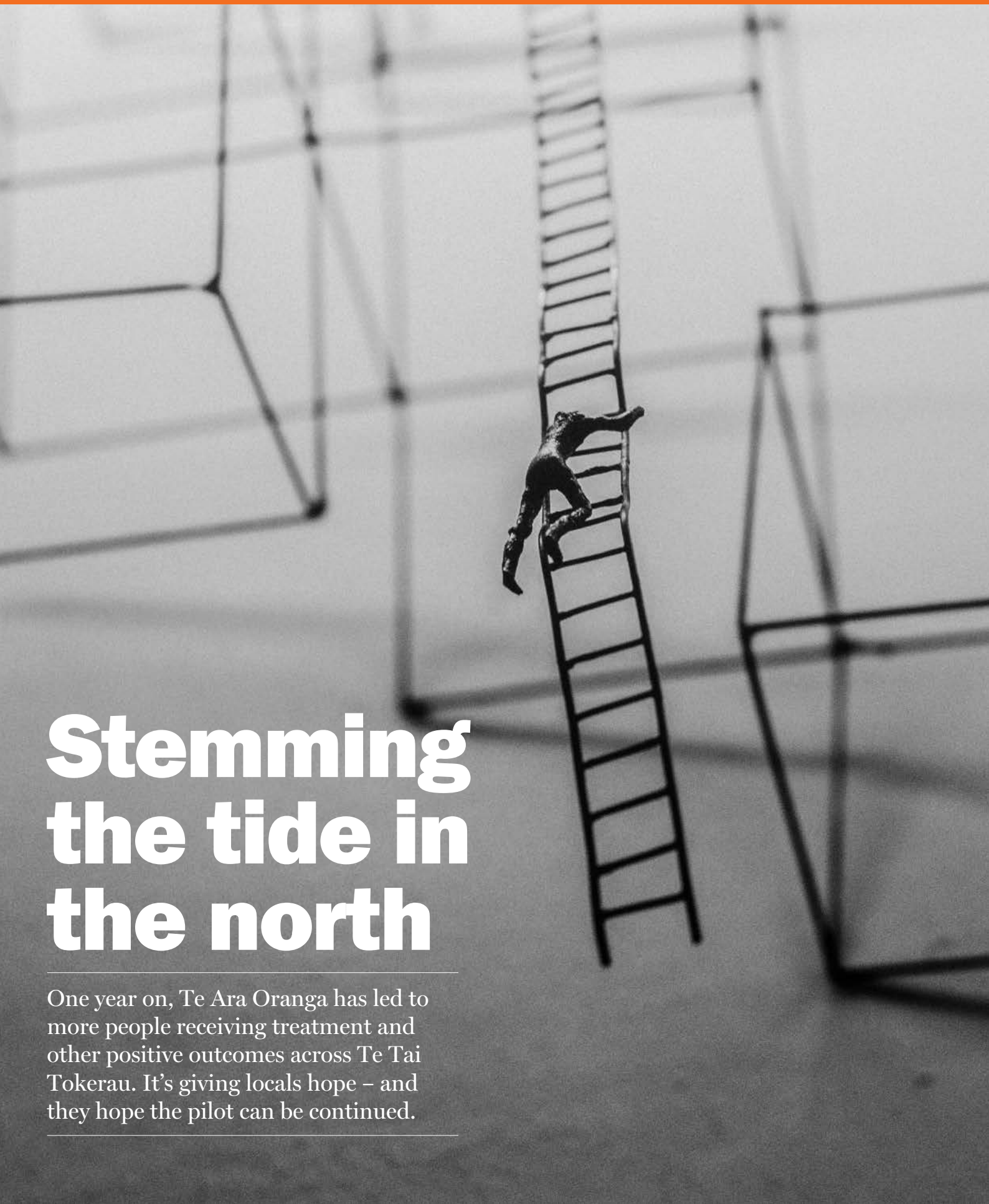
Matters of Substance.
JULY 2018 | Volume 29 Issue No.2 | www.drugfoundation.org.nz

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



Stemming the tide in the north

One year on, Te Ara Oranga has led to more people receiving treatment and other positive outcomes across Te Tai Tokerau. It's giving locals hope – and they hope the pilot can be continued.

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Stemming the tide in the north

30 YRS

Cover Image: Photo by Jason Wong on Unsplash

FEATURES

REGULARS

Become a member

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

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

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

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THE DIRECTOR'S CUT

ROSS BELL
Executive Director

The government has a huge clean-up on its hands following the recent release of the Chief Science Advisor's meth-contaminated houses report.

Lead author Anne Bardsley (see Q&A page 40) and Sir Peter Gluckman have put an end to this ridiculous, long-running, harmful scam. I must admit to a certain pleasure at the shutdown of this cynical industry.

The government is still trying to understand the scale and impact of the mess created by the heartless policy of Housing New Zealand – and how to redress those families who have been hurt, who have had property destroyed, who have lost housing security, who face debt and, in some cases, who have been torn apart.

I didn't realise the problem would be many times worse than we warned. In the aftermath of this meth mess, the media are now uncovering absolutely heart-breaking stories of hurt and humiliation.

For us, this has always been about the evictions of very vulnerable people from their homes by our largest social housing landlord. Yes, some of those tenants would have been using meth, and many of those vulnerable people would have struggled with a meth addiction. When the government and its agencies should have been providing help and support to those people, it was instead causing greater pain and harm.

That has now changed. I am left feeling so grateful and optimistic with the radical change in direction led by Housing New Zealand and its Minister, Phil Twyford.

We should all applaud the new 'no eviction' policy, along with reintroduction of compassion and pastoral care. But let's be realistic about the challenges of this new approach. Increasingly, Housing New Zealand will be supporting tenants with complex vulnerabilities. That's no easy task considering the legacy of underfunded treatment and social services.

The government has led off on the right foot with redevelopments starting for the Auckland City Mission and the infamous Greys Avenue site. These will see quality new residences combined with wrap-around health and social support on site. Such models are well proven overseas.

There are three lessons we should learn from the meth hysteria.

First, when evidence and science don't inform drug policy, people suffer greatly. New Zealand's Misuse of Drugs Act exemplifies that.

Second, the media is so influential. Poor journalism helped the growth of the meth-testing industry and its hysteria. But there are cases where quality journalism helped expose the human impact of bad policy. I hope those journalists can look now at failed drug law. Finally, political leadership is so important when we need transformational policy. Without it, the consequences are terrible. As New Zealand continues debating the future of drug law, we will need senior politicians – government and opposition – to be brave, honest and mature.

These lessons should not be ignored.

SOCIAL

@KnowYourStuffNZ Can we please stop arguing about how to refer to synthetic cannabinoid products and instead focus on how to help people not die? ... 12 JULY

@tony_blackett Asking if Canada is leading the way with cannabis law reform: 'legalise, regulate, and minimise...' Sounds like three strikes to me! ... 21 JUNE

@JustinTrudeau It's been too easy for our kids to get marijuana - and for criminals to reap the profits. Today, we change that. Our plan to legalize & regulate marijuana just passed the Senate. #PromiseKept ... 20 JUNE

@philquin Even the Poms are getting with the programme on post prohibition drug reforms, albeit meekly. Come on, NZ, if that crusty bunch of dysfunctional toffs can get their head around it, surely our comparatively woke leaders can! ... 13 JUNE

@bernardchickey A meth tester says landlords are smarter than the chief science adviser Sir Peter Gluckman, and it's not about health anyway... it's about something else. I wonder what ... 30 MAY

KEY EVENTS & DATES

15 AUG	**Alcohol Action Conference 2018: Who should pay for all the harm from alcohol?, Wellington alcoholaction.co.nz**
12–15 SEP	**Cutting Edge, Rotorua cuttingedgeconference.org.nz**
15–17 OCT	**NZ Harm Reduction Conference: Reflecting on 30 Years of Harm Reduction, Christchurch nznep.org.nz**
31 OCT – 1 NOV	**Healthy Futures: Inspiration, Inclusion and Integration, 13th Biennial Asian Pacific Mental Health and Addiction Conference, Auckland cmnzl.co.nz/healthy-futures**
4–7 NOV	**APSAD Scientific Alcohol and Drug Conference, Auckland apsadconference.com.au**
6–9 NOV	**5th National Indigenous Drug and Alcohol Conference, Adelaide nidaconference.com.au**
26–29 NOV	**8th Gathering of Healing Our Spirit Worldwide, Sydney hosw.com/**

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NZ.

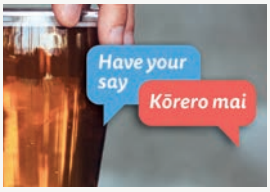
01 $17M FOR ALCOHOL AND DRUG TREATMENT

The government will use seized drug money to provide a $17 million funding boost to Auckland City Mission's Alcohol and Other Drug treatment centre.

Prime Minister Jacinda Ardern says it's "entirely appropriate" that money seized under the Criminal Proceeds (Recovery) Act will finance two new floors and an extra 10 beds for the centre, bringing the city's total to 30. "This development will help turn lives around. I can't think of a better use of the funds recovered from the proceeds of crime than that," says Ardern.

The one-off payment comes on top of $18m the previous National Government committed for the rebuild of the Auckland City Mission, which is now expected to cost $85m.

02 LAPs "put alcohol interests above health"



LOCAL GOVERNMENT New Zealand (LGNZ) says local alcohol policies (LAPs) aren't working and has asked central government to tighten licensing laws to stop the alcohol industry undermining community interests.

