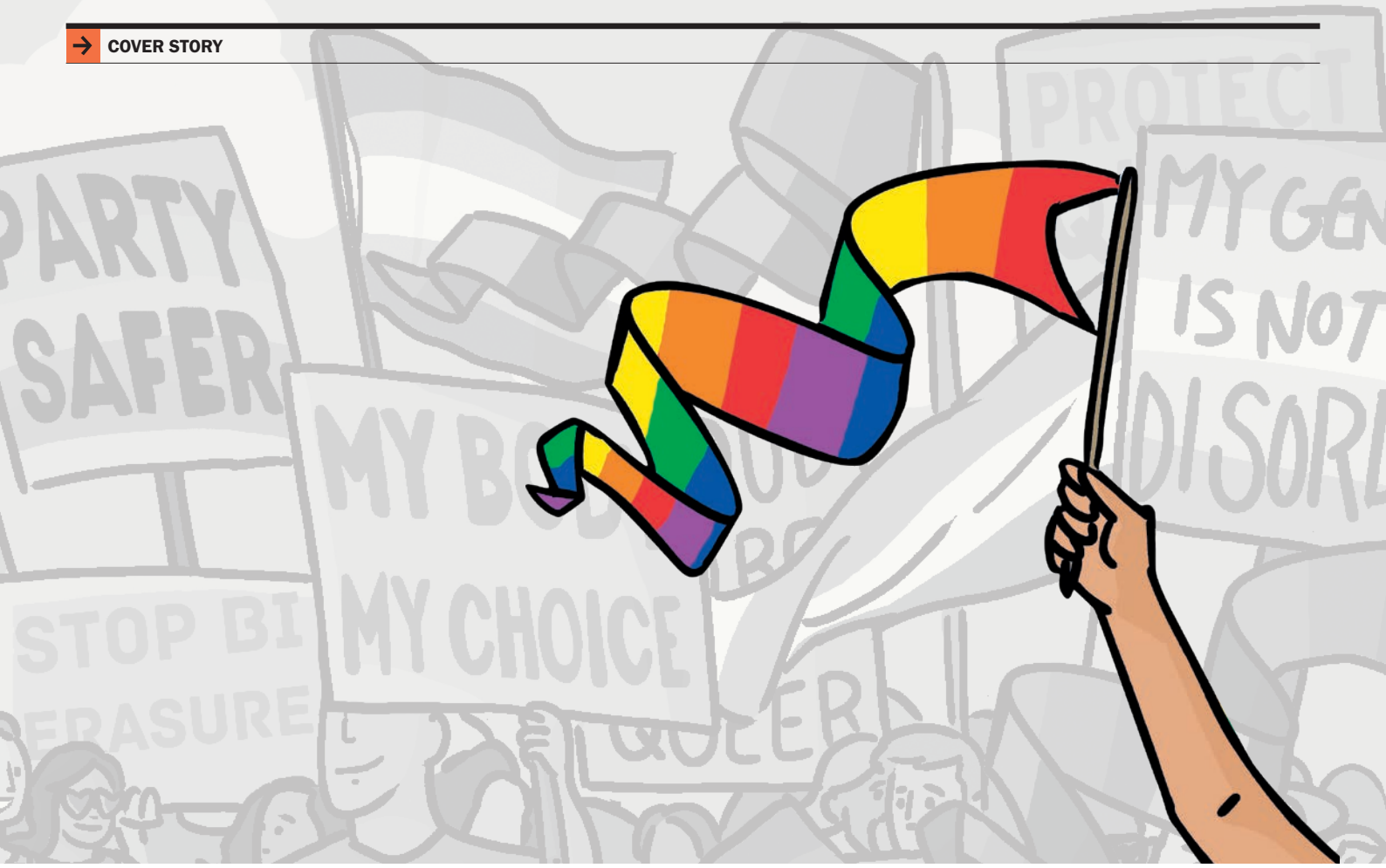
When someone recognises they have a problem there remain significant barriers to seeking treatment and asking for help.

"Judgement is at the top of the list there," says Seb Stewart, community engagement manager at the NZ AIDS Foundation. "The fear of being judged or misunderstood can stop someone seeking help in the tracks."

That fear of judgement extends to places that are designed to provide treatment.

"Fifty percent of gay men have never disclosed their sexuality to a GP, so – for sexualised drug use anyway – there's already a barrier to opening up to a doctor that you've been having sex on meth (or whatever chems) with men," says Stewart.

There's also a "lack of Rainbow-specific services, lack of sensitivity to Rainbow populations across all services, and no established referral pathways between sexual health and addiction treatment services", says Andrews. "For chemsex a big barrier is the high level of criminalisation from drug-related crimes… for people who seek treatment, it requires disclosing drug use as well as what are considered extreme sexual practices."



Resources are now being prepared for the New Zealand context.

"Ending HIV is about to launch an online chemsex harm-reduction resource," says Stewart. "We are also currently planning a methamphetamine harm-reduction programme for men who have sex with men – Re-Wired, based on a successful Australian programme by Thorne Harbour Health – which will provide a framework to assess personal meth use and check in on whether they want to review, reduce or stop their meth use."

HUGS

In 1961 a drug was introduced to Aotearoa that radically altered our relationship to bodies and broader culture. Within five years of introduction, 40% of its target populace became users. Today, it's relatively cheap: $5 will last six months. And while feminist analysis correctly raises eyebrows as to why no alternative has been formulated for men, it's difficult to disregard the impact of the contraceptive pill: a symbol of sexual liberation, a disruptor to our understanding of gender, biology, sex.

It's worth taking a step back and thinking more discursively around drugs, extending our ideas on use and effect. At its most basic definition, a drug is any chemical you take that affects the way your body works, and with this in mind, we can start seeing how they can provide joy and liberation.

Pre-exposure prophylaxis (or PrEP) is an example. Taken daily, the use of these antiretroviral drugs significantly reduces the risk of becoming infected with HIV during unprotected sex – by 99%. Obviously the little blue pill won't shield you from other STIs, so condoms are important, too (though condoms might not protect you from gonorrhea of the throat. PSA: testing regularly and being open about your sexual health is the best form of treatment).

At 99% effectiveness, PrEP is being heralded as a liberating force for HIV negative men, but there's still a long way to go to ending discrimination. "As it is now a funded medication, access to PrEP is improving," says Stewart, "but we still run into similar barriers for LGBTQI+ people seeking services that require them to out themselves, and sometimes even blatant homophobia from conservative doctors."

In New Zealand, a three-month supply of PrEP will only cost you $5 if you meet the Pharmac criteria. A small investment to ensure increased sexual safety.

"As long as adherence is kept up and there is an understanding that PrEP cannot prevent STIs other than HIV, PrEP is a valuable tool for people engaging in chemsex," explains Stewart. "There are currently no known negative drug interactions between common recreational drugs and PrEP."

It's also important to recognise that the same drugs used in PrEP – emtricitabine/tenofovir – are used in HIV's treatment. "Undetectable viral load… UVL… U=U… whatever name you want to use, this is one of the most important HIV discoveries in the history of the epidemic," says Stewart.

"If a person living with HIV is on successful treatment and their viral load becomes undetectable (unable to be detected with a standard blood test), then HIV cannot be transmitted sexually."

Take a moment to reread that last paragraph again. Memorise it. Tell your family and friends. Because despite these developments, this drug cannot cure stigma.

In 2014, research looked at New Zealand's attitudes towards people living with HIV. While the vast majority of respondents understood that HIV could not be transmitted through touch or sharing food, 56% still admitted they'd be uncomfortable with having their food prepared by someone living with HIV. While drugs like PrEP are liberating people in wildly important ways, there's still a long way to go in curing ourselves from the ailments of discrimination, stigma and shame.

The way we classify what a drug is – what it looks and feels like, and whether

it legal – is complicated but simultaneously arbitrary. Coffee and cocktails are, by definition, drugs, yet they don't fit so nicely under the umbrella term as ketamine or cocaine. Their legal and social status helps them to become normalised and accepted into culture, whereas conceptions of Class As are typically laced with fear (surely we're all familiar with the urban legend of the girl who took ecstasy and drowned after drinking too much water).

Why the differences? Because our relationship to drugs is pinned to what we understand from our legislative systems and our social norms. This is more or less understandable when considering risk and effect (alcohol and tobacco are still statistically our most fatal drugs and they're still very legal).

The law is a living and breathing system; a reflection of the dominant values anchored to our status quo. These values aren't entirely representative of our population and tend to err towards the most privileged and powerful (white, male, historically religious, straight).

The next problem is that just as the law is a reflection of our values, so too do our values become reliant on our laws. We grow up fearing and stigmatising drug users because of the law's heavy hand, blind to nuance, critique and deeper interrogation. This brand of legal puritanism lends itself to a cyclic, punitive and limited vision for broader society. This is something we in the Rainbow community is all too familiar with.

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In 1961 – the same year the contraceptive pill swept through Aotearoa – our Crimes Act saw an important revision. In place of life imprisonment, the penalty was reduced to a maximum of seven years in prison for any two consenting adult men found to have engaged in sexual acts. It's difficult to describe the amount of intergenerational trauma, shame and violence these laws have scarred onto our community. The fact that our very existence was written into law as obscene, abhorrent, dangerous – that our stigma and shame was legitimised by the state – is devastating. It wasn't until 1986, when the Homosexual Law Reform Act was passed, that sex between consenting adult males was recognised just as their heterosexual counterparts.

The enactment of our criminal codes isn't exactly dripping in justice either. Māori are disproportionately represented in our criminal justice statistics, "to an alarming degree", reports the Department of Corrections, admitting that bias within the system could account for the numbers. As of March 2018, 50% of our prison population identified as Māori.

We also don't have to look very far throughout history to note where discrimination and stigma was legitimised via the very institutions that were supposedly set up to "protect" us. It was only on 25 May this year that the World Health Organisation stopped classifying transgenderism as a 'mental disorder'.

The 2019 Wellbeing Budget saw a great win for our trans community with the government dedicating $3 million to increase access to gender-affirming surgery. This medical recognition will ensure that transgender people are steps closer to respectful health care across New Zealand. Gender Minorities, a predominantly volunteer-run organisation, has resources on how transgender Kiwis can access hormone replacement therapy (HRT). But while HRT has made vital contributions to the health of transgender people, it's interesting to note that these are the very same drugs used – without consent – on intersex children to enforce binary gender.

