Matters of Substance.

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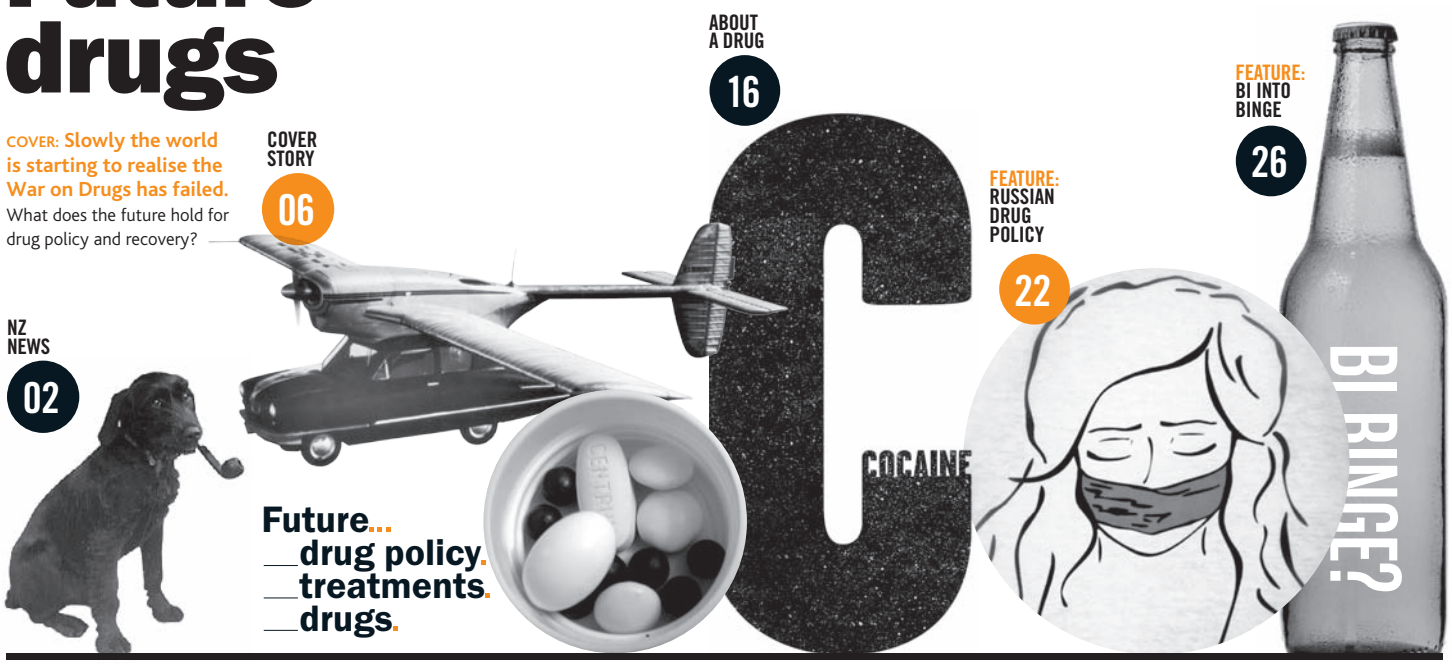
AT THE HEART OF THE MATTER, NZ DRUG FOUNDATION.
Te Tūāpapa Tarukino o Aotearoa

Future drugs

All around the world, things are rapidly changing. There are signs the War on Drugs may be running out of steam, new technologies promise new treatment possibilities, and scientific developments may be altering the very nature of drugs themselves. Here in New Zealand, bold new policy initiatives mean the treatment landscape will soon look vastly different.

Future drugs

COVER: **Slowly the world is starting to realise the War on Drugs has failed.** What does the future hold for drug policy and recovery?



FEATURES

REGULARS

Become a member

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

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

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

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THE DIRECTOR'S CUT

I'm not convinced cannabis deserves all the attention it gets.

When it comes to drug policy reform, shouldn't we be looking at all substances, à la Portugal, rather than single out cannabis? That's certainly the view of the New Zealand Law Commission, which recommended our obsolete drug law be replaced with a cautioning and health referral process for all substances, albeit with a fast track referral for more harmful drugs like methamphetamine.

ROSS BELL
Executive Director

The Commission's argument is that New Zealand's 'drug problem' is fundamentally a health and social issue best addressed through health-focussed drug law which seeks to reduce harm from all substances, not just the common one. We strongly back this position.

Yet much of the drug law debate in New Zealand, and globally, is dominated by cannabis.

I understand why this is; cannabis is the world's most popular illicit drug. 4 of the 5 percent of the world's adult population that uses illicit drugs use cannabis. 385,000 adult New Zealanders have used cannabis in the past year and about half of us have tried it; 9 percent of whom will be cannabis dependent. The total social cost of cannabis in New Zealand is $314 million, excluding the cost of enforcing cannabis prohibition (which is $116 million). So any talk about drug policy reform necessarily will focus on this high prevalence.

Daily, it seems, a growing evidence base is emerging on the health and social harms of cannabis. Last year New Zealand research received global attention when it found a link between early and heavy use of cannabis and IQ loss. This month other research queried whether cannabis use increases stroke risk. A new Canadian study highlighted the road safety risks of cannabis impaired driving. Rather than supporting the status quo criminal justice response to cannabis, this evidence reinforces a challenge against it, and towards a new public health approach where we prioritise prevention, harm reduction and treatment interventions.

You must excuse the serious cognitive dissonance displayed in this editorial. I've argued that cannabis shouldn't get special attention in drug policy debates, yet, based on shear prevalence alone the attention is deserved. I'm sure I'm not the only one confused and, to help, the Drug Foundation has decided to convene an international symposium starring cannabis.

To our international friends, I extend a very warm invitation to visit us in late November this year to attend New Zealand's second "Cannabis and Health" conference. Our website provides more detail. ■

SOCIAL

@TIM_BURGESS Can't we give Lance Armstrong a break? I tried riding a bike once on drugs. If anything, it was a lot harder. I was in a hedge within seconds. 19 JANUARY

@REEDFLEMING My parents are going away for the weekend. Dad: "How much wine have you packed?" Mum: "Heaps." #ItsInOurDNA 23 NOVEMBER

@GHETSUHM Woo. Taking the whisky-soaking cake fruit out of the oven has cleared my sinuses. And possibly dealt to that pesky sobriety... 20 NOVEMBER

@DAMIANCHRISTIE New Zealand. So clean we even call our beer and our drugs Pure. 27 NOVEMBER

@J2OR I don't have to be drunk to talk about my feelings, it's just coincidentally when I usually choose to do it. 29 NOVEMBER

KEY EVENTS & DATES

7–9 MARCH

School of Addiction
Christchurch, New Zealand
The theme for DAPAANZ's School of Addiction is people with drug use problems who have cognitive impairment – clinically assessing them and how to adapt for them.
www.dapaanz.org.nz/school-of-addiction

9–12 JUNE

2013 International Harm Reduction Conference
Vilnius, Lithuania
This 23rd conference is a must-attend for harm reduction practitioners from around the world.
www.ihra.net/conference

19–21 JUNE

Mental Health and Addiction Nursing Conference
Auckland, New Zealand
For all nurses who want to get a better handle on mental health and addiction best practice.
www.conference.co.nz/mhn13

27–29 NOVEMBER

Through the Maze: Cannabis and Health
Auckland, New Zealand
The New Zealand Drug Foundation is hosting a conference about cannabis. Essential to attend for all AOD people.
www.drugfoundation.org.nz

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NZ.

PRISON SMOKING BAN UNLAWFUL

The High Court has ruled the Department of Corrections' ban on smoking in prisons out of order.

In late December, Justice Murray Gilbert ruled the ban was "unlawful, invalid and of no effect" because it falls outside the scope of rule-making power under section 33 of the Corrections Act.

Despite the ruling, Corrections is still enforcing the ban, with Corrections Minister Anne Tolley saying it had been successful and they would not back down.

"If we need to change the law to maintain this, then that is what we will do," said Mrs Tolley.

Arthur Taylor, a prisoner at Paremoremo and the person who took the case, is now seeking a High Court ruling to force Corrections to drop the ban.

As previously reported by *Matters of Substance*, the price for tobacco in prisons has skyrocketed to over $300 for a 30 gram pouch.

02 Minor drug offences

CANNABIS		METHAMPHETAMINE	
POSSESSION	UTENSIL	POSSESSION	UTENSIL
Charges: 17,931	Charges: 11,057	Charges: 2,185	Charges: 3,899
Convicted: 13,131	Convicted: 7,563	Convicted: 1,523	Convicted: 2,765
Imprisoned: 890	Imprisoned: 737	Imprisoned: 341	Imprisoned: 548

Ministry of Justice figures show minor drug offences are taking up court time and putting hundreds of people in prison.

Over the past six years, more than 17,000 people were charged, with 13,000 convicted and 890 imprisoned for cannabis possession.

Only one in three people are being offered diversion, and nearly as many people are going through New Zealand's courts for possession as people are for dealing.

READ MORE HERE

CHECK OUT pages 18 and 19 for more details about how locking up people caught for minor drug offences is costing New Zealand.

03 'Crack' in dairies

A NEW synthetic drug marketed as Crack hit the shelves of Auckland dairies in late 2012.

Drug Foundation Executive Director Ross Bell said even illicit drug users were "gobsmacked" at the naming of the product.

"The industry has crossed the line by branding a product Crack and having drug paraphernalia on it. It's just one big piss-take because they know they can get away with this," said Mr Bell.

Associate Minister of Health Peter Dunne said the packaging was alarming.

"The issue with it seems to relate as much to the way in which it's being presented as being an imitation of the real thing rather than perhaps its contents, but nonetheless, it's pretty shabby. I think it's nasty, I think it's pernicious and I think it's unacceptable," said Mr Dunne.

04 Animal testing

ANIMAL rights activists sparked fears over whether Associate Minister of Health Peter Dunne's proposed regime for synthetic drugs will include animal testing.

Mr Dunne was quick to point out that, while animal testing was mentioned in scoping documents, no final practices had been settled and that he had expressed a preference for no animal testing.

Non animal-based testing methods, such as those put forward by Johns Hopkins University, were also in the document.

Legislation for the synthetic drug testing regime is likely to be introduced into Parliament early this year.

RESOURCES

Learn more about alternatives to animal testing at **nzdrug.org/animalalt**

05 "Alcohol and trampolines do not mix. That's just asking for trouble."

FORMER trampoline and aerobics coach Stephanie McMillan commenting on statistics released by ACC, which show over 39,000 claims for trampoline-related injuries over the past four years.

Of those, 126 were aged over 65.

"I can just imagine it; a family occasion, a few drinks, a grandkid telling nana or granddad to 'come on, come on, get on with me'."" STEPHANIE MCMILLAN

06

x8

NUMBER OF dairies in Timaru that have pledged to stop selling legal synthetic drugs.

The Safer Communities Group sent a letter to all dairies across the district asking them to stop selling the products. As of late December, only two had refused to stop selling them.

07 More booze outlets = more violence

A STUDY published in the *Australian and New Zealand Journal of Public Health* has found there is a link between alcohol availability and "negative social outcomes" in Manukau, South Auckland.

The study said increased availability of alcohol leads to greater consumption, which in turn leads to negative social outcomes.

Areas with additional off-licences were associated with 85.4 more Police events and 10.3 more vehicle accidents per year.

READ MORE HERE

Read the study at **nzdrug.org/manukaualcohol**

08 New beginnings may come to an end

FUNDING for Auckland's New Beginnings Court, which deals exclusively with people who are homeless, might come to an end after dedicated funding ended in December 2012.

The pilot programme, which has cut the arrest rate of homeless people by two-thirds, was a pilot scheme funded by Auckland City Council and several other agencies. It has yet to secure funding for 2013.

The court has been achieving impressive goals, with arrest rates for those involved in the programme being reduced by 66 percent and sustained for six months following.

Also, bed nights in prison reduced by 78 percent during participation in the court's programmes and by 60 percent afterwards. Emergency department visits were reduced by more than 15 percent.

09 **QUITLINE NUMBERS**

400

NUMBER OF SMOKERS WHO CONTACTED QUITLINE ON 1 JANUARY 2013.

THE INCREASE ON THE PRICE OF TOBACCO EXCISE AS OF 1 JANUARY 2013.

11.1%

JAN

8,222

NUMBER OF PEOPLE WHO SIGNED UP TO QUITLINE IN THE MONTH OF JANUARY 2013.

2012

15,000

NUMBER OF PEOPLE WHO USED QUITLINE TO STOP SMOKING IN 2012 AND WHO HAVE REMAINED SMOKEFREE.

World.

01 Colorado down to business

AMENDMENT 64

COLORADO state officials are hammering out the details of legalising possession of small amounts of cannabis after citizens voted for the measure late last year.

Governor John Hickenlooper has convened a task force to work out the regulations needed to put Amendment 64 into practice.

Some rules are already known, such as extensive background checks, almost $500,000 in deposits, licensing and application fees, as well as 24-hour video surveillance and every plant must be tracked with extensive records kept.

The Colorado Department of Revenue, which will have responsibility for regulating the sale of cannabis in the state, has said they expect it to be challenging.

One factor was that cannabis is still illegal under federal law. Because of this, banks, which are federally regulated, face legal risks for taking in funds from the sale of narcotics. Also, the Drug Enforcement Agency has remained quiet about its stance on the issue of legalisation in Colorado and Washington.

This did not stop the state's first legal 'pot clubs' opening, one of which celebrated on New Year's Eve with a BYO cannabis party and a screening of *The Big Lebowski*.

02 Fitzroy Crossing and FASD

50 percent of 8-year-old Aboriginal children in Fitzroy Crossing, Western Australia, suffer from foetal alcohol spectrum disorder (FASD).

The study by the Lililwan Project also found there were 55 deaths in 2007 caused by alcohol in the small community – 13 of them suicide.

The study has implications for the Northern Territory and Queensland governments, which plan to deregulate drinking in Aboriginal communities that had previously decided to be 'dry'.

READ MORE HERE

Read the full study at **nzdrug.org/fitzroycrossing**

03 Portugal battles legal highs

SYNTHETIC drugs are becoming popular in Portugal among people looking for legal highs.

Portugal's National Health Director Alvaro Carvalho said consumption of these substances had increased dramatically, and they were seeing serious consequences.

"Since January, four people have died and 170 others have needed hospital treatment for psychotic episodes and cardiac complications," said Carvalho.

The regional government in Madeira has closed shops selling the products, and the national government has plans to follow with a Bill.

As has been seen in other jurisdictions, synthetic drug makers switch the chemical make-up of their products as each new substance is outlawed.

04 US$13m more for drug courts

US PRESIDENT Barack Obama has requested $13 million more for drug courts and treatment in 2013 than in 2012.

The US now has approximately 2,700 drug courts, with an estimated 120,000 people referred to treatment instead of jail.

