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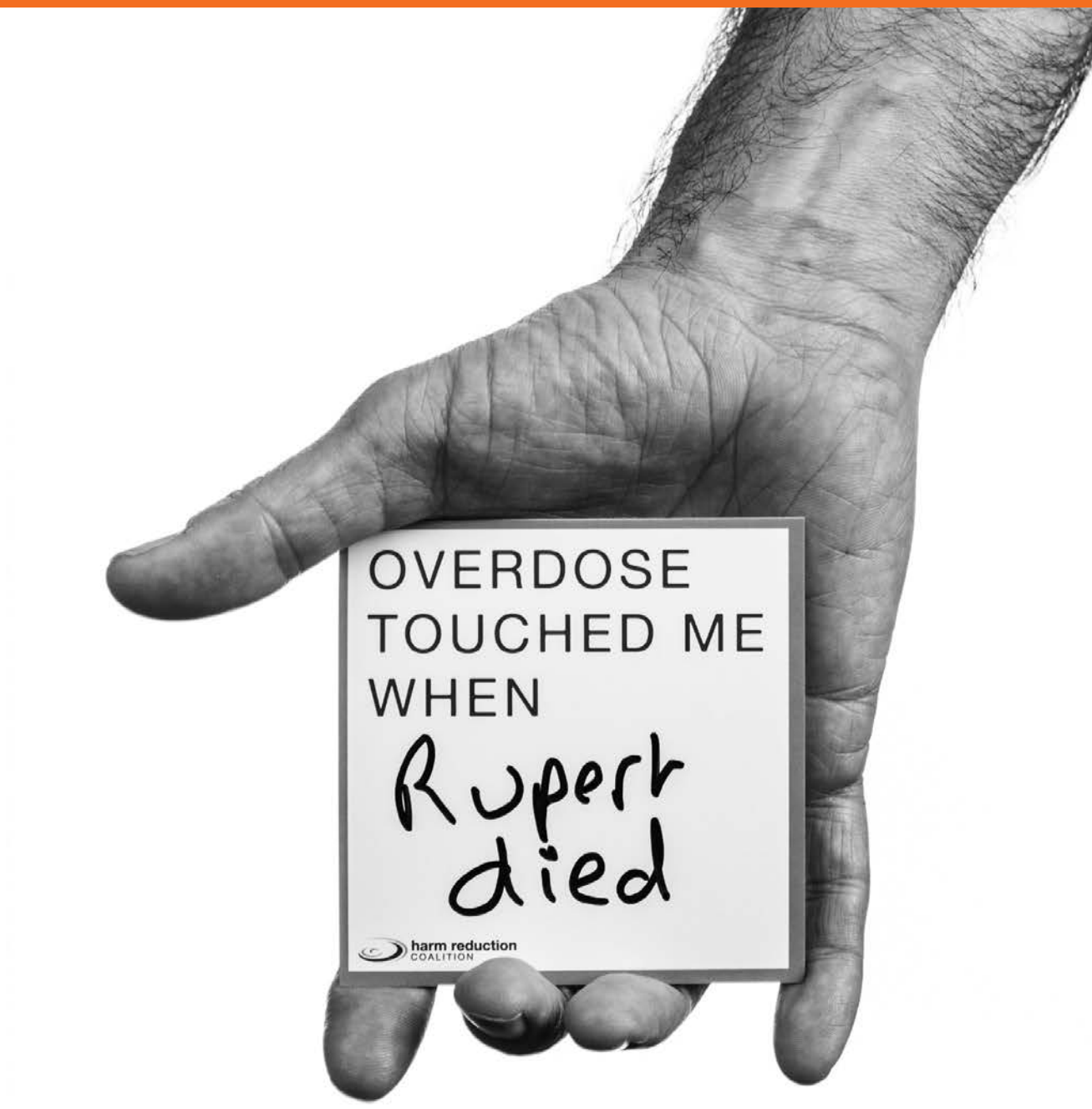
AT THE HEART OF THE MATTER, NZ DRUG FOUNDATION.
Te Tūāpapa Tarukino o Aotearoa




# Underdosing naloxone

Overdose rates from opioids may not seem much of an issue in New Zealand, but they're important enough to warrant intervention. Prevention starts with making naloxone more freely available.

## CONTENTS

# Underdosing naloxone

COVER: **Naloxone is a drug that can stop an opioid overdose, so why isn't it more widely available?** Cover photo by Matt Slaby for the Harm Reduction Coalition.

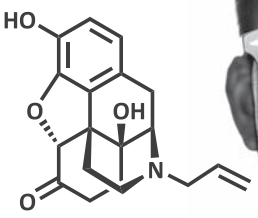

COVER STORY 06

FEATURE: GOOD BOOZE NEWS 14

NZ NEWS 02

ABOUT A DRUG 20

GUEST EDITORIAL 34


## FEATURES


**14**
**Good booze news from across the ditch**
Why have half of Aussie drinkers reduced the amount they drink?

**18**
**Secondary school student drug use stats**
Despite media hysteria, drug use amongst young people is actually falling.

**22**
**On the road to reducing drug-driving harm**
Experts from around the world came to Wellington to talk drugs and driving.

**24**
**Voting for change was the easy part**
Public policy conundrums can be found aplenty after the ballot cast on cannabis law reform in four US states.


## REGULARS


**30**
OPINION
**Time to be honest about the pleasure**
Drugs give humans the pleasure we naturally seek, argues Adam Winstock.

**34**
GUEST EDITORIAL
**Hello Friday Afternoon?**
Chris Raine on how to reclaim your entire weekend.

**35**
Q&A
**Norman Baker MP**
The former minister responsible for drugs in the UK explains why he resigned.

| | |
|---|---|
| The Director's Cut | 01 |
| Events | 01 |
| News | 02 |
| About a Drug | 20 |
| Viewpoints | 32 |
| Q&A | 35 |
| Mythbusters | 37 |


## Become a member

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

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

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

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## THE DIRECTOR'S CUT

I have some sympathy for the how the Misuse of Drugs Act must feel as it turns 40 this year, having myself experienced that milestone in the recent past.

But while I'm still in my prime [Wishful thinking – editor.], New Zealand's drug law has long shown serious signs of aging and is now well past its use-by date.

**ROSS BELL**
Executive Director

Like many 40 year olds, the law has got sluggish. Despite being amended 18 times in the past eight years it has failed to keep pace with a rapidly changing drug market, including the influx of new psychoactive substances effortlessly traded over the internet.

And then there's the big question about the law's fundamental effectiveness. Has it succeeded in doing what it was designed for? Over its lifetime drug use in New Zealand has not been supressed. We remain among the world's highest users of cannabis, and until recently were up there with methamphetamine. While wider social factors will be the main determinant of drug use patterns, it is our drug law that determines how we respond. It has performed poorly.

In the five years since the Law Commission's review of the law there's been an almost seismic shift in global drug law reform. New drug control models are being tried in Uruguay and the Czech Republic, and great momentum is building in the US. And let's not forget New Zealand's experience with regulations, which itself contributes to the global knowledge base of innovative approaches.

We must now turn our attention to modernising our drug law, a project that should go hand-in-glove with the government's refreshed National Drug Policy. It's here that we must grapple with the devilish detail and move beyond the proclamations of 'decriminalisation' or 'legalisation' or 'tough on drugs'.

As the wonderful Mark Kleiman says elsewhere in this magazine, "Debating whether to legalise pot is increasingly pointless…the important debate now is how to legalise it."

This demands from us all a much better informed level of discussion on specific models for law reform. Fortunately, we've just been here with the recent development of the regulatory approach over new psychoactive substances. You'll recall the very specific details about matters we were required to consider, such as where can products be sold and who can sell them; can we test products on rats only, or rabbits or none at all; what are safe dosage limits; should the containers be child-proof, and so on.

The Law Commission has already presented a possible model, proposing a cautioning and health referral system which could be fast-tracked for substances with greater harm profiles. I reckon that's a pretty good starting point for our current law's retirement plan.

## SOCIAL

**@PAULKIDD** "It has a ring to it." 1985 letter from Donald Abrams suggesting the name '#HIV' for what was then called HTLVIII/LAV. DECEMBER 01

**@AUSTDRUG** We agree with @smh; if we want to reduce drug harm, sniffer dogs are waaaay down the list of effective ways to do it. DECEMBER 01

**@MINHEALTHNZ** Fewer smokers: 15- to 19-year-olds smoking rates dropped from 20 to 13% in 7 years. Quitting rates rose from 8 to 11%. DECEMBER 05

**@TRI_SOLUTIONS** "We cannot solve our problems with the same thinking we used when we created them" - Albert Einstein. DECEMBER 07

**@THENEWIMPOSTOR** Hungarian prime minister says journalists and politicians should undergo mandatory drug tests. DECEMBER 16

**@NZHERALD** The 'Not Beersies' ad fooled a viewer who complained it was being shown too early. DECEMBER 10

**@SMH** 'What use will executing us be?': Bali Nine member speaks out after bid for clemency rejected. JANUARY 08

**@GUYWILLIAMSGUY** "Popular Irish bar Molly Malones, in Courtenay Place, has closed." - Check that... "Unpopular Irish Bar Molly Malones". JANUARY 22

## KEY EVENTS & DATES

| | |
|---|---|
| 17-20 MAR 2015 | **7th Australasian Drug and Alcohol Strategy Conference, Brisbane Convention and Exhibition Centre**<br>**http://event.icebergevents.com.au/adasc-2015/** |
| 17 JUN 2015 | **Alcohol and Cancer Conference, Te Papa, Wellington**<br>**http://www.alcoholaction.co.nz/?p=433** |
| 2-5 SEP 2015 | **20th Cutting Edge Conference – Its all about Whanau, dapaanz, Nelson**<br>**http://www.cuttingedge.org.nz/** |
| 23-25 SEP 2015 | **4TH APAC FORUM 2015 - Leading Healthcare Transformation, Auckland**<br>**http://apacforum.com/** |
| 18-21 OCT 2015 | **Int'l Harm Reduction Conference, Kuala Lumpur, #IHRC2015**<br>**http://www.ihra.net/** |

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# NZ.

## 01 One law for all?

Recidivist drink drivers are up to 12 times more likely to be sent to jail in one New Zealand region, but the Ombudsman is refusing to release the information needed to identify where that is.

Research done at Victoria University, published last year, highlighted considerable differences in sentencing from region to region for similar offenders and might also show where a drink driver is less likely to be jailed. Lawyers have expressed concern at the disparities in the way the law is applied, saying it undermined the principle of the rule of law.

## 02 Methamphetamine use up after legal highs banned

**FORMER METHAMPHETAMINE** users have returned to the drug after a ban was placed on synthetic highs, MidCentral District Health Board's alcohol and other drug service said. Staff at the Manawatu addiction service say it is their "clinical impression" that more patients are relapsing since the legal high ban came into effect. Mental health service Clinical Director Dr Syed Ahmer said staff had seen an increase in use of methamphetamine.

"People who have used methamphetamine in the past are now going back to using it after the legal highs came off the market," he said.

## 03 Booze main factor in family violence

**THE GLENN** Inquiry released its final report recommending sweeping alcohol reforms in order to tackle the epidemic of domestic abuse in New Zealand. The inquiry, instigated and funded by Sir Owen Glenn, says Parliament should reconsider the findings of Sir Geoffrey Palmer's 2010 Law Commission report into alcohol and ought to adopt them in full. "Alcohol can never be an excuse for family violence, but it can feed and accelerate family violence and make it worse," Inquiry Chair Bill Wilson said.

**RESOURCES**

glenninquiry.org.nz/the-peoples-blueprint

## 04 Methadone funding cut at the Mount

**PATIENTS WHO** accessed a publicly funded methadone treatment programme at a Mount Maunganui medical practice now have to pay for their visits or go to the DHB. The Bay of Plenty District Health Board has been paying for Mount Medical Centre's stand-alone methadone service for people dependent on opioids but cut the funding in November 2014. Mount Medical has been receiving $2,000 per patient each year for the service and has 65 patients. One patient, who didn't want to be identified, said they were concerned about the move as they felt more comfortable going to their local GP to get treatment.

## 05 Victory LAP

**THE TASMAN** District Council has won a landmark legal ruling allowing it to enforce a 2am closing time for on-licence venues. Under alcohol reforms in 2012, maximum trading hours of 8am to 4am apply across the country unless they are altered by a Local Alcohol Policy (LAP). Tasman's 2am closure came into effect with its policy in December last year. Hospitality New Zealand appealed, saying the plan would have an adverse impact on patronage of bars and restaurants, but the Alcohol Regulatory and Licensing Authority ruled in favour of the Tasman District Council.


## 06 Capital's council caught out over closing time


**THE WELLINGTON** City Council's plan for late night drinking hours is in tatters after the Alcohol Regulatory and Licensing Authority accepted appeals against plans to allow bars in the capital's CBD to stay open till 5am. The proposed council rules outlining when and where people could buy alcohol had no legal standing, said the judge. Liquor laws implemented in 2012 set a national closing time of 4am. However, communities are able to set their own rules around drinking through Local Alcohol Policies. The Police advocate for a 3am proposal, but hospitality associations say that would hurt the vibrancy of the central city. It is unclear whether the council will appeal the Authority's decision in the High Court or revise its plan.

## 07 Busted over Buddha in Burma


**PHILIP BLACKWOOD,** a 32-year-old bar manager from Wellington, is facing up to two years in a Burmese prison for posting a picture of Buddha with headphones on Facebook. The image was posted to attract customers to his bar in Yangon, the nation's largest city. However, the nation's military government places harsh restrictions on insulting religion. Blackwood's family are appealing to the New Zealand Government for assistance.




## 08 Ministerial forum: sport and alcohol don't mix


**THE GOVERNMENT** has been told to end alcohol sponsorship of sports clubs and ban any television advertising of beer, wine and spirits during matches. The recommendations come from a ministerial forum set up in 2012 by former Justice Minister Judith Collins to investigate alcohol law reform. Chaired by former rugby league coach and businessman Graham Lowe, the forum concluded after a two-year inquiry that the total cost of alcohol-related harm in this country was "enough to justify further restrictions on alcohol advertising and sponsorship". In its report, released the week before Christmas, the forum recognised an association between exposure to alcohol promotions, an earlier age of initiation to drinking alcohol and increased consumption.

## 09 Survey shows evolution of Kiwi drinking attitudes

**THE MINISTRY** of Health released its Alcohol Use 2012/13: New Zealand Health Survey on February, with Associate Health Minister Peter Dunne calling the results encouraging. Of note are the comparisons between similar data collected in 2007/08, which shows progress around consumption behaviour, said Mr Dunne. "It is particularly pleasing to see risky behaviours such as drinking to intoxication and working under the influence of alcohol declining and fewer reporting first drinking before 15 years of age." The government was concerned with other findings, such as one in five pregnant women drinking during pregnancy.

**1 IN 5**

PREGNANT WOMEN DRINK DURING PREGNANCY.



**79%**

OF ADULTS AGED 15+ YEARS HAD CONSUMED ALCOHOL IN THE PAST 12 MONTHS.

**1/3**

OF DRINKERS DRANK ALCOHOL REGULARLY, AT LEAST THREE TO FOUR TIMES A WEEK.

**1/2**

OF DRINKERS HAD DRUNK TO INTOXICATION AT LEAST ONCE IN THE PAST 12 MONTHS.

**8%**

REPORTED DRINKING TO INTOXICATION AT LEAST WEEKLY.

1 IN 6 DRINKERS WHO DROVE IN THE PAST YEAR HAD DRIVEN WHILE FEELING UNDER THE INFLUENCE OF ALCOHOL.

**6.8%**

OF DRINKERS WHO HAD WORKED DID SO AT LEAST ONCE WHILE UNDER THE INFLUENCE OF ALCOHOL IN THE PAST YEAR. THIS EQUATES TO ABOUT 165,000 DRINKERS.