This is precisely why binary thinking isn't useful. Just as our bodies, genders and sexualities float fluidly along a spectrum, so too do the social constructs and societal consequences of our drug use. The Pill sparked an era of sexual liberation for women who could escape the bondage

Writing about drugs is difficult

To touch on the multitude of issues, to approach holistically, to acknowledge harm without propelling fear, shame, stigma, is difficult. As a writer I value politicising my personal experience; using anecdotes and memories to breathe into my words and give blood to my ideas. But there's a lingering fear – a series of consequences – particularly when my pages are flipped and scrolled by those nearest to me. What will my parents think? How will this affect my current or future employment? The fear can be traced squarely back to a menacing sense of shame, triggered by a dread of stigma.

The times I have spoken candidly about my own experiences with family and friends I've noticed that they tend not to change the way they think about me, but rather the way they think about drugs. This makes sense: we change our minds about any issue when we have conversations with people we trust.

But there's a deep privilege to this. My experiences are savoury only because I fulfil adequate and respected roles in society known to be markers of success: I have an education, a stable job, rent I can pay. Add this to a long list of coded privilege: I'm white, healthy, able-bodied. My own admission of drug use is therefore softened – made palatable – because of the cultural currency I already hold. Those with less privilege – the poor, people of colour, people living with disabilities (particularly mental illness) – aren't given the same nuance or understanding. It's here that narratives of shame, judgement and incarceration take possession. My own fear – of being shamed, judged, stigmatised – doesn't seem paramount in comparison.

of their biology, but modern research looking at its longitudinal effects has found evidence of a link between hormonal contraceptives and depression. There's no good vs bad, there's merely a delicate balancing act cutting throughout consequences and contexts.

Many argue that there are obvious differences between recreational drugs and those used for treatment of medical conditions. Except the line is becoming blurred. MDMA is used as treatment for PTSD, ketamine is being considered to treat severe mood and anxiety disorders, and LSD to address depression and addiction.

Perhaps it's not really about the drugs at all. Perhaps it's our relationship with them.

OR BOTH

Kathryn Leafe has over 20 years' experience in drug and alcohol services in both New Zealand and the United Kingdom. She currently sits on the board of the International Drug Policy Consortium, has served on the board of the NZ AIDS Foundation, and is former executive director of the New Zealand Needle Exchange Programme.

"Internationally, HIV prevalence among people who inject drugs is 13%," explains Leafe in her TEDx talk 'The war on drugs isn't working. Here's a better way'. "In New Zealand, largely due to the early introduction of needle exchange, it is just 0.2%."

She calls for a radical reimagination of the system: "We have to get real if we want to reduce drug harms. Addressing the drug problem is more than new equipment, health services and counselling… it's about housing, employment, poverty… it's about economic and social reform."

But it's also about the decriminalisation and regulation of drugs, something that The Global Commission has advocated for in its recognition that moving towards a model of harm minimisation is imperative.

"People who use drugs should not be criminalised," argues Leafe. "Our drug laws are not based on any logic related to the harms that the different drugs cause. Alcohol remains one of our biggest problems today and if suddenly discovered tomorrow would be a Class A.

"We have to accept and understand that most people use mind-altering substances. The vast majority never experience difficulties and that amongst the small percentage that do, the poor, young people, our Māori, Pacific and Rainbow communities are overrepresented."

Standing alongside Kathryn's advocacy for a health-first approach to drug use is former New Zealand prime minister, Helen Clark. Clark, a member of the Global Commission on Drug Policy, has been publicly vocal about the need to rethink our measures – particularly on the need for pill testing at music festivals.

"We have to look at the evidence of what works – and if we looked at Portugal or Switzerland or any number of countries now, we see more enlightened drug policies, which are bringing down the rate of death and not driving up prison populations," Clark told a conference at parliament last year.

Portugal pops up time and time again – and for good reason. In 2001 it decriminalised all drugs. It then noted a severe reduction in overdose, HIV diagnosis, and drug-related crime.

In 2020 New Zealand has an opportunity to put these issues into public discussion with the cannabis referendum. This will be a time when we can speak openly about stigma, shame, discrimination – but also joy and liberation. We can bust the binaries that surround the taboos, and answer some of those burning questions with authority on the data.

Looking back at our history, it's clear that the Rainbow community has always been pretty good at walking. This June marked the 50-year anniversary of the Stonewall riots when the New York gay community rose up against their treatment by police. It's a time to reflect on the moment we decided to push back against institutionalised power and control. We'd had enough. We knew that the status quo wasn't serving us.

To commemorate those who fought for our rights, we decided to take to the street – to walk – in Pride, each and every year.

Whether it's about who we love or how we love, HIV treatment or rights to gender affirmation, drug use and health minimisation, we need to keep positioning ourselves ahead of the curve.

We'll always keep walking. And pretty quickly, too. ■

Dejan Jotanovic is a freelance writer who grew up in Auckland and has lived in NYC and Melbourne. Tweet him at @heydejan

Sam Orchard is a queer and trans illustrator, comic creator and designer based in Auckland.

THIS ARTICLE IS JOINTLY PUBLISHED WITH THE SPINOFF

Reaching out for help

Anyone in the LGBTQ community worried about their drug use can reach out to get help.

Rewired is an 8-week support group for people rethinking their relationship with meth run by the NZ Aids Foundation. Starts 18 July, Auckland. nzaf.nz/rewired

SERVICES THAT CAN HELP

AIDS Foundation
Free confidential counselling
www.nzaf.org.nz
0800 802 437 to request an appointment

Alcohol and Drug Helpline
24/7 confidential free phone, text and live chat service
alcoholdrughelp.org.nz/helpline/
Call 0800 787 797 or text 8681

Alcoholics Anonymous
www.aa.org.nz/map.html

Drug Help
Online self-help and stories of New Zealander's recovery drughelp.org.nz

Ending HIV
Information on how to be safer as well as book an HIV rapid
https://endinghiv.org.nz/

OUTLine
Confidential and affirming LGBTIQA+/Rainbow telephone peer-support line and face-to-face counselling
Call 0800 688 5463

Living **Sober**

The friendliest place to talk honestly with others about your relationship with alcohol

Join our thriving community at
livingsober.org.nz

Tools to take control
Keep on track in your journey with alcohol using the *Sober Toolbox*, *Days Sober* and *Money Saved* calculators.

Caring online community
Many New Zealanders visit Living Sober every day to talk honestly about their drinking habits.

Wealth of content
Find advice on how to reframe your thinking, wisdom from people who have faced their own drinking issues and insight from experts.

Āta haere i a koe e hōpara i te ao

Butane hash oil.

Photo: Andres Rodriguez - flickr.com

Strength and harm – the uncertain cannabis equation

Some cannabis is becoming stronger as producers refine their methods and product. How can a legal market manage potency and offer safe consistency to users?

NAOMI ARNOLD

With medicinal cannabis use now legal and the 2020 referendum just over a year away, New Zealand is moving towards a more nuanced understanding of the drug. But it means there are new questions about whether cannabis use can or should be controlled to reduce harm for people who use it.

One of those questions is around regulating potency, which would seem likely to increase if cannabis is legalised in New Zealand and it becomes subject to regular market forces. With 10 US states that have legalised recreational cannabis, 15 that have decriminalised it and 14 that have limited THC content, cannabis products vary widely in potency in the US now, in both their 'natural' form and in more processed products.

Generally, when we talk about potent cannabis, we're talking about the concentration of THC – the compound that gives users their high (and in some cases, intoxication or impairment). Average potency of cannabis products in legal US markets is now triple what it was 20 years ago, and there has been a sharp increase in the potency of the flower in those two decades. A recent analysis of cannabis samples confiscated by the federal Drug Enforcement Administration showed a steady increase in THC content, from 4% to 12% between 1995 and 2014. High-potency cannabis is generally classified as containing more than 10 or 15% THC.

It's difficult to say what percentages are here. The Institute of Environmental Science and Research (ESR) studied cannabis potency in 1996 and 2010 and found that the latter had THC levels of up to 30%, compared to levels ranging between 1.3 and 9.7% in 1996 – a level that had stayed stable since 1976. But that was comparing one sample from one plant from one grow cycle, compared to those seized by Police. The average was 7 or 8%.

ESR forensic toxicology and pharmaceuticals manager Mary-Jane McCarthy says New Zealand cannabis potency isn't well researched, and there isn't a valid dataset that can tell us about THC content in the drug here.

"It's a really good question and it's one we need to do some more investigation into," she says.

"THC content in New Zealand cannabis does range enormously depending on whether it's grown indoors or outdoors. All we could say is that it's an interesting question that needs to be defined further. We haven't been asked by Police and haven't done it as a research project in quite a while."

In Cheech and Chong's heyday, joints were oversized but less potent than those rolled today.

Photo: Cannabis Culture – flickr.com

With Police "defocusing" on cannabis and concentrating more on drugs such as methamphetamine, she says the amount of cannabis they have been submitting has dropped.

"Ahead of the cannabis referendum, I think it has some important considerations. Particularly if we are going to set limits on the THC in licensed varieties of cannabis, then we need to know what was circulating in the illicit market."

We do know that, globally, THC concentrations have been on the rise in the majority of cannabis products. That's according to Dr Ryan Vandrey, Associate Professor of Psychiatry and Behavioral Sciences at Johns Hopkins Medicine in Baltimore, Maryland. He says an inhalable dried flower product typically has THC concentrations in the 18–24% range, while processed high-THC extracts like wax and shatter could have 70, 80 or 90% THC. A *Lancet* study said 94% of the drug sold on the streets of London had a THC content of 14%.

If legalisation goes ahead, it's not a stretch to see the markets opening up to offer such variation here, too. But it's a concern, because a recent study says high-potency cannabis products are implicated in faster onset of cannabis use disorder – what we can also call addiction. Symptoms include cravings, withdrawal, lack of control and negative effects on a person's life. The study, published in the journal *Drug and Alcohol Dependence*, found young people who started using cannabis in years when the average national potency was higher were more likely to go on to develop one or more symptoms of cannabis use disorder within a year of use. However, the average national potency wasn't linked to regular cannabis use or transition to daily use.

> **"THC content in New Zealand cannabis does range enormously depending on whether it's grown indoors or outdoors."**
>
> ESR FORENSIC TOXICOLOGY AND PHARMACEUTICALS MANAGER MARY-JANE MCCARTHY

The parallel in alcohol is that spirits are more potent than wine, and wine is more potent than beer. But if packaged and labelled appropriately, people understand that you don't pour a pint of vodka into your glass. You pour a little or mix it, and

Dr Beatriz Carlini, Alcohol & Drug Abuse Institute, University of Washington.