Spokesperson for the White House Office of National Drug Control Policy Rafael Lemaitre said that, in the previous fiscal year, the Obama administration had spent $10.4 billion on drug prevention and treatment programmes compared with $9.2 billion on domestic drug enforcement."

2.5m

05

WHO ESTIMATES 2.5 million people die each year because of alcohol, and it accounts for 5.5 percent of total global burden of disease and premature death.

The World Health Organization's global burden of disease report, published in December 2012, shows that alcohol has become the third biggest contributor to the global burden of disease after high blood pressure and smoking.

The data also showed that alcohol was becoming more of a factor in bad health in developing nations.

READ MORE HERE

Information on the global burden of disease report was published in the *Lancet* and can be found at **nzdrug.org/globalburden**

06 $1.9 BILLION

THE AMOUNT HSBC paid in a financial settlement for laundering billions and billions of dollars for Colombian and Mexican drug cartels after the US Department of Justice (DoJ) decided not to pursue criminal charges. Recently, HSBC has admitted it laundered money for drug cartels for over a decade.

Rolling Stone's Matt Taibbi recently decried the DoJ for not prosecuting HSBC executives and the company. Taibbi says the $1.9 billion is only a fraction of the total money laundered, and the DoJ's reasoning is unsound when compared to the punitive approach law enforcement takes against low-level drug offenders.

READ MORE HERE

Read the full *Rolling Stone* story at **nzdrug.org/HSBCjoke**

07 Proximity to alcohol matters

RESEARCH from the Finnish Institute of Occupational Health showed having a bar within 1 km of your home increases the odds of you becoming a heavy drinker by 17 percent.

The longitudinal study followed more than 54,000 Finns for seven years. It analysed how their patterns of alcohol consumption changed when they moved closer to a bar or when a bar opened near them.

Among people who were an average of 0.12 km from the nearest bar, over nine percent were heavy drinkers. Of those 2.4 km away, some 7.5 percent were heavy drinkers.

READ MORE HERE

Read the full paper at **nzdrug.org/UMCPJS**

08 Cannabis dropped

D.A.R.E. has announced it will no longer talk to 10- and 11-year-olds about cannabis, saying it is inappropriate for the age group.

In a one-page curriculum document, the non-profit said, "The two most common and dangerous drugs with which elementary-aged students have knowledge or familiarity are alcohol and tobacco," and because of that, it makes sense to remove cannabis from its programme.

D.A.R.E. is yet to publicly comment further about the reason for the change.

09 Bolivia wins on coca

BOLIVIA has won its bid to rejoin the 1961 Single Convention on Narcotic Drugs after the United Nations' anti-narcotics convention recognised the right of Bolivia's indigenous people to chew raw coca leaf.

Bolivia's president Evo Morales said it was a moral victory for his people.

"It's not easy to change international legislation, particularly when 25 years ago they had decided to eliminate the coca leaf and, with it, our culture," Morales said.

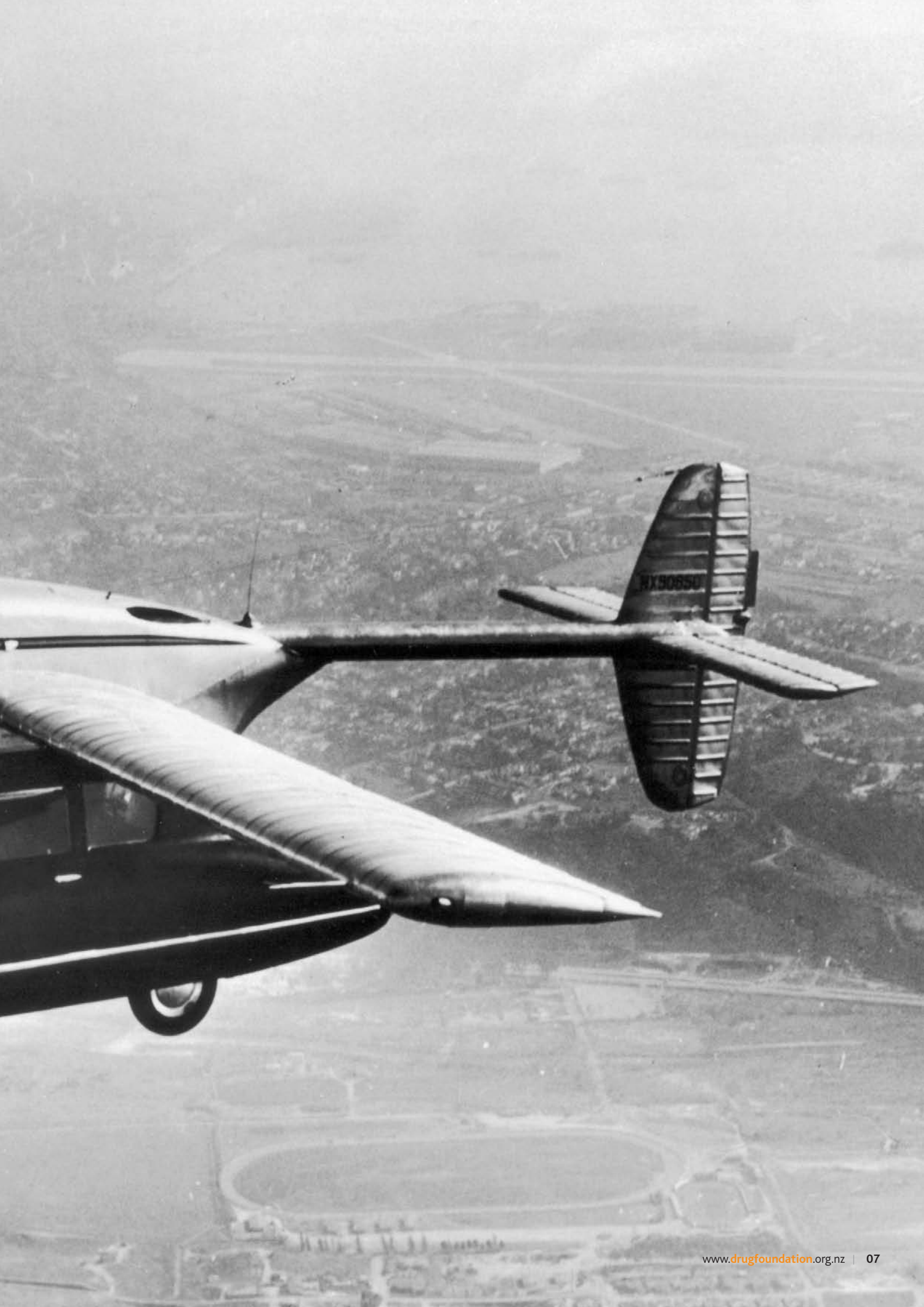
Only a bloc of 15 countries, led by the US and UK, voted against the exemption, with all South American nations voting for it.

Bolivia withdrew from the treaty in 2011 after a change to their constitution to protect the traditional rights of indigenous people.

Coca has been chewed for over 6,000 years in the region for its health benefits.

Future drugs

All around the world, things are rapidly changing. There are signs the War on Drugs may be running out of steam, new technologies promise new treatment possibilities, and scientific developments may be altering the very nature of drugs themselves. Here in New Zealand, bold new policy initiatives mean the treatment landscape will soon look vastly different. **Rob Zorn** talks with a few experts about what we can expect to see over the next few years.



Future drug policy.

> **“Americans aren’t just thinking about it any more. They are ready to cross the threshold now and actually do something.”**
>
> Kasia Malinowska-Sempruch

ROB ZORN

REGULATED cannabis use is now legal in two American states, and the signs are other states will follow. Does this amount to an undermining of America’s staunch prohibitionist stance? And what implications might that have for future international drug control policy?

It seems many of the hard lines in the War on Drugs are slowly turning into soft and widening cracks.

Holland’s regulated cannabis cafés have been famous for years, but other countries have gone much further.

Portugal, for example, has become the poster state for drug law reformers globally. In 2001, it decriminalised all drug possession for personal use, resulting in plunging HIV rates, more receiving addiction treatment and an overall decline in drug use.

Uruguay has announced plans to legalise state-controlled cannabis. Colombia’s and Guatemala’s presidents have called for a debate on legalisation to help reduce drug-related crime. Costa Rica has decriminalised personal use, and Brazil and Argentina have referenda coming up on whether to do the same.

Most shocking and perhaps most promising of all, however, were the referenda held in the November 2012 American elections that legalised cannabis in Washington and Colorado.

What’s remarkable about this is that America has long been the stronghold of global prohibitionist mentality. This is a country where more than a million people (up to half the prison population) are incarcerated for drug offences at any one time. In fact, until recently, prohibition has been embedded so deeply in the American psyche that openly supporting drug policy reform has been a complete non-starter for most politicians.

Director of the Global Drug Policy Program at the Open Society Foundation Kasia Malinowska-Sempruch says it can’t be emphasised enough that the changes in the successful states were not pushed through the legislature; they came from the voting public.

“Anyone who’s had a dinner table discussion about drug policy knows there is significant support for reform in America, and there’s a growing understanding that the War on Drugs has failed. The numbers show Americans aren’t just thinking about it any more. They are ready to cross the threshold now and actually do something.”

And ironically, it’s been America’s enthusiastic investment in the War on Dugs that has hugely contributed to changing public opinion.

Malinowska-Sempruch believes people are now starting to see that the epidemic of arrests, debilitating stigma, mass incarceration and disproportionate penalties have not achieved any of prohibition’s stated goals. And news stories about the savage drug war butchery that happens almost daily in places like Mexico are perhaps making many wonder whether those espousing alternatives are worth another listen.

“America’s certainty has now become irreversibly fractured. It’s going to be difficult to continue pushing such a hard and simplistic line when your own people and neighbours are all saying something different.”

Mike Trace

“They’ve also seen that the sky doesn’t necessarily fall when you introduce new drug policy models,” Malinowska-Sempruch says.

“The cafés in Holland did not provoke a massive spike in drug use. In fact, lifetime cannabis use there is lower than for many European countries, and among 15 to 16-year-olds, it is much lower than in the US. Similarly, Portugal did not witness an explosion of drug use when it decriminalised.”

And what’s happened in Washington and Colorado may just be the tip of the iceberg. Oregon also had a referendum to legalise recreational cannabis use, which only narrowly failed. Rhode Island and Maine have signalled plans to introduce similar legislation, and California almost crossed the legalisation line with Proposition 19 during the November 2010 mid-term elections.

It is likely even more American states will now be emboldened to pursue their own policies, and perhaps most importantly, politicians will be less reticent about their support for a public health approach. How quickly reform will spread across the US remains to be seen, but there’s little doubt there will be increased pressure on the federal government to relax domestic War on Drugs policies at a national level.

In fact, says Malinowska-Sempruch, the response to Colorado and Washington from the White House will be interesting as cannabis use is still illegal under federal law.

“Will the federal government sue? Will the Drug Enforcement Administration start patrolling the streets of Denver and Seattle? That all seems pretty unlikely.”

The Obama administration is indeed in a difficult position. On the one hand, it is committed to prohibitionist UN drug conventions, but it also has a responsibility to uphold democratic change. If it does try to counter the Washington and Colorado referenda, its most likely approach will be to hold state officials criminally accountable for administering legalisation and regulation, but the changes in public opinion probably mean this will be an unpopular move.

America is also facing international pressure to relax its hardline approach at home. Colombia, Mexico and Guatemala have all called on the US to consider other approaches such as decriminalisation. These are producer or transit countries that have long been plagued by black market violence and crime as a result of illegal drugs largely destined for the US.

How much this internal and external pressure will affect the international drug control policy stage, where America has such a strong and conservative voice, is presently anybody’s guess. But at the very least, Malinowska-Sempruch speculates it should encourage the sort of debate that has been suppressed until now.

“It’s been bottled up for so long, and perhaps now these initiatives will set off lots of calls for discussion at state, federal and international levels. There isn’t a country on earth that hasn’t been affected by bad drug policies,” she says.

Mike Trace, Chair of the International Drug Policy Consortium, says America’s prohibitionist influence has been slowly waning in the face of undeniable successes in places like Portugal.

“But with public opinion changing and the Latin American countries saying they’ve had enough, America’s certainty has now become irreversibly fractured. It’s going to be difficult to continue pushing such a hard and simplistic line when your own people and neighbours are all saying something different.”

Nevertheless, Trace doubts there will be an immediate global rush towards something like the Portuguese model.

“There are plenty of states, such as Russia and some Asian countries, still wanting to eradicate their way out of this social problem, so I think we’re yet a long way from finding the sort of consensus that will result in worldwide drug policy reform.

“One thing we could get broader agreement on is moving away from arrests and harsh punishments for people who use drugs. We are seeing a growing consensus that the money used for incarcerating and punishing users is not at all money well spent.”

And while hardliners remain, UN leadership seems well aware there is a new global mood for change. Trace says a General Assembly Special Session on global drug control strategy, originally scheduled for 2019, has been rescheduled for 2016.

“At the UN, where everything happens at a snail’s pace, bringing something forward by three years amounts to great urgency.”

So what happens during the years leading up to 2016 will be really important. Organisations like the International Drug Policy Consortium will be doing what they can to influence UN leaders and ambassadors towards a more enlightened approach, but the future of global drug policy may well depend significantly on just what America does next.

Future treatments.

IF there’s one thing we know about future addiction treatment in New Zealand, it’s that things will be very different – and perhaps in unexpected ways. Resources will be tight and demand will be high, but could new advances in computerised treatment be the answer to all our problems?

Co-chair of the National Committee for Addiction Treatment Robert Steenhuisen says government policy released during

> **“Health Workforce NZ predicts a doubling in required treatment over the next decade. But this is all occurring against a background of increased demands for accountability and efficiencies, and there will only be a modest increase in funding.”**
>
> Robert Steenhuisen

2012 presents a pretty bold vision for New Zealand’s mental health and addiction sectors that will require innovation in how future treatment needs are met.

“The first thing that becomes abundantly clear is that we will need to do much more with the same or fewer resources,” he says.

“Increasing younger and older populations, ethnically diverse groups and the knowledge that alcohol and drug problems have a significant impact on other sectors like education, health, welfare and justice mean demand for services is only going to increase.

“In fact, Health Workforce NZ predicts a doubling in required treatment over the next decade. But this is all occurring against a background of increased demands for accountability and efficiencies, and there will only be a modest increase in funding. We simply have to find ways to be much more efficient.”

Traditionally, addiction services have understood their target as being the 3 percent of the population most impacted by mental health and addiction problems, but Steenhuisen says a new ‘whole of population’ approach will mean a reorientation towards earlier intervention and a much broader focus on the wider impact of substance abuse.

You’d have to wonder how the New Zealand treatment sector is going to cope.

One way might be by embracing new developments in interactive computerised technology being used to augment conventional treatment overseas and providing enhanced outcomes and more efficient use of counsellor time.