LGNZ President Dave Cull says the process puts "the right to trade in alcohol above measures to reduce its harm". If a community has made its wishes clear, he says, their local representatives should have the autonomy to follow those wishes. Instead, they are being forced to spend sometimes millions of dollars fighting industry interests.

Parliament is currently considering an amendment to the Sale and Supply of Alcohol Act, and the Drug Foundation submission strongly recommends scrapping the LAP appeals process.

03 Mental health and addictions: New Zealand knows the answers

THE GOVERNMENT'S Mental Health and Addiction Inquiry is well under way, and submissions closed on 5 June. We have recommended urgent changes to the way New Zealand responds to addiction issues and well defined steps to achieve them.

The Drug Foundation reminded the inquiry that many good solutions have already been proposed in response to previous commissions and reviews. Too much time and money has been spent on writing strategies that were never properly funded or implemented, so we think it's time to hold government and agencies to account.

The full submission is available online.

RESOURCE

NZdrug.org/news

04 New Bill demands eight years' jail for synthetics supply

AN AMENDMENT to the Psychoactive Substances Act (PSA) was pulled from the government's ballot earlier this year, and a report is due in September. The members' Bill put forward by new National MP Simeon Brown would increase penalties for supplying synthetic psychoactive substances from two years in jail to eight years.

Despite the best of intentions, research shows that increasing penalties has no effect on supply. In fact, suppliers are often using the drug themselves, so they need health solutions not harsh penalties. The original PSA is due for review this year anyway, and this will be an opportunity for a major overhaul to get it working as it was originally intended.

05 Māori voices strong at UN's indigenous issues forum

INDIGENOUS RIGHTS took the world stage in New York recently. The Drug Foundation's Gilbert Taurua travelled to the UN Permanent Forum on Indigenous Issues in April to talk about how much unfair drug laws impact indigenous people around the world.

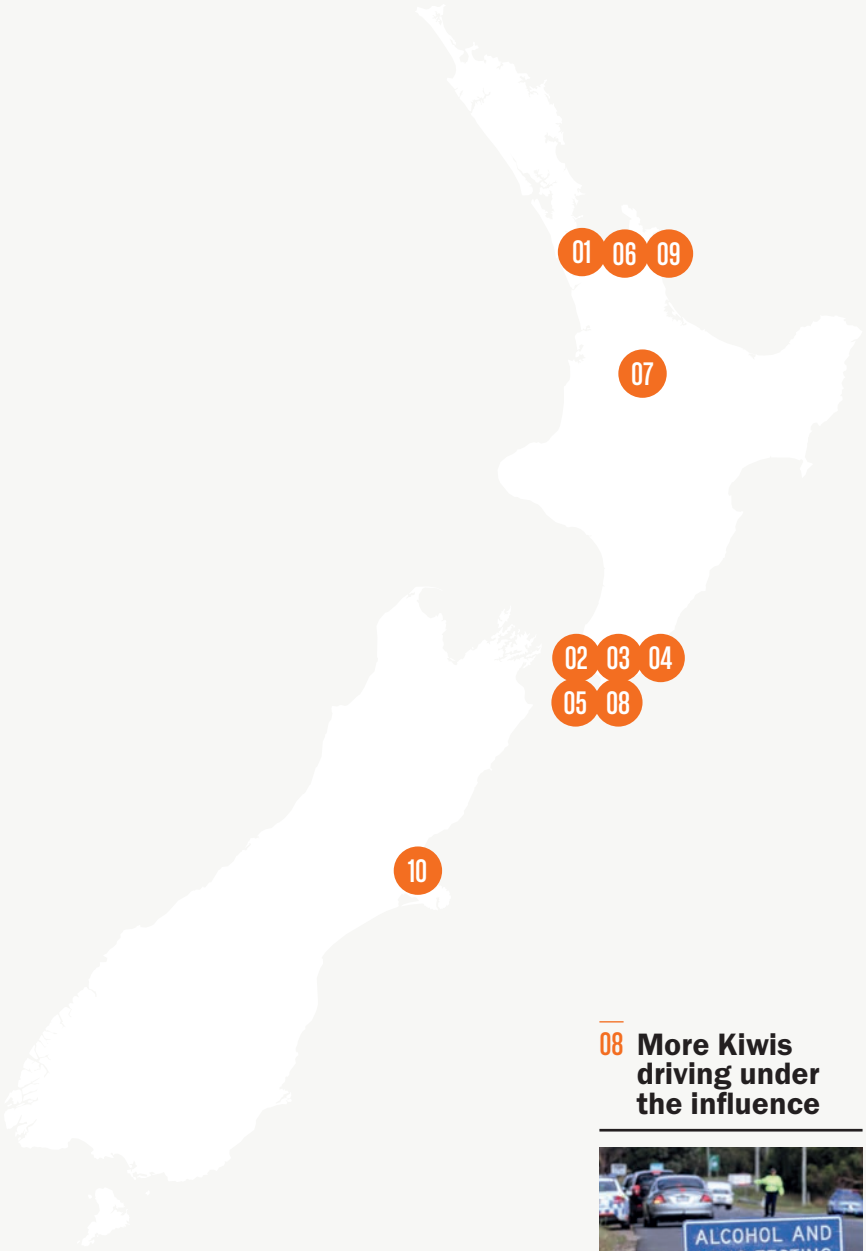
Gilbert says indigenous people often go unheard in the drug policy space, so he called for other indigenous people to add their voices to the debate. He asked the UN to support an international indigenous drug policy network to strengthen those voices.

06 Synthetic callouts triple as new symptoms appear

AUCKLAND EMERGENCY services have noticed a sharp rise in callouts linked to synthetic drugs over the past few months, with a new set of symptoms emerging.

Last year, patients were often found convulsing, but paramedics say lately they're finding people unconscious with difficulty breathing. As they wake up, they can become confused, agitated or violent. Drug Foundation Harm Reduction Projects Adviser Samuel Andrews says symptoms need to be closely monitored, because ESR data shows the chemical makeup of synthetic drugs changes regularly. "It's important for everyone involved to do their bit, to contribute to that data puzzle."

Coronial services confirmed three deaths were potentially linked to synthetic drugs in May, two of them in Auckland and one in Canterbury.



30 YRS

07 Mega-prison out, mental health treatment in

A CLEAR signal about government commitment to reducing prisoner numbers has been sent through the decision not to build a billion dollar mega-prison at Waikeria in the Waikato. Instead, a smaller unit with a purpose-built mental health facility will be built.

The new mental health unit will mark a turning point in the way prisoners with problems are cared for, with psychiatric staff permanently on site.
In announcing the plan, Corrections Minister Kelvin Davis said American-style mega-prisons just turn low-level offenders into more hardened criminals, and backing them is lazy politics.

08 More Kiwis driving under the influence

ADULTS CHARGED with driving under the influence of alcohol or other substances hit a six-year high last year, according to figures published by Figure.NZ.

Media attention has turned to roadside saliva drug tests lately, and a private members' Bill currently before Parliament would allow Police to conduct random tests for cannabis, MDMA and methamphetamine. However, the Bill does not have the backing of the Transport Agency. Associate Transport Minister Julie Anne Genter says solutions need to be "based on evidence and, ultimately, be effective".

09 $200 for reckless drinking stories

A WEST AUCKLAND licensing trust removed an irresponsible Facebook post recently, following a complaint from Alcohol Healthwatch. West Liquor's post invited people to share their "craziest memories" involving five brands of spirits, with a $200 prize up for grabs. Commenters shared stories of drinking until they passed out, fighting, injuring themselves, having unprotected sex, wetting themselves, vomiting and being arrested.

Alcohol Healthwatch said the post and its replies could be considered advertising, putting it in breach of the principles governing alcohol promotion. Concerns about the remaining licensing trusts have been building since a 2014 Auditor-General report found they lacked accountability, and the West Auckland community has criticised local trusts for not giving back to the community.

10 High-profile speakers for Harm Reduction Conference

THE NZ Needle Exchange Programme has confirmed two keynote speakers for New Zealand's very first Harm Reduction Conference in October. They are Nicole Lee, Adjunct Professor at Australia's National Drug Research Institute and Director of 360Edge consulting, and Dr Marianne Jauncey, Medical Director of Sydney's Uniting Medically Supervised Injecting Centre.

Thirty years ago, a much-maligned community found the strength to stand together and say "nothing about us without us". That philosophy still stands at 20 peer-based outlets throughout New Zealand. The three-day conference will look back at how needle exchange programmes got started and explore ways to keep up the momentum.

RESOURCE

nznep.org.nz/conference-introduction

World.

01 SINGLE MUMS FILLING MEXICO'S PRISONS

Worldwide, the number of women in jail is rising – mostly for drug-related offences. In Mexico, according to feminist organisation Equis, the female prison population rose 103 percent between 2014 and 2016.

Coletta Youngers, Senior Fellow at the Washington Office on Latin America, says many of those women are single mothers who took the fall for a husband, boyfriend or family member. In a country where 50 percent of the population live in poverty, they see it as a way out: "It's an easy way to combine their childcare responsibilities with earning an income." Locking them up makes for good statistics, Youngers says, but has no impact whatsoever on the drug trade.

02 Aussies lagging behind in cutting down

AUSTRALIA, ONCE a leader in anti-smoking policies, has fallen behind Iceland, Norway, USA, the UK, Canada and New Zealand in lowering rates of smoking.

To mark World No Tobacco Day, GPs and public health experts released data showing that Australia's decline in annual smoking rates had almost stalled, at 0.2 percent, from 2013 to 2016. Just as other countries have begun permitting non-cigarette alternatives like vaping, heat-not-burn devices and snus (a moist powder tobacco popular in Scandinavia), the Australian Government has gone in the opposite direction, banning vaping from public spaces.