Photo credit: University of Washington

> **"The probability of having a psychotic episode or panic attack when you use marijuana is relatively rare, but if it is high potency, it's more common – and if you legalise it, it becomes more common."**
>
> SENIOR RESEARCH SCIENTIST BEATRIZ CARLINI, ALCOHOL & DRUG ABUSE INSTITUTE, UNIVERSITY OF WASHINGTON

you can roughly gauge how many standard drinks you've had so you don't get sick or pass out. Loosely, you're dosing, or titrating, yourself with alcohol.

So, what will happen in New Zealand if personal use is legalised? Do we need some sort of regulation around what makes up a 'standard smoke'? And if high-potency cannabis can be compared to drinking neat vodka, what does it mean for the user's health? If you use high-potency cannabis, you increase the risks that you will have a psychotic crisis, says Beatriz Carlini, a senior research scientist at the University of Washington's Alcohol & Drug Abuse Institute.

"The probability of having a psychotic episode or panic attack when you use marijuana is relatively rare, but if it is high potency, it's more common – and if you legalise it, it becomes more common," she says. "More people are using it so there are more chances for that episode. You are seeing that here; there are more people in acute episodes. They might be calling the poison centre, emergency calls, they're going to emergency rooms with the same kind of symptoms. So this is something that is happening here, and it's relatively rare, but with the potency increasing, it's happening more and more."

Researchers in a *Lancet Psychiatry* study estimate one in 10 new cases of psychosis may be associated with strong cannabis, based on their study of 11 European cities and towns and one region of Brazil. Daily use of any cannabis makes psychosis more likely, but the study is not definitive proof of harm.

The concerns from a health perspective are twofold, Vandrey says. A single acute dose can make people very uncomfortable or provoke an acute anxiety or panic attack or even an acute psychosis episode.

"THC can have a substantial impact on your heart rate and heart functioning, so people at risk for cardiovascular events should avoid high doses of THC. From an acute drug effect perspective, you can also get impaired, so your ability to drive a car and operate and function can be impacted negatively."

From a long-term chronic use perspective, the science is clear that some people who start using cannabis develop problems relating to it, building up a tolerance and making it tough to quit. "And the prognosis for people going into formal treatment to quit is not very good unfortunately," he says. "So, it needs to be recognised as a drug of abuse and treated as something that can cause those kinds of long-term problems as well as short-term problems."

The risk factors for developing both acute and chronic problems with cannabis are co-occurring mental health problems, using cannabis to cope with problems and heavy daily use. In terms of the acute effects, people with a family history of schizophrenia or other forms of psychosis are at a higher risk of having acute psychosis-like symptoms as a result of cannabis, and it's associated with an early onset of schizophrenia.

"Adolescent use is typically not recommended due to developmental harms, and then individuals with cardiovascular disease need to be very careful," he says. "Now all of that being said, that's within the context of using high-THC cannabis products, and we can't yet generalise that to other types of cannabis products, of which there are many."

He says it's important to remember, when talking about potency, that it doesn't equal dose – it's just the concentration of a particular compound in a cannabis product, like the alcohol in vodka compared to beer. "The dose is how much of that you take."

"If you're inhaling the drugs, one inhalation of a product with 80 or 90% THC may be too high of a dose for a novice user, whereas a lower potency product would allow the individual to titrate total dose across multiple inhalations," he says.

Cannabis products that have very high potency tend to be used by people who use cannabis multiple times a day, every day, he says. "They tend not to be novice users.

A generic warning message about potency issued by the Perth District Health Unit in Canada.

If you have a novice user use a high dose of THC, unwanted and potentially severe adverse effects are possible if not likely. That's a major concern.

"If you evaluate people who use higher-potency products, they tend to have more problems related to their cannabis use. What we don't know yet is whether that's because of the THC concentrations or if it's because high-THC concentrated products are marketed towards those people who have extreme use patterns. There haven't been any really nicely controlled studies that have been able to tease that apart.

"I think we need more research in that area, but from a general perspective, there is no reason to believe that a high concentration of THC in something makes it more dangerous if you can use the same amount of THC in a less-concentrated form – it's still the same amount of THC," he says.

"Where there is concern is if you increase the potency in a cannabis product to a point where a person cannot titrate their dose."

But to know that for sure, you need reliable regulation of dose and knowledge of its effects.

Vandrey believes one answer, if legalisation goes ahead, is public education about cannabis products that steer novice or infrequent users away from those that deliver very high THC doses.

"It's comparable to telling the person who is starting to be able to drink alcohol to not go straight to [95% alcohol] Everclear, start with a beer. We need some of that with cannabis as legalisation rolls out to prevent people from unintentionally consuming too much."

Other "really important" factors in policy are ensuring quality control in manufacturing, packaging and labelling so the finished product should be as consistent and reliable as possible to best inform the consumer.

Then there's creating an understanding of and establishment of unit doses. "What's an acceptable amount for somebody to consume that you can keep track of and that makes sense for the novice user so you keep them from getting into too much trouble?"

Also needed are assessments to identify people who are potentially getting into problematic use patterns. "There should be cannabis misuse prevention programmes and a pathway to evidence-based treatment options for those who need them."

Other ideas include putting a cap on the concentration of THC allowed in a product – controlling the unit dose allowed in various delivery forms of products so that concentration can vary but the maximum dose that can be delivered would be standardised.

"THC can have a substantial impact on your heart rate and heart functioning, so people at risk for cardiovascular events should avoid high doses of THC."

DR RYAN VANDREY, ASSOCIATE PROFESSOR OF PSYCHIATRY AND BEHAVIORAL SCIENCES, JOHNS HOPKINS MEDICINE, BALTIMORE

This means that x number of mg, however it's taken, is one dose – just like paracetamol. People can take however many doses they need to get their desired drug effect, which should be reliable and reproducible.

Currently, scientists have little understanding of the impact of these high-strength products, says Stanford's Esther Ting Memorial Professor Keith Humphreys, a former White House drug policy adviser.

His advice for government is to consider regulating and taxing THC content.

"In general, more potent drugs are more addictive and dangerous than less potent ones, so any legalising country would be wise to take steps to limit potency, just as is done with alcohol," he says. "One possibility is to cap potency outright, and another is to have a surtax on products of higher potency to encourage lower-potency products in the market."

For users, he says they need to simply be aware that, yes, the product is a drug. "It is a myth that it cannot be harmful."

Admittedly, we are a long way away from having cannabis packaged, marketed and sold in individual 2.5mg-dose blister packs in the supermarket. Across the world, the drug is often being legalised ahead of policy and potency regulation and ahead of the science that would be valuable in informing policy. So, there is some catching up to do.

"There needs to be some kind of investment in research that can help steer policy," Vandrey says. "In most cases, legalisation isn't waiting for all of that science, but it doesn't mean it shouldn't be done. You can always do the research and then modify policy and regulation after the fact." ■

Naomi Arnold is a Nelson-based journalist.

Why no human rights section in 2019 UNODC World Drug Report?

A United Nations report has highlighted the huge scale of annual deaths from drug use around the world, but the damage done by increasingly abusive prohibition doesn't rate a mention. ***Filter* magazine** prepared this critique.

FILTER STAFF

Worldwide, more than half a million people died from, or in relation to, illicit drug use in 2017, as the United Nations Office on Drugs and Crime (UNODC) presented in its *World Drug Report 2019*, published on 26 June. But the report failed to significantly evaluate widespread drug-associated human rights abuses inherent in prohibition and accelerated by the ascendancy of far-right leaders from the United States to Brazil.

The report mostly focuses on the public health impacts of drug use, such as overdose deaths and the persistent issue of injection drug users disproportionately impacted by HIV and hepatitis C infections (1.4 million and 5.6 million, respectively, out of the 11 million people who inject drugs globally). Touching on criminalisation, the report notes how incarceration exacerbates lack of access to healthcare for people who use drugs in general, with only one in seven of all people with substance-use disorders accessing treatment.

"Every year at this time, our members attend the launch of UNODC's World Drug Report where we hear about the same approaches with the same poor outcomes," said Heather Haase, Chair of the New York NGO Committee on Drugs, but "this year's drug report was pretty strong on actually being honest about how bad the situation is".

For Haase, however, "one thing that stood out in the report was there was no section on human rights. That's a huge issue in drug policy." The report briefly notes the issue of compulsory drug detention centres in Southeast Asia. In 2014, these centres were detaining 50,000 people in 948 facilities across seven countries without their consent and, in some cases, without due process or clinical evaluation. The report recognises this as being in "direct conflict with human rights obligations and contrary to medical ethics".

The report also recognises that the lack of "effective treatment interventions based on scientific evidence and in line with international human rights obligations" for all people who use drugs is a failure – yet no mention is made of the actual violations of those obligations.

The criminalisation of drug use is documented in the report, which notes incarceration rates. Yet it does not investigate, nor name as such, the human rights abuses that are, time and again,

> **"… this classification or 'scheduling' of drugs is the cornerstone of the current repressive approach to drug policy, which has resulted in the 'collateral damage'…"**
>
> GLOBAL COMMISSION ON DRUG POLICY CHAIR AND FORMER PRESIDENT OF SWITZERLAND RUTH DREIFFUS

UN World Drug Report 2019.

Image courtesy of the United Nations Office on Drugs and Crime

shown to be rife in prisons and jails. These omissions go against Haase's conviction that "we should be talking about compliance with human rights instruments".

This month, a slate of United Nations human rights special rapporteurs called on the UN to launch an independent investigation into Philippines President Rodrigo Duterte's campaign of extrajudicial executions of people suspected of selling or using drugs, given the "scale and seriousness of the reported human rights violations".

This comes as such policies are spreading to other countries such as Sri Lanka, which is relaunching its formerly abandoned policy of death penalties for drug offences. Commenting on Sri Lanka, Haase lamented, "None of that was mentioned in the report. And that's very typical of the UNODC."

But the UNODC's was not the only major drug report released that week. On 25 June, the Global Commission on Drug Policy – a heavyweight body comprised of numerous former national leaders and other high-ranking officials – published *Classification of Psychoactive Substances: When Science Was Left Behind*. The report set out in detail the irrationality of current global drug laws – policies that pay little or no attention to the respective risks of different substances or to prohibition's impact on people who use drugs.

Unlike the UNODC, the Global Commission centred human rights in its framing. Ruth Dreiffus, Chair of the organisation and a former President of Switzerland, wrote in the foreword:

"… this classification or 'scheduling' of drugs is the cornerstone of the current repressive approach to drug policy, which has resulted in the 'collateral damage' of the 'war on drugs' – tragic consequences that the Global Commission on Drug Policy has condemned since its founding in 2011. The effects of prohibition – in terms of public health and security, discrimination and prison overcrowding, the rise in power of criminal organisations and the associated violence and corruption, as well as the lack of access to essential medicines – highlight the urgent need to change course and implement policies that are more effective and more respectful of human rights."