For example, computer-based training for cognitive behavioural therapy (CBT4CBT) developed by Yale University’s School of Medicine, uses videos, quizzes and games to help patients recognise and avoid situations that put them at higher risk of using and to teach skills for refusing drugs and coping with cravings.

CBT4CBT trialled well, with 66 percent of participants returning drug-free urine samples for longer, as opposed to 47 percent who did not use CBT4CBT. In the trial, it was used with patients before their twice-weekly sessions with counsellors, and its developers suggest it works so well because it helps patients focus on their most acute problems when they meet with clinicians.

The Community Reinforcement Approach Plus Vouchers programme (CRA+), developed by the National Development and Research Institute in the US, also uses videos, quizzes and games to teach abstinence and life skills, such as self and financial management.

However, CRA+ can also interface directly with a clinic’s urinalysis equipment. It analyses samples and prints out motivational monetary vouchers where they are negative. If samples are positive, it identifies the drug traces present and goes through interactive exercises with the patient to assess the circumstances of their drug taking and develops a personalised plan to help the patient avoid using in future.

The Video Doctor is part of a computerised program called Positive Choice, which has been trialled at five clinics in the San Francisco area. Clients log in to Positive Choice in a private area of the clinic. If they report drug taking or some other risky behaviour, such as unprotected sex, the Video Doctor appears and makes a brief intervention by selecting the most appropriate from a large store of files and video clips.

After their Video Doctor session, the client receives a printout out summarising the main points covered along with some suggested next steps. Their physician receives a summary of their risky behaviours, suggested counselling approaches and a list of appropriate treatment centres.

Video Doctor’s proponents say one of its strengths is that it overcomes factors that may impede assessment and counselling such as discomfort with talking about sexual practices and drug use and patients’ fear of stigma.

The Dartmouth Psychiatric Research Center in New Hampshire has produced a range of internet and mobile phone technologies that also offer evidence-based psychosocial interventions including goal setting and monitoring, drug use analysis, self-management, drug refusal skills, problem solving and counselling. They are currently developing a model especially for people with co-existing problems.

Along with cost savings, computerised interventions promise to increase access to treatment because counsellors who delegate some of their routine clinical functions to computers will be able to

> **“An awful lot of treatment could be delivered using computers. In fact, there’s not a lot that can’t.”**
>
> Fraser Todd

schedule more patients. But how likely is it this sort of technology will catch on in New Zealand and what sort of difference could it make here?

According to National Addiction Centre Deputy Director Fraser Todd, these interventions can be as effective as one-to-one counselling for people with mild to moderate problems, and the cost savings and efficiencies they bring make their use here inevitable.

“An awful lot of treatment could be delivered using computers. In fact, there’s not a lot that can’t,” he says.

“I suspect they could even make clinicians redundant for a wide range of problems.”

What Todd means is that a person with mild to moderate needs may not need to see a clinician or may not need one right away, because they could receive computer-based treatment supervised by someone differently qualified. A nurse with general skills, for example, could work through a programme with a drug-dependent person and rely on the software for the in-depth knowledge about drugs and counselling required.

“It won’t work for everyone, and we’re always going to need clinicians for more serious cases, but I can see a real shifting of roles occurring in the future, especially towards primary care, as computerised interventions become more mainstream,” he says.

While there has been some work done in New Zealand’s addiction treatment sector around computer-based education programmes, it is unlikely we’ll be developing anything of our own to rival overseas interventions any time soon. And there’s probably no need to.

Todd believes we should simply buy the software from overseas developers, most of whom, he says, would be willing to supply modified versions that are culturally appropriate for New Zealand.

> **“...I can see a real shifting of roles occurring in the future, especially towards primary care, as computerised interventions become more mainstream.”**

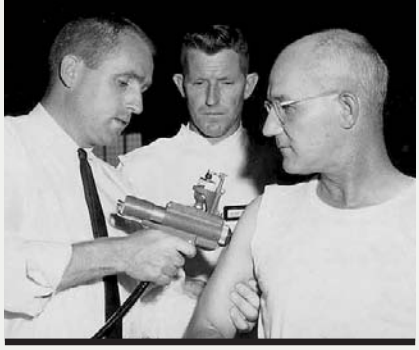
“The Dartmouth program, for example, sell for about the cost of two clinicians’ annual salaries. And when you think about the efficiencies and cost savings involved, buying them just makes good sense on all sorts of levels.

“But the question this raises, of course, is what are we going to do with all our surplus clinicians?”

And yes, he’s serious. Computer-based interventions could downsize the need for clinicians so much that a lot could find themselves out of work.

“Sure, this stuff is still in its infancy, even in the States, but it’s the sort of thing that will take off very quickly. There’s a real risk that some enthusiastic government is going to do the maths, see the potential savings and try to put this in place here overnight.

Getting your anti-drug shot



THEIR KIDS starting smoking is every parent’s nightmare. Most will dabble with cigarettes at some stage, and many will become addicted.

Wouldn’t it be great if we could just have our kids vaccinated for nicotine (or any other drug – like methamphetamine, for example) at the same time they get their shots for measles, mumps and rubella?

Well, a study published in *Science Translational Medicine* in June 2012 claims just such a thing is not only possible, it already exists.

According to Dr Ronald Crystal, Professor of Genetic Medicine at New York’s Weill Cornell Medical College, a vaccine can be created to prevent addiction to any substance, from nicotine to methamphetamine, for the rest of one’s life.

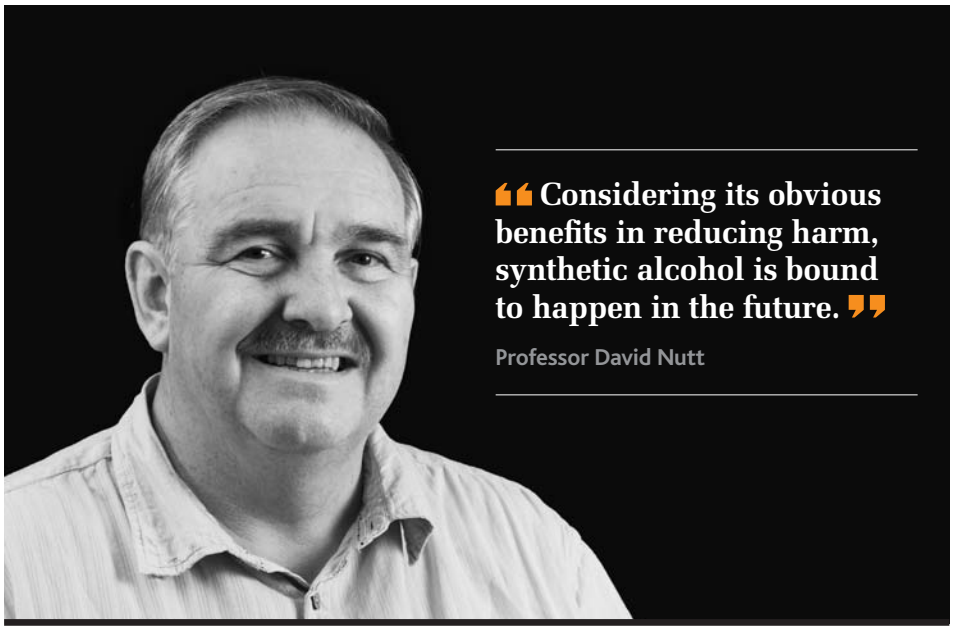
The vaccine works in exactly the same way as one used to prevent disease. A small amount of a specific type of drug is introduced to the body, causing the immune system to create antibodies. Before the drug can pass through the blood to the heart and brain, the antibodies destroy it, making it impossible for the user to feel the drug’s effects – a bit like what happens with varenicline tartrate (Champix).

The difficulty until now has been that molecules within addictive substances like cocaine, methamphetamine and nicotine are so small, they tend to be ignored by the immune system. To combat that, scientists created synthetic versions of the molecules and attached them to larger proteins, which makes them a little more noticeable. Finally, they add what is known as an ‘adjuvant’, a chemical mix created specifically to attract the immune system.

In Dr Crystal’s study, the process worked really well with mice. Scientists are now preparing to test the vaccine in rats and then primates before humans.

"It's really important we take the time to implement it properly, say over 3–5 years, and that the government works with the treatment sector to make sure risks like this are managed."

And, of course, computerised interventions will never be the answer to all our problems. In fact, they are likely to introduce a few new ones, and New Zealand having to deal with having too many treatment specialists will be a very unique problem indeed.



Future drugs.

WOULDN'T it be great if you could enjoy the pleasures of alcohol without all the negatives, such as hangovers, liver cirrhosis and drunk-driving convictions? Professor David Nutt thinks current scientific ability to target specific areas of the brain means such a drug may not be too far off and that 'synthetic alcohol' could also function as an effective treatment tool for alcoholism. And if we can make synthetic alcohol fly, what else might we be able to do?

Medical problems associated with alcohol are increasing alarmingly in the developed world. Deaths from liver disease are rising rapidly and may soon overtake heart disease as the biggest killer.

In fact, a recent assessment of drug-related health hazards in the UK scored alcohol as the worst drug overall. It is so toxic that, if introduced today, it would be among the most controlled of substances. And it is a poison without an antidote.

Alcohol is metabolised into acetaldehyde, which literally pickles the liver (and other organs) over time, leading to acute illness and death.

And alcohol has a number of more immediate effects because it affects so many different GABA neurotransmitters, of which there are many subtypes, in the brain. These effects include loss of inhibition, memory impairment, sedation, relaxation and interrupted motor neuron control.

Professor David Nutt, former advisor to the UK Government on drug policy, thinks it is high time we used what we know about neurons and how to target them to develop safer, alternative intoxicants that deliver the same results as alcohol but without the harms.

He suggests that, with current knowledge, it would be possible to develop a substance that targeted the GABA neurotransmitter subtypes that affect relaxation and

Addiction-proof painkillers

OPIOID PAINKILLERS have long been a two-edged sword, and the world is full of people who once had chronic pain but now have addictions to their medication. For years, scientists have been trying to separate the pain-relieving characteristics of opioids from the addictive high they offer, and until now, most thought it impossible. A recent study published in the *Journal of Neuroscience* has found a drug that not only reduces the addictiveness of prescription painkillers but also boosts their effectiveness.

The drug, (+)-naloxone, is a molecular mirror-image of the drug naloxone, which is used as an overdose antidote. In the study, scientists found that, when rodents were given a combination of (+)-naloxone and opioids, the drug seemed to prohibit the expected effects of the opioids.

When given an opioid such as morphine, test subjects displayed the usual characteristics of addiction, including self-administering the drug. However, when given a dose of (+)-naloxone with the opioid, the subjects exhibited no characteristics of addiction.

Lead author Dr Linda Watkins of the University of Colorado says she thinks that, when administered, the drug interacts with glia, immune cells that make up 90 percent of the brain. When standard opioids or painkillers are administered, glia enhance the activity of the neurons that respond to the drug. However, over an extended use of painkillers, they become increasingly active, reducing the drug's pain-relieving effect and increasing tolerance. Ironically, as glia become more active, they also produce pain, effectively eliminating the painkilling effects of the opioid.

But when (+)-naloxone is introduced, it has an immediate calming effect on glia by blocking a type of receptor they contain. By calming the glia, less pain is caused, more is prevented, and negative effects such as addiction and tolerance are severely reduced.

Watkins isn't yet ready to call the drug a success as positive results on humans are yet to be conducted. But lots of things that work on rodents can be made to work with humans so she admits to being excited at the new possibilities this discovery holds for the future of both pain relief and opioid addiction.

intoxication in the brain in the same way as alcohol but do not affect, for example, the subtypes controlling memory or steadiness.

Furthermore, the benign effects of consumption could be reversed by antidotes. He points out that antidotes already exist for some of the effects of benzodiazepines, which stimulate GABA action in much the same way as alcohol. If adapted for alcohol, this would mean, effectively, you could 'take a pill' after indulging in a heavy drinking session and be perfectly safe driving home.

And of course, other benefits to synthetic alcohol would include that it doesn't target neurons associated with addiction and that it would not break down into toxic acetaldehyde and slowly but surely kill your liver and you.

"Considering its obvious benefits in reducing harm, synthetic alcohol is bound to happen in the future," Professor Nutt says.

"What's probably making this unviable at the moment is the implicit assumption by the public and legislators alike that alcohol is a foodstuff rather than a drug. Current regulations mean that replacing alcohol with a 'real drug' would be challenging. It might have to pass the same safety hurdles as medicines rather than the much lower hurdles for foods.

"These futuristic drugs are almost exciting as flying cars, jetpacks and meals in a pill, but no doubt they will come with a raft of challenges."

"But if governments signalled they wanted a safe alternative to alcohol, I am sure the combined skills of the pharmaceutical industry and academia could rapidly produce viable candidates."

Nutt admits synthetic alcohol would not quickly become a ready substitute for the average drinker. Those who enjoy going out to a wine bar or who like a few 'brews with the bros' are not going to see a flavoured cocktail with added artificial alcohol as an attractive alternative.

But for those whose purpose in drinking is primarily to get drunk rather than to savour deep cherry undertones or the light refreshing bitterness of Pacifica hops, it might be just what the doctor ordered. Quite literally.

While ordinary members of the public could conceivably choose to take synthetic alcohol to a party rather than their usual six-pack – sober drivers, for instance, or those with a big day at work tomorrow – its most immediate benefits are for those in treatment or needing to reduce the harms associated with their consumption.

Being non-addictive and far less physiologically destructive, synthetic alcohol could be used as replacement therapy in much the same way methadone is used for those addicted to heroin and other opiates. So, synthetic alcohol as an approved medication could be a first step towards mainstream acceptance, once governmental red tape is overcome.

Eventually, those whose alcoholism is only in early stages could be encouraged towards a synthetic alternative, and some may avoid what might have been an inevitable addiction by choosing it early on.

Nutt first proposed the notion of synthetic alcohol in 2004, and the idea is catching on. A 2008 Sigma Scan (by the UK Government Office for Science) predicted the advent of just such a drug. In fact, it went much further, suggesting enhancement through lifestyle drugs may well become the norm in the future as we get better at targeting certain receptors in the brain.

'Cogniceuticals' could improve memory, our ability to learn and even our decision-making abilities. 'Emoticeuticals' could enhance our responses in private life or in challenging work situations, such as those that demand high motivation. 'Sensoceuticals' might enhance pleasure by restoring or accentuating the senses. Special sleep drugs could condense a refreshing night's sleep into a few hours or allow us to skip bed altogether with no ill effects.

These futuristic drugs are almost exciting as flying cars, jetpacks and meals in a pill, but no doubt they will come with a raft of challenges and ethical implications that governments will need to sort through.

"In the meantime, though," says Nutt, "governments should be doing all they can to expedite production of substances like synthetic alcohol. What's at stake for them here is a future with fewer substance-addicted citizens." ■

Rob Zorn is a Wellington-based writer.