**RESOURCES**

nzdrug.org/AlcoholUse_NZsurvey

# World.


## Not just a bunch of hot air

**'VAPE'** was named 2014's Word of the Year by the Oxford English Dictionary. The term's official definition is 'to inhale and exhale the vapour produced by an electronic cigarette or similar device'. Increasing use as a cessation tool by smokers resulted in vape gathering some serious linguistic steam last year – its usage doubled, according to the dictionary's editorial board. Vape beat out contenders including slacktivism (lazy internet activism), bae (a term of endearment similar to babe) and indyref (shorthand for Scotland's independence referendum) to take the title.


### 02 Would you like beer with that?

**FAST-FOOD CHAIN** KFC has applied for a liquor licence for a new 'concept' store it plans to open in Sydney so it can sell beer and cider alongside its fried chicken. A spokesperson confirmed the move but refused to give further details. It is thought KFC is attempting to keep up with the growing popularity of casual dining restaurants, which often feature alcohol on their menus. The move has been met with condemnation from health advocates and family groups alike.

### 03 Venture-capitalise it?

**THE FAMILY** of the late reggae superstar Bob Marley has announced a partnership with private equity firm Privateer Holdings to develop 'Marley Natural'-branded weed. The cannabis will be Jamaican in origin but will be grown in the US state of Washington. Many fans were outraged to hear of the collaboration with a corporation. Marley's daughter, who owns the rights to Marley's name along with other family members, disagreed. "My dad would be so happy to see people understanding the healing power of the herb," she said.

### 04 Alcohol prices headed north

**IN AN** attempt to combat alcohol abuse, Northern Ireland is set to introduce minimum pricing on alcohol. Minister of Health Jim Wells said, "The level of harm caused by excessive alcohol consumption in Northern Ireland is staggering."

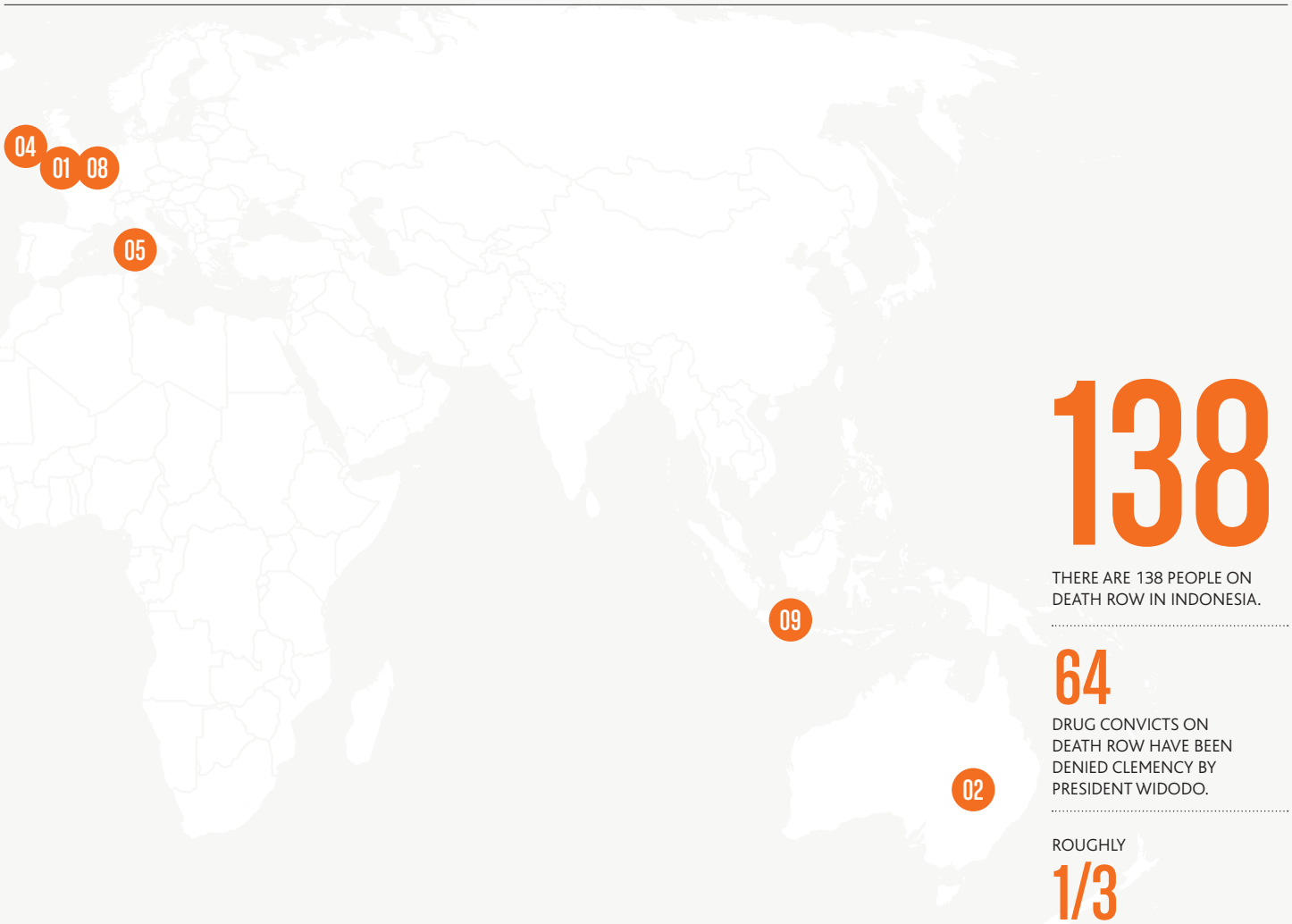
The total cost of drinking is estimated to be just under a billion pounds. Minimum pricing would reduce alcohol consumption by disincentivising price-sensitive customers as well as ensuring that the cost of a drink directly reflected its strength, Mr Wells said.

### 05 Malta makes way for medical cannabis

**SPECIALISED DOCTORS** will be able to prescribe the extracts of cannabis in medicinal form to patients if they believe no viable alternative exists, says Malta's Justice Minister Owen Bonnici. A Bill before Parliament would allow pharmacies to sell the medicinal cannabis. In rare cases, doctors will be able to prescribe cannabis leaf in its natural form, but the Health Superintendent will set certain conditions about its sale.

### 06 US halts war on medical cannabis

**THE UNITED STATES** Congress has passed a law that effectively blocks the Department of Justice from arresting or prosecuting anyone who sells or uses medical cannabis in the 32 states that currently have some type of medical pot law on the books. Originally intended as a spending Bill designed to prevent a government shutdown, the law included an amendment from two California Congressmen, Democrat Sam Farr and Republican Dana Rohrabacher, that would forbid the Department of Justice and the Drug Enforcement Administration from using taxpayer money to interfere with state medical cannabis laws.




## 07 Study: smoking, obesity both costlier than war

**A MCKINSEY** Global Institute study has found that smoking is a bigger burden on the world economy than armed violence, war and terrorism, and obesity isn't far behind. The analysis is a measure of the social cost of each activity and accounts for both public and private efforts to mitigate these different social burdens as well as the economic productivity lost due to disabilities and early deaths. According to the study, smoking and obesity on their own cost more than drug use and car accidents combined.

## 08 UK tackles drug driving


**POLICE IN** the UK will be able to test drivers for drugs on the roadside for the first time as a result of the Home Office approving a mobile drug-testing device. The Drugwipe device can test for cocaine and cannabis from a saliva sample within as little as three minutes. Traffic officers will now be able to test drivers on the roadside rather than taking them into a Police station, meaning the number of tests and convictions is likely to soar as the device is adopted by forces.

## 09 Firing squad causes diplomatic firestorm

Indonesia executed five foreigners and an Indonesian woman convicted on drug-trafficking charges by firing squad in the early hours of 18 January, setting off a diplomatic storm. Brazil and the Netherlands both recalled their ambassadors to Indonesia after the execution, with Brazilian President Dilma Rouseff saying the incident had "severely affected" relations with Indonesia. The Indonesian Government has defiantly vowed to continue to execute those found guilty of serious drug offending despite the diplomatic pressure. Rights groups have condemned execution for drug offences in Indonesia, with Amnesty International calling the latest round "a retrograde step" for human rights.

> **"What we do is merely aimed at protecting our nation from the danger of drugs."**
>
> INDONESIA'S ATTORNEY-GENERAL MUHAMMAD PRASETYO

> **"A cruel and inhumane punishment ... an unacceptable denial of human dignity and integrity."**
>
> DUTCH FOREIGN MINISTER BURT KOENDERS

**138**

THERE ARE 138 PEOPLE ON DEATH ROW IN INDONESIA.

**64**

DRUG CONVICTS ON DEATH ROW HAVE BEEN DENIED CLEMENCY BY PRESIDENT WIDODO.

ROUGHLY **1/3** OF THEM ARE FOREIGNERS.

IN **2013** EXECUTIONS RESUMED IN INDONESIA AFTER A FOUR-YEAR MORATORIUM ON THE DEATH PENALTY.

**15,000**

ECSTASY PILLS WERE BEING PRODUCED PER DAY BY ONE OF THE PEOPLE EXECUTED, ANG KIEM SOE.

**40–50**

PEOPLE DIE FROM DRUGS IN INDONESIA EACH DAY.

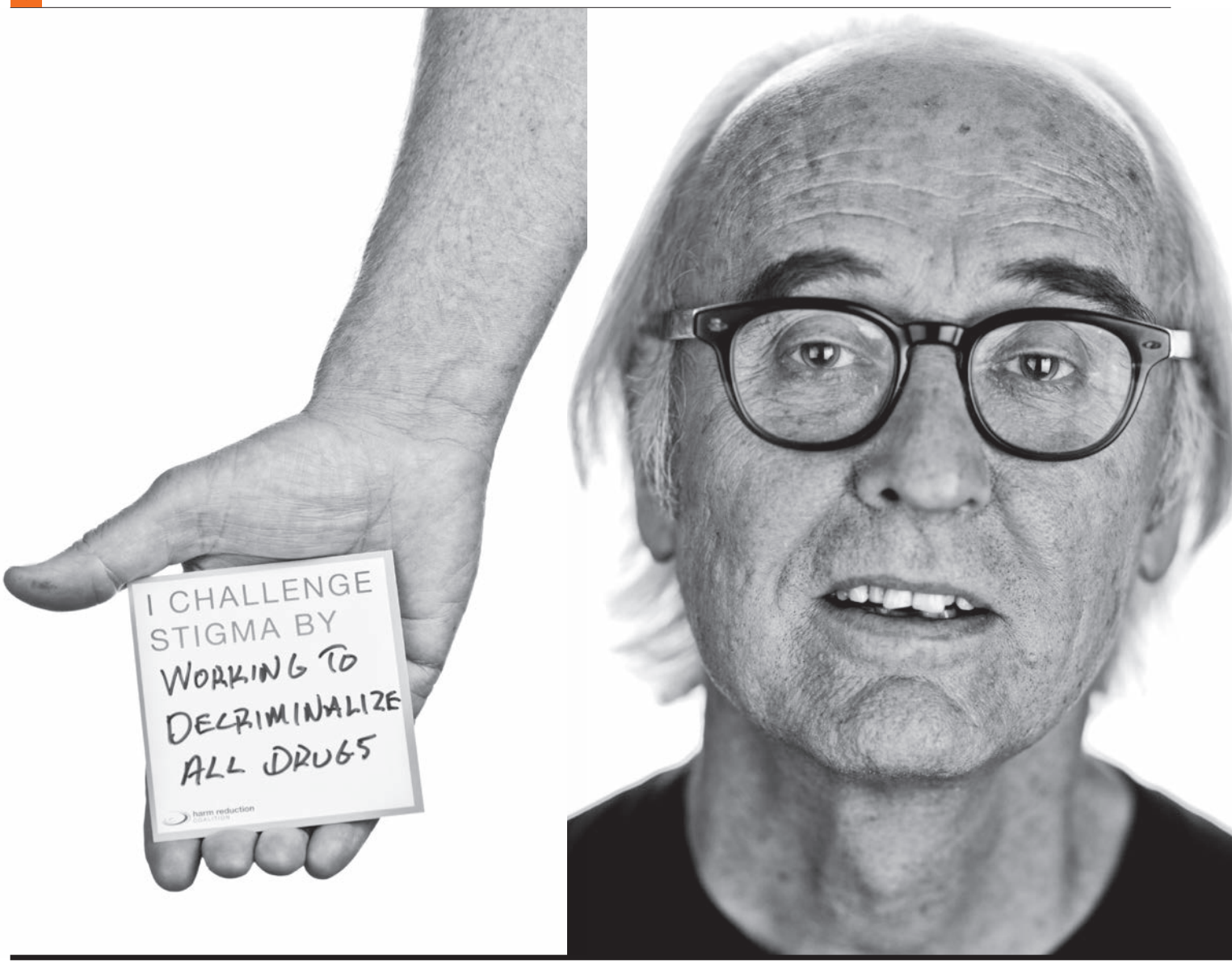
**45%**

OF THE SOUTHEAST ASIAN DRUG MARKET IS CIRCULATED IN INDONESIA ALONE.


# Underdosing naloxone

Globally, an estimated 69,000 people die each year from opioid overdose. The drug naloxone can quickly block opioid receptors in the brain and is used in some cases to bring people back from the brink of overdose death. **Amberleigh Jack** looks at why naloxone is not being used more widely.


DRUG TREATMENT WORKS WHEN IT'S NOT Time Limited
HARM REDUCTION MEANS DRUG USERS ≠ CRIMINALS
DRUG TREATMENT WORKS WHEN "FAILING" IS OKAY.
OVERDOSE TOUCHED ME WHEN I lost 4 people that I loved in 3 years
HARM REDUCTION MEANS People's Lives Matter!
DRUG TREATMENT WORKS WHEN you make it personal !!!
HARM REDUCTION MEANS autonomy over my body, and how I use it.
DRUG TREATMENT WORKS WHEN There is Understang
WE CAN PREVENT OVERDOSE BY GETTING #NALOXONE INTO THE HANDS OF THOSE WHO NEED IT MOST — DRUG USERS!
WE CAN PREVENT OVERDOSE BY bringing people out of the shadows.
WE CAN PREVENT OVERDOSE BY Decriminalizing drugs
WE CAN PREVENT OVERDOSE BY providing Naloxone to EVERYONE who could use it.
WE CAN PREVENT OVERDOSE BY #UNMASKING DRUG USERS.
WE CAN PREVENT OVERDOSE BY Reducing Stigma
I CHALLENGE STIGMA BY




AMBERLEIGH JACK

Mark Kinzly almost died from opioid overdose. Twice. He survived thanks to a life-saving drug known as naloxone. Others he knew weren't so lucky.

"I've watched my community die," he tells me. "The community is dying – either from AIDs or drug overdose – and the community has been dying for decades."

These days, he's off the drugs, lives in Texas and is an overdose prevention advocate. Unsurprisingly, he thinks the medication that saved his life should be an over-the-counter drug.

Naloxone works by instantly blocking opioids from receptors in the body, stopping them having any effect. It works in minutes and has the ability to bring people back from the brink of death. Its availability is a major part of overdose prevention programmes, particularly in the US.

The recent attempts by government to prevent overdoses is a good start, according to Kinzly, but there's still much more than can be done. And largely, it comes down to that vital drug.

"I have a 16-year-old son," he tells me, referring back to his own near-fatal experiences.

"I bet if you talked to him he'd be pretty happy that naloxone was available."

But for too many others, the potential lifesaver has not been at hand. Now, overdose prevention advocates, often with the backing of government officials around the world, are increasing efforts to actively prevent overdoses and make naloxone more readily available, saying hundreds of lives are being unnecessarily lost. As yet, nothing is happening in New Zealand, and perhaps it's time to ask why.

In the US in October 2014, the Office of National Drug Control Policy's Acting Director Michael Botticelli (otherwise known as the White House Drug Czar – the first person to hold the title who is in

> **Recent statistics suggest that more than 400 people died of a drug overdose in the four years between 2009 and 2013.**

recovery himself) told the Harm Reduction Conference in Baltimore a disturbing fact. In 2010, there were 38,000 overdose deaths in the US – a figure that superseded the road toll deaths in the same year (35,000). The number of road deaths has been steadily declining for the past two decades, while the drug overdose death rate has more than tripled.