One of the personal stories used to humanise these issues in the Global Commission report was that of Carol Katz Beyer, co-founder of the US advocacy organisation Families for Sensible Drug Policy. Beyer, whose journey and work was profiled last year by *Filter*, lost two of her three sons to fentanyl-involved overdose. The section is titled 'A mother's account of losing her sons to prohibition'.

Governments' abuse of human rights in the name of drug policy is near universal. As *Filter* has reported, the Russian Government, with a hostile track-record of depriving life-saving medication and targeting harm reductionists domestically, is also supporting Ukrainian separatists who have banned medication-assisted treatment, leading to suicides and riskier use likely to result in more preventable infections and overdose deaths.

In South America, Brazil is being led by newly elected fascistic President Jair Bolsonaro, who has a history of endorsing executions of people suspected of drug trafficking and recently slashed harm reduction from national drug policy.

In light of all of this, the UNODC's lack of focus on human rights is indefensible. ■

This article was originally published by *Filter*, an online magazine covering drug use, drug policy and human rights through a harm reduction lens. Filtermag.org

Sarah Blyth, outside the Overdose Prevention Society in East Vancouver.

Photo credit: Travis Lupic

New options to avert North American opioid crisis

Despite some valiant efforts to reduce drug harm, such as by safe-injection facilities, the body count is still growing in North America. Are new approaches and more resources needed? What form should they take? **David Young** investigates.

DAVID YOUNG

Marchers in a parade through downtown Vancouver in April called for "safe supply".

Photo credit: Peter Kim

With one of North America's densest populations of injecting drug users, Vancouver's Downtown Eastside has the grisly distinction of being the Canadian epicentre of the opioid crisis. Young men here die 17 years earlier than men living in the city's more prosperous west side.

But if Downtown Eastside is Canada's crisis epicentre, it has also been ground zero of efforts to ensure that the response is evidence-based and focused on harm reduction. It was here that Sarah Blyth and volunteers from the Downtown Eastside market set up a tent, and a table in an alley behind their market in 2016, administering the overdose reversal drug naloxone. At first, they were breaking the law.

"I said I didn't really care what the city [officials] or anyone else said because it just made sense," says Blyth, now Executive Director of Vancouver's Overdose Prevention Society. "There's no way they could argue with it. People were dying here, in front of us. That's just not something we can let happen."

Perhaps surprisingly, today, those working with the epidemic in Downtown Eastside are calling for a brand-new approach, arguing that even an expanded harm-reduction response cannot resolve this crisis.

The North American opioid epidemic is so lethal that life expectancy in Canada has flatlined for the first time in 40 years, and in the US, it has actually fallen. It has its roots in the 1990s when Big Pharma aggressively lobbied doctors to dish out drugs like OxyContin that they wrongly claimed had no real addiction risk.

North American opioid prescriptions rose suddenly and rapidly. Opioid-based painkillers became a common remedy for conditions such as back pain and arthritis. Across North America, medical opioid consumption has more than tripled over three decades.

In 2010, OxyContin was reformulated to make it more difficult to abuse. The US and Canada issued guidelines for doctors to restrict opioid prescriptions.

These actions did little to stop the crisis in places like Downtown Eastside, because foreign-based drug cartels flooded North America with cheap heroin and synthetic opioids including fentanyl, a drug 50–100 times more potent than morphine. If getting hold of legal painkillers became more difficult, users were able to turn to cheap, readily available and far more dangerous street drugs.

Today, illegal narcotics are more readily available than ever before, and illegal drug distribution networks have expanded from inner cities into rural and suburban areas.

> **"People were dying here, in front of us. That's just not something we can let happen."**
>
> VANCOUVER OVERDOSE PREVENTION SOCIETY EXECUTIVE DIRECTOR SARAH BLYTH

"The reality that the drug market is so toxic is the biggest obstacle to overcome," says Donald MacPherson of the Canadian Drug Policy Coalition. Federal and state governments in the US and Canada have struggled.

In October 2017, President Trump declared the epidemic a US public health emergency, freeing federal funds and loosening some restrictions on treatment access. Millions of doses of naloxone have been distributed in the US, but the federal response otherwise has largely been based around law and order.

British Columbia declared a public health emergency a year before the US. With eventual support from the Canadian federal government – and playing catch-up with community actions like those from Blyth and other volunteers – British Columbia put harm reduction at the heart of its response to the epidemic.

"I would say that the response in British Columbia has probably been better than anywhere else in the country," says MacPherson. He credits the momentum to a politically supportive government, a strong public health chief medical officer who declared the emergency and a history of grassroots mobilisation. "Most of what has been achieved was initiated by the community, by people organising."

British Columbia eventually led the way in opening overdose prevention sites, also known as supervised consumption or injection sites, following the one set up in a back alley by Blyth, which was funded by online donations. Not a single person has died in the overdose prevention sites.

The province was also fast at distributing naloxone and moved to scale up substitution treatment (getting people on opioid replacement therapies like methadone and Suboxone) and to allow drug toxicity testing.

Still, MacPherson says that the response has now stalled. "It became patently obvious to everyone that this

Donald MacPherson, Executive Director of the Canadian Drug Policy Coalition, advocates for a full range of harm reduction responses.

Photo credit: Peter Kim

> **"The harm-reduction work that we've been able to support and expand is really no match for people consistently injecting toxic drugs."**
>
> UNIVERSITY OF BRITISH COLUMBIA EPIDEMIOLOGIST PROFESSOR MARK TYNDALL

is not a situation where harm reduction, while important, is going to be a really major part of the answer to the crisis."

That's a view shared by Professor Mark Tyndall of the University of British Columbia, a Harvard-trained doctor of infectious disease and epidemiology. Tyndall has worked with drug addiction in Downtown Eastside ever since moving to Vancouver in the late 1990s after treating HIV patients in Kenya.

From 2014 until January 2019, he served as Executive Director of the British Columbia Centre for Disease Control (BCCDC). As head of the BCCDC, Tyndall once urged a local community group to set up a 'pop-up' overdose prevention site inside a tent and invite the press. He has co-authored dozens of peer-reviewed studies on the benefits of supervised injection sites.

More than anyone, he was at the forefront of advocating for evidence-based harm reduction. But today, based on his experiences in Downtown Eastside, he says that giving people safe spaces to use drugs is not going to turn the tide.

"I've been working in harm reduction for 20 years or more in Vancouver, and what's happened to us in the last three-and-a-half to four years with the disappearance of diverted pharmaceuticals and the appearance of fentanyl in my mind really changed the equation entirely. The harm-reduction work that we've been able to support and expand is really no match for people consistently injecting toxic drugs."

It's not that harm reduction hasn't worked – Tyndall credits approaches like naloxone distribution and supervised injection sites with saving at least 1,000 lives each year in British Columbia. But he, MacPherson and many other campaigners in Vancouver's Downtown Eastside say even expanded harm reduction can do little more because the drug supply is so toxic. They say this requires far more expansive responses that actually focus on the supply.

"We've done the natural experiment of harm reduction in Downtown Eastside," says Tyndall. "There's supervised injection sites, everyone has naloxone, paramedics are all over the place reviving people, there are [clean] needles everywhere, but it just doesn't help the fact that people are buying toxic drugs from back alleys, and it's just a matter of time until they overdose."

He says there is a need for a "delicate balance" between continuing to support evidence-based harm reduction, which continues to face a backlash (especially in the US), and "starting a new dialogue about the fact that we have to actually supply people with safer drugs".

Blyth agrees that it is time for a rethink of the response to the epidemic – and for safer supply measures to be at the heart of the response. "I think we need to look at who this epidemic is really affecting and try and change the way we think about things, and we have got to be more compassionate."

What would a more compassionate approach based around ensuring safety of supply actually look like? Various measures are promoted by campaigners. All are controversial.

One idea is for British Columbia to enact de facto decriminalisation of drug possession. This has the backing of the province's current top health officer, Dr Bonnie Henry, who issued a 50-page report in April called *Stopping the Harm: Decriminalization of People Who Use Drugs in BC*.

"The current criminal justice-based framework keeps people at home, not talking about their drug use, using alone and dying," Henry told a press conference. She outlined two ways the Police Act could allow the province to effectively choose not to prosecute drug possession. It would still be illegal to make and traffic drugs.

"What we're talking about is alternative pathways for people who are caught with small amounts of drugs for personal use, where there are alternatives to incarceration."

The problem, MacPherson says, is that "there is no consensus at the provincial level" on whether to take her advice.

In the meantime, advocates argue for other approaches to make sure injecting drug users have access to safer drugs. The Pivot Legal Society, based in Vancouver's Downtown Eastside, went to court to fight for heroin-assisted treatment – a medical intervention in which prescription pharmaceutical-grade heroin is prescribed to people with long-term opioid dependency who have not responded to traditional treatments.

When the federal government banned heroin addiction therapy in 2013, Pivot took legal action on behalf of five patients from the 200-person SALOME study, which gave some drug users heroin. Pivot won an injunction protecting the research participants' access to the therapy until trial. In 2016, the federal government gave up and repealed the law.

Elsewhere in Downtown Eastside, the Providence Crosstown Clinic has been providing chronic injecting drug users with injections of medical-grade heroin for years as part of two landmark longitudinal research projects.

Blyth thinks that she and her team should be able to provide opiates to users. "Ideally now that overdose prevention sites are set up, we could hold onto prescriptions and give them out to people. I can hold people's medications – and meds also include opiates."

For Tyndall, it's important that heroin distribution is moved out of the medical realm. "In Canada at least, we've trained all our physicians that these drugs are bad. To reverse that idea now is difficult. We need to get it out of medical hands and also give up the idea that we can somehow get enough doctors to undertake one-on-one assessments" every single time someone injects. He adds that many people who use drugs would prefer not to be observed and supervised so avoid clinical settings.

Tyndall is leading a pilot programme, which grew out of the SALOME study. In the study, he is giving Downtown Eastside's most at-risk drug users a regular allotment of hydromorphone pills (a powerful prescription opioid), which they can use elsewhere instead of buying potentially toxic street drugs.

"We need something that is cheap and easily accessible and people can take with them," says Tyndall. He wants to go further. Right now, in the first stage of his study, patients are still required to come to a clinic to pick up their drugs from medical staff.

> **"The current criminal justice-based framework keeps people at home, not talking about their drug use, using alone and dying."**
>
> BRITISH COLUMBIA DEPUTY PROVINCIAL HEALTH OFFICER DR BONNIE HENRY

Tyndall's idea – not yet fully approved and funded – for the trial's second stage is to do away with the clinic environment and with the medical staff altogether. He gained international attention for his proposal to distribute the drugs in opioid vending machines.