RESOURCES

- For references to this article, please see the online version at **nzdrug.org/futuredrugref**

I-Sniffbot

EMERGENCY and security services have always relied heavily on the sniffing abilities of dogs. From searching for disaster survivors to following the trail of wanted criminals, dogs have always done it best.

Their olfactory abilities have also done our canine servants proud in detecting illicit drugs and other unwanted substances at our borders, but Professor Ken Grattan of London's City University believes we may now have an even better option. He heads a team developing the world's first robot sniffer.

Nicknamed the cargo-screening ferret, the robot will have an artificial sense of smell capable of sniffing out any number of programmed odours. The sensors are made up of chemically coated optic fibres that would glow when contact is made with a targeted aroma.

While many would argue you can't beat a dog's natural sense of smell, Professor Grattan says a robot can do things no dog can. For example, dogs tire, get hungry, make mistakes and require the constant care of at least one trained professional. They also tend to slobber a bit and can be a bit pongy themselves. Robots, on the other hand, would be fully automated and capable of running for 24 hours a day without any need for reward or encouragement.

However, there are still drawbacks with the robot that would need to be overcome.

For one, the robot would only be capable of detecting odours it had been programmed to identify. Replicating specific odours and programming robots to detect them is still tricky, and science is yet to match a canine's natural sense of smell.

Further, robots aren't yet able to detect the difference between a combination of smells, which means they would struggle to identify a programmed odour if one or more other odours were detectable at the same time.

And while it's probably inevitable they'll one day replace their canine counterparts, the robots probably won't be anywhere near as cute.

Why the UN needs civil society

Whether building bridges or breaking dams, civil society is crucial when dealing with drug, crime or terrorism, writes **Yury Fedotov**, Executive Director of the United Nations Office on Drugs and Crime (UNODC).

MANY civil society organisations provide important research, do valuable field work and make a sizeable contribution to policy development in the area of problem drug use. Therefore, the UNODC sees civil society, as an equal partner. It needs to be listened to and respected for its expertise.

Although the driving force behind UNODC's work are the UN Conventions on drugs, crime and corruption, as well as the international instruments on terrorism, our ability to deliver on this mandate is often reliant on civil society organisations. For this reason, UNODC has developed many years of engagement with them. The importance of the relationship is heavily emphasised in our Strategy for 2012–2015 and translates into close working relationships in the field. Indeed, UNODC works with numerous organisations across the world on a wide range of activities.

These activities include work on alleviating the suffering of people who use drugs and their families; we also work together on empowering the victims and witnesses of crime. Elsewhere, we are strong partners with civil society in the fight against corruption and the need for effective criminal justice systems.

Just as importantly, this collaborative work is regularly carried out in difficult environments. We are often in weak and fragile nations, especially countries that have only just escaped from conflict and which are slowly moving along the path towards democracy.

I should add that such joint activities also represent the wishes of Member States who believe in the importance of transferring knowledge, skills and information across organisations in order to enrich their operations. Such activities are vital to ensure good policy is bound to sound operations.

The converse, however, is also true. For operations to succeed, they must also be driven by prudent policy. This is why the Commission on Narcotic Drugs (CND), and UNODC's secretarial role for the drug conventions are so important. The annual CND is also enhanced by civil society's participation as observers.

UNODC has also established effective working partnerships with umbrella organisations such as the Vienna NGO Committee on Drugs (VNGOC). They allow for coordinated and effective civil society participation in the CND, while bridging the gap that often exists between international policy-makers, national authorities, and civil society.

Civil society has also provided excellent contributions to the high level segment of the 2009 CND through the "Beyond 2008" project, undertaken jointly by UNODC and the VNGOC. The event gave a platform to 900 people representing thousands of organisations within their networks and millions of members in around 145 countries.

There are other situations where the voice of civil society has made a difference. Some civil society organisations, for example, have shown how the drug conventions have been overruled in some countries producing greater suffering for cancer patients due to shortage of opiates available to alleviate their pain. The campaign led to a CND resolution aimed at addressing this gap, and it shows how policy can be successfully allied to experience in the field.

I would also encourage civil organisations to continue to be the eyes and the ears of society and to constructively contribute to the CND. I participated in the first informal Civil Society Hearing during the 2012 Session of the Commission CND and I am planning to do so again this year.

The meeting provides a welcome space where civil society, UN Member States, and key international bodies can exchange views and discuss best practices in the area of drug policy. It is likely that this year the focus will be on civil society contributions to the 2009 Political Declaration and Plan of Action. With this in mind, UNODC will continue to support the work of civil society and to take an active role in promoting the dialogue between civil society and Members States.

Whether building bridges between organisations, or breaking the dams that hinder their effective action, civil society organisations play a leading role in the area of drugs, crime and terrorism. Over the years, mutual suspicion has given way to mutual respect to everyone's mutual benefit. Today, civil society is listened to and much admired wherever it works.

My role, as head of UNODC, is to ensure that our enduring partnership continues on this path and delivers assistance to the millions of people around the world who need us most. ■


“I encourage civil organisations to continue to be the eyes and the ears of society and to constructively contribute to the CND.”

“If you got bad news, you wanna kick them blues; cocaine. When your day is done and you wanna run; cocaine. She don’t lie, she don’t lie, she don’t lie; cocaine.”

JJ Cale, *Cocaine*

It comes from a plant grown deep in the jungles of South America. Planted, picked and processed by peasants, the shimmering white powder crosses borders and finds its way up noses and into the veins of people around the globe. Portrayed as one of the most glamorous drugs, cocaine has made a huge splash in pop culture and left a huge scar on South America.

THE thin oval leaves of a scrubby bush known as the coca plant have long been important to the people of South America. The Moche and Incans knew chewing the leaves could help reduce fatigue and combat altitude sickness. It was a gift from the gods.

Coca first travelled across the Atlantic in the 1600s where it was often chewed like tobacco. In the 1800s, it became a popular craze among the well to do of Europe, with Pope Leo XIII giving papal endorsement to a coca-treated Bordeaux wine.

In the 1850s, Paolo Mantegazza, an Italian neurologist, started chewing coca leaves and was enamoured by its effects, writing, "I sneered at the poor mortals condemned to live in this valley of tears while I, carried on the wings of two leaves of coca, went flying through the spaces of 77,438 words, each more splendid than the one before."

In 1859, inspired by Mantegazza's work, German chemist Albert Niemann isolated the primary alkaloid from the leaves and named the product cocaine. Also like Mantegazza, he couldn't help but test the substance out. Writing about the experience in his dissertation, he said it has a bitter taste, promotes the flow of saliva and leaves a peculiar numbness, followed by a sense of cold when applied to the tongue."

Cocaine was heralded as a medical miracle, used in everything from lozenges to pep pills and, of course, Coca Cola. Renowned Antarctic explorer Ernest Shackleton took liquid cocaine to drip onto the eye as a cure for snow blindness and Forced March pills, a blend of cocaine and caffeine. The pills' directions suggested "one to be dissolved in the mouth every hour when undergoing continued mental strain or physical exertion".

Today, cocaine is hardly used medicinally. Use of cocaine and its synthetic derivative is confined to anoesthetic for nose and throat operations because of its vasoconstricting properties. Most medical research involving cocaine now is focused on understanding its addictive properties and the harm it causes.

To quote Rick James, "Cocaine is one hell of a drug." It is a serotonin-norepinephrine-dopamine reuptake inhibitor, and its effects last for up to an hour depending on how it is taken. Commonly, the powder form is snorted through the nose, but it can also be injected and smoked. It gives an initial rush of euphoria, alertness and numbness and increases blood pressure and heart rate. The rush wears off fast and is followed by discomfort, depression, paranoia and a strong craving for more.

Extended use has many negative consequences from hallucinations and paranoia (think *American Psycho*) to impotence, heart problems and, if the user is snorting, disintegration of the nasal membrane.

Look at pop culture and you'll see a fine layer of cocaine dust. From Sherlock Holmes using the tincture to inspire his investigations to Tony Montana sitting behind a snowy mountain, it has been idolised as the drug of choice by the rich and famous.

Robert Louis Stevenson used cocaine to hurriedly rewrite the entire Dr Jekyll and Mr Hyde manuscript. Eric Clapton and Stevie Nicks sang about it and many movies depict cocaine use as a central plot. After cannabis, cocaine is the most commonly shown drug in movies. There is a strong culture of movie stars themselves becoming addicted to it.

Joking about his addiction, Robin Williams said, "Cocaine is God's way of saying that you're making too much money." Williams has a valid point. Plantation prices are cheap. In the risky process of reaching high demand markets – the USA and Europe – the price skyrockets. In 2010 across Europe the average retail price of one gram was $NZ297, and in the USA it was $NZ201. Street prices in New Zealand can range from $350–$800 a gram.

"I suppose that its influence is physically a bad one. I find it, however, so transcendently stimulating and clarifying to the mind that its secondary action is a matter of small moment."

Sherlock Holmes in Arthur Conan Doyle's *The Sign of the Four*

Cocaine is not widely used in New Zealand. Many posts on tripme.co.nz, a New Zealand-based drug users' online community, lament the lack of cocaine, positing reasons for its scarcity such as our small market, good Customs Service and the cheap price of methamphetamine.

New Zealand must, however, have some connection to the cocaine trade. In 2012 Algerian police found 165 kg of cocaine in a container of Fonterra milk powder shipped from New Zealand. It has never been made public where the cocaine came from or how it got into the container.

For all its intrigue, there is a dark side to the white powder. The War on Drugs has made coca growing very profitable for many South American countries, namely Colombia, Bolivia and Peru. Cocaine producers operating deep in jungles often garner their workforce through slavery and seek to protect their profits with intimidation, guns and violence. Corruption is also rife because of the large amounts of cash the drug cartels can throw around.

Indigenous rights of peoples across these countries have been trampled by the UN Single Convention on Narcotic Drugs signed in 1961. Coca played a big part in many spiritual and traditional practices of many tribes throughout the South American continent, but to the international community, use of the plant had to be stopped. Bolivia has, after fighting for many years, been granted an exemption from the convention that allows inhabitants to use and chew coca. They have rejoined the Convention with the exemption despite many western – War on Drugs supporting nations – submitting against the move. ■

1,700 KM²
THE ESTIMATED AREA COVERED BY COCA PLANTATIONS GLOBALLY IN 2012. THIS IS ABOUT THE SAME SIZE AS NEW ZEALAND'S STEWART ISLAND/RAKIURA

3.6%
OF NEW ZEALANDERS HAVE TRIED COCAINE

$500
FOR ONE GRAM IN NEW ZEALAND

$200
FOR ONE GRAM IN THE USA

15–60
NUMBER OF MINUTES COCAINE'S EFFECTS LAST (DEPENDING ON ROUTE OF ADMINISTRATION)

9.6 KG
THE AMOUNT OF COCAINE SEIZED BY NZ CUSTOMS IN 2012

42 TONNES
THE AMOUNT OF COCAINE SEIZED BY ECUADORIAN POLICE IN 2012

The cost of our convictions

EVERY year there are two and a half thousand convictions of people aged 25 and under for possession and/or use of an illicit drug or drug utensil in New Zealand.

Between 2007 and 2011, there were 12,895 convictions in this age range. Over this period, New Zealand has spent more than $59 million imprisoning those who are convicted of minor drug offences and have to serve custodial sentences. This money is spent on imprisonment costs alone – it does not include costs to Police, the courts, treatment or probation.

With an average cost of over $18,000 per person imprisoned for minor drug offences, we have to start asking, what is the cost of convicting young New Zealanders?

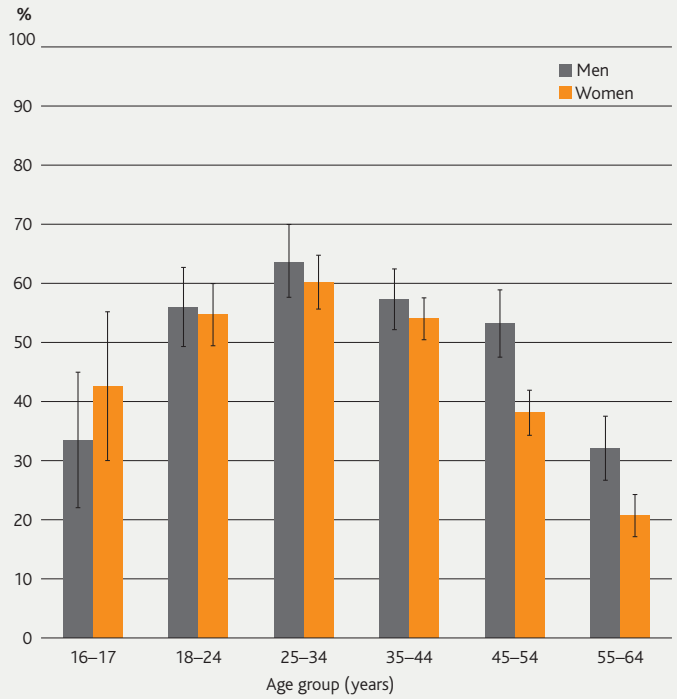
The reality is that lots of New Zealanders will use drugs at some stage in their lives.

According to a Ministry of Health survey, about half of all adult New Zealanders – or around 1.4 million people – have used illegal drugs. Around 485,500 had done so in the past year.

Most people will use drugs when they are young. The Ministry of Health found that over half of those aged 18–24 and almost two-thirds of those aged 25–34 admitted to using illegal drugs.

Data from the Christchurch Health and Development Study found the rates of youth drug use to be even higher. By the age of 25, over 77 percent of the young people in their study admitted to using illegal drugs.

Ever used any drugs for recreational purposes in lifetime, among total population aged 16–64 years, by age group and gender (unadjusted prevalence).



Unsurprisingly, young New Zealanders are often the ones being caught up in the criminal justice system.

This is a bad thing for many reasons. It severely narrows opportunities: it's harder to get a job, harder to travel, harder to get credit and harder to do many things most of us take for granted. It also exposes them to a negative environment, and it puts them in prison – a university of crime where drug use is rampant and joining a gang is often necessary for protection. All of this at a time when their brains and identities are forming.

We are stacking the odds against our young people. Almost half of all people convicted of possession and/or use of an illicit drug or drug utensil are aged between 17 and 25.

Number and percentage of 17–25-year-olds convicted of possession and/or use of an illicit drug or drug utensil.

YEAR				
2007	2008	2009	2010	2011
44%	45%	45%	44%	41%
2,456	2,662	3,020	2,702	2,055

Gender and ethnicity plays a role too. Significantly more males are convicted every year than females.

	YEAR				
GENDER	2007	2008	2009	2010	2011
Female	351	363	394	366	277
Male	2,103	2,297	2,623	2,336	1,778
Unknown	2	2	3	0	0
Total	2,456	2,662	3,020	2,702	2,055

Despite Māori making up 15 percent of the population, Māori aged 17–25 make up 37 percent of those convicted of possession and/or use of an illicit drug or drug utensil.