In 2012, 41,502 drug overdose deaths were recorded in the US – almost 80 percent of which were accidental, and almost 7 percent were of unknown intent. And the drugs? More than half were pharmaceuticals, and more than 70 percent of these were opioid analgesics. The non-pharmaceutical deaths? Heroin, mostly, either on its own or combined with alcohol, pharmaceuticals or cocaine. Looking further into the stats makes for some depressing reading. In 2011, there were about 2.5 million visits to US emergency departments due to drug misuse and abuse. Around 71,000 of those were by people under 18 years of age.

And it's not just the US. Globally, an estimated 69,000 people die each year from opioid overdose (both pharmaceutical drugs like Oxycontin and morphine as well as illegal drugs like heroin and 'homebake' opioids). In the US, it's hit epidemic status, and the rest of the world is seeing increases, especially as prescription medicine misuse is on the rise. It's also no longer limited to the streets. With the rise in prescription opioids, middle-aged women are one of the rising demographics for overdose rates.

And the world is starting to take notice as it struggles to get the rates under control. While the ultimate goal is to reduce use and abuse, as Allan Clear of the Drug Harm Coalition in New York says, "You can only help people get off drugs if they're alive."

Enter naloxone. It's a major component of overdose prevention programmes and methods. A lifesaving drug that, if injected quickly enough, reverses opioid overdose and does so safely. It's been around for decades, yet in a number of states, it's been difficult to obtain until recently. It was in 2001 that the Chicago Recovery Alliance first established a US programme to allow injectible naloxone to be prescribed. By 2010, this decision had resulted in more than 15,000 naloxone prescriptions being filled to potential overdose witnesses, with more than 1,500 reported overdose reversals. In 2011, 15 states had introduced more than 180 programmes that had doctors available to prescribe naloxone. By this time, more than 10,000 overdoses had been recorded and more than 53,000 people trained in naloxone administration.

In New Zealand, users can obtain naloxone in an emergency situation when paramedics are called or by being presented to a hospital emergency department while overdosing (as long as the hospital carries naloxone – most do, but a few don't).

When asked why the drug is so difficult to obtain in New Zealand, Susanna Galea – a consultant psychiatrist and Clinical Director for the Alcohol and Drug Service within the Waitemata District Health Board – says she doesn't believe we have a need for it. She's worked previously in the UK. Compared to there, she tells me, our issue is minor.

"We don't have a massive overdose problem. Yes, people are dying," she admits, "but it's not a big problem. I'd say in terms of people dying, it's more around medical complications from overuse (such as cardiac arrest due to excessive methamphetamine). That's not to say we don't do any overdose prevention at all. It's integrated within the harm reduction philosophy and within the patient's care plan. So, no, there's no need to start dishing out naloxone."

Yes, comparatively, the figures are small in New Zealand. They're also incredibly difficult to find. Recent statistics suggest that more than 400 people died of a drug overdose in the four years between 2009 and 2013. Of these, it's estimated that an average of about 30 people per year die of opioid overdose. Sure, it's nothing compared to the figures in the US, but compared to our road toll figures, it's a decent chunk. To borrow a term commonly used by the Police concerning road fatalities, "One death is one death too many."

There's also another factor to consider. Oxycontin has been available since the 90s in the US, whereas it was introduced in New Zealand in 2005. In that time, prescription numbers have increased by more than 700,000. And we have 10 years of catching up to do.

But Kinzly says the best way to deal with the problem is to catch it before it becomes a massive problem. "Why would you wait until you're in a situation like the US?

"It's always nice when you get the opportunity to deal with something that could potentially become an issue and put something in place early enough so that it doesn't. It just makes sense, it's really good public health," he says emphatically.

"It's going to happen. Why would New Zealand be any different? Why would you wait until you're in a situation like the US is where it's an epidemic? One of the great things about New Zealand, you guys have been really progressive around areas of public health. Why would this be any different?"

> **One of the great things about New Zealand, you guys have been really progressive around areas of public health.**

MARK KINZLY

So what exactly does New Zealand do by way of overdose prevention? It's hard to say. The needle exchange centres (there are 21 across New Zealand) include information and education on overdose prevention for clients. It seems that for most, though, it's not a huge priority. This is probably due to the theory that heroin, in the last couple of decades, hasn't been a major issue in New Zealand. We have users, but they're relatively confined and pretty rare. Heroin's hard to get here and expensive. Charles Henderson, the head of the Needle Exchange Programme, is quick to point out, though, that when the figures are looked at on a per capita basis, injection drug use is very much alive in New Zealand. For many, it's a case of "out of sight, out of mind".

Peter Kennerley of the Ministry of Health's Addiction Treatment Services admits New Zealand has a problem with drugs but says the problem is more alcohol and amphetamine related. Our people are dying, but they tend to die of medical complications brought on by other drugs rather than overdose, he says. Government funding tends to be focused on harm reduction and education around drug and alcohol abuse.

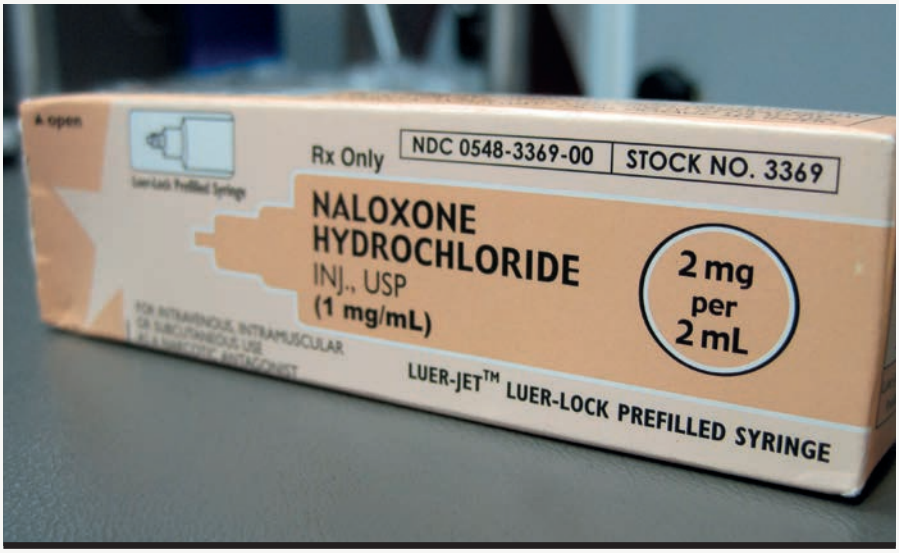



Photo credit: flickr.com/photos/intropin

**“It takes about one to three hours. If I call you up and say, ‘I’m getting ready to use, check on me in an hour or so’ …”**

MARK KINZLY

Kennerley explains that New Zealand has a multifaceted approach to harm reduction, and the idea of overdose prevention is integrated within that, focused mostly on education and stricter prescription monitoring.

“It’s a part of the overall service,” he says.

“There’s no one approach, but it’s partly around giving consumers choices and different sources of information. My concern would be when opioids are prescribed for pain management. People may end up with an addiction and start using them inappropriately. It’s something that needs to be looked at.”

He’s right, too. In New Zealand, deaths are occurring. Similarly with the US, the headlines are happening in the provinces. And it’s been happening for a few years. Vito Vari was 40 when he was found dead in his Nelson home in August 2011. The *New Zealand Herald* reported the coroner finding to be death by accidental overdose. The drug? Oxycontin.

IIIIIIIIII

It was the surging rates of accidental overdose death in the US that led to recent law changes, of which there are two main arms. The first is wider access to naloxone, the second is an increase in states that have passed Good Samaritan laws, providing immunity for people who seek help when someone has overdosed without fear of civil liability or prosecution.

In New Zealand, paramedic and hospital staff don’t tend to call the Police unless necessary, but Henderson suggests that the Police often tend to turn up in an overdose situation.

“We recommend that the first point of call is to dial 111,” he tells me.

“One problem we’ve got is that, if drugs are mentioned, it can be likely that the Police will arrive. There’s plenty of anecdotal evidence that the Police then do think about arrests.”

The Needle Exchange’s advice to rectify this isn’t without its flaws, though.

“We’re in a bit of a no-win situation, because our advice to clients would be that they should possibly avoid the naming of the drug used, because that immediately can result in charges. But it’s my understanding that St John’s only carry naloxone with advanced paramedics.”

So the risk is that, by avoiding arrest, a paramedic may arrive who simply doesn’t have the lifesaving drug on hand. Following suit with US immunity laws, Henderson suggests, would help a lot.

In the US at the end of 2014, 20 states had introduced Good Samaritan laws providing immunity from prosecution or civil action if someone used a prescription that wasn’t theirs or was found to be intoxicated or to have gear on them at the overdose scene.

Since then, availability has increased further. Now, 22 states have increased naloxone availability for users and bystanders, and while traditionally only a doctor can prescribe directly, states such as New York and California have loosened the rules to allow doctors to prescribe for harm reduction and syringe exchange programmes without having to be present to distribute the prescriptions. As well as this, with the backing of the Federal Government, the Police forces and armed defence forces have been trained and supplied with naloxone over the past year.

The big rise in the use of prescription opioids, and the resulting increase in addiction and overdose, have brought the problem to the forefront of the public mind, says Allan Clear, and so have the high-profile deaths of celebrities including actor Philip Seymour Hoffman.

“The focus on opioids is a strategy we adopted a few years ago,” he tells me about the Harm Reduction Coalition’s approach to education and overdose prevention.

“There’s a ban on using any federal money to supply syringes to anyone else. So our focus [for funding and support] became much more on opioid overdose [and pushing for access to naloxone and education tools]. Even when you talk to Democrats around syringe exchange, if they come from places like Minnesota, they basically say, ‘This is a big city problem. It’s not our problem. We don’t have it’.”

It’s a different story with prescription medication though.

“But when you talk about prescription drug use – people [in government] from

places like Minnesota or Wisconsin – they all get it. And very often they say things like, 'My brother-in-law had a problem,' or 'My cousin has been in rehab'."

That stigma and discrimination around drug use is an issue in Australia as well – one that isn't necessarily stopping strong overdose prevention measures but one that can definitely make them more difficult to implement without support from the top down.

In Australia, Tony Trimingham knows more than he'd ever want to about drug overdose – and the stigma around use and abuse. In 1997, his son Damien, aged 23, was found dead in a disused hospital corridor in Sydney after overdosing on heroin. He was a regular user but had recently had a period of abstinence. The lowered opioid tolerance contributed to his fatal mistake. Shortly after, Trimingham found himself struggling to find support and information and ultimately created Family Drug Support – a non-profit organisation that helps families find support, information and help when it comes to loved ones' drug use. When he talks about his son and the stigma around his untimely death, Trimingham has the same tone of voice I'm now all too familiar with. The quiet conviction – something that conveys both deep pain and regret as well as a fierce determination – especially when it comes to that all-too-common stigma.

"It's still as strong as ever," he insists.

"I've known lots of families that lost people and have never stated the fact it was a drug overdose. There's a lot of pressure on families not to talk about it.

"I don't think it applies in any other area. People with mental illness are now speaking out, and the stigma is reducing as they do that. But not for drugs. It's still the leprosy of the modern age. It affects the drug users more than anybody, but next to that, it's the families."

It's an attitude that's not just confined to Australia.

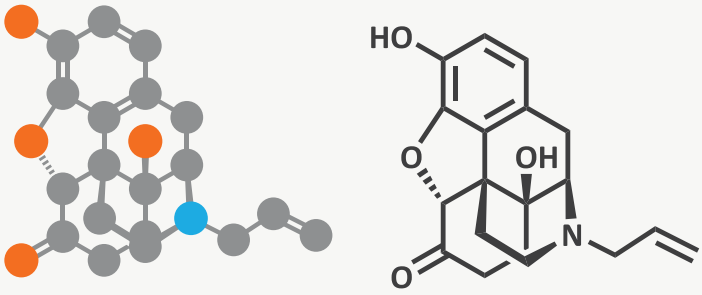
Back in Texas, Kinzly believes that stigma is one of the biggest hurdles to making appropriate services available – whether that's harm reduction, overdose prevention or even housing. And it can make overdose more likely simply because of the shame attached to using.

"That stigma means we don't tell people we're using," he says.

"We need to encourage people to be more open. Find someone you trust, even if they're not with you. Most of us don't die immediately. It takes about one to three

**FACTS**

## Naloxone




Naloxone (also known by its trade name Narcan) is a full opioid antagonist, which has been used globally for more than 40 years. It is generally distributed as an intramuscular injection, and it is most commonly injected into the upper arm to avoid any potential nerve damage. In the US, it is also available in a nasal spray, eliminating any concerns over risk associated with needle injection. It reverses the effects of opioids such as respiratory depression, sedation and hypotension. When injected, naloxone works within three to seven minutes and is said to be 97 percent efficient.

### Global availability

Most developed or developing countries have naloxone available in emergency departments, and more than a dozen countries have introduced naloxone distribution at a community level. These include Afghanistan, Australia, Canada, China, India, Italy, Kazakhstan, Kyrgyzstan, Tajikistan, Thailand, the United Kingdom of Great Britain and Northern Ireland, the United States, Ukraine and Vietnam.

In New Zealand, naloxone is administered by ambulance officers and in hospitals. It is not available for community distribution.

### Cost

The cost of a naloxone kit in the US is about $20, although naloxone prices are increasing.

**$20**

### Dosage

Since the duration of action of some narcotics may exceed that of naloxone, the patient should be kept under continued surveillance and repeated doses of naloxone should be administered as necessary.

For the reversal of known or suspected opioid overdoses in adults, an initial dose of 0.4–2.0mg is recommended, repeated every few minutes if needed. If there is no response it is likely the condition is not an opioid overdose.

Naloxone is also safe for use with children and newborns, with a suggested dose of 0.01mg per kg of weight.

### Side effects/risks

Naloxone has no psychoactive effect and is non-addictive.

As naloxone only temporarily reverses the effects of opioids, it is essential that the overdose victim be monitored following the injection to ensure that overdose does not reoccur once the naloxone wears off (usually about 60–90 minutes). It is also imperative that opioids are not retaken, despite the user experiencing likely withdrawal symptoms.

It is recommended that emergency services ensure full monitoring following an overdose reversal.

The only known risk associated with naloxone is the onset of opioid withdrawal symptoms due to the blocking of any opioids in the system. These include body aches, diarrhoea, tachycardia, fever, sweating, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness and increased blood pressure.

Naloxone is ineffective against non-opioid overdose or other non-opioid-related medical conditions.


Photo credit: flickr.com/photos/mannaz

> **"So the affluent, influential mothers and fathers, sisters and brothers are now making noise. It's like, well now our *kids* are dying, so we have to do something."**
>
> MARK KINZLY

hours. If I call you up and say, 'I'm getting ready to use, check on me in an hour or so' – do you know how many lives we could save just by teaching people not to use alone or to have somebody check on them?"

It's something I understand. My own brother Barnaby died of a heroin and cocaine drug overdose in his San Francisco apartment. While intervention measures such as naloxone would likely have been able to save him (the drug doesn't affect the non-opioid cocaine in the system, but often with combination overdoses, removing the opioids is enough), there wasn't an opportunity as he was alone. He wasn't found until it was too late. He also hadn't told anybody he was using. He was highly intelligent, a world-class computer security expert who travelled the world speaking at conferences and to government officials. Friends have suggested he never told us of any drug use because he feared we'd be disappointed. By the time we found out, it was too late. And even then, the word 'overdose' is just beginning to be spoken within our family. My mother is only now willing to let people know how he died. The stigma is real, and everyone seems to agree it needs to change for any real overdose prevention intervention.

In some ways, though, attitudes are changing. And the reasons seem to be related to the rise in prescription opioid pain medications.

"What's happening in regards to overdose is that, because of prescription drugs and how it's affecting suburban areas, white middle and upper class kids are being affected," says Kinzly.

"So the affluent, influential mothers and fathers, sisters and brothers are now making noise. It's like, well now our *kids* are dying, so we have to do something."

Allan Clear has found a similar shift in attitude with the Police he's worked with through naloxone distribution and training.