A Canadian tech company, Dispension Industries, which had been working on vending machines to distribute cannabis, has designed a prototype: a 350-kilogram kiosk that uses biometric scanning to identify approved users.

But the challenges are less technical and more political. Organisations representing both pharmacists and doctors have expressed concern. Tyndall unexpectedly lost his BCCDC leadership role in January in a move that created press speculation that he had been too outspoken. (He continues to lead the research.)

In the meantime, some activists in Downtown Eastside are reportedly considering engaging in civil disobedience to illegally buy and provide safe supplies of heroin – an approach that MacPherson describes as "very, very high risk".

"In harm reduction, people started handing out syringes when that was illegal; people set up supervised injection sites when that was illegal. The precedent globally is that people break the law to provide life-saving health services, and governments follow."

Tyndall says he knows many doctors who "stray" outside rules on opioid prescription in order to ensure users aren't forced to rely on potentially lethal street drugs.

In April, hundreds marched through downtown Vancouver calling on the government to offer pharmaceutical alternatives to unknown substances purchased on the street. The march for safer supply attracted drug users, advocates and community organisers.

"We've been talking about this for years," Dean Wilson, former President of the Vancouver Area Network of Drug Users, told a journalist. "For the last four years, we've been dying in numbers like we were dying of HIV. The solution is really simple: prescribe." He accused politicians of not caring. "They don't have to do anything, and we die off in huge numbers. I just don't believe in government any more. They all lie. And they're all full of shit."

For Blyth, ensuring users have safer supply would be good for all of society. "I hear the argument, 'Why would we do this with taxpayer money?' Because it would save money in the long run. If you give people money, it's not going to cost as much in break-and-enters, in survival sex trade, in trauma, in all the things that people do in a desperate situation."

Wherever British Columbia goes next, it is entering uncharted territory. "The fentanyl epidemic is largely a North American thing," says Tyndall. "Other countries have had it a little but nothing like here. As we stumble along pushing harm reduction, the toxic drug supply and the high numbers of overdoses have changed the equation for us, and people who understand that jump on the bandwagon of safer supply."

MacPherson worries that the crisis could get even worse. "It depends on what is going on in the unregulated drug market. It's really hard to draw a line, because even with all of the harm-reduction work going on, it's still only covering a minority of the population. The people who are dying, they are dying alone." Alone and in great numbers. ■

David Young is a former Radio New Zealand journalist now living in Washington, DC.

WE NEED

YOU!

#CANNABIS REFERENDUM

GET BEHIND #HealthNotHandcuffs

healthnothandcuffs.nz

BE PART OF HISTORY

Next year's general election will offer what is likely to be a one-time opportunity to change drug laws for the better. Recent polls show some people think a hard-line enforcement can still work. To put a stop to treating people who use drugs as criminals and focusing instead on health, there needs to be concerted action now.

The upcoming referendum on cannabis legalisation is a once-in-a-lifetime opportunity. People have been lobbying for a change to our hugely damaging status quo for as long as I can remember. They are people who care about public health, social justice and the outrageous criminalisation of young people and Māori.

Now we have a chance to change things. But the race will not be an easy one. Recent polls suggest we will need to fight for every vote. Health Not Handcuffs has been set up to build a movement for healthy drug laws.

Our biggest campaign over the next year will be the referendum. This is our chance to wrap a cloak of love and protection around people who use drugs.

Kākahungia te tangata ki te aroha, kaua ki te whakawhiu.

That's because it's irresponsible to leave cannabis for the black market to control. Under prohibition we've seen soaring cannabis use, high conviction rates and inadequate investment in prevention, education and treatment. Designing a compassionate model that focuses on health is how we will turn that all around. Strictly regulated, legal cannabis is the only way to achieve this.

If you think this one's important, think about what you can do to help. If we mess this up, we might not get another chance.

STEPS TOWARD THE REFERENDUM

New Zealanders will vote on whether to legalise and regulate cannabis at next year's election. Here's what we know about the process.

The referendum will be a simple yes/no question based on detailed draft legislation. A select committee may be formed to engage with the public on this single issue, and a public education programme will be key to the process.

The final draft legislation will be released as the education campaign begins, some time between June 2020 and the election.

READY FOR ACTION?

Get involved in the campaigning that we need to do to ensure a yes vote in 2020.

Here are some ways you can get involved straightaway:

- Sign up to Health Not Handcuffs and encourage others to do so too.
- Share our messaging over your social networks, or even better, create your own.
- Set a target to convince a dozen friends and family to vote yes in the referendum – we have resources to help with this. Once you've convinced a dozen, convince a dozen more.
- Donate – we need help, especially to run advertising campaigns and events.
- Use your networks creatively to get people talking and understanding the key issues. Can you run a workshop at your office? Can you convince a famous friend to be a spokesperson?

In the lead-up to the referendum, there will be plenty of other ways people can contribute. Here are just a few:

- Run a stall over summer to convince the public, gather support and fundraise by selling cool t-shirts.
- Set up a local campaigning group.
- Volunteer to help as the referendum approaches.
- Your ideas here ...

To make sure we win, we need everyone who feels strongly about this to take responsibility for winning the vote.

SIGN UP to Health Not Handcuffs today.

REFERENDUM OUTLINE

Between now and July 2019:	Cabinet to design a regulatory model for discussion and debate
Between now and March 2020:	Cross-party reference group made up of all interested parties
August–September 2019:	Stakeholder engagement/expert consultation
September–November 2019	Stakeholder feedback considered and draft finalised
January–March 2020	Cabinet approval
June 2020–election	Final documents released, public education campaign begins

Source: 2020 Cannabis Referendum – legislative process and overarching policy settings for the regulatory mode cabinet paper, 6 May 2019.

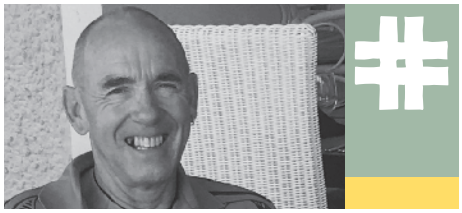
120 REASONS for drug law reform

Can you think of a reason why drug law should change? We've been asking this very question. And the results may make you angry, sad or fired up. Here are a few of the reasons we've collected so far, with many more online. Got one to add? We want to hear it. Submit your reason online:

RESOURCE

Sign up to healthnothandcuffs.nz

JOHN



In 1968 I was 18 when convicted of cultivation of cannabis. Police, through an anonymous 'tip', discovered a soup plate of dirt containing six ungerminated cannabis seeds at my home. My motivation for this act was pure curiosity. Over the last 51 years this conviction has impacted my life on many occasions. My working career has given me opportunities to work and reside overseas. Each time I have applied for an overseas working visa I have been required to provide a full Justice Dept record of convictions. This conviction recorded on this report has impacted those visa applications. 51 years ago I made a simple mistake, no further convictions since but it still impacts my life today.

AIMEE

I have seen the damaging effects of pushing drug users down the criminal justice path both personally and professionally. We have seen the positive impact around the world when we take our whānau who use drugs, connect them with their community, help them address their substance use and the underlying issues and support them rather than penalize them. The statistics show that crime rates in those communities drop and more people gain access to services due to the redirection of funds.

I am an advocate for more treatment, more harm reduction services and reconnecting our whānau rather than locking them away where the issues just increase, as do their problems upon release. For over a 100 years we've been doing the same thing and it doesn't work. The time to change is now! It's time to sing songs of love to our whānau rather than songs of misunderstanding and disconnection. They are us too.

EUGENE

He take hauora tēnei ngāngara, arā te kiriwara, ehara he mea mō ngā pirihimana me ngā kōti anahe. Me panoni te Kāwanatanga i te ture kia āhei ai te hunga māuiui ki te tono mō te āwhina.

This affliction, addiction, is a health issue, it's not just an issue for police and the courts. Government should change the law to enable those who are unwell to seek help.

TUSILIMA

I was convicted for the cultivation of three female plants that awarded me nine months jail time or four and half month's home detention, I lost my driver's licence for two years also as a result. Public taxes paid for a helicopter, a light aircraft who spotted my three plants from the air, two four-wheel drive light vehicles filled with drug squad personnel and a probation officer, all of these resources for three personal plants.

CHRIS (AS TOLD BY IAN)

We scattered Chris's ashes last week, after a small service of whānau and friends. He had lived with a strain of hepatitis normally passed around with a shared needle. How long it had been in his system, hard to tell, but the symptoms and treatment began eight years ago. He died in his 66th year from the complications that hepatitis induces. As a young Ngāi Tahu scholar gifted in English, Chris had a promising career as a journalist. A naive cannabis user, he was induced by an undercover policeman to supply LSD. Arrested, tried and sentenced, he experienced the degradation inherent in our penal system. Chris never fulfilled the promise of his early career and could never break free from his connection with the criminal world. The conviction closed opportunities, prison changed his personality.

2019 Budget set to deliver

Prime Minister Jacinda Ardern with Health Minister David Clark at a pre-budget announcement.

Photo credit: NZ Herald/Mark Mitchell

The Wellbeing Budget released on 30 May 2019 is set to be a game-changer. Access to addiction treatment will significantly improve with a mix of new services and support for existing ones. It will take time to implement, but in the meantime – we can celebrate this significant victory!

Budget 2019's top focus was mental health and addictions. Investment of $1.9 billion over the next four years has been allocated. Importantly, new investment will cover those who are just starting to struggle with their mental health or drug use, as well as those with more serious problems. No longer will loved ones have to wait until their problems are out of control before they can access help.

The proposed investment is comprehensive and aims at addressing the root causes. There will be more money for mental health and addiction care in schools, in primary health care, in existing treatment centres, in hospital emergency rooms and in prisons.

SOME OF THE HIGHLIGHTS INCLUDE:

- A plan to get 5,000 people a year early support through primary care (such as GP surgeries) for alcohol and drug issues.
- Access to a range of free services that support and maintain mental wellbeing for every New Zealander who needs it, within five years.
- $213.1 million of total DHB funding ring-fenced to enhance mental health and addiction services.
- $44 million over four years to improve existing drug addiction services.
- Nurses in schools to reach a further 5,600 students.
- $197 million for Housing First, aiming to bring 2,700 vulnerable people into permanent homes.
- $128.3 million over four years for mental health and addiction services in our Corrections system.
- $8 million over four years to improve responses for those who turn up at hospital emergency departments needing mental health support.

$1.9 billion

invested over the next four years for mental health and addictions

The Wellbeing Budget is really great news for those struggling with addictions and their whānau. It also represents a significant milestone and victory for the Health Not Handcuffs movement.