	YEAR				
ETHNICITY	2007	2008	2009	2010	2011
Pākehā	1,259	1,391	1,605	1,501	1,112
Māori	965	990	1,131	989	765
Other	80	73	94	69	68
Pacific	103	143	159	130	99
Unknown	49	65	31	13	11

Twelve percent of all people under 25 who are convicted are given a jail sentence.

	YEAR				
SENTENCE TYPE	2007	2008	2009	2010	2011
Imprisonment	13%	11%	11%	12%	12%
Community work	28%	28%	30%	30%	30%
Monetary penalty	37%	33%	31%	27%	25%

The average sentence that comes with a conviction is short but just long enough to mean loss of job, loss of flat or failure of study courses.

AGE GROUP	MEAN SENTENCE (DAYS)
Under 17	30
17–25	64

Also, there are discrepancies between the sentences for various drugs.

DRUG TYPE	CLASS	MEAN SENTENCE (DAYS)
BZP	C	425
Cannabis	C	49
Cocaine	A	60
Ecstasy	B	131
Methamphetamine	A	75
Heroin	A	75

The mean sentence for possession of BZP is 425 days, while people who are in possession of heroin or methamphetamine get 75 days. This is obviously not a system based on relative harms.

All this is costing us.

Putting people in jail costs us. The Department of Corrections puts the cost of imprisoning one person at around $250 per day.

AGE GROUP	NUMBER OF PEOPLE SENTENCED	MEAN SENTENCE (DAYS)	COST PER PERSON	TOTAL COST
Under 17	3	30	$7,500	$22,500
17–25	1,278	64	$16,000	$20,448,000

Per drug, the costs are even more astounding. These are the costs of those imprisoned between 2007–2011 for minor drug offences, broken down by drug type and sentence.

DRUG TYPE	NUMBER OF PEOPLE SENTENCED	MEAN SENTENCE (DAYS)	COST PER PERSON	TOTAL COST
BZP	2	425	$106,250	$212,500
Cannabis	1,050	49	$12,250	$12,862,500
Cocaine	4	60	$15,000	$60,000
Ecstasy	21	131	$32,750	$687,750
Methamphetamine	387	75	$18,750	$7,256,250
Heroin	11	75	$18,675	$206,250

That means we spend over $4 million a year imprisoning young people for minor drug offences. This is just the cost of imprisoning. It does not include Police costs, court costs, legal aid costs, probation costs or social costs.

THE COSTS

$250

to imprison one person for one day.

12,895

number of convictions for minor drug offences between 2007 and 2011.

$59,000,000

spent between 2007 and 2011 imprisoning people for minor drug offences.

$20,470,500

spent between 2007 and 2011 imprisoning people 25 and under for minor drug offences.

425

average number of days people are in prison for possession of BZP.

049

average number of days people are in prison for possession of cannabis.

075

average number of days people are in prison for possession of methamphetamine.

The Drug War in retreat?

Are we witnessing the beginning of the end for the global War on Drugs? Attacks on drug war ideology are coming from all quarters, argues **Russell Brown**, to the point where the United Nations has been forced to act. But how much regard the UN will give to the widening calls for reform remains to be seen – and not all the signs are good.

RUSSELL BROWN

NO one expected outgoing Mexican President Felipe Calderon to make the speech he made to the UN General Assembly in September 2012. Calderon, the staunch drug warrior, called time on the Drug War.

He begged member states – and in particular wealthy nations that account for most illicit drug consumption – to examine the "limits" of the war on drugs.

"Well intentioned efforts" to try to keep drugs out of the hands of young people via legal enforcement had led only to a black market and enormous earnings that provided criminals with power and "an almost unlimited ability to corrupt". Wealthy countries, he said, needed to explore "regulatory or market-based alternatives" for curbing the illicit drug trade.

In the official UN summary of Calderon's speech, you will not find these words – at least not in the context in which they were uttered. His scathing criticism of the Drug War is absent from the record.

"The summary was scandalous in itself," says Sanho Tree, the former military historian who has run the Washington-based Institute of Policy Studies Drug Policy project for the past 14 years.

"They doctored it to make it sound as if he gave a rousing endorsement of the Drug War – everyone needs to redouble their efforts and so forth – and then the entire video disappeared, along with the summary. It's unprecedented as far as I can tell. A head of state giving a formal speech at the opening of the UN General Assembly and having it expunged from the record."

Both summary and video are now back on the UN website, if you know where to look, but there is no transcript. Casual readers will need to navigate half an hour into the clip to hear Calderon's strongest criticisms. Such are the politics of global drug policy.

But there is no removing the fact that, on the same Wednesday that Calderon made his speech, two other Latin American leaders told the Assembly the same thing.

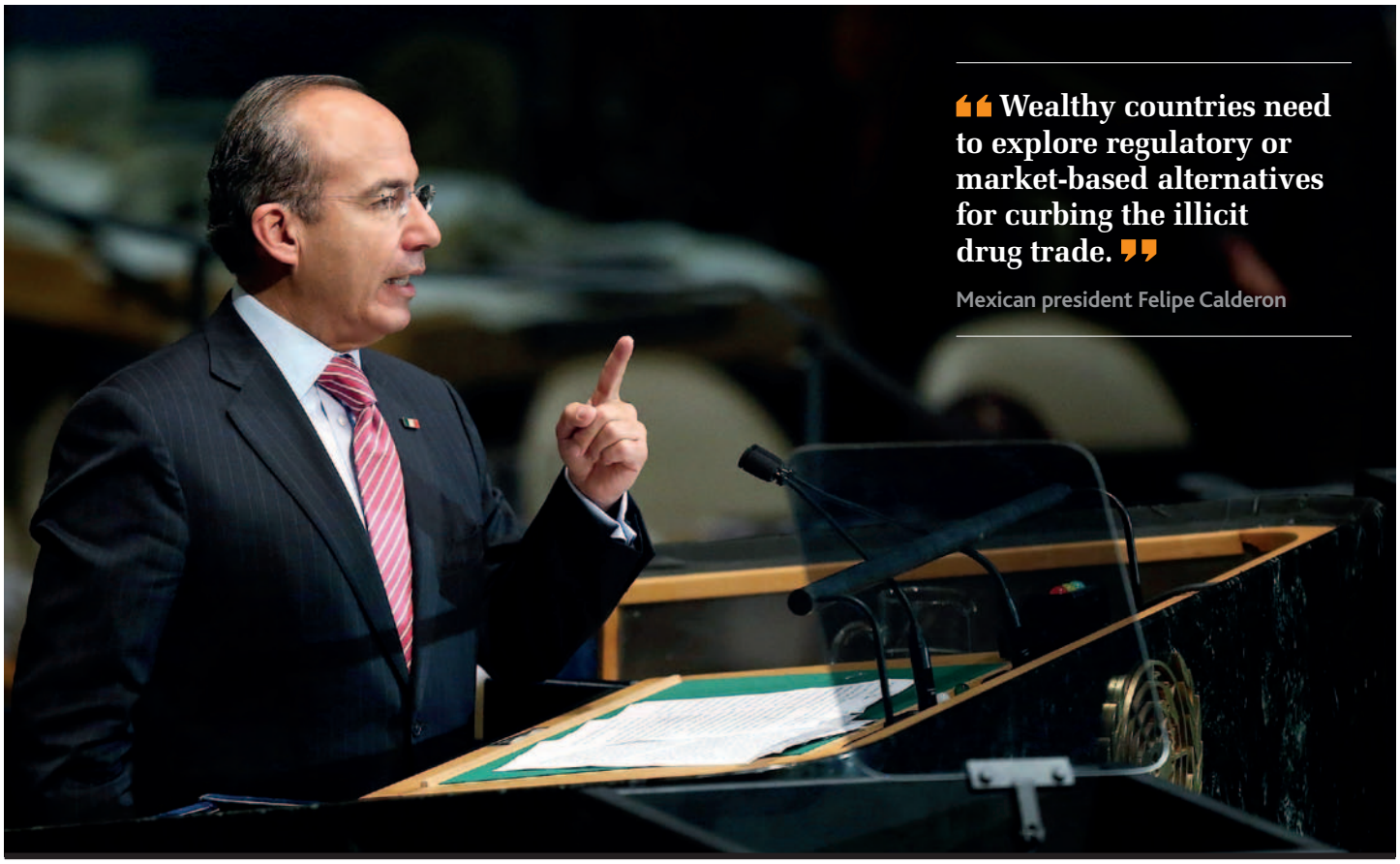
"The premise of our fight against drugs has proven to have serious flaws," said President Otto Perez of Guatemala.

Once-inveterate drug warrior and Colombian President Juan Manuel Santos demanded "an objective and scientific" search for "better options to battle this scourge".

Collectively, the three leaders formally asked UN Secretary-General Ban Ki Moon for a review of the organisation's drug policies. In November 2012, along with the leaders of Costa Rica, Belize and Honduras, they won a UN vote to set a special session on global drug policy for 2016.

> **"The UN is very skilled at deflecting such initiatives. It's the dark cul de sac down which drug reform proposals are lured and quietly strangled."**
>
> Sanho Tree, Institute of Policy Studies, Washington

The South Americans are not alone in their desire for reform. Two years ago, Germany, Britain and two dozen other countries tried to have the phrase "harm reduction" adopted as a principle in the 10-year political declaration, which embodies the UN stance on drugs. The advocates of the longstanding zero-tolerance philosophy – principally the US, Russia and Japan – prevailed, but the rebels made it clear they would regard the declaration's



> **“Wealthy countries need to explore regulatory or market-based alternatives for curbing the illicit drug trade.”**
>
> Mexican president Felipe Calderon

eventual compromise language as equivalent to a harm-reduction stance.

Nonetheless, Tree is cautious. The UN is “very skilled” at deflecting such initiatives, he says. “It’s the dark cul de sac down which drug reform proposals are lured and quietly strangled.”

The key reform development may in fact be the state ballots in the US general election, where voters in Colorado and Washington State opted to legalise the recreational use and possession of marijuana. In a statement that caused some surprise, the re-elected President Obama said federal enforcement in those states was “not a priority” for his administration. Tree wasn’t as surprised as some.

”There’s not a whole lot Obama can do with any credibility. Technically, legally, he can do any number of things – and he could probably take it to the Supreme Court and win. But it would be an absolutely pyrrhic victory. And one that’s not in the interest of the executive, legislative or judicial branches of government.

“What are you going to do? Send in 10,000 DEA officers to arrest people for smoking a joint? That would be a silly waste of resources. And what if they go all the way to the Supreme Court and the highest court in the land says ‘No, no, no’ – and the people say ‘Screw you. We’re going to have a giant smoke-in in front of the federal building’? Then you have a legitimation crisis, which is not supposed to happen in advanced democracies. That’s a total breakdown of governance.”

> **“What are you going to do? Send in 10,000 DEA officers to arrest people for smoking a joint? That would be a silly waste of resources.”**
>
> Sanho Tree, Institute of Policy Studies, Washington

The wider implications, he says, lie in the way “the drug war in general is driven by US domestic politics. By domestic posturing. And you have two states in the US, including a major swing state, where marijuana got more votes than Obama – or Romney. This gives international actors, particularly Latin American countries, a lot more political space. They can say, look, if the citizens of your own country are starting to turn their back on the Drug War, where is the legitimacy for you to force these policies down our throats?”

Tree is at pains to note that, while he believes the US has reached a “tipping point” on cannabis reform, dealing with hard drugs is some way off yet.

“Even the word ‘legalisation’ is a very awkward term to use, because most people I know who support ending prohibition don’t regard it as the same as legalisation. It’s not selling heroin to children in candy machines – it means different types of regulation, some of which would be stricter than others. It doesn’t mean we have to legalise – but draconian penalties, if there’s high demand in a black market, are counterproductive.

“I don’t know what an ideal policy would look like for this country or for other countries. However, we know what doesn’t work – the current system doesn’t work. And we’re not allowed to find out what does work because we can’t experiment because the prohibitionists have had a lock on policy for so long. So the current policy is not only never going to provide a solution – it is the obstacle to us ever finding a sustainable solution.” ■

Russell Brown blogs at publicaddress.net and hosts Media3.

Crime and punishment:

the sorry state of Russian drug policy

MAX DALY

Russia's treatment of its addicted citizens is characterised by cruelty, writes **Max Daly**. They are denied life-saving medicine. They are beaten, fitted up by the cops, raped and tortured. They are, according to Russian state-sponsored propaganda, subhuman scum whose schizophrenic minds need correcting with anti-psychotic drugs. Yet according to the country's narcotics official, these are the luckiest drug addicts on the planet.

IN Europe, America and Australasia, says Russia's Chief Narcologist Evgeny Bruin, unfortunate addicts are fobbed off with a cheap, green poison, methadone, which turns them into homeless, dementia-ridden zombies with no livers in under five years. Some are even encouraged to take more drugs, with the provision of free, sterile injecting equipment. Luckily for Russian addicts, their motherland's treatment system is, unlike in the West, a socially responsible one.

In the mixed-up world that is Russian drug policy, scientific evidence and compassion are concepts that have become twisted hideously out of shape. Despite that the Russian government is overseeing a rapidly unfolding health and human rights disaster, its solutions remain couched in Soviet-era repressive psychiatry, propaganda and wilful ignorance of widely accepted scientific truths.

At 1.8 million, Russia has one of the highest numbers of injecting drug users in the world. Most inject heroin, but more often now, drug users are injecting the even more damaging home-cooked synthetic opiate desomorphine, known as krokodil because of the scale-like effect it can create on the skin.

Crucially, the country's long-term opposition to internationally accepted methods of harm reduction has laid the foundations for one of the world's fastest growing HIV epidemics.

There were 100,000 people with the HIV virus in Russia a decade ago. Today, there are more than one million – three-quarters of whom are drug users. More than one in three injecting drug users in Russia has HIV, while the vast majority have hepatitis C. Estimates vary, but between 10,000 and 30,000 people suffer

> **Problem drug users are expected to get drug free within three weeks at one of the country's wide network of detox clinics. Methadone and buprenorphine are nowhere to be seen.**

drug-related deaths each year in Russia.

Yet amid the growing devastation, Russia's rulers belligerently continue to ignore what the rest of the world has found to be the most useful weapon against heroin epidemics: tried and tested harm-reduction measures such as methadone and needle exchange.

According to Mikhail Golichenko, a former UN drugs official in Russia who is now a senior policy analyst with the Canadian HIV/AIDS Legal Network, their attitude is: "We know that getting you off drugs is painful, it's cruel, but if you do it, we will welcome you back to society.

> **Russia is the world's cautionary tale on drugs and HIV. No other government is so willing to deny the evidence on harm reduction, silence open debate and witness the deaths of its own people.**
>
> Damon Barrett, Deputy Director of Harm Reduction International

If you are not ready, if you fail to kick the habit, then fuck you. You will be arrested and you will get disease. You are doomed to die."