03 Canadian Senate votes yes to recreational cannabis

CANADIANS WILL be able to legally buy and use cannabis from 17 October, with legislation introducing a strictly regulated market for use. The historic law change was passed at its final reading in the Canadian Senate 52 to 29.

In the lead-up to the vote, indigenous senators in particular had significant concerns with the Bill and wanted a guarantee that more resources would go towards mental health and addiction services for indigenous people.

For more detail, read "What to expect when Canada legalises" (page 32).

04 Too much pot to sell

WHAT HAPPENS when the market is left to self-regulate? Ask someone from Portland, Oregon, where a gram of weed is now worth less than a glass of wine. That's because over-enthusiastic Oregon farmers have grown three times what their customers can smoke in a year, leaving the state with a glut of legal cannabis.

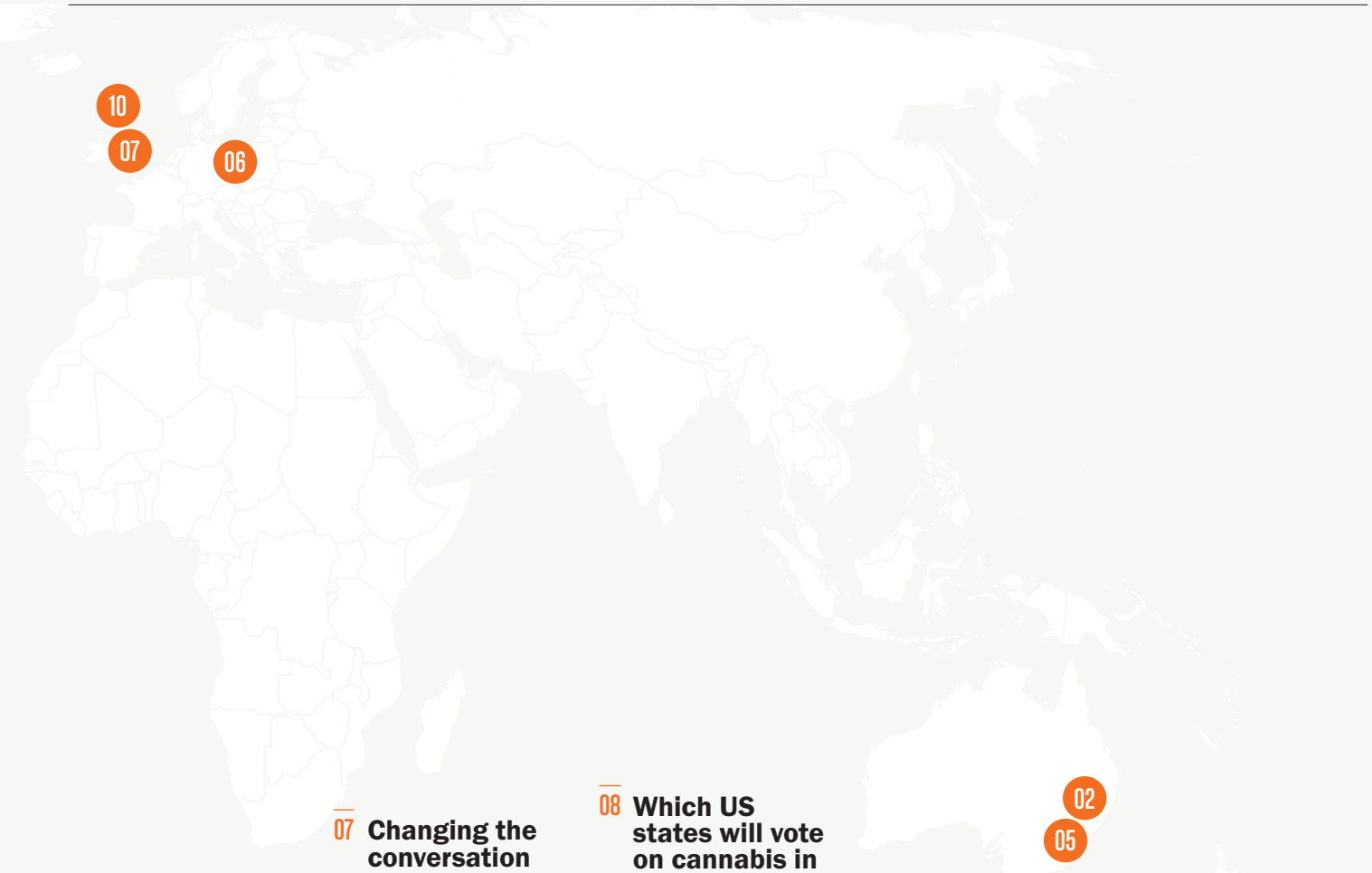
Currently, Portland has no cap on cannabis production, and regulators must give permits to all valid applications. However, the lack of restraint has caused a significant price drop, and now small businesses are laying off employees and some farms have shut down altogether. As small growers are forced to sell to investors, the market is being bought up by a few big players. And there's a new temptation: to illegally leak excess crops across state lines. Growers hope that, as more states legalise, interstate sales will be permitted.

05 Groovin the Moo paves the way for more drug checking

SUCCESSFUL DRUG checking at Canberra's music festival Groovin the Moo has advocates convinced it's just a matter of time before Australia sees testing expand to other events.

Of the 85 samples tested by STA-Safe Consortium at the April festival, two were found to be deadly. One was the synthetic drug N-ethylpentylone, responsible for 13 hospitalisations here in New Zealand. The other was NBOMe, a powerful synthetic hallucinogen linked to three Melbourne deaths in 2017.

Harm Reduction Australia President Gino Vumbaca says they will send a report to the ACT Government because big-name festivals are unlikely to risk having drug tests present without government and Police backing.



06 Amnesty International make stand on drug policy

IN A first for Amnesty International, the global NGO voted to adopt a policy on how states should address the challenges posed by drugs from a human rights perspective.

The policy was adopted at the annual meeting of Amnesty country representatives who meet to debate and vote on the direction of Amnesty's work.

At this stage, high-level key points have been agreed, with detailed policies due to follow. The policy calls for a shift away from the current 'scorched-earth' approach of heavy-handed criminalisation, to an approach where protection of people's health and rights are at the centre.

07 Changing the conversation to make drug use safer

THE SCIENCE is stacking up, and reputable medical journals are starting to speak out for drug law reform. The *British Medical Journal (BMJ)* and *The Lancet* have both added their weighty opinion to the drugs debate, with the *BMJ* coming out strongly in favour of legalising and regulating all drugs.

"This is not about whether you think drugs are good or bad," the May *BMJ* article said. "It is an evidence-based position entirely in line with the public health approach to violent crime … on which doctors can and should make their voices heard."

Shortly afterwards, *The Lancet* called for governments around the world to take off their blinkers, stop selecting evidence that supports their position and lead honest conversation to make drug use safer.

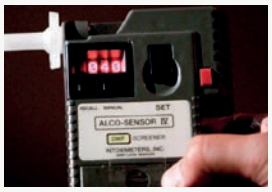
08 Which US states will vote on cannabis in 2018?

IT'S GOING to be a busy election season for the US, with six more states poised to put pot to the vote.

Michigan and Oklahoma will probably vote before the year's out. Michigan's proposed law will allow possession of up to 2.5 ounces for personal use, while Republican-leaning Oklahoma will vote on medicinal cannabis. Patients will need a licence to be prescribed cannabis by a board-certified physician, which will allow them to carry up to three ounces of marijuana on their person and eight ounces at home.

Another four states are on the cusp but may not make it into the 2018 ballot. Arizona and Nebraska plan to vote on recreational cannabis, while Utah and Missouri are set to add medicinal cannabis to their ballots.

09 Cannabis yes, random testing no



WHILE ROADSIDE breath tests are commonplace here, it seems that, in Canada, some conservative politicians think random alcohol testing is unconstitutional.

Conservative senators voted to delete a provision from new impaired driving legislation that would allow Police to conduct random tests without reasonable grounds to suspect the driver may be alcohol impaired. The move came as a surprise after all parties previously supported the Bill in principle, with Conservatives being particularly enthusiastic. Justice Minister Jody Wilson-Raybould said the government would not accept an amendment that drops the random breath testing measure.

10 Scotland: £0.50 per unit minimum

AFTER SIX years battling the alcohol industry, Scotland has become the first country in the world to implement a minimum unit price for alcohol.

Since being finally introduced last month, the 50p per unit minimum price has been welcomed by medical professionals and health campaigners as the biggest breakthrough in public health since the ban on smoking in public. It's been estimated the move could save around 392 lives in the first five years of its implementation in Scotland, where, on average there are 22 alcohol-specific deaths every week and 697 hospital admissions.

Stemming the tide in the north

A pilot scheme aimed at stemming the damage methamphetamine is causing in Northland has reached the 12-month milestone. Te Ara Oranga was allocated $3 million for extra treatment, more Police and community-led prevention activities with an emphasis on people working collaboratively across Te Tai Tokerau. A short extension has been granted a progress report delivered to the government in June is reviewed. Those involved are adamant Te Ara Oranga has proved its worth and should continue.

Keri Welham travelled to Northland to see what Te Ara Oranga has achieved in its short life and how other communities across New Zealand could use this model.

KERI WELHAM

The message is clear when you enter Kaikohe.

Photo credit: Keri Welham

When Kevin* wanted to finally break 15 years of daily meth use, he moved to Northland. That was five years ago. These days, that's the last place you'd go to escape meth.