Now we just need to make sure it's all put in place as quickly as possible. Realistically it will take a while before every doctor's practice can include a staff member trained in mental health. We'll need to keep the pressure on government to keep them honest and make sure the money is used as efficiently as possible. We also need to make sure enough funding goes to kaupapa Māori approaches to reduce inequities for Māori. ■

Surprise finding: cannabis may beat cold turkey

A growing body of overseas research has revealed that cannabis could help break harder drug dependence. Legalisation could allow the research that could produce more definitive scientific evidence and establish the most effective cannabis to use.

RUSSELL BROWN

Russell Brown is an Auckland-based journalist and publisher of publicaddress.net

Word on the street

In the early 1990s, something interesting happened in hip hop music: rappers stopped talking about crack. Even as Jay-Z and Snoop Dogg, who had once sold crack cocaine on the streets, became mainstream figures, the content of hip hop turned to another drug: cannabis.

Rappers who had once depicted crack as a reality of street life suddenly began to eulogise weed. Social commentators lamented the trend. But ethnographic researchers on the streets of New York City's toughest neighbourhoods were hearing something else. The rise of weed didn't just coincide with the end of America's crack epidemic – it may have helped bring that end about.

"Crack sellers who also used the drug themselves used to essentially dilute it with cannabis, rolling it in a tobacco leaf rather than smoking it rapidly in the typical glass pipe," says American journalist Maia Szalavitz. "This allowed them to reduce their cocaine consumption. When a crackdown meant that those leaves were no longer available from head shops, they switched to placing the mix into 'Philly blunt' cigars. It was a way to manage use."

Drug kingpins weaned down, then eliminated their own crack use this way – and began encouraging their families to do the same.

"At the same time," says Salavitz, "the younger generation saw how their older siblings and parents had been harmed by crack, and they deliberately avoided that drug but did favour blunts filled with weed."

In this light, the explosion of blunt culture into the mainstream emerges less as rappers eulogising drugs and more as positioning against a drug that had ruined families and neighbourhoods.

Early research

More than a quarter of a century later – and 4,800km away in Vancouver – a different generation of researchers put some data behind the narrative.

An observational study, published in 2017 by the British Columbia Centre on Substance Use focused on cohorts in downtown neighbourhoods that the centre has been following for as long as 20 years, established a pattern.

The researchers found "significant increases in cannabis use during periods when [participants] reported they were using it as a crack substitute, followed by decline in the frequency of crack use afterwards".

Dr M-J Milloy, who led the Vancouver work, cautions that an observational study relying on self-reporting can't show causation, "but there are other studies from other places, which are qualitative in nature and also describe the same sort of thing. There are also pre-clinical studies that suggest there are plausible biological reasons for this."

Milloy isn't the only researcher to be thinking this way. Dr Bernie Pauly, a scientist at the Centre for Addictions Research of British Columbia, was studying Canada's managed alcohol programmes (MAPs) when she decided that perhaps cannabis was more than a hazardous coping mechanism for people with alcohol dependence. Perhaps cannabis substitution could be a harm-reduction strategy.

Pauly recently won funding to conduct a feasibility study of cannabis substitution in MAPs to determine the system's readiness for a full clinical trial.

Both Milloy and Pauly believe that the efficacy of cannabis is not principally in providing a less harmful high but in easing symptoms of withdrawal and preventing relapse, and a new study conducted in New York seems to bear that out.

Medical research poses new questions

For a double-blind study published in the *American Journal of Psychiatry* in May,

42 participants with heroin-use disorder but currently abstinent were exposed to heroin-related cues. All experienced cravings in response to the cues, but those who had received cannabidiol (CBD) had significantly reduced cravings compared to a placebo group, along with reduced physiological symptoms of stress and anxiety. Effects lasted up to a week, well after CBD had cleared from participants' bodies.

Lead researcher Dr Yasmin Hurd told journalists that one of the next steps would be to study CBD as an adjunct therapy to current opioid substitute medications, such as methadone or buprenorphine.

But it's complicated. Hurd's work used pharma-grade CBD: GW Pharmaceuticals' FDA-approved Epidiolex (GW also partly funded the study). The participants in Milloy's study were using retail weed.

"Long story short: we don't believe that there was really any CBD content in the cannabis that these people were using in our study," says Milloy. "In the recreational market, the growers were growing cannabis with as much THC as possible, because that's what the marketplace wanted.

"So now as we try and move from observational studies to experimental studies, we face the question of what cannabis should we give people? The findings from Dr Hurd suggest that high-CBD stuff is the way to go. Our studies, however, suggest that this is a function of high-THC (tetrahydrocannabinol) cannabis, so what exactly is in there, what is having these effects is really a central question."

Might high-THC products suit crack users more? Whatever the precise answer is, it probably lies in the human endocannabinoid system.

"Pre-clinical studies show us that, and it's increasingly accepted in the scientific community," says Milloy. "Not only the sort of acute intoxication, but also some of the more latent phenomena, including possibly modulation of the immune system. And we're beginning to understand how the endocannabinoid system is involved in many of the same processes that are implicated in substance use disorders and related co-morbidities, things like pain or trauma."

Adding to the complexity, the apparent benefits of CBD in the New York study showed up clearly in a controlled setting – but did not, according to self-reporting participants, moderate cravings nearly as much when they were back at home.

> **"Crack sellers who also used the drug themselves used to essentially dilute it with cannabis."**
>
> JOURNALIST MAIA SZALAVITZ

But a welter of other studies suggest there is something to pursue. In 2014, Italian researchers found that THC reduced the neurotoxic effect of methamphetamine, by moderating against brain inflammation, in lab animals. By contrast, a 2004 study looked at meth users who were also heavy cannabis users – and couldn't find a neuroprotective effect. They did decide that cannabis didn't make things worse, but it did cast doubt on the real-world benefits of casual use.

A 2017 study found that CBD made sleep-deprived rats (sleep impairment is strongly associated with relapse into methamphetamine use) less likely to return to meth-seeking behaviour. The authors of a 2004 study published in the journal *Neuropsychopharmacology* found that THC made rats less likely to reinstate methamphetamine-seeking behaviour and said THC and possibly other "endocannabinoid-activating substances" showed promise as anti-relapse agents – but suggested that those should be combined with COX inhibitors (i.e. most common painkillers).

Meanwhile, back on the street

Some people simply aren't waiting for the research. Several studies have found that many medicinal cannabis users consciously use cannabis as a substitute for other substances. And since last year, Vancouver's Cannabis Substitution Project, founded by old-school weed warriors, has simply been giving away donated cannabis in various forms to dependent street opioid users – and claiming results.

Those results could simply be to do with sleeping and eating better. Pauly says her study of a similar project found that users reported "benefits normally associated with cannabis such as decreased anxiety, improved sleep and appetite. This means that people are less likely to overdose on a toxic drug supply."

The Cannabis Substitution Project would have been hard to sustain without cannabis legalisation and the de facto period of decriminalisation that preceded it. And both Pauly and Milloy say legalisation has removed some obstacles to their research.

So as New Zealand sizes up its legalisation referendum, what are the prospects for cannabis substitution therapy here? Fairly dim right now, according to one treatment professional I spoke to.

"That's a huge leap from what's currently on offer," he told me. "It's hard enough to stay on methadone in an abstinence-dominated environment. Offering anything non-prescribable in this environment would be difficult. Harm reduction balances risk and usage, but expressly putting pot in a plan is not something I've seen."

On contemplation, he granted that it could be happening, informally and on the quiet: "As with anything progressive in this country, it won't be written down."

How might legalisation help?

It may be that legalisation, if it happens, makes trials easier to conduct and widens the range of cannabis strains and products available to use in substitution, as it has in Canada. Perhaps prescribing guidelines under the medicinal cannabis product guidelines may stretch enough to allow such an approach.

But Milloy warns legalisation is not necessarily a fix – largely because a cautious regime may not help the most marginalised.

"It does not seem as if the people at the highest risk of overdose in Canada are using legalised cannabis. We think that less than 5% of the people that are using cannabis in our studies are using cannabis from the legal market. We think a big barrier to that is cost."

It's also why the Cannabis Substitution Project is giving away the weed. Milloy says he's studying what the group is doing.

"I can certainly understand people saying just give people cannabis in the hope that it works. We're working to evaluate this strategy – there are probably benefits and probably risks. But given the public health catastrophe we're currently facing, I can certainly understand the impetus."

If the evidence for cannabis substitution as a therapy continues on a positive trajectory, it seems likely it will eventually be accepted as a form of harm reduction. But the people it may benefit may not have that long to wait. In New Zealand, as in Canada, it could be that the first we see of it is activists taking the matter into their own hands. ■

To test or not to test? That was the question ...

Otago University Students Association chief executive **Debbie Downs** had initial misgivings about introducing testing of recreational drugs for students but, after some informal research of her own, she concluded it was not just a good thing but a necessity. The rest is history.

DEBBIE DOWNS

It is not so often in life that one gets to look back with the clarity of hindsight and feel like something couldn't have gone better; interestingly that's how I feel about the drug checking that we have carried out this year.

The decision to go ahead with drug checking during Orientation (the week before the academic year officially begins at University) was one that was months in the making. It was an interesting journey to say the least, and I now know far more about illegal substances than I ever thought I would!

The journey began with the suggestion from one of our student representatives that we should introduce drug checking. My initial reaction was a definite and stern "no". How could I let our organisation with its proud 129-year history of providing services to students possibly be involved in activities that are not strictly legal? What would the response from the wider community be? What would our stakeholders think?

Had this journey started with a profound belief in needing to make this happen the journey would have been shorter and probably easier; instead I started not even knowing if I should or indeed wanted to do this.

I am a 'why' person, I needed to understand the why, and ignore the 'what' for a while. Once the why was sorted in my head – to help keep people safe – I knew drug checking actually did fit with who we are as an organisation; and something I could personally support.

My first step was to talk to students to get an understanding of how prevalent drug use is in our young people. Anecdotal research at best I know, but an important part of my understanding of how valuable this service might be, and whether or not it was worth the risk. I had heard about deaths in Australia and hospitalisations in Christchurch the previous year, but wanted to understand drug use in a local context. Turns out according to those that I spoke to, pill taking is almost as common as alcohol in our young people. I was told how easy pills are to buy, and how cheaply. I was told how when having a night out, one merely decides whether to buy a pill or a box of beer (or the like). Now I know this doesn't apply to all young people, but nor does it apply to only the few that I spoke to. This also isn't a student problem, nor did the people I speak to fit a certain socio-economic demographic. Drug use in our young people is real, it is common, and it is dangerous. Box one

Testing during OUSA Orientation week came with frank advice.