It's the kind of tough, no-nonsense approach to drug addiction that is coveted by right wing libertarian politicians and authoritarian regimes the world over. But with the UN seemingly powerless to intervene and increasingly harsh policies being adopted across the border in Ukraine, it is a stance that is being viewed internationally with increasing unease.

As Damon Barrett, Deputy Director of Harm Reduction International, puts it, "Russia is the world's cautionary tale on drugs and HIV. No other government is so willing to deny the evidence on harm reduction, silence open debate and witness the deaths of its own people."

Russia's heroin problem has snowballed since the end of the Cold War and collapse of the old Soviet Union. In the 1990s, traffickers made inroads across the former Soviet states, particularly along the Silk Road from Afghanistan via Russia's vast southern border with Kazakhstan. At the same time, Russia was seeing a rise in unemployment and poverty, and for some, heroin became a way of dealing with life.

When she first started as an outreach worker handing sterile injecting equipment to Moscow's heroin-injecting population in the late 1990s, Anya Sarang rarely saw a drug user with HIV. Now, in a city that has bizarrely claimed success in beating the virus, a person gets HIV every three hours. Today, Sarang's campaigning organisation, the Andrey Rylkov Foundation for Health and Social Justice, remains a lone voice in calling for a humane drug policy and proven methods of harm reduction as a way of dealing with her country's archaic treatment system.

Russia's system relies on a two-pronged attack on addiction: detox and rehab. Problem drug users are expected to get drug free within three weeks at one of the country's wide network of detox clinics. Methadone and buprenorphine are nowhere to be seen. The substances, used in the treatment of most of the world's heroin addicts and deemed essential drugs by the World Health Organization (WHO), were banned until at least 2020 under the State Anti-Drug Policy Strategy of the Russian Federation, adopted in 2010.

Instead, detox is rooted in the kind of behaviour-correcting methods used to suppress the will of Soviet political prisoners in the 1960s. Patients are given a mixture of tranquillisers and anti-psychotics such as the neuroleptic haloperidol, a drug more commonly used to treat schizophrenia and delirium. Then follows a course of psychotherapy. But the success rates are not good post-detox. According to the Russian Federal Drug Control Agency (FSKN), over 90 percent of drug treatment patients resume the use of illegal drugs within a year.

Once a patient has gone through detox, they may enter Russia's vastly overcrowded rehab system. There are three dedicated state rehab centres, assisted by more than 70 rehab wards, providing 2,231 beds for the treatment of alcoholism and drug addiction. But with two million registered alcoholics and 1.8 million injecting drugs users, getting a place in a state rehab is difficult.

Unfortunately, the ineffectiveness of the government's own drug treatment system and the high demand for help has led to a plethora of dubious private rehab centres, often situated in remote areas. Charging at least $500 a month, this is where many middle class Russian families will send their drug-addicted sons and daughters.

But behind closed doors, for some lurks a dark world of pain and punishment. It's a system riddled with what Dr Evgeny Krupitsky of the Department of Addictions at the Bekhterev Research Psychoneurological Institute in St Petersburg has dismissed as little more than "science-decorated shamanism".

A report handed to, and later ignored by, the UN Committee on Torture in 2011 by Anya Sarang and other campaigners, *Atmospheric Pressure: Russian Drug Policy as a Driver for Violations of the UN Convention against Torture*, gave an account of hundreds of quack methods used to treat addiction in state and private rehabs, many in the form of patents lodged by the Russian Ministry of Health. It reads like a 'how to' manual for medieval dungeon masters and mad scientists.

Methods include punishment by starvation, long-term handcuffing to bed frames, 'coding' (hypnotherapy aimed at persuading the patient that drug use leads to death) and even the xeno-implantation

“We are worried and afraid for every one of our activists, especially since Putin’s inauguration and the scale of political repression we have witnessed.”

Russian outreach worker Anya Sarang

of guinea pig brains. Out of 34 methods of opioid-dependence treatment, 18 were deemed by analysts in the report as being ‘life threatening’.

Yet casual violence and bullying has been one of the more popular methods used by private rehabs to try and get people off drugs. One 31-year-old man who attended the City Without Drugs private rehab centre in Ekaterinburg – raided by Police last year after the death of an inpatient – was interviewed for *Atmospheric Pressure*. He recalled:

“There is a couch... you lay down, get undressed... there were three people who beat me up at the same time. It’d be even worse if you tried to protect yourself. Then they hit you on the hands with shovels, clubs. So are you going to inject drugs again? Will you? – ‘No, I will not, I am not going to use drugs any more, stop, I swear, just stop flogging, don’t flog me any more please…’”

Professor Vladimir Mendelevich, a harm-reduction advocate who has been censored by the authorities for providing information on methadone treatment, sums up the philosophy of dealing with drug addiction in his country: “The Russian drug treatment system has a definition of treatment as edification. You suffer, and the next time you won’t do anything bad.”

But the abuse doesn’t just occur in private rehabs. Russian drug users, particularly those with physical signs of abuse such as track marks, can expect similar or worse at the hands of the Police.

“The daily life of drug users is characterised by a constant terror arising from the widespread illegal practices employed by law enforcement officials,” says *Atmospheric Pressure*, which details how the concept of ‘bespredel’ (lack of any limits for Police) results in “routine law enforcement tactics” against drug users.

“Detention without legal justification; planting clues to make an arrest or detention; extortion of money or drugs; or sexual violence targeting sex workers.

“Prison medical services cannot cope with the flow of – if you allow me to use this word – ‘human material’ that ends up in the penitentiary facilities.”

Russian Minister of Justice Alexander Konovalov

These can also be much more extreme practices, such as physical violence used to obtain a ‘confession’ or as torture-like punishment,” says the report.

It details the experience of a 23-year-old drug user from Moscow:

“And I didn’t sign [the confession]. They didn’t hit me at first. I was even surprised. And they say: ‘Go, have a smoke.’ And led me to some gloomy room. I smoke. And then the door opens. The bright light hits my eye, I inhale, and straight into the [cigarette] coal they just hit me on the face. And then it starts: bang, bang, bang, bang. And you just go: ‘Yes, yes, I confess to everything,’ and off you go to the prosecutor’s office.”

There is even a word, ‘subbotnik’, to describe the forced provision of free-of-charge sexual services to Police officers by sex workers.

If, during their journey through the criminal justice system, in Police stations and in the country’s TB-ridden, Gulag-style prisons Russian drug users are beaten, tortured or just left to rot, then they only have themselves to blame. Russia’s Minister of Justice Alexander Konovalov summed up the prevailing attitude of the government to its most vulnerable citizens while discussing the inability of the prison service to cope with the large number of ill inmates.

Prison medical services, he said, “cannot cope with the flow of – if you allow me to use this word – ‘human material’ that ends up in the penitentiary facilities”.

That drug addicts are treated with so little regard by Police in Russia is no surprise.

Zero tolerance for drug users is actively promoted by the state. The FSKN has gone on record to clarify the government’s contempt for drug users.

“An addict degenerates as an individual. His intellect decreases fast, his interests become primitive, his mind weakens. He loses interest in life, his friends and relatives abandon him. His appearance becomes repulsive, bum-like. Moral and ethical norms do not exist for such persons.”

> **Out of 34 methods of opioid-dependence treatment, 18 were deemed by analysts in the report as being 'life threatening'.**

In February 2011, NTV, a federal channel, aired a TV programme called *How to beat the crap out of an addict*. Meanwhile, the Russian clergy has adopted a fairly unsympathetic 'out of sight, out of mind' mindset in dealing with the country's problem drug users. The head of the Synodal Unit for Collaboration with the Armed Forces and Law Enforcement, Arch-presbyter Dmitry Smirnov, said, "An addict either undergoes treatment or should be isolated from society. I'm not talking about prison. We have many islands in our country; in the north, in the far east."

Stigma is not the word. Russia's drug users, and the people who try and help them, are at the sharp end of what Anya Sarang calls "an ideological war" that is being waged by the state against what it deems as anti-Russian forces in society. It is the same war that saw last year's jailing of the feminist punk rock band Pussy Riot for singing an anti-government protest song against Russian president Vladimir Putin at an Orthodox cathedral in Moscow.

Also last year, the Federal Drug Control Service decided to close down the Anfrey Rylkov Foundation (ARF)'s website. When asked why the site had been outlawed, the minister responsible accused the ARF of promoting the use of methadone. And like Pussy Riot, several drug activists who have been vocal in criticising the government have ended up in jail.

ARF lawyers are currently fighting eight legal cases involving activists or drug users who have suffered at the hands of the system. Among them, Ivan Anoshkin had drugs planted on him and was subsequently arrested and jailed, while Evgeniy Konyshev had drugs planted on him shortly after accusing the City Without Drugs rehab of practising torture under the guise of drug treatment.

But as Mikhail Golichenko points out, Russian user-activists cannot be effective for two reasons.

"Firstly, they are too busy looking for illicit drugs while there is lack of access to life-saving substitute treatment. Secondly, they are too often in prison – because every drug-dependent person is doomed to spend his life in jail for nothing but an illness – addiction."

Other citations against the authorities on ARF's caseload include inhumane treatment through denial of TB treatment, inhumane treatment of a pregnant woman with drug dependency through coercion to have an abortion and inhumane and degrading treatment of a drug-dependent woman through denial of cancer treatment in prison.

"We are worried and afraid for every one of our activists, especially since Putin's inauguration and the scale of political repression we have witnessed," says Sarang.

"Now the repression of political and human rights activists by the current dictatorship has become mundane. More and more political activists are thrown in prison."

Sarang has expressed solidarity with Pussy Riot and all the other victims, including Russia's poor, of what she calls the "shameless Russian justice".

"For heroin users, the state and the medical system are their enemies," she says.

"They are treated like scum, and people are in a vicious circle where they cannot get any treatment for their addiction and end up slowly dying."

Now that much of the funding for harm-reduction programmes in Russia has dried up, partly due to the fact that Russia became a donor rather than a recipient of the Global Fund to Fight Aids, Russia's drug-fuelled public health disaster is set to become catastrophic. Apart from organisations such as the ARF, which are thin on the ground in Russia, what assistance can the country's problem drug users, HIV, TB and hepatitis C sufferers hope to get from the international community?

Sarang says, since the appointment of her compatriot Yuri Fedotov as Executive Director of the UNODC in 2010, Russia has merely become more efficient at snuffing out all semblances of UN influence on its domestic policy. The UN human rights system has simply failed to respond.

"The UN has offices here, but it should withdraw them because they are powerless. It is a waste of time and money, and they should spend it somewhere else. Here, the UN has become a puppet. Like our citizens, the UN has become a hostage of Russia's drug policy." ■

Max Daly is a UK journalist and was previously the editor of *Druglink*.

Putting the 'bi' into binge

Emma Hart suggests there's a reason why bisexual people binge drink more than straight dudes and dudesses and that the biphobic media aren't helping the situation at all.

EMMA HART

ONE of the whimsical stereotypes about bisexuals is that we drink like falling over in high heels and short skirts is going out of fashion. Unlike a lot of our other tropes, there's solid evidence to back this one up. Population studies in New Zealand and the US show that more-than-one-gender attracted people binge drink at higher rates than exclusively same-sex or opposite-sex attracted people. We really are irresponsible lushes.

So when *Stuff* published an article on a recent University of Otago study with the headline, "Binge drinking problem for young bisexuals", you could be forgiven for assuming the study had said the problem was binge drinking. The *Otago Daily Times* led with "Study reveals binge-drinking bisexuals", which seemed to indicate the same and also that there might be pictures. Pictures you'd want to see.

The thing is, it's not how we're drinking, it's why we're drinking. That's the underlying issue with any alcohol abuse problem: why? And surprisingly, that's what the study was about. This is rather more obvious in the headline on gaynz.com: "Exclusion leading some bi youth to binge drink." We're not drinking because we're happy-get-lucky good-time people. We're drinking because we're miserable.

A couple of questions came to mind. Didn't the study size – 32 participants – seem a bit small to be drawing these conclusions? And how was a 'binge' defined? As a friend said, sometimes their 'binge' is our 'drinks with dinner'.

Another thing the gaynz.com article managed, which most others didn't, was to link to the research. When you dig a bit, you find that this wasn't a quantitative study but a qualitative one.

"The thing is, it's not how we're drinking, it's why we're drinking. That's the underlying issue with any alcohol abuse problem: why?"

Frank Pega, the lead researcher on the project, says, "The validity and strength of quantitative research is often judged on size and the representativeness of the study sample... In qualitative research, issues of sample size and representativeness are of less relevance. What counts is rather whether the study sample was diverse along important characteristics such as ethnicity and socio-economic status."

What they found was that, among that diverse sample, many of the participants reported similar experiences of biphobia, abuse and social isolation in both heterosexual and gay-and-lesbian environments. They are stereotyped as being confused about their sexuality or going through a phase and as 'greedy'. To manage the stress and anxiety this caused, some were self-medicating with alcohol. The quotes from the participants throughout the research paper make this very clear:

"I drink more when I'm under high stress, when I'm stressed out and maybe sometimes at parties when, after conversations with people, where they want to know, no one gets the bi thing. It's really hard to explain. Quite a bit because you get people who want to know why you are not lesbian, why you are not straight, and I kind of feel that it's slightly easier to be one or the other."

And what do they mean by drink? The study used a standard definition of a 'binge' as six or more standard drinks in one session, but the participants were also asked to think of occasions when they got "really drunk". That last means that the experiences they are describing are far more in line with what people generally imagine a binge to be.

When it comes to mental and physical health issues, different groups within the lesbian-gay-bi-trans population are normally lumped together. It's nice to see some research focusing on more-than-one-gender attracted people, which has moved

“That more-than-one-gender attracted people experience discrimination that hurts them to such a degree that they binge drink in order to cope seems an obviously serious problem. So why is it so difficult to get it reported as such?”

past whether we exist or not. This has happened because there is actually specific funding.

According to Mr Pega, “Little funding is made available for research on the public health of sexual and gender minority populations in Aotearoa New Zealand. However, the former Alcohol Advisory Council of New Zealand (now the government’s Health Promotion Agency) has funded a programme of research on alcohol use in sexual minority populations since 2009. The topic of the current study was identified as a priority in terms of a need for evidence and received funding through this research programme.”

The study was also conducted in partnership with Rainbow Youth, which was not just integral to participant recruitment but was involved at every stage of the process.

That more-than-one-gender attracted people experience discrimination that hurts them to such a degree that they binge drink in order to cope seems an obviously serious problem. So why is it so difficult to get it reported as such? Why wasn’t *Stuff’s* headline something more like “Study recommends bisexual support groups”?

Craig Young of gaynz.com offers some insight: “If we receive notification of an article about this subject, we usually have the time to do greater and more diligent investigation because we’re a specialist publication and have archival resources available on our website. We’re also in contact with specific addiction specialists to evaluate research when it comes to hand.”