The drug has its hooks in Te Tai Tokerau. Wastewater analysis indicates higher meth use in Whāngārei than in any other city or town in New Zealand.

An innovative one-year pilot has sought to reduce the chaos meth is causing up north. Te Ara Oranga [see sidebar] has brought together Police, Health, NGOs and residents – a community working together to address a problem and develop tailored solutions. The pilot is nearing completion, and many say it has been a game changer.

Kevin is a huge supporter of Te Ara Oranga. He thinks he might have given up years earlier if a GP had talked to him about treatment options and a support worker had called offering to walk the journey with him. He could have been spared years of pain.

Kevin is now a business owner and a support worker with the Ngāti Hine Health Trust – the same organisation that gave him life-changing residential treatment when he arrived in Northland.

He lives in Kaikohe and estimates "at least" 20 percent of the town's 4,000 residents are using meth. He claims it's a similar picture in Moerewa, Kawakawa and most of Northland's other small rural towns.

Recently, a man came in to his shop to buy treats for his children. His bank card was declined, and Kevin said the man could have the ice creams and pay him back another day. As the man fumbled to put his card back in his wallet, a bag of meth fell onto the counter. The man was quick to reassure that he was only using "part-time". Kevin briefly and gently outlined his lived experience and the services in their town, including the boosted support available through Te Ara Oranga.

A week later, the man came back and asked Kevin for help.

Northland stretches from southeast of Mangawhai across to the Kaipara Harbour and all the way up to New Zealand's northernmost tip, Cape Rēinga. The region spans 13,286 square kilometres, has 10 harbours and is home to 165,000 people – almost 85,000 of them in Whāngārei.

In tiny Moerewa (population 1,400), you can buy pork bones and watercress at roadside shops. A grown man rides a tiny BMX in gumboots, beefy dogs roam, cacti grow, lawns are tight clipped on some

"Kevin ... thinks he might have given up years earlier if a GP had talked to him about treatment options and a support worker had called offering to walk the journey with him. He could have been spared years of pain."

* Kevin is pseudonym for the person we interviewed who requested their true identity not be used.

Wayne Whitney, Ivy Tenana, and Darin Goodwin promoting 'Te Ara Oranga' at Waitangi in February 2018.

Photo credit: Photograph by Michael Cunningham for The Northern Advocate

sections and tractors decay on others. In the drizzle, a man walks down the street, hood up, fighting vigorously with his jacket pockets as though trying to free himself. One home has rotting weatherboards and no curtains, and from the road, you can see a single mattress on the ground. Many other homes seem to be disintegrating in the damp tropical warmth, melting into the earth. A fairly new car seat lies in a sopping wet driveway. On the main street, men in white AFFCO gumboots walk into the bakery.

State Highway 12 passes the Northland Region Corrections Facility, and then you're in Kaikohe. It's a service town where you can buy cars, pre-loved clothing, headstones. The Police station roof is covered in lichen. A man struts up and down the main street on a relentlessly wet day holding a small radio, yelling and kicking billboards.

Kevin says he knows of homes in Kaikohe where methamphetamine is being consumed by three generations. He knows of intermediate-age children caught with meth at school.

"The problem in a town like this is people look up to the wrong people."

He says gang members are viewed as role models, and many people are drawn in by the potential to make a lot of money dealing meth. But, as a former meth manufacturer and dealer himself, Kevin knows the reality is that it's highly unlikely individuals will be in the game long enough to get rich dealing a messy, highly addictive, problematic drug like meth.

"There is no one that we know who is retired and living with their millions on an island in the Bahamas."

A couple of years back, Northland Police and Health began working together on two other critical issues – youth suicide and family violence. They jointly applied for Proceeds of Crime funding to support the Family Harm focus, but Cabinet said it'd like the agencies to look at tackling methamphetamine – the drug that was becoming a regular fixture in family violence, causing a wave of social harm across Te Tai Tokerau.

Police, Health, NGOs and community representatives brainstormed together and came up with the framework for Te Ara Oranga.

Work to flesh out the programme started with intensive community consultation across Northland, led by community action expert Pam Armstrong. Hundreds attended. Communities were listened to, and their ideas became the basis of some of the most effective elements of Te Ara Oranga.

One example is a cheap, easy-to-distribute fridge magnet. It features the meth cycle – information that is highly valued by families faced with a person who is changing before their eyes. Initially, 1,000 magnets were printed and distributed. They were such a hit, Police funded an additional 5,000.

Another suggestion was to create resource kete to go to each community containing stickers, videos, magnets, billboards. Five of the kete were created, blessed and delivered back to the communities through a second series of hui attended by 600 people.

Throughout the consultation phase, Pam asked people at hui to share their stories.

"The drug's a terrible thing," she concluded. "With smoking dak, it's not problematic. The behaviour's nowhere near as problematic. They are not ripping people off and doing these out-of-it crimes."

People exploit their children's basic needs to extract money for methamphetamine from their families. Many women sell sex to pay off drug debts. Many Northland families have been financially stripped bare by one family member who has lost control. Clinicians say night industry staff use it to stay awake and get hooked. Middle class professionals use it recreationally – and it takes over. On marae, people turn up pre-loaded – their whanaunga take one look at them and know they're "on the fries". There's even talk that it's swapped by teens at high school in exchange for lunch money.

Kaikohe Dance Crew with local Police filming the 'Let's make a change' music video in Kaikohe.

Photo credit: Liz Inch

> **"This is a health issue. Substance abuse is a health issue...We [Police] have been disconnected from the health issue. Traditionally, we might have just criminalised everything, but we went out to engage with communities."**
>
> DEAN ROBINSON

During the consultation, many marae requested resources to help them discuss methamphetamine use with members of their hapū.

"They could see their community was starting to be impacted," Pam says. "They wanted to prepare themselves."

Across Northland, one-third of residents are Māori. North of Kawakawa, that figure is 43 percent. Roughly 50 percent of clients in alcohol and other drug (AOD) treatment across the region are Māori.

Pam says the high rates of drug use among Māori are a direct link to the poverty in which many Māori live.

"When you don't have much, you're willing to take the risks. Poverty goes hand in hand with drug use. It would appear that some of the most vulnerable people are the ones that it's impacting on more significantly."

Jenny Freedman is the professional leader of AOD treatment for Northland District Health Board (DHB) Mental Health and Addiction team. She says it was critical Te Ara Oranga was anchored in Māori tikanga.

"You've got to match your community," she says. "You want people's ears to be open, [for them to] feel as comfortable as they can."

Recruitment for the new community outreach positions created by Te Ara Oranga was challenging. People had to come from the community, and the contracts were only for one year, so there was no job security. Where possible, the project team worked to attract applicants with experience of living in the towns where the positions would be based, familiarity with te ao Māori and experience living with addiction.

Jenny says Te Ara Oranga has broken new ground in drug harm reduction. One example is an employment programme where people are supported into jobs before they have stopped using. In many instances, this means the job seekers are still committing crimes to fund their use.

Rebecca Priest, an occupational therapist from Workwise employment agency, approached community-centric employers who understood that employment aids recovery and had some tolerance for unreliability and the other issues people using methamphetamine often bring. She helped prepare the job seekers with fresh CVs and meditation techniques to calm anxiety and worked with each job seeker and employer to negotiate appropriate terms.

In total, there were 67 referrals to Te Ara Oranga's employment programme. Of those, four people who were in danger of losing their jobs were supported to keep them, 26 people obtained new work and eight people undertook vocational training.

Jenny: "We've got people with significant criminal histories now in jobs."

She says the programme has also enabled the DHB to access a whole new swathe of people in need. Of the 308 referred to Northland DHB for treatment in the six months to 31 March this year, 120 were not previously known to mental health and addiction services.

Normally 50 to 60 percent of referrals come from Corrections – people who are forced to seek treatment as part of their sentence. Through Te Ara Oranga, referrals came from Police, GPs, Whāngārei Hospital's emergency department and other previously untapped avenues.

Jenny says people who use methamphetamine are particularly suspicious and paranoid and therefore more help-avoidant than most others who use drugs. On top of this, they tend to be involved in more serious crimes, so often there really are gangs chasing them over debts or issues with dealers.

Jewel Reti project manages the health arm of Te Ara Oranga. She says it can be a very hard drug to identify if you're not aware of the symptoms. In the beginning, many users lose weight, have energy and look amazing.

"Some will look better than they've ever looked," Jewel says.

It can be a decade before they lose their teeth and are bone skinny – the classic

Ross Smith and Martin Kaipo receive the Whangarei Te Ara Oranga kete from Mare Clarke (right).

Photo credit: Liz Inch

'meth look' from scare tactics campaigns. But by then, they will likely be alone, destitute and living in drug-induced fear.

What if the programme is dropped?

Jenny: "If we only get six months, we won't get to see the true value of the project."

What if it is funded, but to a lesser degree. What part of the programme will they drop?

Jewel: "Not one bit of this is any good without all the other bits. That's the reality of it. You need all the pieces to be effective."

As a Māori woman living in Whāngārei, Jewel Reti says she has always been a little wary of Police. That has changed since she has come to work alongside Te Ara Oranga's Meth Harm Reduction team.

Inspector Dean Robinson is Northland's District Prevention Manager and Police lead for Te Ara Oranga. Jewel helped him recruit his Meth Harm Reduction team, and the Police staff who were handpicked as members were those who displayed empathy for people using drugs and who were comfortable with the pilot's healthcare approach.

Dean says Te Ara Oranga has changed the mindset for Police, from enforcement towards a healthcare response. His staff say they cannot arrest their way out of a meth crisis, so instead they are referring people to treatment.