In the US, 21 states currently have trained Police departments carrying naloxone. New York has more than 150 departments involved in the programme. Already in January, one department – Buffalo PD – recorded three overdose reversals. In Massachusetts, known to have a major heroin problem, one department – Quincy PD – had recorded 300 overdose reversals as of September 2014. Most departments list at least one recorded save or reversal since beginning the programme.

Perhaps that's what has helped make the work with the police and other frontline staff more open to being involved. It's no longer just a problem for typically homeless black addicts, suggests Clear, but for neighbours and friends of the fairly affluent working class. He highlights this with his recent experience training Police officers in the administering of naloxone.

"I was taken aback to watch a cop do the trainings with other cops," he says.

"I've done Police trainings [in the past], and they're usually incredibly hostile. I recall back in the 90s, I once said, 'You can't get HIV from heroin,' and one of the cops said, 'Well that's a shame isn't it'."

But now?

"It was astonishing [recently] to hear [a Police trainer] talk about how it's the duty of the Police to revive someone from an overdose. Back when we started, the Police notion was that we're better off without them. When you see Police reversing overdoses and taking an active role in preserving the lives of drug users [by organising treatment rather than making arrests], it's astonishing they're taking that on, because a few years ago, they wouldn't have seen it as part of their job."

The reason? Clear thinks the rise in prescription overdoses is a big part of it.

"A place like Staten Island is considered predominantly white, blue collar working class – it's a Republican part of New York – and it's been hard hit by overdose. Cops and firemen are seeing the problem in their own communities. People they know are dying of overdose. That may affect the attitudes."

Not that the stigma doesn't exist though or that there aren't problems with introducing prevention programmes that people get on board with.

"I guess it's all relative. It's still highly stigmatised. We do amazing work in New York, for example, but then you go down south, and it's incomprehensible to me.

*People from any walk of life can be affected by overdose, says Allan Clear, Drug Harm Coalition*

**“I recall back in the 90s, I once said, ‘You can’t get HIV from heroin,’ and one of the cops said, ‘Well that’s a shame isn’t it’.”**

ALLAN CLEAR

It seems the efforts of local government down south deprive people of healthcare. You won’t find sympathy for drug users in virtually any of the southern states. You have great disparities in services and enormous disparities in health outcomes.”

Closer to home, Australian heroin use has been a growing issue for decades, with 1,100 heroin overdose deaths being reported during the country’s “heroin glut” in 1999. While heroin deaths have decreased since then, opioid overdoses are on the rise. Naloxone is available through syringe exchange centres and programmes such as Victoria’s COPE (Community Overdose Prevention Education). While the drug is available, there are still major restrictions. Naloxone in Australia can only be prescribed to the user, not to a potential witness. This, of course, relies on users specifically seeking out a doctor and rules out concerned family or friends from being prepared with the antidote. As with the US, overdose rates were higher than road toll deaths in 2013, with road accidents in Australia resulting in 242 deaths compared with 374 overdose deaths (including intentional). 310 of these involved prescription medications.

Belinda McNair of the Penington Institute – which works on improving overdose prevention across Victoria – says she struggles to understand why naloxone isn’t widely available.

“I’ve been trying to find ways where the drug could be misused in some way,” she tells me.

“If you give it to someone who isn’t suffering an opioid overdose – nothing happens. If, God forbid, a child finds it and injects its brother – the brother will cry because he just got a needle in his arm – that’s it.”

One thing everyone agrees on is that a major aspect of overdose prevention is education. The US, again, has multiple community groups and programmes designed to educate users and families on how to prevent overdose, ranging from simply not using to full video tutorials online about how to administer naloxone.

Back here, Galea says that education is a large part of overdose prevention in New Zealand – that it’s incorporated into programmes, particularly in regard to lowered tolerance due to abstinence following hospital or rehab stays.

“We do have an inpatient unit. Once they’ve been detoxified, if they go back to their pre-treatment dose, there is a risk of overdose. We do teach them that, and we teach them about tolerance. We also have what we call post-detox groups for vulnerable periods.”

So what needs to happen? Some say a lot. Henderson is a firm supporter of naloxone being made available in New Zealand, And he’s quick to point out, if the estimated figure of 30 deaths per year is correct, that’s not an insignificant number. His hope? That the drug will be rolled out, and that the easiest way to implement it would be through the Needle Exchange Programme.

“Through needle exchanges, we certainly hear enough anecdotes of overdoses occurring ... We need to be able to have the training measures in place to roll out something like naloxone.”

Kinzly believes at some point naloxone will be available as an over-the-counter drug. But there’s a way to go yet.

“It’s rare that we have the opportunity in our lifetime, with an epidemic going on, to dramatically curb it just by making a couple of simple things accessible. We can make a dramatic decrease in overdoses just by making the medication available. For whatever reason, we don’t do that.

“How do you give somebody something that’s potentially fatal and not give them a medication that could potentially save them from that fatality? It’s just unethical.”

Similarly, Australia needs improvement, according to Trimingham, and it’s something that needs to start from the top.

“I’d like to see a more willing attitude from the people that have the power to exact legislation. People don’t want to go anywhere near anything that might have anything to do with drugs or be seen to be condoning use,” he says.

“It’s not though,” he continues.“It’s accepting reality.”

And for New Zealand? Kinzly has a word of advice. Our overdose rates may not be large, but they’re important enough to warrant intervention. And prevention starts with making naloxone more freely available.

He refers back to my own situation and to his near fatal overdoses.

“That’s it right there,” he says.

“Whether it’s 30 deaths or one death, it doesn’t matter. To that one person’s family, it’s a big fucking deal.” ■

**Amberleigh Jack is a writer based in Auckland**

*Photos on the cover and pages 6 and 8 were taken by Matt Slaby (www.luceoimages.com) for the Harm Reduction Coalition.*

# Good booze news from across the ditch

In late November 2014, the Australian Government's Institute of Health and Welfare released its full report on the 2013 Australian National Drug Strategy Household Survey. The survey has been conducted every two or three years since 1985, and 2013's iteration collected information from almost 24,000 people, asking them about their use, attitudes and opinions on alcohol, tobacco, illicit drugs and what they think about alcohol and drug policies. As **Rob Zorn** reports, the results are pretty encouraging.

ROB ZORN

> **“In fact, 40–49-year-olds have now replaced young people as the group most likely to drink at risky levels.”**
>
> JULIE RAE

The 2013 Australian National Drug Strategy Household Survey has revealed some pretty good things are happening in Australia in terms of drugs and alcohol. Methamphetamine use has remained stable, and the proportion of young people who have never smoked has risen from 58 percent to 77 percent. Risky drinking has declined overall, and about half of all drinkers have reduced the amount they drink because of health concerns.[1]

This last finding is good news because it indicates a fair proportion of drinkers now are well aware of the health benefits of reducing alcohol consumption. But what’s particularly encouraging is what’s happened with the stats around youth. Young people are now waiting longer before trying their first drink (15.7 years of age, up more than a year from 14.4 years of age), and the proportion of 18–24-year-olds engaging in risky drinking behaviours has fallen from around 30 percent to around 20 percent. In fact, 40–49-year-olds have now replaced young people as the group most likely to drink at risky levels. The proportion of young people aged 12–17 years of age who are choosing not to drink at all has risen from 64 percent to 72 percent.

While this doesn’t indicate that everything’s rosy with alcohol and drug use across the ditch, that the majority of young people are not drinking and taking drugs is news so exciting we should be shouting it from the rooftops, according to Australian Drug Foundation (ADF) Head of Information and Research Julie Rae.

“The later a young person first tries alcohol, the less likely they are to have a problem with alcohol as an adult,” she is quick to remind.

The three big guns in combating alcohol misuse have long been accepted as marketing, pricing and availability – all three largely legislative. But Australia has not made any major moves in these areas in recent years and could hardly call itself a world leader in terms of alcohol law reform. It’s the only country in the world where alcohol is available 24 hours a day, and it still has alcohol advertising on free-to-air television. While this is usually only allowed after 8.30pm, it can feature at any time during the broadcast of live sporting events, which are often watched by children.

“So Aussie kids are seeing these ads,” says Rae, “and we know this sort of marketing has an enormous effect. British research by the Joseph Rowntree Foundation, for example, reveals kids as young as four can identify alcohol by its bottling.”

In the absence of significant legislative changes, there’s been a lot of discussion at the ADF about what the positive changes in the 2013 survey could be attributed to. And the answers are probably community awareness and culture change – often two sides of the same coin.

“We can only speculate,” says Rae, “but we know there’s more talk going on in the news about risky drinking and young people drinking.


Photo credit: Australian Drug Foundation

*A seminar in June 2014 looked at best-practice approaches to prevention that communities can use.*
Photo credit: Australian Drug Foundation


> **"Unfortunately, Big Alcohol will respond to these positive figures by trying to reverse them and have people drinking more, rather than less."**
>
> ADF GROGWATCH

"We know there are a lot of programmes out there looking at the risks and protective factors for young people, and we've got messages out there to parents that they need to set behavioural expectations for their kids."

The ADF isn't the only organisation working towards that culture change, but some of its programmes serve as excellent examples.

Its Good Sports programme has been rolled out across the nation to help ensure young people drink more responsibly. Sporting clubs go through a three-stage accreditation system that steps them through responsible alcohol management. It includes things like not having alcohol present at junior competitions and offering alternatives to full-strength alcohol at events.

The ADF's Other Talk programme encourages parents to have conversations with their kids about alcohol. It uses forums and parental advisory groups to have those discussions.

"We're also working in workplaces towards responsible event management around alcohol," says Rae.

"We just knock on the doors of these businesses and offer policy tips if they are starting to think about alcohol use in the workplace. We use an occupational health and safety approach and talk about absenteeism due to hangovers and the harms that could be done to both safety and profitability when someone is under the influence of a drug at work. It's just basic awareness raising really."

> **"Underage drinking could be greatly reduced if all states and territories introduced secondary supply legislation to prevent unauthorised supply of alcohol to children."**
>
> JULIE RAE

While it seems fairly certain initiatives like these have helped cause cultural change, Rae is quick to point out that there remains a long way to go in the Lucky Country. Alcohol still causes around 5,500 deaths and 150,000 preventable hospitalisations and costs the country A$15 billion each year.

She says legislative changes are a must if further progress is to be made.

"Alcohol needs to be properly labelled to warn people of the dangers of excessive drinking and trading hours need to be reduced in the interests of people's health. Underage drinking could be greatly reduced if all states and territories introduced secondary supply legislation to prevent unauthorised supply of alcohol to children.

Photo credit: Australian Drug Foundation


> **“British research by the Joseph Rowntree Foundation, for example, reveals kids as young as four can identify alcohol by its bottling.”**
>
> JULIE RAE

“We’ve made seatbelts compulsory even though the hospitalisations and deaths from road accidents are much less than those from alcohol, so we need to have that preventative legislation in place.”

And it seems such legislative changes would meet with the approval of the average Aussie. The survey reveals most want to stop alcohol marketing to young people. Most support a ban on alcohol sponsorship of sporting events. As many as 73 percent want alcohol advertising on television restricted to late-night viewing after 9.30pm.

So if there’s now a national palate for alcohol law reform, why is the Australian Government reluctant to act? It may be that it doesn’t think reform will be all that popular (unlikely by now). It may be that it isn’t convinced by the research and findings of its own body (it’s been convinced by much less), or the answer may be the same as it is just about everywhere else – the alcohol industry.

The industry wields its might to oppose reform on whatever front it can. For example, Brewers Association CEO Denita Warn was quick to use the survey’s findings around the decline in risky drinking to soothe public concerns around alcohol harm by saying they “dispel the myth of a growing alcohol crisis”[2] despite the fact that Australia’s alcohol harm statistics are still a gruesome read.

“Unfortunately, Big Alcohol will respond to these positive figures by trying to reverse them and have people drinking more, rather than less,” says a 22 July 2014 issue of ADF’s Grogwatch.[3] “Australia is still very much in the grip of a dangerous love affair with booze.”

And of course, as a multi-billion dollar industry, Big Alcohol wields significant political influence.

“There’s a huge push and pull between agencies like ourselves and government policy,” says Rae. “The alcohol industry is a powerful lobbyist – and its arguments are all around the free market, creating jobs and supplying goods. Great, but our response is, ‘With what harm and at what cost?’.

“We’re finally getting somewhere, but the real fear now is that government inaction may see the foot coming off the pedal.” ■

**Rob Zorn is a Wellington-based writer**

1 The full report is available online at nzdrug.org/2013-andshs.

2 Media release: New data highlights ongoing trend in decline of risky drinking. Brewers Association of Australia & New Zealand Inc. 17 July 2014. Retrieved 18 January 2015 from http://www.brewers.org.au/wp-content/uploads/2014/07/Brewers-Association-Media-Release-New-data-highlights-ongoing-trend-in-decline-of-risky-drinking-17-July-2014.pdf.

3 Less under 18s drinking alcohol but more to be done. Grogwatch, 22 July 2014. Retrieved 18 January 2015 from http://grogwatch.adf.org.au/2014/07/less-under-18s-drinking-but-job-far-from-done/



## The New Zealand situation

New Zealand does not have a regular government-sponsored equivalent to the Australian National Drug Strategy Household Survey. We did once have the national Alcohol and Drug Use survey, but this was last conducted in 2007/08. The survey has now been discontinued with questions incorporated into the New Zealand Health Survey.

The 2013/14 New Zealand Health Survey Update reveals there has been a very moderate decline in overall hazardous drinking in New Zealand’s population over the past seven years (from 18 percent down to 16 percent).

The rate of hazardous drinking amongst men has dropped minimally from 26 to 22 percent, but the rate remains the same in women at (11 percent). Encouragingly, the rate has decreased in 15–17-year-olds (19 percent down to 14 percent). However, mirroring circumstances in Australia, the rate amongst 45–54-year-olds has increased from 12 to 16 percent – meaning our young middle-agers are also the group now drinking most riskily.

A two-point percentage drop in hazardous drinking can’t be bad news in and of itself – but is it really something to crow about if we’ve just been through a couple of years of major alcohol law reform?

One wonders how much greater that drop might have been if more attention had been paid to the Law Commission’s recommendations around pricing, marketing and availability.

**RESOURCES**

See the latest New Zealand Health Survey results at nzdrug.org/nzhealthsurvey13-14

# Secondary school student drug use stats

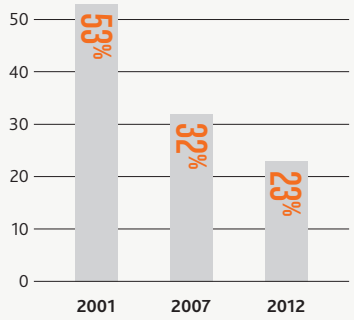
The third Youth2000 survey shows drug use by secondary school students continues to drop.

Findings presented in the *Problem substance use among New Zealand secondary school students* report, released in November 2014, show declines in the numbers smoking cigarettes, binge drinking and using cannabis. Nevertheless, 11 percent of students met the criteria for very high substance use, with binge drinking the most common problem use.

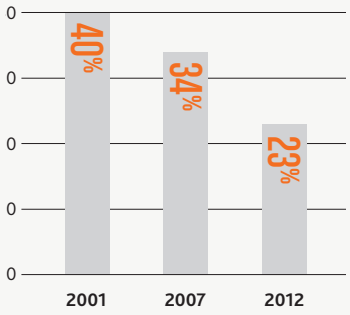
The Youth'12 survey was completed by 8,500 students from 91 schools (3 percent of the national school roll).