Photo credit: supplied

ticked, the why firmly embedded in my brain.

I was put in touch with Wendy at Know Your Stuff; what a fabulous organisation. We talked about what we were trying to do, if we could work together, could we make this work. A bit more research about their work and their organisation and it was time to talk to our stakeholders. In the context of OUSA (Otago University Students' Association), these are the organisations that we work with the closest, they understand us, work with us and support us. Our stakeholder groups (as we see it at least) include the University of Otago, Dunedin City Council and Police. I knew there was no point asking for support from any of these organisations in an 'official' capacity. I already knew what the answer would be, what it in fact would have to be. So my conversations were with some of the individuals within those organisations that I know well, trust, and respect the opinions of. Other than some reasonable reservations everyone I spoke to was really supportive. Box two ticked.

A brief read of media over the Christmas period saw some interesting commentary in support of drug checking around summer festivals. Seemed the wider community might just be more receptive to this initiative than I thought they would be. I knew when I started this journey that if we did make the drug checking happen it would be me that would front the media. I have never wanted my 15 minutes of fame, if we went ahead I was going to have it anyway. The stories I read in the media weren't quite a box ticked, but it certainly helped. It also led me to the NZ Drug Foundation as they had been asked to comment in the media. A quick call to them early in the New Year, helped me to understand even more the importance of providing this service.

It was about here that I had a conversation with a colleague who told me firstly, that I would be damned if I did go ahead with testing, and damned if I didn't; he also added how guilty I would feel if someone was hospitalised or worse died from taking something that was not as it was supposed to be. I know that I can't be held responsible if that had happened, but I would hold myself responsible if I had not done everything I could to make sure that didn't happen. Especially knowing what I now knew about the prevalence of drug taking in our young people. Last box ticked – I should do this because it is needed, I can probably get away with providing drug checking, and make others see that drug checking is an important harm prevention service that can save lives. Just like having condoms freely available (something we already do) doesn't make more people have sex, drug checking wasn't going to make more people take drugs, they were already doing that, we just needed to educate them and do what we can to keep them safe.

Finding a location for testing was also not straightforward. This was going to be the first time in NZ history that drug checking was going to be publicly available. This was not going to happen behind the closed gates of a ticketed event away from prying eyes, we were going to make the service available to anyone that wanted to test. It was always going to be at the 'student-end' of town, but we would never be able to have the service on someone else's premises. After discussions with Know Your Stuff and the NZ Drug Foundation we decided that a carpark at the back of one of our buildings would be ideal. Close, relatively easy to find but discreet and, importantly, private property; if things didn't go exactly to plan we could remove people.

The rest, as they say, is history, testing went ahead during Orientation. Sixty one people went through the testing tent. Unfortunately we were only able to offer reagent testing, while this was better than nothing, it is not nearly as useful as testing with a spectrophotometer. The media storm ensued, but even that wasn't too bad. Except the one journalist who thought a good question to ask me would be: would I be testing my own drugs. Really?

We brought testing back for the Hyde Street Party, 80 through the tent this time, and due to the use of the Drug Foundation spectrometer an unknown substance was detected. Know Your Stuff were able to put out warnings, these were passed to first responders, I think that's when I really knew we had done the right thing and why it was so important. Not just for the young people that we provide services for, but for anyone. We proved that drug checking can be carried out in public and good things come from it.

Drug checking needs to be made legal! If the service were legal far more resources would become available. More funding, more specs, more testing, more people educated and kept safe.

Since February I have been approached by people I know, people I don't, people on the side of the rugby field while I'm watching my kids play, people in the supermarket who saw me on the news. Every single person was positive and thought that it was about time drug checking was available. Not a single person had a negative thing to say.

Lastly, I need to thank Know You Stuff and the NZ Drug Foundation and the amazing people within these two organisations, they actually deserve all the credit. They made this possible, thanks for trusting us to take your endeavours out into the public spotlight, and not destroy everything you have worked so hard for. ■

Why we need to vote yes

Many people consider cannabis to have been helpful in mitigating their physical, mental and emotional health problems, as well as being less harmful than other options, such as alcohol. **Chloe Ann-King** and **Hannah McGowan** argue that New Zealand needs to vote yes for those people.

CHLOE ANN-KING

HANNAH McGOWAN

The 2020 cannabis referendum announcement has reignited public debate on the issue of legalising drugs for personal use, but mostly we've heard from well-dressed economists, middle-class academics and politicians. The voices that are often marginalised and missing from the conversation are ones we need to hear from the most. People who are poor, jobless and surviving on pitiful welfare payments who might also utilise cannabis for personal or medicinal use to mitigate the symptoms of anxiety, chronic pain, long-term illnesses or disabilities.

Once such person is Hannah McGowan, who told me that "legalisation of cannabis would fundamentally change the way I live my life". Hannah spoke about the referendum from her perspective as someone who suffers from both fibromyalgia and Crohn's disease (CD), which leaves her in chronic pain and interferes with her ability to work. She has relied on welfare payments to get by, despite trying several times to become financially independent.

Hannah has used alcohol, and pain medications such as tramadol and codeine to mitigate the often crippling and agonising symptoms of fibromyalgia and CD, but these pain meds often left her feeling tired, foggy and nauseous. A combination of work stress, financial difficulties, parenting, household duties and worsening health led to drinking as a way of coping with increasing pain and anxiety.

"I was drinking on a daily basis and getting seriously drunk at least two or three times a week. I would have drunk more if I'd had more money or better general health."

After making sure her children were taken care of and had food, she would spend all her remaining money on alcohol, replacing meals with beer. She began experiencing blackouts and altered moods and hurting the people she cared about. Knowing she was becoming a "crummy parent", Hannah did some research and concluded cannabis could offer a possible way to ease fibromyalgia and CD symptoms while weaning herself off alcohol dependence.

Fortunately, Hannah has a good relationship with her GP, who knew that she was struggling with alcohol abuse. He was open minded about the various potential benefits of medicinal cannabis, and when she asked him about trying it, he told her that she was old enough to make that choice and to "go for it". Her inflammatory bowel disease specialist warned that he wasn't satisfied that cannabis was terribly helpful for Crohn's from the evidence he'd seen but, if she believed it could help, she should try it. When Hannah pointed out that using cannabis would make her a criminal, he said; "You're not a criminal! Just take it anyway."

What is affirming is that Hannah's healthcare team was supportive and came from a point of knowledge, which isn't always the case.

After the positive, informed response from her medical team, Hannah saved up, bought an ounce and worked on her rolling skills. Six weeks into using cannabis consistently, she noticed she'd stopped drinking daily. Her mind was clearer, she was more productive and wasn't as sore. In fact, she felt as if her chronic inflammation – a feeling of low dull burning pain in her belly, joints and muscles – had waned.

Although there is a major data gap around the effects of cannabis on CD, a promising 2011 observational study by the Israel Medical Association Journal stated: "Disease activity was assessed by the Harvey Bradshaw index for Crohn's disease. Results showed that 21 of 30 patients improved significantly after treatment with cannabis." Cannabis isn't a silver bullet, but mounting evidence suggests that it's effective in the treatment of chronic pain, which Hannah lives with every day.

While the government has guaranteed it will take a historic step for Aotearoa with the Misuse of Drugs (Medicinal Cannabis) Amendment Act, it's unclear whether people such as Hannah will qualify for

Self-medication without legal cannabis.

Photo: Opacity, Flickr.

a prescription for medical cannabis under the Bill.

We know that cannabis use carries risks – the 2012/13 New Zealand Health Survey on cannabis use found that 8% of people who used cannabis said they had experienced a harmful effect on their mental health as a result – but Hannah and many other medicinal cannabis users have greatly improved general wellbeing. Hannah mentions that strains of cannabis on the black market are designed more for recreational than medicinal effects. Those who do experience adverse reactions may not have suffered if there were more public knowledge and access to the right varieties.

In two years since Hannah began trialling the plant she hasn't had any negative side-effects. She still drinks too much sometimes, usually when she can't access or afford cannabis, but her quality of life is better. She can turn down a drink. She can stop drinking after a few rather than always drinking into oblivion. She can go for months without drinking or having cravings. Forbes reports that alcohol sales are down 15% in US states where medical cannabis has been legalised.

During our conversation, we discovered many commonalities. I too have alcohol-dependence issue, diagnosed anxiety and I'm on welfare. I get the accommodation supplement to meet Auckland's spiralling living costs. I've used alcohol to numb painful emotions and mitigate anxiety. But where our stories differ is that, when I've gone to doctors asking for help, I've been lumped into the 'drug seeker' category.

Just last week, I went to my local GP and asked for a script of Valium because I want to practise abstinence again. My doctor refused to prescribe it, her reasoning being "I don't want to give you another problem on top of your drinking". Valium can be addictive but not if prescribed responsibly and is frequently used to mitigate alcohol withdrawal symptoms, so I wasn't asking for anything unreasonable or dangerous.

I explained to her that cross-addicting has mostly been debunked and isn't backed up by hard evidence. She dismissed me and said I'd just have to suffer through withdrawal. After my doctor's response, I am considering playing Russian roulette and buying some street Valium and cannabis from a dealer.

What else am I meant to do? My GP's position feeds directly into rhetoric perpetuated by the failed War on Drugs, applying the cruel narrative that people with dependence issues have no impulse control and deserve to suffer and feel pain. Health professionals should operate from a place of empathy and have at least some understanding of dependence issues.

Attitudes about addiction, recovery and drug use need to change across the board. But I am hopeful the ongoing public robust discussions about the referendum will get some sceptical politicians and doctors/GPs thinking more deeply about, not only cannabis use, but how they frame dependence issues and talk to and about people struggling with dependence issues.

Hannah still lives with constant low-grade anxiety about her use. Using cannabis is illegal. Taking it, even as a medicine, makes her a criminal. It bothers her immensely. While breaking the rules makes life bearable, risking criminalisation as someone on welfare without decent access to legal aid creates ongoing, unnecessary stress.

Better education around drug use, proper dispensaries and the ability to choose the strain of cannabis that fits your needs will minimise harm. Decriminalisation will give people like Hannah more autonomy in their health, lives and communities. All of this can potentially be achieved if a majority vote yes in the referendum. All it takes is a tick in the right box. ■

Hannah McGowan is a published writer with an interest in psychology, advocacy journalism and drug reform.

Chloe Ann-King is a workers' rights and welfare advocate who also writes about the impacts of poverty and dependence issues. She is reading for a Master of Human Rights at AUT.

Minister for Social Development Carmel Sepuloni.

Photo credit: supplied.