"This is a health issue. Substance abuse is a health issue," Dean says. "We [Police] have been disconnected from the health issue. Traditionally, we might have just criminalised everything, but we went out to engage with communities."

He realises many New Zealanders would prefer Police locked up all people involved with illegal drugs. But he is convinced of the merits of an approach where officers line up treatment options and support people using drugs and suppliers to get help.

Police have taken what he describes as "a considered approach" to suppliers.

"We talk with users and most suppliers and offer access to treatment programmes. From science, we know [you] can't always convince people they need treatment."

So, sometimes charges are used as a tool to get suppliers to engage with treatment – a kickstart, with a clear objective to get the person help. People have told officers they never expected their first offer of help to come from Police. Around 50 percent of those Police have referred for treatment in the past six months were not known to the DHB.

However, Dean is clear Police are not holding back on the organised criminal bodies putting meth onto Northland streets.

"If you are supplying drugs and it's for the purpose of making money off it and you're creating a whole lot of harm, we will use the law to intervene," he says.

"We talk with users and most suppliers and offer access to treatment programmes. From science, we know [you] can't always convince people they need treatment."

DEAN ROBINSON

Muriwhenua community gathered in Kaitaia to accept the Te Ara Oranga kete in August 2017.

Photo credit: Liz Inch

Police began testing Whāngārei's wastewater in August 2017 to establish a baseline against which treatment and enforcement could be measured. If there is a major meth seizure, does the rate of meth in the wastewater fall? Whāngārei wastewater shows population meth use there is currently four times higher than Christchurch and three times higher than Auckland.

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Back in the early 2000s, Dean and his colleagues started to see methamphetamine hitting the streets of Northland. Police jurisdictions offshore had warned that the drug was highly addictive and, therefore, commonly unleashed a disastrous impact on the lives of people using it.

In the beginning, it was locally manufactured in relatively small batches, and base products were sourced in New Zealand. Consumers then didn't have a sophisticated knowledge of the drug, so the 'meth' they were buying was sometimes more salt and glucose than anything.

At this stage, a point bag (usually 0.1g but not always, depending on supply and demand) was about $100, and at that price, the clientele was largely middle to upper income earners such as truck drivers or business owners.

This began to change as organised criminal groups put more effort into growing demand. Adopting marketing tactics common to shops promoting everyday consumer goods, people were enticed into trying this new drug. A committed clientele for meth began to grow.

At one bust, Police found a whiteboard with a comprehensive operational business plan laid out. It detailed how often the gangs needed to change their delivery routes and how often they needed to buy new phone cards.

Initially, the Police focus was on enforcement – dismantling labs and locking up those involved in manufacture. But the gangs just used their contemporaries' experiences offshore to find new ways to source methamphetamine and its precursors and to avoid detection. This is when the importation of the drug and its key ingredients really ramped up.

A surge in the availably of methamphetamine means there is barely a corner of the region unaffected. Unlike cannabis, which has long been synonymous with the languid Northland lifestyle, Dean says there is widespread disgust for meth in Northland. "The community absolutely hates it."

Jenny Freedman agrees.

"The community would tell you it's massive," she says. "Everybody you meet has a story."

"Clinicians have come across kaumātua in the grip of the drug, losing their life savings and their mana. And entire workforces at some small-to-medium Whāngārei businesses are on it, passing around a P pipe on a Friday night after work in the same way they may once have passed around a joint or sat together drinking beer."

“In the five months from January 2018, 37 patients were screened for methamphetamine use and provided brief intervention or referral to treatment at 20 different practices.”

Many high-functioning business owners, lawyers, doctors and others with generous incomes and considerable assets are using methamphetamine as are those living in extreme poverty, who don’t have a job or home to lose.

“Initially, it was those who could afford it,” Dean says. “Then, it was those who couldn’t afford it but would do crime to fund it.”

Clinicians have come across kaumātua in the grip of the drug, losing their life savings and their mana. And entire workforces at some small-to-medium Whāngārei businesses are on it, passing around a meth pipe on a Friday night after work in the same way they may once have passed around a joint or sat together drinking beer.

Dean: “We’ve now got a culture of use which has become increasingly normalised.”

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Maurein Betts led development of Te Ara Oranga’s various screening and brief intervention tools for GPs.

Around 60 primary care nurses received fresh training in managing patients with mental health and addiction requirements. Documents about methamphetamine, which GPs could print out and go through with patients, were added to practice databases. Counselling packages were available for GPs to offer patients. Addiction treatment organisations were also added to the GPs’ e-referral system, making it much easier to arrange a referral.

The tools were made available in 40 practices across Northland. In the five months from January 2018, 37 patients were screened for methamphetamine use and provided brief intervention or referral to treatment at 20 different practices. Maurein was delighted with this result. It’s not possible to check, but she suspects there would not have been a single referral from those 40 GP clinics in the year preceding the pilot. This is not about a lack of interest or indifference – it’s about finding time to become familiar with methamphetamine use issues when there is a line out the door and the day is compartmentalised into 15-minute slots.

Sisters Gina Rihari-Pedersen and Lovenia Hillman with the meth cycle that’s been useful for their whānau

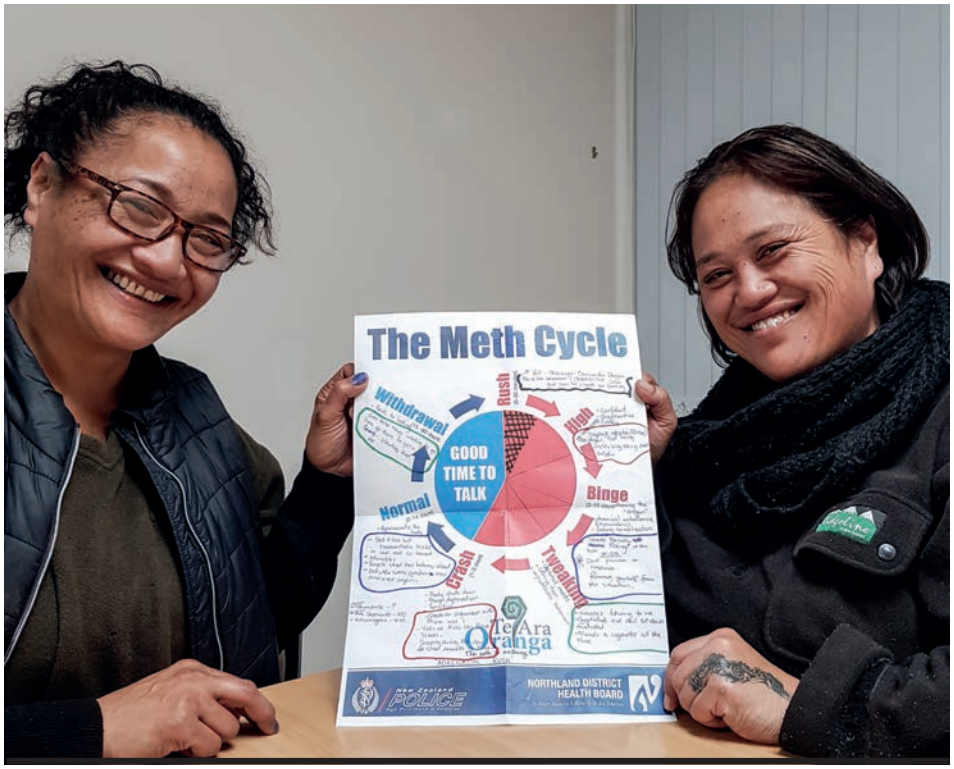

Photo credit: Keri Welham

“We often get the pilots, but we don’t get the plane.”

MAUREIN BETTS

Recently, in a poorer suburb of Whāngārei, a 19-year-old father of two came to see his GP. He’d been smoking methamphetamine and thought he had some wax stuck in his throat. Staff at the practice were confident in their response. They openly discussed treatment, and when the patient refused, they devised a plan. Without breaching patient confidentiality, they gained kaumātua consent to disseminate generic meth cycle information throughout the wider family so those around him could keep themselves safe.

“For us,” Maurein says, “that’s amazing.”

She says the community will feel betrayed if Te Ara Oranga programmes built on community suggestions – which appear to be helpful in their infancy – are not continued.

“All the places where people might touch patients, we’ve strengthened. A lot of our stuff only really started working four months ago,” she says.

“We often get the pilots, but we don’t get the plane.”

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Sisters Gina Rihari-Pedersen, 49, and Lovenia Hillman, 48, were worried about their brother.

His behaviour had changed markedly. He was a quiet, loving, gentle man with an envied knowledge of tribal customs. He became an angry, threatening, antagonistic dad and uncle. He chucked his job in and walked out on his family.

“He was a totally different man who demanded everybody’s respect and wanted everybody to listen to him,” Gina says. “We were all walking on eggshells.”

Around the same time, Te Ara Oranga came to Kaikohe. A support group was started for families of those using methamphetamine (these support groups were one of the most common requests from communities during development of the pilot).

The sisters didn’t think meth was the issue but agreed some of the kōrero at the support group might be helpful in determining a way forward for their whānau.