Key findings are presented here. The full report is online: nzdrug.org/youth12_drug_use

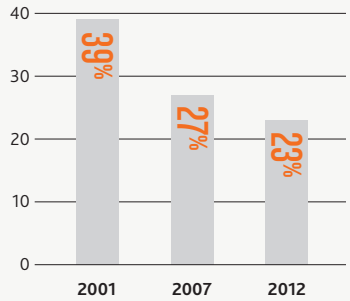
**STUDENTS WHO HAVE EVER SMOKED A CIGARETTE**



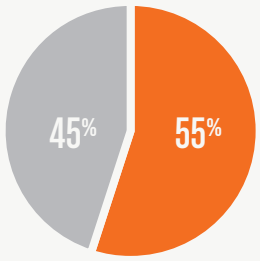

**BINGE DRINKING BY STUDENTS IN THE LAST FOUR WEEKS**




**STUDENTS WHO HAVE EVER USED MARIJUANA**




**CURRENTLY USE ALCOHOL**




**AMONG STUDENTS WHO CURRENTLY DRINK ALCOHOL**

**DRINKING FREQUENCY**

APPROXIMATELY 7 OUT OF 10 CURRENT ALCOHOL DRINKERS HAD **HAD A DRINK IN THE LAST FOUR WEEKS**

APPROXIMATELY 2 OUT OF 10 CURRENT ALCOHOL DRINKERS HAD HAD A DRINK **WEEKLY OR MORE OFTEN**

**BINGE DRINKING***

**24%**

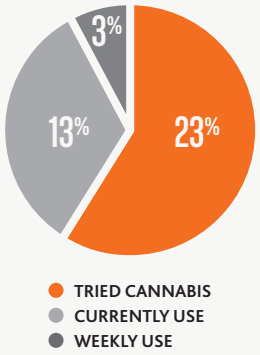
*UNDER 16 YEARS DRANK FIVE OR MORE ALCOHOLIC DRINKS IN ONE SESSION TWO OR MORE TIMES IN THE PAST FOUR WEEKS

OVER 16 YEARS DRANK FIVE OR MORE ALCOHOLIC DRINKS IN ONE SESSION EVERY WEEK OR MORE

**REFERENCE**

Fleming, T. Lee, A.C., Moselen, E., Clark, T.C., Dixon, R. & The Adolescent Health Research Group. (2014). *Problem substance use among New Zealand secondary school students: Findings from the Youth'12 national youth health and wellbeing survey*. Auckland, New Zealand: The University of Auckland.

## CANNABIS USE



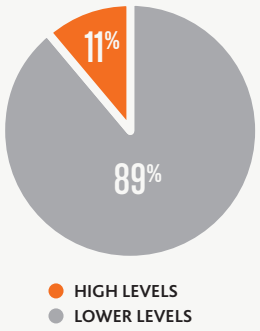

## OTHER DRUG USES ARE UNCOMMON

**4%** USED PARTY PILLS

**3%** USED ECSTASY

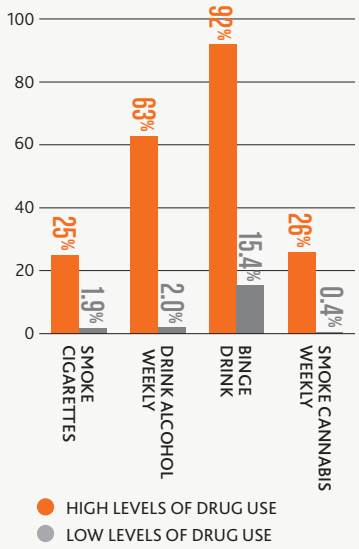
**<1%** USED P

## LEVELS OF DRUG USE




## OF THE 11% OF STUDENTS WITH VERY HIGH LEVELS OF DRUG USE

### MORE LIKELY TO




### WHAT IS PROBLEM (VERY HIGH) SUBSTANCE USE?

The Adolescent Health Research Group (AHRG) definition is based on the following factors: alcohol frequency, binge drinking, cannabis and other substance use. There are criteria for students aged under 16 years and those aged 16 years or over.

## STUDENTS WITH VERY HIGH USE HAD POORER HEALTH AND WELLBEING ACROSS ALMOST EVERY AREA EXAMINED

### THEY WERE MORE LIKELY TO:

- report negative family experiences
- have witnessed or experienced violence or abuse
- report negative experiences of schooling
- have had an injury that needed treatment
- be overweight or obese
- gamble
- have been in trouble with the Police in the last year (39% compared to 7%)
- have had sex (68% compared to 18%)

## OF THE 11% OF STUDENTS WITH VERY HIGH LEVELS OF DRUG USE

**30%** WORRIED ABOUT HOW MUCH THEY ARE DRINKING

**18%** HAD TRIED TOCUT DOWN OR GIVE UP DRINKING

**37%** WORRIED ABOUT HOW MUCH MARIJUANA THEY USED

**36%** HAD TRIED TO CUT DOWN OR GIVE UP MARIJUANA

**ALMOST 2/3rds** HAD EXPERIENCED PROBLEMS BECAUSE OF THEIR ALCOHOL USE

**31%** had done things that could have got them in serious trouble, **33%** were injured, **25.5%** had unsafe sex and **24%** had friends or family members tell them to cut down

**MOST YOUNG PEOPLE WITH SUBSTANCE USE PROBLEMS ARE NOT WORRIED ABOUT THEIR USE, NOR ARE THEY SEEKING OUT HELP**

## CONCLUSIONS

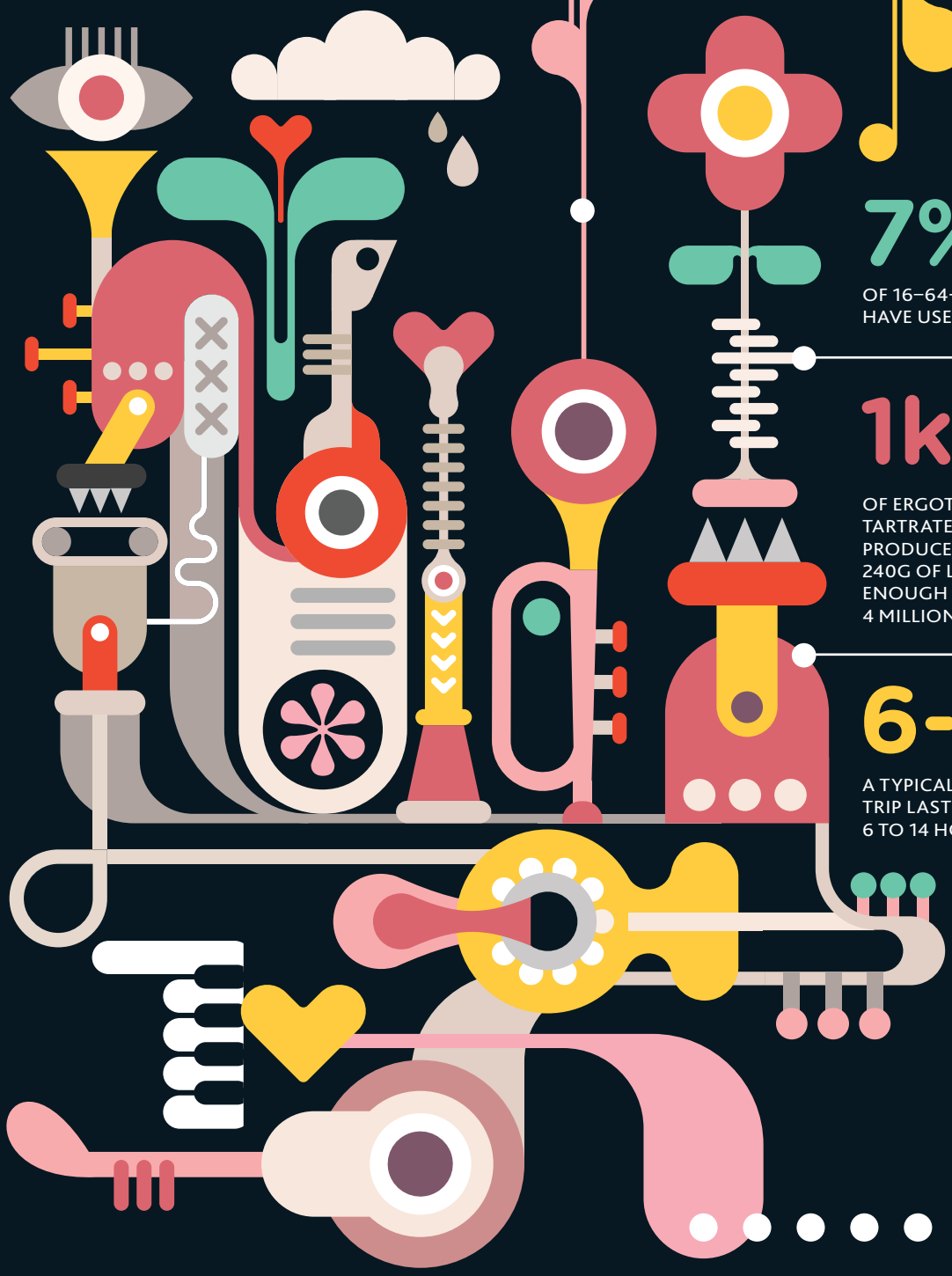
Efforts must be made to reduce the level of substance use (and related harm) by school students.

Holistic or systemic approaches will be more effective at meeting the needs of students than those that focus on single issues, i.e. they need to also address such things as problems in a student's family and school life, experiences of violence, risky driving, poor mental health etc.

Social norms, such as high rates of use among peers and family, and the availability of alcohol and other substances in communities must be tackled in efforts to reduce high levels of substance use among young people.

Enhancing young people's protective factors, such as family and school connections, is equally as important as access to counselling or other social services. ■

# LSD



**7%**

OF 16–64-YEAR-OLDS HAVE USED LSD

**1kg**

OF ERGOTAMINE TARTRATE CAN PRODUCE AROUND 240G OF LSD – ENOUGH FOR 4 MILLION DOSES

**6-14**

A TYPICAL LSD TRIP LASTS FOR 6 TO 14 HOURS

Lysergic acid diethylamide (or LSD) has many street names including yellow sunshine, window pane and Microdot but it is most commonly known as acid.

It is mainly used recreationally, as an entheogen (a fancy word for a chemical that brings you closer to the divine) and – in the 60s and 70s and again more recently – in psychedelic therapy for alcohol dependence and anxiety.

In its pure form LSD has no colour, odour or taste. It is usually taken orally via absorbent blotting paper, in a sugar cube or in gelatine. It can also be administered by injection when in liquid form. It is generally accepted to be non-addictive and is relatively non-toxic.

LSD's effects include altered thinking processes, visual hallucinations and an altered sense of time. However, an LSD trip can vary greatly from person to person. One trip can also be very different to another for the same person, and trips can have long-term psycho-emotional effects. Some users say LSD has caused significant changes in their personality and life perspective.

Adverse psychiatric reactions such as anxiety, paranoia and delusions are possible, and LSD may temporarily impair the ability to make sensible judgements and understand common dangers, so users can become more susceptible to accidents and injury. It may cause temporary confusion, difficulty with abstract thinking and impaired memory or attention span. The January 2013 edition of the *Journal of Addiction Medicine*, for example, reports a case where a man with no diagnosed mental illness manually removed his own testicles during his first LSD trip. Fortunately, that sort of thing doesn't seem to happen very often.

Flashbacks, in which an individual experiences an episode of some of LSD's subjective effects long after the drug has worn off, are also a reported phenomenon. No definitive explanation is currently available for these.

The United Nations Convention on Psychotropic Substances requires its parties to prohibit LSD for recreational use. Hence, it is illegal in most countries, including New Zealand, the United States, Australia and most of Europe. However, medical and scientific research with LSD in humans is permitted under the Convention.

In New Zealand, LSD is classified as a Class A drug under the Misuse of Drugs Act 1975. This means it attracts the highest penalties possible for manufacture and sale, including life in jail. Possession can attract up to six months imprisonment, a $1,000 fine or both.

According to the Drug Use in New Zealand Survey 2007/2008 published in 2009, 7.3 percent of 16–64-year-olds have used LSD, and 1.3 percent of 16–64-year-olds used it in the previous 12 months.

LSD was first developed in 1938 by Dr Albert Hofmann at the Sandoz pharmaceutical company in Basel, Switzerland. It was synthesised from ergotamine, a chemical derived from ergot, a grain fungus that typically grows on rye. But he didn't discover its psychedelic properties until 1943.

Sandoz introduced it commercially in 1947 under the trade name Delysid as a drug with various psychiatric uses, and it quickly became a therapeutic agent that appeared to show great promise in the treatment of alcohol dependence syndrome and pain relief.

Some psychiatrists believed LSD helped patients unblock repressed subconscious material. A 1959 study published in the *Quarterly Journal of Studies on Alcohol* concluded: "The root of the therapeutic value of the LSD experience is its potential for producing self-acceptance and self-surrender."

In the 1950s, Central Intelligence Agency (CIA) officials thought LSD might be useful for mind control and chemical warfare and began a research programme codenamed Project MKULTRA. Experiments included administering LSD to CIA employees, military personnel, doctors, other government agents, prostitutes, mentally ill patients and members of the general public in order to study their reactions, usually without the subject's knowledge. LSD was eventually dismissed by CIA researchers as too unpredictable in its results, and Project MKULTRA was scrapped in 1973.

LSD became very popular as a recreational drug among 1960s counterculture enthusiasts, the most prominent of whom was probably American psychologist Timothy Leary (famous for the catchphrase "tune in, turn on and drop out) and whom President Richard Nixon once described as "the most dangerous man in America" for his pro-psychedelics stance. LSD became a prohibited substance in the US with the adoption of the UN Convention in 1971.

The psychiatric use of LSD is enjoying a small renaissance with organisations such as the Beckley Foundation, the Multidisciplinary Association for Psychedelic Studies (MAPS), the Heffter Research Institute and the Albert Hofmann Foundation co-ordinating research into the medicinal and spiritual uses of LSD and related psychedelics. New clinical LSD experiments in humans started at MAPS in 2009 for the first time in 35 years. ■

# On the road to reducing drug-driving harm

The Drug Foundation was delighted to bring together a wide mix of people to deliberate on the intricacies of drug-driving policy at Te Wharewaka o Poneke, 12–13 November. **Stephen Blyth** compiled this short report on the key themes covered.

STEPHEN BLYTH

When researchers, Police officers, community road safety campaigners, drug treatment professionals, academics and policy makers gathered at the Second International Symposium on Drugs and Driving, you would have a thought a few sparks would fly – so many different perspectives under one roof. But the good-natured debate and disagreement about the many complexities around both policy and implementation didn't lead to a conflagration.

Overseas speakers were amazed at the frankness of Minister of Police Hon Michael Woodhouse and wished they could see a similar level of engagement in their own jurisdictions.

"It's right that we treat this as a road safety issue, otherwise messages get a bit mixed. I don't think that approach necessarily undermines the general prohibition issue around drugs," he explained.

Minister Woodhouse signalled that the government wants effective approaches to drug-driving enforcement but only when based on good evidence. Establishing how a drug being present correlates with the level of impairment was noted as a particular sticking point.

If there was any commonality across the diverse presentations made by New Zealand researchers and policy makers, it was acknowledgement of the paucity of local data on which to base sound policy. Helen Poulsen, Forensic Toxicologist, Institute of Environmental Science and Research, bemoaned the small number of samples available for the ESR lab to test.

National Road Policing Manager with the New Zealand Police, Carey Griffith, said that, between 1 November 2009 and 31 August 2014, only 1,309 compulsory impairment tests were recorded. With around 400 trips by vehicle drivers each, it's an astonishingly low ratio of drives to tests.

The contrast with Australian states is marked. In Queensland alone, there have been more than 129,000 tests since 2007. Several Kiwi presenters hinted at the need for better data. Unless this is collected, it will be hard to make a case for any policy and enforcement changes.

The presenters dived into the technical complexities associated with detecting drug presence, instrument reliability, the validity of research methodologies, statistical analysis of changes in driver behaviour and other bottomless wells.

Keynote speaker Professor Mark AR Kleiman, UCLA Luskin School of Public Policy, dragged discussion into the policy realm. He challenged the fairness of per se laws for drugs and cautioned against taking attention away from alcohol. He argued for three principles to govern any drug-driving legislation: any law must be consistent with public safety, administrable and just.

"Copying over our alcohol laws and filling in the names of various other recreational drugs is a terrible idea," Kleiman warned.

Citing the example of residual THC in blood samples, he explained this does nothing to prove how recently cannabis was imbibed nor if a driver is actually impaired. To penalise someone for THC presence is something he describes as both unjust and a failure in terms of reducing risk.