For other media, this study could fall at a nexus of sleaze. Both sexuality and drug abuse are issues often both sensationally headlined on websites like *Stuff* and also regularly turn up in the ‘most popular’ section. Recently, Taranaki’s comprehensive youth sexuality strategy ran on *Stuff* under the headline “Pill for kids on cards”.

Mr Pega, who fronted the study in the media, says they did everything they could. “We put out a media release, and I accepted a large number of interviews to ensure that our study findings were disseminated as widely as possible... Newsmakers generally do not include researchers in the news-making process beyond using their media releases and interviews. Therefore, researchers have limited influence in the presentation of their studies.”

The report on the study does end with some optimism. It contains a number of recommendations for easy, concrete things that could be done to improve the mental health of young more-than-one-gender attracted people. It also notes the general resilience of the community and its members’ ability to be “secure and confident in their sexuality and their right to be integrated members of New Zealand society”.

One of the phrases *Stuff* removed from the study’s press release was the assertion that one of the solutions needed was “broad anti-stigma campaigns that increase society’s understanding of this group of young people and how prejudices and bigotry negatively affect them”.

Accurate reporting of studies like this one would have done exactly that. Inaccurate and sensationalised reporting actually increases the stigma and negative stereotyping that are causing the problem in the first place.

For once, we’d quite like to not have it both ways. ■

Emma Hart is a Christchurch-based writer who blogs at www.publicaddress.net/up-front

Where now for opponents of cannabis law reform?

As a new high-profile group is established in the US to fight legalisation, **Steve Rolles**, a long-time advocate for regulating drugs, considers how recent reform victories are reshaping the landscape of the oldest debate in drug policy.

STEVE ROLLES

THE debate around the legalisation and regulation of cannabis has been with us since the 60s, but recent years have seen it move increasingly from the margins into the political mainstream. In the US, support for legalising cannabis has crossed the 50 percent threshold; even in the spiritual home of the War on Drugs, and despite bipartisan political hostility, a majority now support an end to cannabis prohibition.

Last November, the issue made the decisive move from theoretical debate to political reality as the states of Washington and Colorado passed ballot initiatives that not only legalised personal cannabis possession for adults but also set in motion the first regulated markets for non-medicinal cannabis anywhere in the world. If, as seems likely, the laws are implemented (the federal government is still considering its response at time of writing), this will represent the first real breach in the global prohibitionist regime.

While reform advocates have been understandably jubilant, for opponents, a strategic rethink has become necessary, perhaps best represented by a new group called Smart Approaches to Marijuana (learnaboutsam.com). This initiative is led by Kevin Sabet, a US Office of National Drug Control veteran under three administrations and probably the highest profile opponent of cannabis legalisation in the US with hundreds of print and broadcast credits to his name. Sabet is supported in the SAM leadership team by former congressman Patrick Kennedy, journalist David Frum and a group of academics and medical professionals.

The SAM project appears to represent a clear strategic repositioning for Sabet and, by inference, the wider coalition of cannabis law reform opponents. Most striking is the recommendation that cannabis possession should become a civil offence and that criminal records for possession be expunged. The additional requirement for a "mandatory health screening and marijuana-education program as appropriate" has met with indignation amongst some US reformers, but suggestions that SAM advocates mandatory rehab are not supported by the text on the site (referrals to treatment are specifically advocated only if needed).

While the term 'decriminalisation' does not appear, it is precisely what is being advocated by most definitions used in drug policy (closely mirroring the Portuguese decriminalisation model, albeit only for cannabis). It is a significant shift for Sabet who, as recently as April 2012, was writing of decriminalisation that "such a policy may actually make us worse off" and flat out that it "won't work".

"It would be gratifying to think [Sabet's] group has been convinced by reform arguments or evidence from 14 US states and 25 or so other countries around the world that have already adopted decriminalisation models."

It would be gratifying to think his group has been convinced by reform arguments or evidence from 14 US states and 25 or so other countries around the world that have already adopted decriminalisation models. However, equally plausible is the dawning realisation that decriminalisation, at least of cannabis, is now a political inevitability and Canute-like defiance is futile. Obama's recent statement that 'we've got bigger fish to fry' (than arresting cannabis users) suggests that SAM may also be echoing (or informing) shifting priorities at federal level. There is certainly considerable convergence between the SAM proposals and the US Office of National Drug Control Policy's talk of a third way (between the extremes of legalisation and a War on Drugs) and retreat from more hawkish War on Drugs rhetoric.

Some hardline prohibitionist groups, however, seem determined to dig in. The World Federation Against Drugs for example, describes advocates of decriminalisation as "driven by greed, disrespect of human rights and lack of understanding of the harms of drugs and of addiction". SAM by contrast, appears to be conceding on decriminalisation but drawing a line in the sand on legalisation/regulation.

The arguments against are familiar, with, perhaps unsurprisingly, "cannabis use is harmful" front and centre, supported by extensive detail and references. For Transform, debating the risks of cannabis is a distraction from the more salient point that, however risky cannabis is, it is more risky when produced and supplied via an unregulated criminal market (and this is quite aside from the harms of that criminal market). Cannabis needs to be legally regulated because of its risks, not because it is safe.

More interestingly, SAM places great emphasis on the threat of the commercialisation of a legal cannabis market, dwelling on the spectre of Big Tobacco. This, certainly, is a legitimate concern but, in fairness, hardly one that has been ignored.

Regulation is a blank slate; governments can establish any legal and policy framework they deem appropriate. As demonstrated by Uruguay's proposals for a state monopoly on cannabis supply and the emerging non-profit cannabis cooperatives in Spain, a commercial model is far from a given, let alone one that "will act just as the tobacco industry acts" as SAM dramatically proclaims.

Indeed, the tobacco industry has seen increasingly strict regulation of dosage, price, packaging, public consumption, branding and marketing over past decades. In much of the West, even in the US, these smarter approaches to tobacco (regulatory tools are impossible under prohibition) have helped dramatically reduce tobacco use in a matter of decades at the same time as cannabis use has been rising.

It's hard to escape the observation that SAM may be making a case against free-market legalisation while actually supporting a strictly regulated market model. Maybe having seen the light on decriminalisation, they will soon join principled reformers in helping design the optimal regulatory frameworks for legal cannabis that can deliver the shared goals we all seek. ■

Steve Rolles is Senior Policy Analyst at Transform – www.tdpf.org.uk – and author of *After the War on Drugs: Blueprint for Regulation*.

How we see things from our front gate

In 2011, Russell School became the centre for one small neighbourhood's battle. Its success in reducing harm from a poorly managed local liquor store shows what can be achieved when communities engage and mobilise.

> **“Even during school hours, people would come onto the grounds intoxicated… One person even urinated in the playground while kids were being taught physical education.”**
>
> Sose Annandale

THE presence of Fantame Liquor almost right across the road from Russell School in Cannons Creek, Porirua, has long been a source of concern for parents and the board of trustees.

Principal Sose Annandale says the store was open until midnight, and people would come from all over Wellington because it was the only place selling alcohol that late.

“They would hang around into the wee small hours, and the school grounds became the obvious place to drink. In the morning, there would be cans half full of alcohol in the playground that kids could find, and there would frequently be broken bottles, smashed windows and other vandalism.

“But even during school hours, people would come onto the grounds intoxicated or carrying boxes of alcohol they’d just purchased. One person even urinated in the playground while kids were being taught physical education.”

Damage at the school costs the taxpayer about $60,000 a year, but it’s the dangers to the pupils that are most alarming, and these include the normalising effects the shop’s marketing might have on them.

Board of trustees Chair Matt Crawshaw says Fantame Liquor’s advertising was very aggressive, especially around RTDs.

“The shop front was completely plastered with colourful posters, and there would be sandwich boards all over the footpath extolling the virtues of alcopops.

“Teachers walking kids to swimming lessons would hear them talking about how ‘yum’ the drinks looked and saying which ones they’d tried. These are primary school kids!”

When Fantame Liquor’s off-licence renewal was due in August 2011, the school community saw it as an ideal opportunity. If they couldn’t have the store shut down, perhaps at least they could have its hours curtailed.

What they did

Matt and others formed a core stakeholder group and began upskilling themselves to effectively oppose the licence renewal. They attended some workshops by the It’s Our Turn To Shout campaign about how to come across well in the media and how best to write a submission.

The group decided to hold a public meeting for all those concerned to help bring about a collective ‘show of force’. They knocked on doors throughout the neighbourhood inviting people to the meeting and delivered flyers to about 1,000 households.

“So many people I spoke to had stories about the damage being done through the store’s bad management. This showed we were on the right course, that the wider community really was eager for an opportunity to speak up,” Matt says.

Sixty people attended the initial meeting, which is a lot for such a small

QUOTES OF SUBSTANCE

> **“I usually got arrested three to five times a year for the last 17 years. In the last 12 months, I haven’t been arrested once and haven’t gone to jail.”**
>
> *An amazing, positive change for one gang member who recently graduated from the* **Salvation Army/ Mongrel Mob** *addiction treatment programme.*

> **“What we’re saying is there are drugs a great deal safer than alcohol and tobacco.”**
>
> **Baroness Meacher**, *chair of the All Party Group on Drugs, which recently recommended the UK Government make fundamental changes to UK’s drug policy to address harms from all drugs, legal or not.*

> **“Frankly, I think we can stop treating everyone as though they’re fools and can’t make decisions for themselves. It was a bit too much taking away people’s responsibility. About 80 percent of New Zealanders drink extremely responsibly.”**
>
> *Justice Minister* **Judith Collins** *says protecting personal responsibility is one reason the Alcohol Reform Bill didn’t go further.*

> **“The pressure that the industry has placed the minister under is absolutely not subtle.”**
>
> *Intensive lobbying by Big Alcohol raised Green MP* **Kevin Hague’s** *hackles.*

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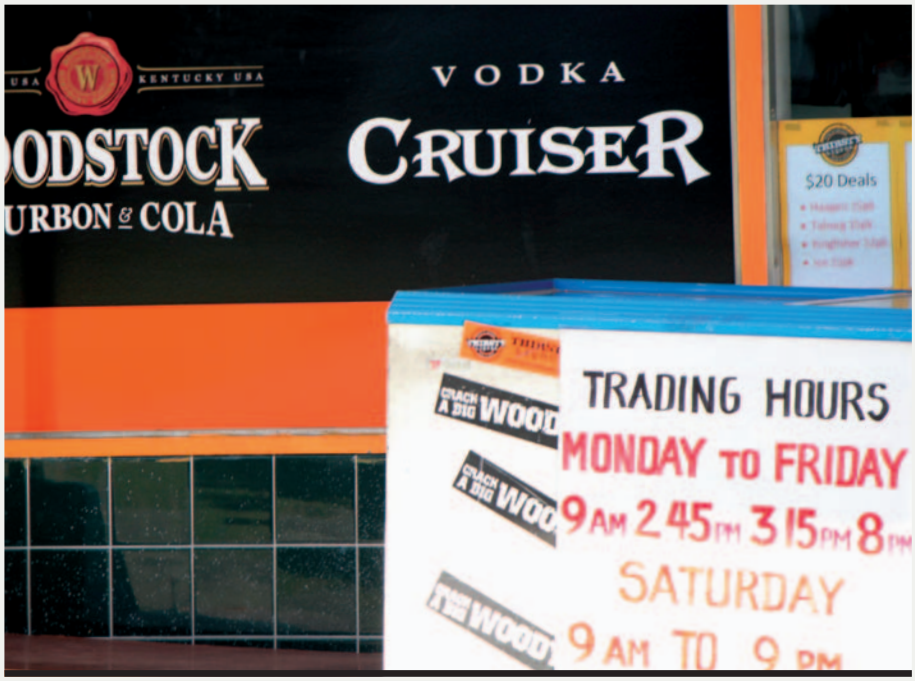
Thirsty Liquor trading hours



community. At the meeting, real effort went into educating people about how to make a good submission to the District Licensing Authority, and templates were given to those who needed them. All in all, they managed to get 88 objections launched against the renewal.

Following advice from organisations like the Drug Foundation, ALAC and Regional Public Health, members of the group sat outside the store until midnight a few times so they would have personal eye-witness accounts of the sorts of things that happened.

They studied the relevant legislation and did some research to see whether the proprietor was of sufficient good character to hold a liquor licence. It turned out the store had twice been caught selling alcohol to minors and had already been sanctioned for excessive advertising.

The school community also made submissions to both the Law Commission Review and the Justice and Electoral Select Committee. These focused mainly on the harmful effects of having a liquor outlet so close to a school and were themed, 'How we see things from our front gate'.

"We wanted to get our point across that this is not the sort of community we want for our kids, where excessive drinking is seen as normal and they have to wake up every day with cans stacked on their lawn," Matt says.

What happened?

What happened at the 30 November hearing came as a devastating blow. Halfway through proceedings, it was discovered the proprietor was illegally operating his liquor outlet and grocery store under the same licence, so the hearing was adjourned before the community had a chance to have any say.

It took more than five months to get a second hearing. In the meantime, the store's lawyers got the legal situation sorted, and Fantame Liquor began trading again as normal. It did, however, remove its aggressive advertising and rebranded under the Thirsty Liquor franchise (which Matt finds a powerfully unfortunate statement – associating alcohol with thirst, right across the road from the school).

> **"The whole legal process felt hostile, and our little community just felt it had been slapped down and ignored yet again."**
>
> Matt Crawshaw

"The hearing result was really bewildering, and we felt completely deflated," Matt says.

"The store was acting illegally, yet it got to carry on while the community had to wait. The whole legal process felt hostile, and our little community just felt it had been slapped down and ignored yet again."

The community also found the second hearing in early May 2012 intimidating. They were not allowed to speak to their submissions or address any new matters that had arisen, yet it seemed the proprietor's lawyers could speak all day. They came away very despondent – thinking no one was listening and that nothing was going to change.

But the result showed they had indeed been heard and the community was elated. Its licence was renewed, but Fantame Liquor's closing times were restricted to 8 pm Monday–Friday, 9 pm on Saturday, and 6 pm on Sunday. It now also has to shut 2.45–3.15 pm on weekdays to protect pupils travelling home from school.

Presiding judge John Hole said there was considerable evidence of bad management at the store leading to liquor abuse.

Principal Sose Annandale says the findings were a really important statement to the community.

"It seems like things have been righted. Now, the bottle store has to shut in deference to the school rather than the school having to defend itself against the bottle store."

Matt, who lives near the school, says

Fantame Liquor

the vibe of the whole neighbourhood is now much better.

"You can walk down the street at 8 pm and not feel threatened. There's this huge sense of peacefulness now, like there should be, and people comment about it all the time."

But the Fantame success was not the first for the Porirua community. In 2008, an application was filed to open another bottle store in Cannons Creek, directly opposite another primary school and just 500 metres from another bottle store. The community collected signatures and organised a well attended march on the day the application was heard.