Te Ara Oranga pilot impact 01.10.17 to 31.03.18

308

METHAMPHETAMINE USERS REFERRED TO NORTHLAND DHB FOR TREATMENT

120 OF THE 308

REFERRED CLIENTS PRESENTING VIA NEW REFERRAL PATHWAYS (THE MAJORITY THROUGH POLICE) AND WHO WERE NOT PREVIOUSLY KNOWN TO MENTAL HEALTH AND ADDICTION SERVICES

236

METHAMPHETAMINE USERS SUPPORTED BY POU WHĀNAU CONNECTORS IN THE COMMUNITY

38

MENTAL HEALTH AND ADDICTION CLIENTS SUPPORTED TO KEEP THEIR JOB OR PLACED INTO EMPLOYMENT OR VOCATIONAL TRAINING

890

PEOPLE SCREENED FOR METHAMPHETAMINE AND OTHER SUBSTANCE USE THROUGH WHĀNGAREI HOSPITAL EMERGENCY DEPARTMENT

30

SEARCH WARRANTS EXECUTED

Figures supplied by Northland DHB.

“Teropu says everyone in her town has experience with methamphetamine. She says a ‘wave’ is coming for Northland. ‘How do we stop this thing?’ Te Ara Oranga is the first step, she says. It needs to be continued – and extended. ‘I think it’s just the beginning. It’s just touching on it. People are still screaming out for more support.’”

A diagram of the meth cycle was shown at the support group, and they stared, nudged each other and shook their heads. Every behaviour outlined was a perfect match for their brother’s new personality. Their brother was on methamphetamine.

The sisters called a meeting with him, his GP, treatment services and their mum. Clearly motivated by a desire to stop hurting his mother, their brother confirmed he was using meth and agreed to treatment.

Meanwhile, the sisters set about writing a whānau safety plan. It outlined when in the meth cycle the children should avoid their uncle and where to go if they had to leave the house because of his behaviour.

Today, in the warm, worn, windowless room where they meet at Mid-North Health and Addiction Services in Kaikohe, they unfold two large sheets of paper and lay them on the table. The first is the meth cycle poster, filled in with words their family had used to describe their brother’s behaviour. The second is their whānau safety plan, including evacuation procedures. These pieces of paper chart this family’s journey.

As well as the knowledge they gained in this room, they also valued the company on what had felt like a lonely journey. Families come from all over the region – some travel for over an hour each way, every Monday night – to be with others facing a similar road. Lovenia says her focus has now moved from being there for her brother, who had not used methamphetamine for three months at the time of writing, to being there for other Kaikohe families.

“I’ve lived here all my life,” Lovenia says, “and they are my whānau and I want to help.”

There is the chance this determined family would have found help in the end, even without Te Ara Oranga. But it would have taken longer to locate, and once they did, the waiting times would have been several weeks longer. During those weeks, more damage would have been done, more people hurt.

Across the car park works Teropu Pou. She is General Manager of Te Hau Ora o Ngāpuhi, which focuses on the wellbeing of children and babies.

She feels used by Te Ara Oranga. She features in the programme’s videos, supported its billboards and was excited to imagine her organisation’s ideas might be used.

She wanted the ability to have a retreat programme where women using methamphetamine could go away, just for a week or two, and have their children come and visit. They’d organise professional guidance for around four women at a time and the kids would be safe – Teropu was going to babysit them herself. All the women involved were specialists prepared to do the work for free.

“It was voluntary. We felt as Māori leaders [that] we needed to contribute back.”

The intention was treatment with a focus on strengthening bonds with children and building resilience and confidence in women. Teropu acknowledges the numbers would have been small but she says the positive outcomes for those whānau would have had far-reaching consequences.

However, her idea was not one of those chosen, and she believes Te Ara Oranga “hasn’t even changed anything” for women and children affected by meth.

Pam Armstrong, who ran the community consultations, says it is valid the community wants to run its own programmes, but the scope was not there for localised initiations in the one-year pilot.

Jenny Freedman from the DHB says building a residential facility to house such a programme would have cost $2 million – the total amount allocated for the health part of the contract.

“We had to make a decision with that money and timeframe, and residential treatment was not viable,” she says.

However, she can see a place for marae-based programmes to cater to ideas such as Teropu's, as the marae setting doesn't require the same clinical rigour and hospital-grade facilities that are a necessity when a DHB is involved.

Teropu says everyone in her town has experience with methamphetamine. She says a "wave" is coming for Northland. "How do we stop this thing?"

Te Ara Oranga is the first step, she says. It needs to be continued – and extended.

"I think it's just the beginning. It's just touching on it. People are still screaming out for more support. There's not enough support.

"It's a start. It's just a start."

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One of the most desperate needs in Northland is still unmet. The project hoped to increase DHB detox beds in the region from five to seven, to decrease crippling wait times of up to eight weeks for residential treatment.

But building requirements, such as consents to create beds that meet strict healthcare standards, take time. Northland DHB spokesperson Liz Inch says the funding for the beds is locked in and the detox unit extension will be built regardless of whether the pilot is extended.

As they wait to hear about the future of the programme, those involved are moving back to the roles from which they had been seconded and reflecting on this last whirlwind year. Colleagues in other parts of New Zealand are anxious to hear what has worked, what they could repurpose for their region.

Dean says the programmes that make up Te Ara Oranga are a perfect fit for Northland but might not necessarily suit the unique demographics of other communities. A community that was less spread out geographically, with a larger and more ethnically diverse population, might come up with totally different responses to an intruder like methamphetamine.

"This has worked for Te Tai Tokerau," Jewel says.

Could the same programme be replicated elsewhere?

"A big city might do it differently," she says. "We've got some tools that might work [elsewhere], but you have to adapt it to work for your community." ■

Keri Welham is a Tauranga-based writer and journalism trainer.

What is Te Ara Oranga?

Te Ara Oranga Methamphetamine Demand Reduction strategy pilot is an innovative collaboration to reduce meth harm in Northland. The one-year $3 million programme has been funded by the Criminal Proceeds (Recovery) Act and is jointly led by Health and Police.

With the initial pilot phase over, the programme has been granted a six-month extension to allow the Ministry of Health to thoroughly review the evaluation report submitted in June. A decision on whether the programme will be continued is expected later in the year.

$3M

PROGRAMME, FUNDED BY THE CRIMINAL PROCEEDS (RECOVERY) ACT

2018

ONE-YEAR PILOT, JOINTLY LED BY HEALTH AND POLICE

The pilot was developed with significant community input, and by October 2017, a range of initiatives were under way:

- Screening to identify meth use among emergency department patients.
- Choice – a programme designed to impart knowledge about the drug and develop relapse prevention skills.
- A programme to help medical centre staff identify patients experiencing substance use and to make treatment referrals easier for GPs.
- Whānau support to better equip families of people using meth.
- Pou Whānau connectors to reduce wait times and give timely support to those who are treatment avoidant.
- 16-week matrix model intensive community-based treatment using existing Northland services, which clients attend at least three times per week.
- An evidence-based employment service supporting people into work even though they are still using and potentially committing crimes to fund their use.
- A suite of whānau and community resources, including fridge magnets, pledge stickers tailored to 10 different communities and educational videos featuring community champions.
- The song *Let's make a change*, written by a Kaipara community support worker, licensed and used as Te Ara Oranga's theme waiata to generate awareness and motivate people to seek help.

Māori enterprises gear up for medicinal cannabis market

New Zealand could soon have a local medicinal cannabis company. Some Māori enterprises are gearing up to win a share of the market. These early expressions of interest have many motivations, as **Tess McClure** recently discovered. This article is brought to you in partnership with Vice NZ.

TESS McCLURE

Photo credit: Tess McClure

Phillipa, a student on a hemp-growing course, inspects young seedlings.

Photo credit: Thomas Teutenberg

The road to Ruatoria is long – eight hours from Auckland and two from Gisborne, the nearest town to pass as an urban centre. Often, you are the only car on the road. On the radio, channels drop away one by one, until the only station is Radio Ngāti Porou – bulletins in te reo, jukebox jams with Ken. Undulating mānuka gives way to the dark uniformity and order of radiata pine.

At an isolated sheep-shearing shed in a Ruatoria valley, a crew of growers arrive to pick up planting pots. It's well past harvest time now, but a few weeks back, this room was filled with bunches and bunches of drying hemp. A few sacks of buds are still here, giving off their sweet, heavy scent. One of the men ducks out of photos: "Camera shy." Before he did this, he used to grow cannabis illegally. "Got sick of ducking and diving," he says. Now he's looking at doing hemp by the books.

"Think about it. That's a positive thing," his companion chips in. "These guys" – he sweeps a hand around at the sheep shed – "they're thinking about the people. That's different to corporate companies coming in and taking over."

'These guys' are Hikurangi Industries, racing to be among the first legal producers of medicinal cannabis in New Zealand. Currently, they hold a commercial hemp-growing licence. As they wait for New Zealand's medicinal cannabis reform to move through the legislation process, they've begun training locals to grow and process hemp – the plant cousin of cannabis – so they're ready when the time comes.

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Racial injustice has been a key driver of international drug reform. But in America, a chasm has emerged between the communities of colour disproportionately hit by drug policing and the primarily white entrepreneurs making huge sums off a billion dollar legal industry. In 2016, a Buzzfeed investigation found just 1 percent of weed dispensaries were owned by black people. A number of states had introduced laws meaning those with drug convictions were banned from involvement in the legal industry. "After having borne the brunt of the 'war on drugs'," they write, "black Americans are now largely missing out on the economic opportunities created by legalization."

Here in New Zealand, it's Māori communities who have most often been hit by racial bias in drug policing. Even when accounting for rates of use, at every stage of the criminal justice system, Māori are more likely to be apprehended, charged and given a prison sentence than their

"A lot of Māori are suppressed by low-level cannabis convictions... They can't get good jobs because of a criminal record."

The sustainable primary production course covers all aspects of production.

Photo credit: Thomas Teutenberg

“The hemp, this is something positive for our whenua. We are people of the land, so it’s our turn to give something back.”