Instead, Kleiman argues for testing that shows whether cannabis was recently used (which mouth swab testing may eventually be able to show) and creating a driving offence that penalises anyone caught with a positive test. Stiffer penalties should apply to anyone caught with both cannabis and alcohol present because of the higher public safety risks. Taking this approach meets the principles of good law.

Our neighbours across the Tasman have been pursuing a vigorous roadside testing approach, which began in Victoria in 2004.

*Minister of Police Michael Woodhouse during his opening remarks.*


With tens of thousands of drivers subjected to random roadside drug testing each year, researchers found a reduction in the incidence of drug driving and fatalities caused by drivers with drugs present. Not only is the deterrence effect paying off, but the data is mightily useful in keeping resources flowing into enforcement.

The advice to New Zealand from Jeremy Davey, then Deputy Director of the Centre for Accident Research and Road Safety at Queensland University of Technology, was to get started with a testing regime. Small or big, it doesn't matter, just do something!

Davey cautioned participants that Australians don't take kindly to people trying to change the way they imbibe but will listen to reasonable road safety messages.

"We've not fiddled with people's drinking behaviours, we've fiddled with their driving behaviour whilst they use alcohol," he explained. Contrasting this experience with that in other countries, Davey believes people will accept an imposition such as random testing for the wider good.

Changing drivers' behaviour is something where clever initiatives from New Zealand raised a chuckle and gained some credit. Simon Hager-Ford provided an overview of the participatory approach taken to develop the Drug Foundation's Steer Clear campaign. As CCSA succinctly tweeted, "Kudos @SteerClearNZ, great simulator/resource for changing young drivers' attitudes".

The New Zealand Safe Journeys strategy, referred to by many Kiwi presenters, does see a place for random roadside testing, It will take policy makers some time to settle on an approach. Background research and policy analysis is under way, with a period of consultation being planned. We can expect to be engaging in debate about new policy later in 2015.

The final session was a fast and furious exercise in collaborative authoring: participants were invited to have their say on a framework to support countries seeking to introduce drug-driving law, policies and practice. Rita Notarandrea, Chief Executive Officer (Interim) of the Canadian Centre on Substance Abuse, chaired this session, which concluded with broad agreement on a draft comprehensive framework for addressing drugs and driving. When finalised early in 2015, the framework will be shared by symposium partners with anyone willing to listen.

There was always a danger that we could tie ourselves in knots letting debate about the complexity of the issue get in the way of making decisions. And while the debate is not yet over, it would seem that there is the will to create good policy and enforcement approaches in New Zealand. ■

**Stephen Blyth is the Drug Foundation's Senior Communications Adviser**

**"It's right that we treat this as a road safety issue, otherwise messages get a bit mixed. I don't think that approach necessarily undermines the general prohibition issue around drugs."**

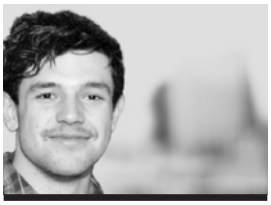
HON MICHAEL WOODHOUSE

**RESOURCES**

Recordings from ALL sessions and copies of ALL presentations are freely available via the Drug Foundation website. nzdrug.org/drugdrivingnz

# Voting for change was the easy part

As state regulation of cannabis moves forward in several US states, it's too early to say how the legalisative experiments will turn out. Professor Mark AR Kleiman, who visited New Zealand as a guest of the Drug Foundation last November, brings a blindingly clear angle to the public policy conundrums that arise. **Cameron Price** delves into what happens after the votes are counted.



CAMERON PRICE

The global trend towards a more liberal approach to cannabis is accelerating. In America, in particular, the landscape is changing rapidly. Four states and the District of Columbia have legalised, and another 14 states have decriminalised. The US territory of Guam has decriminalised medical cannabis, and President Obama recently announced that he would no longer enforce federal cannabis law on Indian Reservation land. More states are in line for changes to their drug laws, with ballot measures due to be voted on in 2016.

Early indications are that reform has diminished the burden of drug harm in liberalising jurisdictions. More people are seeking treatment, governments are receiving millions in tax dollars and saving money that was previously spent on enforcement and gangs have lost a major revenue stream.

And popular feeling towards cannabis is softening. Polling has shown a generational shift in attitudes surrounding cannabis law – 52 percent of Americans now believe pot should be legal compared to just 16 percent in 1990. When broken down by age, 70 percent of those born after 1980 support legalisation.

> **“Right now, Americans spend about $35 billion a year on illegal cannabis. That money goes untaxed.”**
>
> MARK KLEIMAN

> **“All of this adds to the impression that a wave of cannabis liberalisation is inevitable. The question, then, is what we do when it hits our shores.”**

All of this adds to the impression that a wave of cannabis liberalisation is inevitable. The question, then, is what we do when it hits our shores.

## The end or the beginning?

The view that legalisation is the end of decades of debate is alluring but false. As the biggest change in drug policy since the end of alcohol prohibition, it's the beginning of a new one. As Mark Kleiman puts it, “Debating *whether* to legalise pot is increasingly pointless. Unless there's an unexpected shock to public opinion, it's going to happen, and sooner rather than later. The important debate now is *how* to legalise it.”

There is a dangerous tendency among the uninitiated (read: general populace) to think of cannabis law as a simple dichotomy: it's either legal or illegal. This is in part because discourse about pot is dominated by two diametrically opposed camps. Ardent legalisers want a free-for-all system while puritanical prohibitionists want the drug eliminated.

However, the reality is that neither side's ideal system will be implemented. Instead, the regimes that will be put in place are likely to be nuanced, incorporating features of both sides. While the talk is focused on the two extremes, the policy will encompass everything in the middle.

“Despite the simple-minded sloganeering on both sides, the question of creating a legal cannabis market is about as technical as they come, with equally valid public goals in sharp conflict, many unknowns, a variety of tricky design issues and some big risks,” Kleiman says.

## The accidental drug tsar

Mark Kleiman is Professor of Public Policy at UCLA but is better known in the United States as the Washington State Hemperor. The consulting firm he heads advised the state government on the implementation of its legal pot regime. He was chosen as a result of his extensive experience in drug policy, which includes co-editing *The Encyclopaedia of Drug Policy* and writing *Drugs and Drug Policy: What Everyone Needs to Know*.

Kleiman didn't start out with a passion for drugs. He had his start in the public corruption team in the criminal division of the US Department of Justice but was asked to join the narcotics section by a professor who he had admired while studying at Harvard. As a result of being an ‘accidental’ drugs expert, Kleiman says he approaches the drug policy debate without the baggage of preconceived notions about drugs and instead approaches it as you would any other policy question.

Pragmatic is Kleiman's style. He feels that “the penalty for using a drug should not be more damaging than the use of the drug itself”. He doesn't believe in the libertarian argument that people should be free to ingest any substance that they want. Instead, he focuses on the context of the drug in question.

According to Kleiman, practical considerations should outweigh principled ones.

“Can we pick alternative policies for some or all of the currently banned drugs that would get us better social outcomes? I don't think there's a principled answer to that question, and I don't think the answer will be the same in all countries,” he says.

A good example of this style is his stance on cocaine. He believes it could be made legal in the US, as there is a high prevalence of use and heavy enforcement harms people dependent on cocaine. However, because New Zealand doesn't have a high prevalence of cocaine, he thinks it should remain illegal here.

“You want a cocaine problem? Go ahead and legalise it,” he says. “Why import a problem?”

## The least bad option

So, when should drugs be legalised according to Kleiman?

“Where the costs of maintaining illegality are simply too high,” he says, “or where the potential benefits in controlled use are high enough such that current laws

> **Bad reform will leave us in a worse place than we are in now, so failure to actively prepare for the eventuality of drug reform now is reckless.**

cost us a lot in foregone benefit." Importantly, Kleiman acknowledges there will be drug harm in any scenario, regardless of legality. The key to good policy, in his view, is to minimise that harm.

To do that, costs and benefits must be traded off against each other. On the right side of the ledger, Kleiman says, "The undeniable gains from legalisation consist mostly of getting rid of the damage done by prohibition. Right now, Americans spend about $35 billion a year on illegal cannabis. That money goes untaxed. The people working in the industry aren't gaining legitimate job experience, and some of them spend time behind bars and wind up with felony criminal records. About 650,000 users a year get arrested for possession, something much more likely to happen to a black user than a white one."

However, Kleiman also agrees with anti-pot campaigners that ending the war on drugs will lead to higher prevalence and problem use, particularly among teenagers.

"The losses from legalisation would mainly accrue to the minority of consumers who lose control of their cannabis use," he says.

"While a bad cannabis habit usually isn't nearly as destructive as a bad alcohol habit, it's plenty bad enough if it happens to you or to your child or your sibling or your spouse or your parent."

> **Continued prohibition is probably the worst thing we could do about cannabis right now. Alcohol-style legalisation, which is where we are headed, is probably the second worst.**

On balance then, Kleiman is in the 'legalise' camp, with reservations. Commercial sale, low taxes and loose regulation are cited by Kleiman as reasons to be wary of free-market-style legalisation of cannabis.

"Continued prohibition is probably the worst thing we could do about cannabis right now. Alcohol-style legalisation, which is where we are headed, is probably the second worst."

Kleiman is wary of giving free rein to corporations, partly because it will likely result in a commercial lobby not unlike Big Tobacco. But his greater concern is that the logic of the free market creates a financial incentive on companies to promote problem use.

"It's not just that the problem users are profitable; it's that nobody else is profitable. More than 80 percent of what you sell is going to be to people who smoke too much. It's true of alcohol today – responsible drinkers don't build breweries, alcoholics do."

Instead, Kleiman supports a 'temperate' cannabis policy.

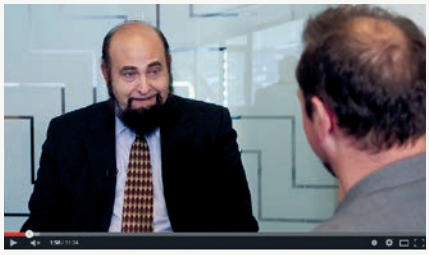
"That would give us the benefits of legalisation without an upsurge in heavy use and use by juveniles," he says. This sounds like the perfect compromise, but what exactly would temperance entail?

## Novel problems, novel solutions

Mind-altering substances do not have the same properties as other goods that are legal to buy and sell. What works in the market for food, say, or clothing will not work in the market for a potentially dependence-forming substance such as cannabis. The aim of the game shouldn't be to maximise the sales or profit of the supplier, it should be to maximise the wellbeing of the consumer. There will be times where the public health interest is at odds with the financial incentive of companies. This clash should be confronted head on by a regulatory regime that follows a mantra of harm minimisation.

Production will have to be monitored. Kleiman says a free market could be replaced by "such interesting ideas as just letting consumers grow their own or requiring that growers and retailers be

**RESOURCES**



**TO VIEW THE FULL INTERVIEW** with Mark Kleiman, where he talks about his views on cannabis law reform, head to the New Zealand Drug Foundation's YouTube page: nzdrug.org/nzdrugtube

> **"What works in the market for food, say, or clothing will not work in the market for a potentially dependence-forming substance such as cannabis."**

not-for-profit co-ops or public-benefit corporations, as well as the alternative of state-monopoly retailing".

Another of his ideas is to give the regulators explicit authority to restrict the amount of cannabis that can legally be grown.

On the demand side, Kleiman believes the key to mitigating the potential for increased uptake lies in the price that people have to pay for pot.

"The basic fact about a legal cannabis market is that the product will be remarkably cheap to grow. Once competition and industrial-style production have taken effect, a legal joint would cost about what a tea-bag costs, rather than the illegal price, which is 100 times as high."

In implementing the legal regime in Washington State, Kleiman focused on imposing an excise tax such that legal cannabis costs only slightly less than its street equivalent.

"My belief is that, if you can keep the legal prices close to the illicit prices, you won't get a big upsurge in heavy users."

Other possible policy options discussed by Kleiman include a requirement that retail clerks at dispensaries have training in pharmacology and substance use disorder to discourage dangerous consumption. Another is for buyers to set a self-imposed weekly or monthly quota. That way, they will be confronted by their actual use and may change their habits as a result. Banning the use of brand names and advertising and instead presenting the drug in a plain package labelled with the dosage and scientific name of the particular strain being sold may produce a psychological effect in people that curbs their use.

The half-opened can of worms that is cannabis law reform seems to produce more questions than answers. Will the law allow smoking in public? Will it treat cannabis leaf differently to hash oil? Will it focus on potency or weight? Will it ban smoking the leaf and instead insist on vapourising? What amount of cannabis, if any, will a user be allowed to ingest before they drive? What will become of drug testing in the workplace? What will happen to patterns of alcohol and other drug use? What changes in the social fibre of the nation will legalised pot result in? These are all obstacles that will have to be navigated on the way to good cannabis policy.

## Lessons to be learned

Public support can evaporate in an instant. It may be that there is a coming backlash to the reforms currently taking place. Voters might lose their appetite for change. As it stands though, reform does seem likely.

But not all reform is good. Bad reform will leave us in a worse place than we are in now, so failure to actively prepare for the eventuality of drug reform now is reckless. Discussions need to happen now to decide what a law change will look like. We have the benefit of learning from the experiments currently taking place in America and the rest of the world. Not everything that works there will work here though, so it is also important to think about what legal or decriminalised weed would look like in Aotearoa. Neither of the extreme sides will ever see eye to eye, but perhaps both could agree with Mark Kleiman when he says that we should "recognise preventing adult substance use disorder among the goals of the law". ■

**Cameron Price works at the New Zealand Drug Foundation as a Communications Adviser**

# State of disunion: different tokes for different folks

Around the world and across the United States, authorities are trialling different versions of legalisation. Each jurisdiction has a different set of rules around the growth, sale and use of pot. These early adopters act as social laboratories of cannabis policy. Countries looking to reform their drug laws should take note of the successes and failures of the various approaches.

## AMERICA

**1970**

USA CLASSIFIES CANNABIS AS A SCHEDULE I DRUG

Under federal law, it is illegal to possess, use, buy, sell or cultivate cannabis, since the Controlled Substances Act of 1970 classifies cannabis as a Schedule I drug, claiming it has a high potential for abuse and has no acceptable medical use. However, although cannabis remains illegal under federal law, the Obama Administration said it will allow state-level rules to stand without much federal interference.

**27 STATES**

27 states and the District of Columbia have passed state laws either legalising or decriminalising cannabis. Four states have voted to legalise it, and Native American tribes can grow and sell marijuana, even in states where it's illegal.

NATIVE AMERICAN TRIBES CAN GROW AND SELL MARIJUANA

**4 DIFFERENT MODELS**

THE FOUR STATES THAT HAVE LEGALISED POT HAVE ALL FOLLOWED DIFFERENT MODELS, MEANING THAT RULES AND REGULATIONS FOR CANNABIS ARE DIFFERENT IN EACH STATE.