Government putting right meth contamination evictions

The government has made a good start to making amends to Housing New Zealand tenants who were evicted after small amounts of methamphetamine contamination were found in their homes, but has it gone far enough?

NATALIE BOULD

Natalie Bould is a Communications Adviser at the Drug Foundation.

It's been a while since the methamphetamine testing scam was busted in mid-2018, but since then, nearly $4 million has been paid out in compensation and the government has agreed to write off millions more in unfair debt.

Housing New Zealand (HNZ) has long since apologised for evicting considerably more than 1,000 people, after admitting that its methamphetamine testing thresholds were set far too low. It's now in the process of compensating those people, and its official policy has been changed to offer support to those struggling with drug use instead of further punishing them.

By mid-June, HNZ had considered 970 cases and paid out discretionary grants of nearly $4 million, with an average payment of just over $7,800. Payments are for costs incurred, not emotional harm.

In further moves, the government has also directed the Ministry of Social Development to write off any debt that was incurred as a result of this unfair policy. That could reach as much as $3.2 million.

It's a good start, says NZ Drug Foundation Executive Director Ross Bell. "We welcome this shift in policy and culture. It shows that, since fronting up to mistakes that were made and recognising the harm that was caused to vulnerable tenants, the government is genuinely trying to put things right.

"Our question would be, is it enough to account for all the upheaval and stress those people suffered?"

After being evicted from their homes and forced to abandon personal belongings that were supposedly contaminated, tenants were then held liable for costs including emergency housing, moving, storage, replacement furniture and bond money for a new tenancy.

Despite opposition from advocates, the practice only stopped after a report from Professor Sir Peter Gluckman, then Chief Science Advisor to the Prime Minister, which said there was absolutely no evidence that people can be harmed by third-hand exposure to methamphetamine residue. The only possible danger was if a property had been used for manufacture.

Since then, HNZ has admitted the bar was set so low that it was impossible to prove any of the evicted people had even smoked methamphetamine in the house, let alone manufactured it.

Although media reports have claimed up to 2,400 people were affected, a HNZ spokesperson said it's impossible to estimate numbers because tenancies change all the time. There is no cap on payments, which are being individually assessed on a case-by-case basis.

Acknowledging that many of the people affected may have been struggling with their drug use, HNZ has also appointed a specific team to manage any tenants who need addiction treatment, rehabilitation or other support.

Minister for Social Development Carmel Sepuloni said she was fairly sure all the people affected had been identified, and each of those people would be individually contacted. Thirty were still living in emergency housing.

Beneficiary advocates have pointed out that many people who were unable to access adequate support may have taken on additional credit card debt or bank loans or fallen prey to loan sharks. However, a spokesperson for the Minister said there were no plans to compensate for private debts. ■

Photo credit: Rob Newell for Megaphone magazine.

Garth Mullins

Crackdown is a new monthly drug and drug policy podcast from award-winning documentarian and long-time community organiser Garth Mullins. Each episode tells the story of a community fighting for its life.

Q: Where did the idea of the *Crackdown* podcast come from?

A: I'm an injecting drug user from back in the day and I'm on methadone now. Here in Canada I'm now living through my second overdose crisis. Making radio is one the skills I picked up. I've also been fighting against the drug war for a long time, and the kinds of stories I want to tell are not making it into the news, so I set up the podcast.

Q: Why is it important to hear from PWUD (people who use drugs)?

A: Because everyone else gets it wrong. The media gets it wrong. Policymakers get it wrong. Researchers get it wrong. Everybody who tries to do something about drug policy without us just fucks it up. So we realised we've got to make our own media. There's lots of conservative media in North America. They call us zombies, scumbags and criminals. When journalism is saying things like that, basically we are backed into a corner where we have to argue for our own humanity. Nobody should have to do that. But here we are, so that's the job.

Q: How is the podcast going?

A: It's going great, going better than I ever hoped it would. For example, we're getting a lot of listeners – we went to the top of iTunes here in Canada right away. Even some of the Cabinet ministers here in Canada are listening in apparently. So it's been fantastic.

It's also been terrible and heartbreaking. During the making of our second episode, we lost a member of our editorial board, Chereece Keewatin, who died. As a community, every week we are losing people to the drug war here, to the overdose crisis. You have to continue to do the work during waves of loss and destruction. That's also something that a lot of us have built up a tolerance for. But it does have an effect. We miss our friend Chereece massively.

Q: Does the podcast contribute to change or debate?

A: It's actually really hard to tell. We've heard that some politicians have listened to the show, so they might get our message directly. People are using it as an organising tool. So they'll hold a little listening party with a few people gathering around to listen to the podcast and have a discussion afterwards. Then maybe the discussion leads into some type of action. We're putting an accessible organising tool in people's hands.

Q: Have some of things you've learned surprised you?

A: Sure. We just went to Portugal, and thought, "Hey, that's great, I can go there and use drugs and that's okay." But it's actually not that simple. People projected a lot of hopes on the decriminalisation model. However, I grew to understand that there's nothing in Portugal that protects them when the overdose crisis comes calling as it eventually will everywhere, I think. Another lesson is looking at people from past struggles, like Act Up during the 80s, early 90s HIV AIDS crisis and being inspired by their activism. They were able to organise and withstand waves of loss amongst their members and leaders. And their tactics eventually broke through.

I think maybe we learn and relearn that nothing is ever given free, that you have to demand and arm twist any rights that you're able to acquire from leaders, from politicians. You need to do the organising. There are no shortcuts. There is no benevolent decision maker somewhere that is going to finally hand you salvation, so we're going to have to save ourselves.

Q: Is the language that politicians use shifting?

A: We've helped people shift their rhetoric here, too. You can get people to say from high office it's not a criminal issue, it's a health issue. But they sure as shit will fucken arrest you for possessing hard drugs. The state is still spending most of its resources on Police but not drug treatment.

This is the mode of the centrist, mushy, liberal politician. They'll pretend they are your friends, then they will gaslight you, whereas if they are conservative, they'll be your enemy. I hope it's not true where you are, but it's certainly true here.

Q: What is next for the *Crackdown* podcast?

A: We're working on decriminalisation right now. We're also doing more work on how colonisation and the overdose crisis are wrapped around each other. Housing precarity and the overdose crisis sort of mutually jack each other up and make each other worse, so we'll cover this. Another issue is how the crisis is experienced by women differently and sometimes in a sharp and more profound way than others. Policing needs to be called out. They continue to stand in the way of progress.

In terms of solutions we've got to cover how the assurance of a safe drug supply could actually end this overnight.

We're also going to look at how the crisis is different rural and remote places. In Canada it's often pretty cold, so we're going to think about how does that change things when you're forced inside when the temperature is 40 below? What type of different services do you need? What different impacts does that create?

Oh yeah, we're going to do it all. ■

RESOURCE

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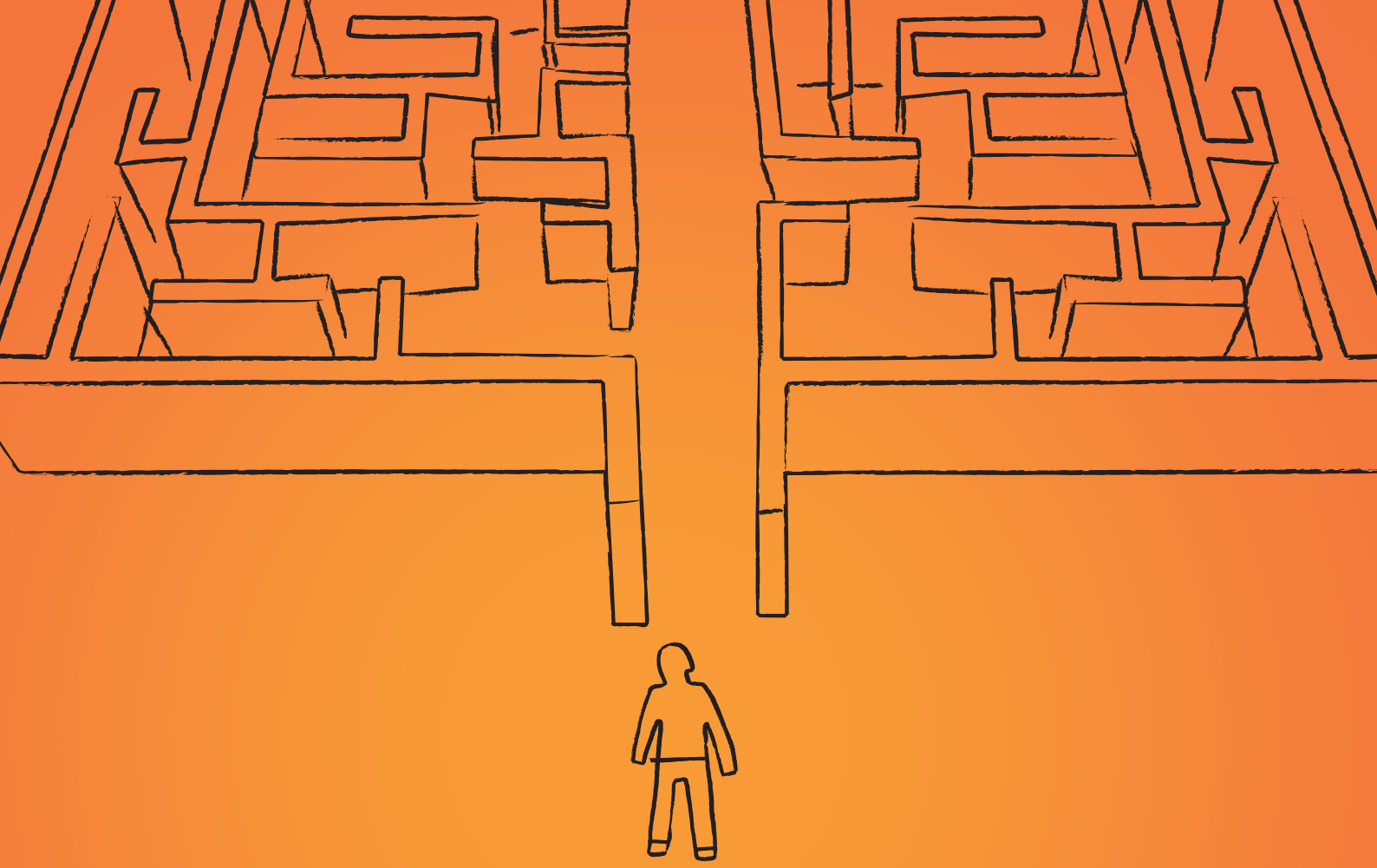
Crackdown



2019
Parliamentary
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Through the maze: Just and equitable drug law reform

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Friday 13 September, 2019
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