> **"There's this feeling now that, whatever comes our way, we're ready for it."**
>
> Matt Crawshaw

Overwhelmed by the public opposition, the judge denied the application and the store never opened.

Jenny Lester, Chair of the Porirua Alcohol and Drug Cluster, which organised the march, said these two instances have had a significant positive influence at a local level.

"First of all, it's like people have become very aware. They realise now that alcohol abuse is something that affects the whole community; not just the school or those involved with the violence.

"But, they've also seen that it is worth standing up for what you believe in and that things really can change when communities act with a united will."

The Cluster is now working closely with Porirua City Council and will be undertaking community consultation in 2013 around a new local alcohol policy for Porirua.

Matt Crawshaw agrees the initiatives have resulted in some real community building. He cites an example of where some families were forced from their homes because of potential for earthquake damage. Members of the community were quick to get involved and already knew how to work for change and support the people affected.

"It used to be the school holding gatherings and hoping people would come. Now, meetings are organised by the community and are very widely attended. People are engaged and enthusiastic.

"There's this feeling now that, whatever comes our way, we're ready for it.

"We can't wait for May when Thirsty Liquor's annual licence renewal comes up, and we're already talking about what sort of shop should replace it." ■

QUOTES OF SUBSTANCE

"If you were waging any other war where you have 2,000 fatalities a year, your enemies are making billions in profits, constantly throwing new weapons at you and targeting young people – you'd have to say you are losing and it's time to do something different."

UK Deputy Prime Minister **Nick Clegg's** *clarion call for compassionate and evidence-based drug policies has been met with nods of agreement from many UK politicians.*

"I personally don't support a Royal Commission. In my view, there's always a danger, as someone said, that they can take minutes and last for years."

But not Prime Minister **David Cameron**, *who quickly backed away from supporting an end to Britain's War on Drugs.*

"We have the world's most renowned process to decide what is medicine and what should go in people's bodies. And marijuana has never been through that process."

Can it really be a medicine if we haven't tested it as such?, asks US Drug Czar **Gil Kerlikowske**.

"To be fair, they do look very similar."

Blooming embarrassing moment for **Alberta police** *whose 'historic' bust of 1,624 cannabis plants are found to be common daisies.* ■

Should unregistered naltrexone implants be used to treat opioid dependence?

Viewpoints presents the arguments on both sides.

THE CASE FOR

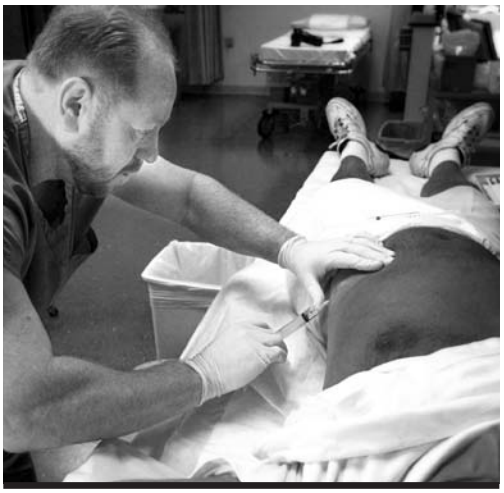
HEROIN addiction is not something you'd wish upon your worst enemy. It tends to come with a lifestyle of chaos, carnage and criminal justice involvement. It also tends to come with health complications, including high rates of communicable disease and even death. The life of a heroin addict is not exactly safe. It's also not an easy life to escape. So when a potential pathway out of that lifestyle is available, even if it's risky, people should have the opportunity to take it. We're talking about consenting adults here. Who are we to prevent sick people from taking something that could help them get better?

Plus, it's not like the current options are perfect. Right now, the gold standard for treating opioid dependence is methadone. Although it is well evidenced, methadone is not without its problems. It is highly addictive, has a longer withdrawal period than other opiates, can be fatal and doesn't prevent people using other drugs, including heroin, while undergoing methadone maintenance. For some, the benefits of methadone undoubtedly outweigh the potential risks. For others, however, methadone either hasn't been or is unlikely to be successful. People deserve to have options.

Although naltrexone implants are less well evidenced than methadone, emerging evidence shows that naltrexone implants appear to compare favourably. Ngo et al. (2008) found mortality rates for patients with naltrexone implants were comparable to those of a methadone cohort. Furthermore, those with naltrexone implants presented to hospital less frequently for non-fatal opioid overdoses than those using methadone.

Although there is less evidence available on the efficacy of naltrexone implants than there is for other pharmacotherapies for opioid addiction, they definitely show promise. Given the limitations of existing therapies and their unsuitability for certain people, naltrexone implants should continue to be available to those who are willing to try them for themselves.

Thousands of Australians have been implanted with sustained-released naltrexone in an effort to help them overcome opiate addiction. Theoretically, it makes sense: block the body from experiencing the effects of opiates. But there are problems. Naltrexone is still being tested and is unregulated. It's a controversial situation, but given the extreme circumstances so often faced by those with an opiate addiction, is the potential return worth the risk?



THE CASE AGAINST

THE reason that we have a process for regulating medicines and other therapeutic goods is that we only want people to be taking things that are proven to be safe and effective. At this stage, naltrexone implants simply do not fall into that category.

In terms of clinical data, there is not enough quality evidence available. The most systematic review conducted to date was carried out for Cochrane by Lobmaier in 2008. It failed to find any randomised controlled trials that assessed the efficacy of naltrexone implants for treating people with opioid dependence.

There have been a number of studies conducted on naltrexone implants since the Cochrane review, but there are still significant issues with the quality of available evidence. For the most part, studies use the same base cohort, data is derived from small samples, and studies with larger sample sizes tend to be based on retrospective analysis. To put it simply, the data is unreliable.

Better evidence is crucial given the reported adverse effects. These include wound opening and localised infection, allergic reactions, implant removal, headaches, nausea, vomiting and psychological issues. These also include death. Comparing a cohort taking methadone with one implanted with naltrexone, Ngo et al. (2008) found that the implant group was at greater short-term risk of non-opioid overdose. Furthermore, hospitalisations due to non-opioid drug use increased significantly. The authors note that changes were robust, long lasting and common across all genders and ages. Similar results were not found with methadone.

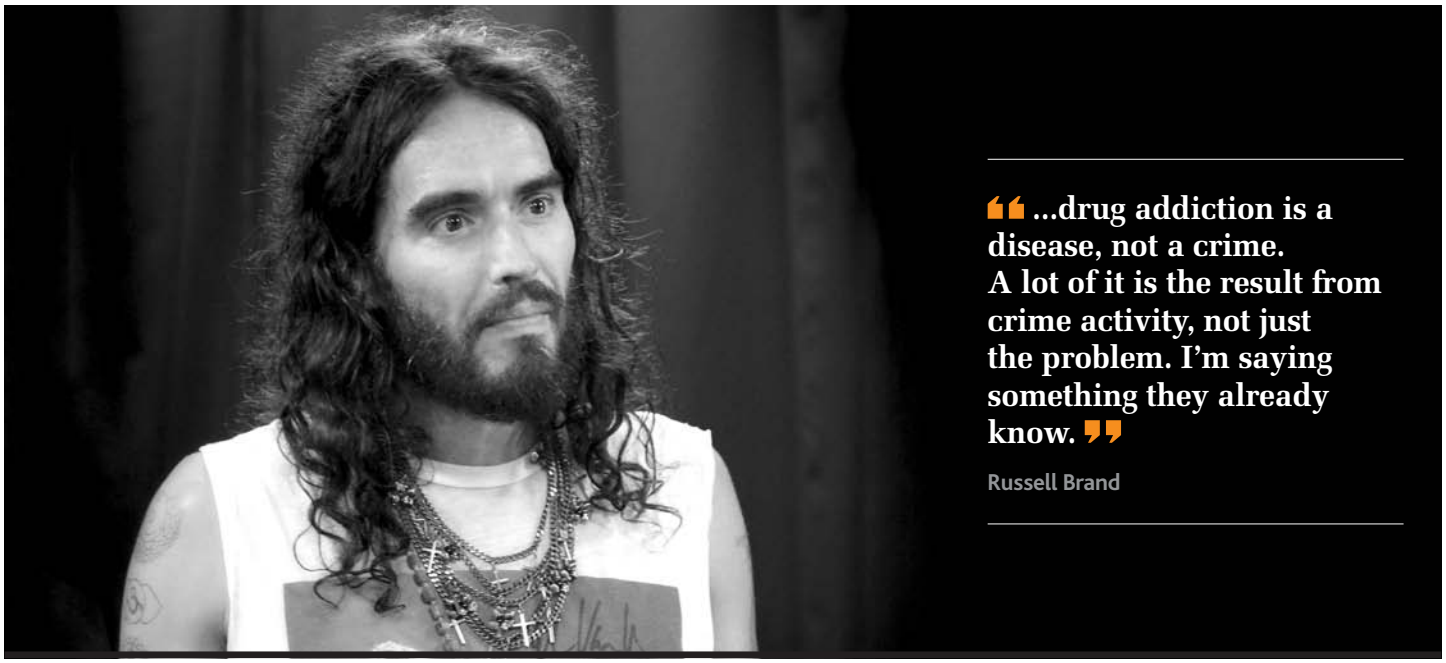
The Australian experience adds even more weight to the notion that these implants are risky – particularly in an unregulated environment. There have been a number of highly publicised deaths – most recently three patients at a clinic run by someone who wasn't even a medical doctor. Yet given that these implants are not regulated, there are no protections offered if something goes wrong. There also seems to be scant oversight on those who are providing these implants at significant cost to people who are desperate to change their lives.

Yes, people who are trying to recover from heroin addiction deserve all the help they can get, but they also deserve to be protected from further harm as they strive to free themselves from their addiction. The current situation is simply not acceptable and could indeed be considered exploitative. While naltrexone implants definitely deserve further clinical trialling, they should not be available as a treatment option until they are proven to be safe and effective.

YOUR VOICE

YOU DECIDE

What do you think? Have your say
www.drugfoundation.org.nz/viewpoints



> ...drug addiction is a disease, not a crime. A lot of it is the result from crime activity, not just the problem. I'm saying something they already know.
>
> Russell Brand

Russell Brand

Comedian, actor, author – and in recovery

On the 10th anniversary of his recovery, comedian Russell Brand invited *Matters of Substance* backstage to the final show of his Australia and New Zealand tour. We talked about recovery, pears and his pro-recovery activism. Happy 10 years in recovery, Russell.

Q Everyone says it's kind of a big deal.

A The 10 years and everything? I'm really happy about that. It's a day for extra gratitude, I suppose. You really have to reflect on what it was like when you were drinking and using. So 10 years of abstinence from drinking and drugs is good. I'm very happy.

[Takes a bite of pear.]

I still eat pears though. Like a maniac. I can't stop. If I had to give these up, God, I'd rather die.

Q Being a celebrity and all, do you feel that extra burden of having to model the recovery?

A: No. I don't. Being a celebrity, that's abstract, innit?

Q You're in the public eye, everyone knows you've used, that you're in recovery. Is there a sense of obligation, then?

A No. I've got it the same. For me, I've got the same disease as anyone else. It affects me the same way as everyone else.

Q But you're in a different position than anyone else.

A That don't make no difference to me.

Q But it makes a difference to other people.

A But that's not my business. That's what my programme is. What goes on with other people – good or bad or indifferent – that's up to them. What goes on in here... [points to head] that's my programme. That works for me.

Q What is recovery?

A Don't take drugs. Don't drink. One day at a time.

Q Is that it?

A Yeah. On a basic level, that's it. Maybe get into a higher power if you want to. But for me, my recovery is one day at a time and don't drink and don't take drugs.

Q One of the things you've done recently, you had a bit of a crack at politicians in the UK about the War on Drugs. What was your message to them?

A That drug addiction is a disease, not a crime. A lot of it is the result from crime activity, not just the problem. I'm saying something they already know.

Q Do you think people in the recovery community should get more engaged in the policy debates around drug policy?

A I don't mind what people do. I mean, like for me what I think is that I'll just do what I can do. Obviously I think it would be better if people who knew about addiction were in charge of the treatment of addiction, rather than people who don't know anything about it. Just the same as with agriculture

RESOURCES

- A full transcript of the interview is available at **www.nzdrug.org/RussellBrand**

Substance and Substantiation

There is no such thing as cannabis withdrawal

Cannabis has a reputation for not being that harmful. It's down the end of most harm scales, some jurisdictions are reassessing its legality, and proponents say it can heal the world.

HOWEVER, as we move towards normalisation of cannabis as a recreational drug, the prospect of withdrawal from its use needs to be considered. Do users experience withdrawal from cannabis, or is it all just smoke? Mythbusters explores the issue.

When a lot of people think about withdrawal, they get an image of the person addicted to heroin. As Renton describes it in *Trainspotting:*

"I don't feel the sickness yet, but it's in the post. That's for sure. I'm in the junkie limbo at the moment. Too ill to sleep. Too tired to stay awake, but the sickness is on its way. Sweat, chills, nausea. Pain and craving. A need like nothing else I've ever known will soon take hold of me. It's on its way."

John Irving's character eloquently shows there are two sides to withdrawal: physical and psychological. During withdrawal, the dependent person will undergo certain changes, behaviours and experiences in the course of their body readjusting to life without the drug.

For a long time, it was thought there was no withdrawal from cannabis because, when dependent people stopped using, they did not undergo the messy and painful scenario often associated with the process. Even the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)-IV does not recognise cannabis withdrawal.

SYMPTOM	PERCENT OF SAMPLE	DURATION IN DAYS
Trouble falling asleep	46.9%	756
Decrease in appetite	38.8%	62
Feeling aggressive	24.1%	52
Feeling sad, depressed	45.1%	122
Feeling irritable, jumpy	45%	113
Feeling anxious, nervous	50.1%	95

However, as our knowledge of drugs and their effects has evolved, we now understand that withdrawal has a wider set of parameters than physical ones. The DSM-V looks likely to include cannabis withdrawal when it is released later this year.

So what does cannabis withdrawal look like? In a study published in the *American Journal of Addiction* in 2004, Levin et al. studied 469 cannabis smokers and asked them if they had experienced withdrawal symptoms.

The study shows symptoms were mainly psychological, with only 23 percent reporting headaches, 10 percent physical discomfort, 2.1 percent vomiting, 4.3 percent diarrhoea and 5.5 percent shakiness. All these symptoms occurred within one and a half weeks of stopping cannabis consumption.

Psychological symptoms of withdrawal, however, were experienced by a greater number of the sample and for longer periods. For example, craving for cannabis happened in 75.7 percent of the sample and lasted for 113 days.

So yes, there are very distinctive, if not tangible, symptoms of withdrawal from cannabis, and as Levin pointed out, withdrawal symptoms make it very likely people who try to quit will relapse.

Given that many countries are looking to legalise cannabis and divert tax income to treatment, the fact cannabis does have negative withdrawal symptoms needs to be considered in determining policy and treatment options. ■

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