### THE COLORADO MODEL

★ COLORADO VOTERS APPROVED AMENDMENT 64 IN NOVEMBER 2012

- Regulated retail sales
- Possession of up to one ounce legal for adults 21 years and over
- Driving rules similar to those of alcohol
- Households may grow up to six plants
- 15 percent excise tax on the average market rate in addition to a 10–15 percent sales tax
- Tax directed to the public school capital construction assistance fund

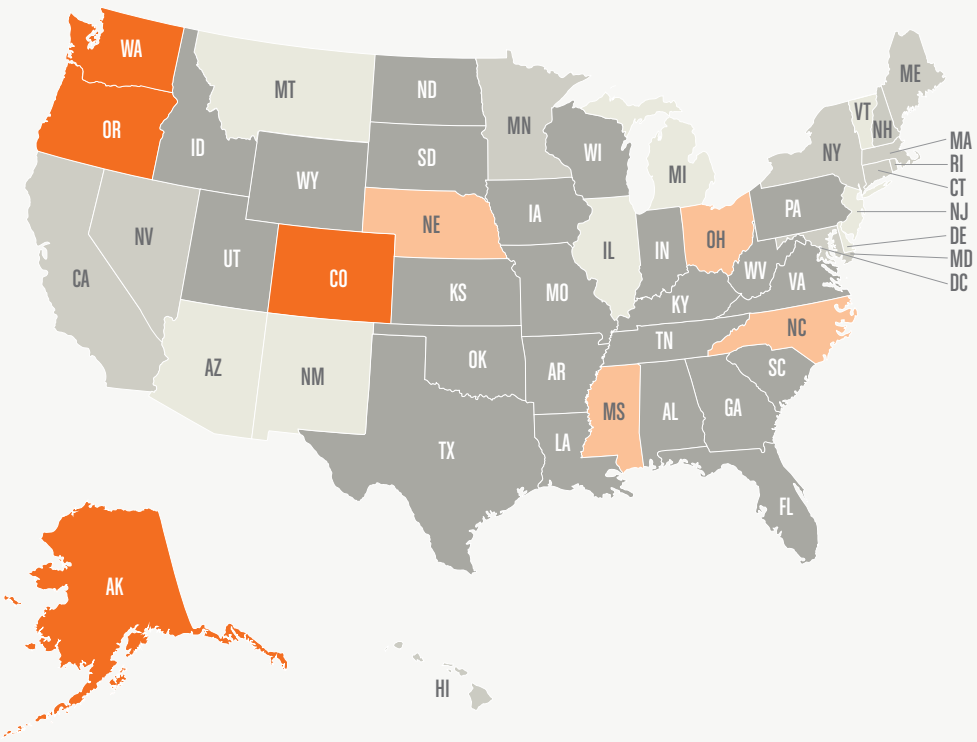
THE

# CANNABIS

LAWS IN THE UNITED STATES

★★★★

Cannabis is now legal in some form or decriminalised in 27 states and the District of Columbia.




**KEY**

- LEGAL
- MEDICINAL USE ONLY AND DECRIMINALISED
- DECRIMINALISED
- MEDICINAL USE ONLY
- ILLEGAL

**NOTE:** Federal law prohibits the possession, selling or harvesting of cannabis. Decriminalisation laws reduce the penalties associated with the use or possession of small amounts of cannabis. **Sources:** National Conference of State Legislature; National Organization for the Reform of Marijuana Laws, Pew Research Center.

## THE WASHINGTON MODEL

### ★ WASHINGTON VOTERS APPROVED WASHINGTON INITIATIVE 502 IN NOVEMBER 2012

- State licences required to grow and sell
- Possession of up to one ounce legal for adults 21 years and over
- Driving allowed with up to five nanograms of THC per millilitre of blood
- Households are prohibited from home growing except for medical use
- 25 percent excise tax on all wholesale and retail transactions
- Tax revenue is directed to a dedicated cannabis fund and split between health-care, addiction services and research

## THE OREGON MODEL

### ★ OREGON VOTERS APPROVED MEASURE 91 IN NOVEMBER 2014

- Possession of up to eight ounces legal for adults 21 years and over
- Households may grow up to four plants
- Retail sales outlets will be set up by the Oregon Liquor Control Commission
- $35 tax per plant, $10 tax per ounce of leaf
- Products must be tested for mould, mildew, pesticides and potency before sale
- Tax revenue is split between local schools, law enforcement, and mental health and addiction

## THE ALASKA MODEL

### ★ ALASKA VOTERS APPROVED MEASURE 2 IN NOVEMBER 2014

- Possession of up to one ounce legal for adults 21 years and over
- Households may grow up to six plants, three of which may be flowering
- The Alcoholic Beverage Control Board will regulate and license cannabis producers
- Adults are not allowed to consume cannabis in public
- $50 per ounce tax on all cannabis sold | by cultivation facilities at wholesale
- Tax revenue not earmarked to any specific funds
- Driving under the influence prohibited

# To reduce drug-related harm, it's time to be honest about the pleasure

Acknowledging the reasons most people actually use alcohol and other drugs could help them use them more safely, argues Global Drug Survey founder **Adam Winstock**.

ADAM WINSTOCK

Despite the language we use about drugs, many people don't see themselves as "drug users" but as rational adults who aren't on a mission to seek moral disintegration and cause themselves harm. People who use drugs are just people who happen to use drugs (they might also do yoga, go the cinema, get degrees, litter the streets or be into base-jumping) – normal people who care about their loved ones, their health and wellbeing and want to make the most of that wonderful thing that we all share: life.

I'm not daft enough to think that any set of guidelines or precautions can make the use of alcohol and drugs completely safe. I spend my working day with people whose lives have been ruined by drugs; from acute toxicity and risks associated with intoxication-related behaviours that everyone who uses alcohol and drugs is at risk of, to longer-term physical complications and dependence that are issues for only a minority of users (depending on the drug).

And predictors for problem use are myriad. While some are constitutional, for the vast majority of people, the major risks associated with alcohol and drug use can be significantly curtailed by adopting certain strategies to minimise risk.

And as the world creaks towards a closer examination of whether current drug laws are the best way to minimise the negative health impact of alcohol and drug use – both on an individual and societal level – it's worth giving a moment's thought to what advice we could give to people who use these substances to assist them in minimising harm.

## There is always risk

Even if drugs were regulated, rather than being illegal, they would not be without the risk of harm. And to date, the world has a poor track record in providing harm reduction information on the world's most popular drug: alcohol. And conversations about reducing risks and harm are just not that sexy. As our Global Health Survey (GDS) showed last year, almost half of the 65,000 drinkers who responded said they were unaware of their country's drinking guidelines, and of those who did, only one in five paid any attention to them.

It's not clear why this is, but a possibility is that guidelines fail to acknowledge that the main priority of those who drink or use drugs is short-term pleasure, not the avoidance of harm. This leaves us with a challenge. How do you engage people who use alcohol and drugs for pleasure in a conversation about the harm associated with their use?

## The pleasure index

The term 'harm reduction' has been a watchword, nay a mantra, for many in the field for 30 years. From supervised injecting facilities to giving methadone or naloxone to people who use heroin and nicotine patches to try and help people smoke less, these harm-reduction initiatives have saved millions of lives worldwide. It saddens me that some people have a problem with the concept of harm reduction and, in the face of overwhelming research suggesting the opposite, still think these kinds of help promote drug use.

I have never had a problem with promoting measures that reduce harm and thought I would be on safe ground with this attitude until I started running the GDS. But after we began receiving emails from people who used alcohol and drugs asking why we didn't provide any questions about pleasure, we decided to.

We came up with the Net Pleasure Index, which was based on tens of thousands of responses weighing up the good, the bad and the ugly things about different drugs. The index rated MDMA, LSD and magic mushrooms as the nicest drugs on balance and alcohol and tobacco as the worst.

Pleasure and drugs went together naturally, and it seemed many people had given lots of thought to how to get pleasure from alcohol and drugs. In fact, compared to harm, pleasure was a rather engaging topic for people who used these substances. So we wondered what the relationship was between harm reduction and pleasure. And as part of GDS 2014, we

Photo: flickr.com/photos/goodnight_london

asked people from around the world to vote on the harm-reduction approaches they usually adopted when they used the following drugs: alcohol, cannabis, MDMA, stimulants, ketamine, psychedelics, GHB and new psychoactive substances for the first time.

These strategies include testing a dose from a new batch, using a trusted supplier, avoiding combining drugs or not drinking while on ketamine.

For each strategy, we asked people if they usually (more than 50 percent of the time) used this strategy, what they would score it out of 10 for the importance of reducing the risk of harm and whether using the strategy increased the pleasure they got from that drug, decreased it or had no effect. So what did we find? Well, put simply, the vast majority of the strategies adopted by people to reduce harm had either a neutral or positive effect on their drug experience. In other words, safer drug use is more enjoyable drug use.

## Taking a new approach

These results pose the question: what sort of guidelines should we have? When it comes to guidelines, most governments tend to treat all illegal drugs like tobacco. For example, there is no safe limit or level of use that is associated with no risk of harm: tobacco kills you, it's highly addictive, so don't smoke.

This is not bad advice because the risk of addiction with tobacco is higher than for almost any other drug, with many people dependent and not just for pleasure.

But I think we should treat illegal drugs more like alcohol – where the risks of harm and dependence vary hugely between people, where the risks of harm can be significantly reduced by adopting safer use strategies and where rates of addiction are relatively low and where, for the majority, (as for alcohol) use is a source of pleasure not harm.

## 'Highway codes'

While I'm not sure whether talking about pleasure will be an effective way to help reduce the risks of using substances, our GDS 'highway codes' – our safety dos and don'ts for different drugs – have been downloaded 30,000 times.

The highway code is just a start of a more objective, independent and informed approach that the GDS is taking, bringing together leading experts to ask you the right questions about drugs and alcohol use and to make a difference to the way we talk and think about drugs and use them – safely. ■

**Adam Winstock is founder of the Global Drug Survey and Senior Lecturer at King's College London**

*Results from the 2015 survey are due later this year from globaldrugsurvey.com*
*Article reprinted with permission from The Conversation (theconversation.com)*

## QUOTES OF SUBSTANCE

**"Suppose the Russians did something now."**

**President John F Kennedy**, supposedly after smoking cannabis for medical relief in the White House in 1963.

**"The biggest cause of alcohol consumption in kids is hand sanitiser by far. They [parents] should keep it out of reach of kiddies."**

National Poisons Centre toxicologist **Leo Schep.**

**"I guarantee that there will be no clemency for convicts who committed narcotics-related crimes."**

Indonesian President **President Joko Widodo** in response to calls for clemency for drug traffickers sentenced to death.

**"I don't believe that executing people is the answer to solving the drug problem and certainly the trafficking of drugs in and out of Indonesia."**

Australian Foreign Minister **Julie Bishop.**

**"One in three said they found it very effective to relieve their pain, that's a score of 10 out of 10."**

**Louisa Degenhardt**, leader of an Australian study that found that chronic pain sufferers get more relief from cannabis than conventional medicines.

# The Brownfield Doctrine

For more than half a century, the drug policies of nearly every nation in the world have been shaped by their commitment to the three United Nations drug conventions – despite those conventions having come under fire as outdated and even counterproductive. But a US ambassador is now proposing a new interpretation of the conventions. Russell Brown looks more closely at these and the implications they may have.

Together, three the drug control conventions provide the legal structure for a global system of drug control by defining control measures to be maintained and prescribing rules to be obeyed by the parties in their relations with each other.

The most prominent champion of the conventions has long been the United States, so it came as a surprise last October when William Brownfield (US ambassador to various South American countries

## EMBRACE IT

- It's a tipping point – a significant step in incremental change. And incremental change is probably the only real change possible. Don't let 'perfect' be the enemy of 'good'. Political change will, and must, precede legal change, and that's what we're seeing here. Only when legal tensions increase to an intolerable point will there be enough pressure to engage in the huge challenge of treaty reform. And we're not there yet.
- It's the only game in town. However necessary real reform of the conventions might be, it is currently not feasible. There is no real route to reforming the conventions at the UN or in the US legislature – and pursuing reform in the short term would be a waste of energy and even counterproductive. If Brownfield fails because reform is being assailed from all sides, it's an own goal for reformers.
- It's the best the US can realistically do. For all the attention on cannabis legalisation in Colorado and Washington State, the votes behind the successful propositions represent a little over 1 percent of the country's voting-age population. It's far from demonstrated that there is a mandate for national legalisation or reform of the treaties – the latter isn't even on the radar. A similar political reality applies in the international community: the leaders of Colombia, Guatemala and Mexico, the three countries that got the UNGASS scheduled, aren't exactly clamouring to offer leadership now.
- This is a constitutional system without a court. The International Narcotics Control Board and the UN Office on Drugs and Crime may express disagreement with the positions of the US and Uruguay, but they cannot enforce their opinions and they certainly are not constitutional courts. Nation states are free to adapt and evolve within such frameworks.
- Whatever happens, treaty breaches are unavoidable in the short term. The US and Uruguay are both in breach of the conventions – are we really to take the position that these two countries and others should be condemned for actions that breach the letter of the treaties, until the treaties change? If so, we might be waiting a while. Worse, we might provide a rationale for a US federal backlash, reversing the law changes in Colorado and Washington State and blocking reforms in California and elsewhere.
- We may have to take this path in the end anyway. If we discover in three or four years that reform of the conventions is not possible, we'll only have to recreate Brownfield. So why not embrace this interim measure and keep moving forward?
- This is a meaningful signal to other countries contemplating the scope of reform possible within the conventions. The US could simply have continued to please itself, but making flexibility explicit will strengthen the positions of a number of countries that would otherwise have hesitated. By the same token, a strategy of 'calling out' the US on Brownfield's shortcomings would probably create domestic obstacles to reform in those same countries. Governments need to be aware of how this may appear to the public, and if reform within the conventions exposes them to the accusation that they're international lawbreakers, that's a bad, bad look.
- The loosening up embodied in Brownfield cannot be compared with weakening the likes of the UN Convention Against Torture, if only because it has the opposite effect. In this case, flexibility enhances human rights, security and public health, rather than harming them.
- The idea of flexibility within the conventions isn't actually new. Reformers have long argued that decriminalisation of possession, purchase and cultivation for personal use fits comfortably within the text of the conventions. Brownfield acknowledges that position. ■

at different times) proposed that there might be some wriggle room in the existing treaties.

In a statement in New York, the ambassador outlined four "pillars" of the revised US position. Pillar one is to respect the integrity of the existing UN drug control conventions. The second: accept "flexible interpretation" of the conventions. Third: tolerate different national drug policies, from the strict and punitive to the liberal.

Fourth: combat and resist criminal organisations rather than punish individuals who use drugs.

Responses to what quickly became known as the Brownfield Doctrine have been polarised. A failure to agree on this fundamental issue could undermine the unity of purpose necessary to effect any change at the 2016 United Nations General Assembly Special Session (UNGASS ) on drugs policy.

## SO WHAT ARE THE ARGUMENTS?

## REJECT IT

- It's just theatre. This is simply a way for the US to square its own circle. It's a way of bowing to domestic political reality by not overruling cannabis legalisation in Colorado and elsewhere, while preserving a system that continues to afford it considerable foreign power. The aim here is not to begin the path to reform but to find a way for the US to permit reforms at state level without the reputational cost of being accused of a treaty breach. In signalling space for reform around cannabis, the US is essentially offering other countries a bribe to maintain its own contradictory position.
- It unquestionably shelves the law reform discussion. And with 2016's UNGASS offering a once-in-a-generation chance to genuinely address the issue of global drug law, that's a bad move. No one is pretending that the 2016 UNGASS will be a meeting of countries to negotiate new treaties, but actually taking real treaty reform off the agenda would be disastrous. That's what Brownfield does – and is arguably what his 'doctrine' is designed to do.
- That horse has bolted. The moral rationale for the US bullying neighbours like Jamaica on cannabis reform is already gone. It went along with the Holder memo confirming that the US Federal Government would not intervene in state legalisation. That was the real signal for flexibility. Brownfield is just the damage control.
- It's limited and self-serving. In tying its new doctrine to state-level cannabis legalisation, the US is really saying that other nations can only break the rules in the same way it is breaking the rules. Brownfield has relatively little sympathy for the other areas where the US had strongly opposed the flexibility it now embraces – general decriminalisation, harm reduction, the legal status of coca.
- Flexibility cuts both ways. If the conventions' guiding principles are deemed meaningless, won't regimes like Russia be able to regress even further? Indeed, Brownfield made this explicit in the third pillar's promise to "tolerate different national drug policies, to accept the fact that some countries will have very strict drug approaches".
- So the pillars are morally irreconcilable. Can the harm reduction community really declare, "We support the efforts of countries like Uruguay to curb the harms of prohibition – and simultaneously acknowledge that other regimes will continue to apply severe and damaging anti-drug laws and even carry out capital punishment and other human rights violations in enforcing them"?
- What are the broader implications of redefining major United Nations conventions as merely optional? Do we want the same "tolerance" extended to key UN positions on torture and human rights? Remember that the Bush Administration did actually attempt to argue that waterboarding was not a breach of the UN Convention Against Torture and that detainees taken and held in the name of the War on Terror were not covered by the Geneva conventions. Should we really open the door for this?
- The US may be comfortable with a loose interpretation of the conventions, but countries like Germany and the Netherlands take international treaty obligations more seriously. They will be constrained from serious reform until the treaties themselves are reformed.
- The conventions are intrinsically prohibitionist and always have been. It's wrong to pretend that a shift in interpretation – to the point of interpreting the conventions to say the exact opposite of what they actually say – will change that. The 1961 convention clearly and undoubtedly prohibits regulated markets in cannabis. We would not assume that New Zealand could make significant reforms without touching the Misuse of Drugs Act 1975 – why pretend otherwise at the international level?
- It's only about demand, not supply. The more flexible interpretation proposed by the US on the demand side is not offered for the more critical area of supply – which is where much of the harm happens. Moreover, the US clearly intends for its new doctrine of flexibility to apply only to cannabis. ■

YOUR VOICE

YOU DECIDE

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

# Hello Friday Afternoon?

Finding ways to address problem drinking one day after another takes a lot of creativity and ingenuity. Hello Sunday Morning founder **Chris Raine** brings these qualities in spades. He shares his thoughts on what day is next.