JUSTIN TIBBLE

Pākehā pot-smoking counterparts. In a 2007 report, for example, Corrections notes that, on the basis of equivalent usage of cannabis, Māori experienced arrest at three times the rate of non-Māori users.

Now, New Zealand is poised to legalise medicinal cannabis. But who stands to benefit from a legal industry? And what’s to stop those who were disproportionately affected by drug laws from continuing to lose out?

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Rob Thomson sits with his partner Lisa at a veranda table of Te Puia Hotel while the rain drums down around him.

He wears a thick knitted wool vest, a carved bone pendant at his neck. His dreadlocks reach almost to his waist. His preschooler daughter is sitting on his lap. Lisa has a thick sweep of black hair, moko kauae tracing her chin.

“I’ve spent probably five or six years of my life in prison for growing marijuana,” he says. “For me, that’s just a waste of life. A waste of our people’s time for a crime that doesn’t hurt no one.”

A lot of Māori are suppressed by low-level cannabis convictions, he says. They can’t go overseas. They can’t get good jobs because of a criminal record. Many are having entire years of their lives frittered away in prison for small-scale drug offending.

“For me, it really hurt me, but it was my wāhine and my tamariki outside that really suffered,” he says.

These days, he and Lisa tutor a hemp-growing course at EIC – the tertiary provider partnered with Hikurangi – and are waiting on a growing licence. His 80-year-old mother has applied for a growing licence too, he grins. “Nanny hempsters!”

Thomson is something of an evangelist for the scheme now. Two of his nephews died in forestry. He wants other jobs for young Māori.

“Our people are just sick of the forestry because of how many deaths – especially with young men. So we don’t want to go in the forest, so what’s the next option we’ve got? Hemp is the option for our people.”

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On the road from the sheep shed, thick acres of pine alternate with the red, scabbed earth left by logging trucks. Justin Tibble is driving, sunglasses perched on top of his cap. He’s from around here, but he spent 20 years away from home, working as a builder and truck driver. “When you talk about employment on th coast, there’s – for want of a better word – sweet eff-all.”

The only place for young men to work is felling the colossal pine trees that line the gravel road he’s driving. And there, they keep dying. Forestry is a dangerous game: 26 dead in the past five years alone. In the records, each death is summarised by a short, brutal sentence: “Crushed by a falling tree.” “Struck by falling tree.” “Struck by tree.”

When he heard about Hikurangi, Tibble came back to train in hemp growing, buoyed by the hope of good jobs at home at the other end.

Twenty-two percent of the region are employed in forestry. But Tibble thinks the people out here who went for the promise of timber 20 years ago are done with it now.

“People are sick of the lies they got sold 30 years ago about forestry. They planted up their land with pines, it takes 25 years. But now it’s time to harvest, and it’s not worth enough.” He points to the banks of pine again. “Out of all these trees, you won’t get many rich landowners. And they’re left with barren land.”

Pine is tough on the land and rivers. In June, an enormous load of fallen trees

Photo credit: Thomas Teutenberg

and logging debris – around 1 million tonnes of forestry slash – swept down the waterways, damaging 61 bridges in its path. The earth, too, has been exhausted. Radiata drains the soil of its fertility. Then, when the pines come down, heavy rains quickly wash away topsoil. The erosion clogs and poisons the waterways.

"The hemp, this is something positive for our whenua. We are people of the land, so it's our turn to give something back. The hemp puts the nitrogen back in the soil that the pine trees drain out," says Tibble, gesturing out the window.

Peter Solitt, on the seat behind him, is nodding. Solitt has also returned to Ruatoria for this. Before, he was working in the quarries in Gisborne.

"It's brought a little bit of hope here," says Solitt. "A lot of politicians haven't done much, to be honest. That's my personal opinion. Hikurangi has created opportunities for us – something that wasn't here before.

"Yeah bro," Tibble nods from the front. "That's it. Something that wasn't here before."

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Hikurangi's plan is to grow and process their crop centrally, but local landowners and residents can also get licences to grow on their own land and supply the company.

We visit one of their gardens. It's winter time, and there's no hemp. Instead there are raised beds for vegetables.

Further up the road, we stop at a greenhouse filled with hemp seedlings. Kathy, a student turned tutor, sets up one of the men watering plants. If she wasn't doing this, she says, she'd be back on the benefit. She used to get calls from Work & Income telling her if she couldn't get a job there, she'd need to look at leaving Ruatoria, shifting out to Gisborne where the jobs were.

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Economically, things are tough out here. Unemployment in Ruatoria sits at 15.6 percent – more than triple the national rate. At the last census, median annual income for a potential earner – that's 15 years and older – was just $17,100, about 30 percent lower than the national average and less than half New Zealand's living wage.

Poverty levels are high. In 2015, economic reports found the area had the worst regional economy in New Zealand and the nation's poorest population. There is a deep-running spirit of generosity and cultural connection. Ninety-three percent of the population are Māori, and about half speak te reo fluently. According to a McGuinness Institute discussion paper, people here donate proportionally more time and money to their community than anyone else in the country.

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Driving an SUV over unsealed road, Manu Caddie points out the window to a scrubby passage of flat land. "This used to all be maize a few years back," he says, "but it could all be hemp."

Caddie is Hikurangi's Managing Director. His head is shaved, and he wears khakis with a grey work shirt. The company is still watching closely to see where New Zealand's legislation goes, but they've designed clinical trials and plan to start them this time next year. In May, they raised $2 million of investment on PledgeMe, generating traffic so high it managed to crash the crowdfunding website. Currently, they employ 15 growers. If they can get their licence to grow once the law changes, he estimates their growing and processing facility will employ 120 staff, many of them locals.

"Seems like, in the states that have legalised, it's been good for young, white guys but not so good for young people of colour," Manu says.

He'd like to see that picture reversed in New Zealand, and the company works with guys who have previously grown illegally, utilising skills that were penalised by the criminal justice system.

"A number of the guys that have grown for us now had been in jail and come out,

Hikurangi Enterprises Managing Director Manu Caddie.

“It’s about whānau being able to live on their land that they might have been away from for two or three generations.”

MANU CADDIE

Photo credit: Thomas Teutenberg

had not wanted to go back to jail, so they weren’t growing any more. but they sort of had those latent skills that they’d developed over many years. And so they’ve come back into growing plants – in a legal way.”

His hope is that the jobs will draw back whānau from years of urban drift.

“It’s about whānau being able to live on their land that they might have been away from for two or three generations. It’s about the health of the paepae, speakers and kaikaranga that can maintain the traditions and ways of doing things. So I think there’s cultural benefits as well as economic and social benefits.

Hikurangi’s future as a medicinal cannabis grower relies on the law makers in Wellington. Even a slight tweak to legislation could present challenges to them existing in the market at all. In Canada and some American states, for example, some legislation means those with criminal convictions – or even connections with others involved in criminal activity – are banned from holding positions in the medicinal marijuana industry. If New Zealand imported similar legislation, it would leave many members of communities like Ruatoria cut out of the picture.

Pinned to Paora Stanley’s office door in Tauranga is a portrait of a man in his mid-20s advancing on the camera. He has four bullet holes through his forehead. Around 30 more are ripped through his paper torso.

Target practice, Stanley says, from when he was CEO at the Listuguj First Nation reservation. There, he had his own Police force and invested in heftier firepower. “I’m from a weapons and explosives background,” he says, gesturing at the targets. There are very few missed shots.

Stanley is Chief Executive of Te Rūnanga o Ngāi Te Rangi. He wears an enormous pair of tan work boots with blue jeans. His head is shaved. On the reservation in Quebec, the tribe said his spirit animal was a bear and gifted him a bear tooth that hangs from the wall. A coyote skin is draped over the desk chair. A taiaha leans on the windowsill.

He is, in some ways, an unlikely candidate for involvement in New Zealand’s cannabis scene. An ex-military teetotaller – doesn’t drink, doesn’t smoke – he introduced random drug testing when he came to take the position at Ngāi Te Rangi. Before he was with the military, he studied public health and wrote his thesis on Māori experiences of addiction. “Keep in mind I’d been an anti-drug campaigner for two decades,” he says, “so I really needed to be convinced.”

Then, one day, he got a call from his long-time friend, unionist Helen Kelly. “Would he consider getting involved in medicinal cannabis?” she asked. He replied no.

“I was stuck on several things,” he says now. “Bloody stoners ruin a lot of my people’s lives!”

She asked him to reconsider. “And I said no again,” Paora says. “Then she told me she was dying.”

He decided to have a look into it. As an ex-military man, he found the evidence around medicinal marijuana’s use for treatment of PTSD compelling. Research around its use for treating epilepsy is also strong. But ultimately, it was some of the evidence of medicinal cannabis’s efficacy as a pain treatment for cancer patients that tipped him over the edge.

“Both my mother and father and many of my family have died from cancer, and again that changed my view to it,” he says.

“For the people who are suffering from the side-effects …” He pauses. His voice cracks slightly. “I wish my dad who died didn’t have to go out on morphine. I wish that this was a product he could have used, he would have gone out lucid. I wish it was there for him and some of my other buddies and friends who died.”

Working as the Chief Executive of Listuguj First Nation reservation, he decided with the tribe to invest in Canada’s emerging medicinal marijuana industry.

Chief Executive of Te Rūnanga o Ngāi Te Rangi, Paora Stanley.

Photo credit: Thomas Teutenberg

“You already know that there is a lot of interest in it, and there is certainly a lot of iwi interest in it.”