CHRIS RAINE

In 2009, I committed to taking a break from drinking for a year to experience life without a hangover for 365 days. As part of that process, I wrote a blog called Hello Sunday Morning (HSM) to share what I learned with the world. I wrote about everything – from dating to parties to dancing – it was a year of experiments. Each Sunday, I would spend a few hours in a café in the morning writing about what I learned and the challenges I faced. At the end of the year, that blog then became a platform for others to also take a break from drinking and share their stories online. We had five people do their three-month HSM in 2010, and today, our community has grown to more than 36,000 people worldwide.

To date, more than 100,000 blogs have been written around the experience of change that we can mine to gain a deeper understanding of the psychology of why we drink and also how we change the culture we have. While Hello Sunday Morning does work – showing an average reduction in World Health Organization AUDIT scores of over 40 percent, I'm not naive enough to think that HSM is for everyone. So, if I could do one thing to change the drinking culture beyond getting everyone to take three months off drinking, what would it be?

I would change the way we do Friday afternoon.

People who blog on Hello Sunday Morning often do so when they have had a challenging experience or a 'slip up'. While we each are challenged in different ways and different times, the one time that is quite consistent with participants is the transition period between work and home – especially Friday afternoon.

This is because alcohol is the perfect drug to help us get three specific things – reward, relief and reconnection. At the end of a hard week of working, we like to give ourselves a reward for the hard day or week we put in, and alcohol is a relatively inexpensive luxury that we can purchase and consume quickly to give us that sense of accomplishment. Secondly, it is a depressant, so it helps us relieve our overactive working brain and think about less stressful things. Thirdly, after staring at a screen all day or being in 'work mode', meeting new people, or even people we know, can be slightly discombobulating – this is where alcohol's ability to disinhibit our mind is extraordinarily valuable.

The problem is that often our choice on Friday afternoon is the lynchpin for the rest of the weekend and that then bleeds into the next week. Your decision to go straight from work to the pub often means you are using alcohol for this combination of psychosocial reasons and are likely to drink more, which means you might wake up with a hangover on Saturday and then feel the need to drink to feel better on Saturday night. This then leads to feeling even worse on Sunday morning.

If we want to create a healthier drinking culture, solving this problem of the 30 minutes between the desk and the fridge is crucial. Here is what I believe society should be doing to change it.

Employers, government and individuals should co-invest in a concept I am going to call 'decompression' time. Take all the money we spend on campaigns trying to scare people away from alcohol, combine that with all the funds from the drinks tray that comes round the cubicles at 4.30pm plus all those Friday afternoon bar tabs and put all that capital into free massages, yoga classes, crossfit classes, spa baths or massive Friday afternoon group sports competitions. In this way, we incentivise people to take 30 minutes at the end of the week to blow off some steam, to relax and to reconnect with people WITHOUT alcohol. Following this, people can go to the pub or home or wherever and, in my thinking, would ultimately be drinking for very different reasons to those they would have normally when they finish work.

The point of all this is that, as health promoters, we only have so much time and so many resources that we need to make hard calls on the right time and place to invest them. If we want to influence the culture, then is it not wiser to go all out on the points in which people would be most influenced rather than spread our campaigns over the whole week? Why not target the 30 minutes that matter? Friday afternoon. ■


Photo credit: www.flickr.com/photos/policyexchange

# A UK Liberal Democrat talks drug policy

Just after his resignation as Minister of State for the Home Office responsible for the drugs portfolio in November 2014, British MP Norman Baker talked to **David Young** about drug policy in the UK and the widespread mood for reform.

One reason cited for the Brisish MP and Liberal Democrat Party member Norman Baker's resignation was a row over drugs policy with Home Secretary Theresa May. Baker is quoted as saying there was little support for "rational, evidence-based policy" in the Home Office.

It was revealed earlier in 2014 that the UK Government had done nothing about an official report showing that tougher drug laws do not result in decreased drug use. Baker likened being the only Lib Dem in a Home Office full of Conservative Party members to "being the only hippie at an Iron Maiden concert".

The Liberal Democrats have strong views on drug policy in the UK – earlier this year, leader and Deputy Prime Minister Nick Clegg called reform "idiotic". Baker has voiced his strong opinion more than once.

Here's what he told *Matters of Substance*.

**Q When the international comparators study came out, you said that the "genie was out of the bottle" on drug reform. Shortly after that, you resigned as Minister of State for the Home Office. Are you still optimistic that the United Kingdom is moving towards drug reform?**

**A** Yes I am because, first of all, there is movement towards reform all across the world.

Secondly, I think the first evidence-based report can't be simply swept under the carpet. It's there now, it's public and it can't be unwritten.

Thirdly, the debate in the House of Commons demonstrated support for reform right across the house from all parties. It's only the official Opposition [the Labour Party] being difficult about it.

Fourthly, the public response to both the medicinal cannabis stuff I did and the wider international comparative study was pretty positive. Including even the press.

> **"So I think that we have moved on to a different place, and the politicians at the top of the Labour and Tory Parties are increasingly out of touch with reality."**
>
> NORMAN BAILER

There was a poll in *The Sun*, for example, which demonstrated a high level of support for reform.

So I think that we have moved on to a different place, and the politicians at the top of the Labour and Tory Parties are increasingly out of touch with reality.

**Q The British tabloids, though, which are very powerful, don't share your views on drug reform.**

**A** Well *The Sun* was quite supportive, and *The Mirror* was neutral on it, so that's a big step forward from where we were.

**Q What were the key points that you took away from the international comparators study?**

**A** Pushing up penalties and putting people in prison does not reduce drug use. On the other hand, it's quite clear, from Portugal, for example, that dealing with these issues as a health issue in terms of the users is actually quite successful in weaning people off drugs.

The question is how do you minimise damage to society? The evidence is that fines and prison sentences don't in fact minimise drug use, they perpetuate it.

At the moment, when people [in the United Kingdom] are arrested, they are given a fine, sent on their way out of the Police station and carry on doing whatever they are doing. In other countries, where people are forced to go through a health regime and address their behaviour, that reduces the drug use.

**Q When the international comparators study came out, the Conservatives who were opposed to reform just pointed out that drug use in the United Kingdom is on a long-term downward decline, so the status quo must be working. Isn't it difficult to make the case for reform so long as that's the case?**

**A** Well there's also a long-term downward decline in countries that have seen reform. I mean, Portugal is way down from where it was.

What we discovered from the international comparators study was that the level of penalty and the approach actually doesn't bear much relation to the level of drug use.

So the issue is really what you do with people who have been using drugs, whether you are seeking to penalise or whether you're trying to help them.

**Q You have mentioned Portugal. Does it offer a policy framework that you would like to see the United Kingdom follow?**

**A** I think Portugal is a very interesting experiment, and it's been going now for 10 years or so, so it's actually got a reasonable amount of experience to draw from.

**Q What was your experience working with the Conservatives and particularly Home Secretary Theresa May on drug policy?**

**A** It was very immovable. Theresa May and her SPADS [government special advisors] were stuck in this 1971 rhetoric that must present drugs as the downfall of society and were deeply harmful. They had the attitude of 'we must countenance nothing'.

That's the public position, and of course, under the radar, they are more rational. Theresa May, for example, authorised the handing out of foil to heroin users, which is a very humane and a sensible policy, getting them to move from injecting to smoking. But it's the state handing out paraphernalia, and she was nervous about the impact of that, so I did it. I fronted it, and I was very happy to front a sensible policy.

So she sometimes did the right thing, but I get the feeling with the Tories that the politics will always trump the science if it's a contest.

> **"Pushing up penalties and putting people in prison does not reduce drug use."**

**Q So what role does coalition politics play in the likelihood of drug reform?**

**A** Of course it makes it more likely. Put it this way, drug reform will not happen for a long time in this country unless we have Lib Dems in government.

**Q You oppose prohibition but you would prohibit legal highs – can you explain that approach?**

**A** I didn't say I was opposed to prohibition. I mean the Portuguese model doesn't legalise drugs, it just decriminalises them in a different context.

And the interesting thing about the review panel was they recommended a ban on sales and marketing of so-called legal highs. They're unhelpfully called legal highs [a term that covers some illegal substances in the United Kingdom], but they are certainly not safe and people are consuming them.

There is an issue about where the threshold kicks in, and I would insert a caveat in terms of damage. But it doesn't criminalise possession of them. I think that's an important principle that I've been trying to espouse generally, which is that we go after dealers, we don't go after the users.

**Q The New Zealand approach to legal highs has been to regulate the market.**

**A** But New Zealand backed off that a bit though. I think the fact that New Zealand did back off that somewhat has made it difficult for anyone who wants to recommend that to do so.

**Q Are there other lessons from New Zealand?**

**A** I'm certainly interested in the psychotropic substances issue, and I have met the minister from New Zealand who was rather good. A liberal. He was interesting and good value.

We'll clearly watch what happens in New Zealand. It's obviously an interesting test case, and that's what it's about: it's always interesting to see other people's test cases without having to commit yourself, so you started off down that track and we will see where it goes.

**Q As a minister, yours was the loudest voice for drug reform in the UK Government. Your resignation takes that voice away.**

**A** I mean Nick Clegg is very strong on drug reform. I have no doubt that Lynne Featherstone, my successor, will be strong on drug reform too. That's where the Lib Dems are as a party. The party is united on that view.

**Q What is next for you?**

**A** We've got six months until the election, so as I have said, I shall have a bit of a break. Nobody believes me of course, but I just want a break.

Four and a half years in office when you're the only Lib Dem in the Department against people who want to stop you doing things is a huge challenge and a huge burden to bear.

> **"We are in a position now where those that started using drugs in the 1960s are now in positions of power and actually have carried on quite well."**

So I will spend the next few months by and large in the constituency, up until the general election.

I will intervene [in debate], particularly over medicinal cannabis I think, because that's something we should be doing. I think it's inhumane and lacking in compassion to have the approach we have got.

But I will be less high profile than I have been because I need to have a break, genuinely.

**Q And what happens next in terms of drug policy?**

**A** The next thing will be the party manifestos coming out ahead of the next election. Our manifesto will be pretty reformist. I suspect the other two won't be. The Labour Party in particular is hopeless on these issues.

And after the election, I think we will see what we get [in terms of a coalition or single-party government] and what comes out in any coalition agreement if there is one.

But increasingly, I hope that politicians have taken the temperature, because the temperature out there is for reform. It's very clear that the papers even think there should be reform, and the public certainly think so.

The fact of the matter is that, rightly or wrongly, you've got a large number of people in high, key positions in public life, whether they are in banks or in politics or anywhere else, who use recreational drugs and have used them and carry on with their lives and their work. And that's just the reality of it.

So when a nucleus of the population in high positions looks at the papers and says, "Actually, it's not the end of civilisation because I've been using this substance for so long," I think that loses credibility.

So we are in a position now where those that started using drugs in the 1960s are now in positions of power and actually have carried on quite well. ■

**David Young is London-based writer**

# All heavy drinkers are alcoholics

Photo credit: flickr.com/photos/cjdjkobe

That guy who is notorious for getting legless at every social gathering might be called an alkie or an alcoholic behind his back. But the label is unlikely to be on the mark, at least not from a diagnostic point of view. New research from the United States has found that nine out of 10 heavy and binge drinkers are not dependent on alcohol and could potentially curb their drinking with a combination of effort and support.

The study, by the US Government's Centers for Disease Control and Prevention, investigated the prevalence of alcohol dependence among 138,100 adult drinkers between 2009 and 2011 and found a relatively low level of addiction even for the biggest drinkers. Alcohol dependence was 10.2 percent among excessive drinkers and 10.5 percent among binge drinkers. The results counter the stereotype that everyone who regularly drinks to get drunk is an alcoholic.

The authors say their findings have important implications for public health measures to tackle problem drinking, since even the most excessive drinkers are unlikely to need drug dependency treatment. Strategies such as increasing tax on alcohol, regulating alcohol outlet density and increasing host liability could help reduce dangerous alcohol use.

For this study, 'heavy drinking' was defined as eight or more alcoholic drinks per week for women and 15 or more drinks per week for men. 'Binge drinking' for women was having four or more drinks in one sitting, and for men, five or more drinks in one sitting. Regardless of whether they meet the threshold for alcohol dependence, it's clear many New Zealanders would recognise their own drinking habits fall into these undesirable categories.

Alcohol is our most commonly used recreational drug, and it's a leading contributor to crime, disease and injury that is estimated to cause 800 deaths annually. Latest Ministry of Health figures (2011/2012) show one in five drinkers (19 percent) have "hazardous" drinking patterns – posing a risk to the drinker's mental or physical health. This equates to about 532,000 New Zealanders. Men are much more likely to have risky drinking habits, at 26 percent, than women, at 12 percent.

The New Zealand Law Commission's 2010 report *Alcohol in our Lives: Curbing the Harm* says national drinking surveys have consistently shown around 25 percent of drinkers – the equivalent of 700,000 Kiwis – typically consume large quantities of alcohol when they drink. Among young drinkers aged 15 to 24, the rate is much higher, with about half binge drinking in this way.

Professor Doug Sellman, Director of the National Addiction Centre at the Christchurch School of Medicine, is not at all surprised by the American research showing fairly low rates of alcohol dependency even for high-risk drinkers, but he says it comes down to definitions. The term 'alcohol dependence' has meant different things over time according to the diagnostic criteria being applied. In the latest handbook for psychiatric disorders, the new term is the much broader 'alcohol use disorder', but whatever the label, Professor Sellman says the underlying problem of excessive drinking remains the same.

"I think we have a similar profile to the United States. The issue is the extent of heavy drinking in both countries and virtually all other Western countries."

A pattern of hazardous drinking is hard to break regardless of whether it has reached the point where drinking becomes compulsive and can be termed an addiction, he says.

"The more ingrained the addictive habit becomes, the more challenging it is for a person to recover from the disorder."

It might be more helpful and more productive to reframe the debate over alcohol away from definitions of alcoholism. The word is freighted with misunderstanding and stigma, and it can put people off seeking treatment or taking steps to cut back their drinking because they're reluctant to associate themselves with such a negative term. Lotta Dann, manager of the support website Living Sober, says the label 'alcoholic' can be a barrier, and for that reason, it doesn't feature in any welcome messages on the site. Dann shot to prominence last year following the release of Mrs D is Going Without, which recounts her journey to quit drinking.

She says the website, launched six months ago, has gained 1,500 registered members and provides a safe forum for people to share their experiences and offer advice as they try to live without alcohol.

"The word 'alcoholic' is rarely mentioned at Living Sober. It is irrelevant to many of our members. We don't spend a lot of time debating how to label ourselves. We all accept the truth that we struggle to control and moderate the drug of alcohol, but we don't get hung up on semantics. We just cut to the chase of trying to not drink day in, day out."

So, yes it's a myth that all heavy drinkers are addicts or alcoholics, but that doesn't mean they don't have a problem with booze. The right question to ask, perhaps, is not "Am I an alcoholic?" but "Why am I drinking so much so often, and what can I do to stop?" ■

# Drug Help

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