PAORA STANLEY

They started relatively small, investing $4 million into building a medicinal marijuana facility. “That $4 million is now worth $26 million,” he says. Back in New Zealand, in his new role at Ngāi te Rangi, he’s cautiously looking at how the iwi can invest in the medical industry.

Ideally, he is looking for the tribe to invest in facilities in Canada to develop business experience in the sector. “And then by the time this country opens up to medicinal marijuana, you then bring that back to this country and initiate it here.”

If New Zealand’s model ends up resembling Canada’s highly regulated industry, there’s enormous buy-in costs, he says. There, paying for indoor growing facilities – security fences, regulation-thick walls, lighting and temperature controls – can quickly soar into the tens of millions. Overseas, those buy-in costs can mean economically disenfranchised groups – like African-American communities – struggle to enter the industry. Here, iwi have cash to invest on behalf of their people.

Stanley says developing a local industry with Māori as key players means the cash tends to stay in the community rather than heading off shore via large-scale pharmaceutical companies. “So the money and the benefit of it actually don’t go out of the province,” he says. “They often don’t go out of the city. Māori organisations, the majority of profits stay within 100km of its epicentre. Ours will usually stay within 50km. 90 percent of our profits and benefits will only be within a 50km radius from here. Māori money that is generated stays locally.”

“...developing a local industry with Māori as key players means the cash tends to stay in the community rather than heading off shore via large-scale pharmaceutical companies.”

“You already know that there is a lot of interest in it, and there is certainly a lot of iwi interest in it. It’s because of the money. Iwi have got to be able to turn around money for the benefit of their people. Some people with a racist streak will say, ‘You horis are good at making marijuana out south.’ Well that ain’t really it either. It’s actually about medicinal marijuana, it’s different.” ■

Tess McClure is an award-winning Auckland-based journalist who writes for vice.com/en_nz

Festival goers more informed – and more cautious

Drug safety checking results from last summer's festivals have landed. This is the second year in a row that KnowYourStuffNZ in partnership with the Drug Foundation offered harm reduction services at multiple festivals. Using an infrared spectrometer and reagent tests festival goers have their substances accurately identified and have a discussion about how to be safer.

RESOURCE

knowyourstuff.nz

At least 20 new substances were detected for the first time this season. These were often more toxic and unpredictable than those seen previously.

A large proportion of the new drugs were cathinones one of which has since been identified as the cause of multiple emergency hospital admissions in Christchurch. Some as-yet unidentified substances also cropped up: these are so new that there are no reference samples in the global database linked to the spectrometer.

When given the option to make safer decisions more than half chose to do so. This year 58% said they would not take a drug when it was not what they thought it was. Those who decided to take the substance anyway said they would make safer decisions around dosage, how and where they used it.

The Drug Foundation will continue to support drug checking into the 2018/19 festival season. With an increase in unknown and highly toxic substances circulating in New Zealand this service is becoming increasingly crucial. The government needs to invest in drug checking and change the law to provide legal certainty to event organisers so this vital harm reduction service is more widely available.

58%

SAID THEY WOULD NOT TAKE A DRUG WHEN IT WAS NOT WHAT THEY THOUGHT IT WAS.

TOP 5 DRUGS PEOPLE THOUGHT THEY HAD

Last summer		This summer	
MDMA	51%	MDMA	58%
LSD	30%	LSD	17%
Unknown	6%	Unknown	9%
Cathinone	2%	Ketamine	5%
Amphetamine	2%	Cocaine	3%

All other drugs combined – last season 13%, this season 9%.

TOP 5 DRUGS PEOPLE REALLY HAD

Last summer		This summer	
MDMA	40%	MDMA	54%
LSD	26%	LSD	15%
Cathinone	11%	Cathinone	7%
Could not be identified	4%	Ketamine	6%
Amphetamine	3%	Could not be identified	5%

All other drugs combined – last season 16%, this season 13%.

Note: Testing identified 24/26 unknown substances that were previously unknown to the client. Please note that the figures for MDMA and LSD include a very small number of samples that were not the specific drug mentioned but from the same family – for example, MDA is included in MDMA.

How often was a sample what people thought it was?

	Last summer	This summer
Consistent with presumed	68%	79%
Consistent with presumed but contained additional ingredients	9%	5%
Not consistent with presumed	23%	12%
Could not be identified	0%	4%
Total	100%	100%

Note: in a significant number of cases, the client did not know what the substance tested was supposed to be. In this table, these samples were excluded. A change in 'consistent with presumed but contained additional ingredients' results may be due to changes in the way data is recorded.

44 PSYCHOACTIVE SUBSTANCES IDENTIFIED

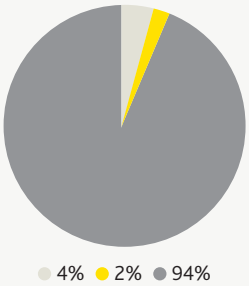
4-methylamphetamine*	4-chloroethcathinone*
methamphetamine	4-methylethcathinone
dextroamphetamine*	4-methylpentedrone*
methylamphetamine*	4-methylbuphedrone*
unknown amphetamine*	alpha-PVP*
MDEA	DMBDB*
MDMA	mephedrone
MDA	methcathinone
1p-LSD*	methylone
4-ACO-DMT	n-ethylbuphedrone*
5-MEO-DIPT*	n-ethylpentylone
DMT	unknown cathinone*
LSD	1-(2-chlorophenyl)-piperazine
5/6-APB	benzylpiperazine
2C-B	unknown NBOMe*
mescaline	5-HTP
caffeine	rauwolfia serpentina*
cocaine	benzocaine*
ketamine	acetophenetidin*
methoxetamine	venlafaxine
ethylphenidate*	quinidide gluconate*
GBL	fentanyl*

* indicates substances identified for the first time this summer

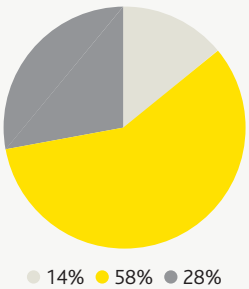
Note: 20 substances seen for the first time, seven of which were cathinones. One cathinone could not be identified.

Finding out what substances really are – does it change people's behaviour?

WHEN IT IS CONSISTENT WITH PRESUMED



WHEN IT IS NOT CONSISTENT WITH PRESUMED



May take | Will not take | Will take

Is Norway set to spark a drug policy revolution?

Until recently, Norway has remained staunchly immovable on its conservative drug law, but that looks set to change in a recent, sudden and surprising turn of events. Are we about to see a softening on the Scandinavian stage that could engender further worldwide reforms? UK-based author **Max Daly** thinks that could be the case.

MAX DALY

Photo credit: Anne Worner

Norwegian Health Minister Bent Høie.

Photo credit: flickr.com/photos/toresetre

“The move towards decriminalisation is a big deal for Norway, but as the world watches, it could also prove a very modern lesson in how drug reform actually happens ...”

Norwegians were left choking on their muesli on the morning of 5 October 2016 when they read an article in tabloid newspaper *Dagbladet* by the government’s Conservative Party Health Minister Bent Høie. He confessed to a complete change of heart on drug policy: Norway should ditch its overly punitive regime to something akin to Portuguese decriminalisation.

It was a thunderbolt out of the blue because, until then, Høie and Norway’s right-wing coalition government had shown little sign of veering off-piste from the uncompromising approach typical of Nordic drug law.

In the article, headlined ‘Help, don’t punish drug users’, Høie admitted the 48m kroner (NZ$8.5m) in drug possession fines paid out by Norwegians in the previous five years were “detrimental and meaningless” and had done more harm than good to both people who use drugs and society. Inspired by the experiences of Portugal, Høie declared that drug use should be a matter for health services, not the justice sector.

Høie’s U-turn set in motion a vehicle of change that could – even though the D word has generally been avoided by the government – end with Norway becoming one more among a select group of countries having decriminalised.

Before the *Dagbladet* article, only the Greens and the Liberal Party endorsed a policy based around decriminalisation. By the eve of last year’s elections, eager to jump on the drug reform bandwagon, seven out of the nine main parties backed Høie’s intent. Last December, the Norwegian Parliament’s Health Committee voted to prepare reform to ensure that “the responsibility of society’s reaction to the use and possession of illegal drugs is transferred from the justice sector to the health sector”.

The committee appointed a working group with a mandate to examine how best to shift drug use from a criminal to a health matter and, specifically, to evaluate whether the Portuguese model is appropriate for Norway. Headed by one of the country’s chief prosecutors and consisting of people from drug user NGOs and the fields of health and justice from across Norway, the working group is due to report back in December 2019. Legalisation is not on the table.

The move towards decriminalisation is a big deal for Norway, but as the world watches, it could also prove a very modern lesson in how drug reform actually happens and perhaps instrumental in inspiring other countries to ditch their old drug war rags and follow the same route.

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Europe’s northernmost country, Norway is best known for its seafaring history, dramatic mountains and fjords and for constantly getting ‘nul points’ in the Eurovision song contest. Drug use rates are low according to government statistics, but snapshot research among clubbers and wastewater analysis in the cosmopolitan capital Oslo has found higher than expected levels of MDMA, amphetamine and methamphetamine use.

Norway is a progressive, flagship democracy and one of the richest countries on the planet. It has one of the world’s highest standards of living for its five million citizens, strong egalitarian and humanitarian ideals and a top-notch welfare and health system – which makes it all the more surprising that it has one of the most repressive drug policy systems and highest drug death rates in Europe. It is this anomaly, experts think, that has led to Norway’s volte-face on drug policy.

Norway is one of only a handful of countries where drug use per se, rather than just possession, is a crime. This means Police can stop and search people or their homes if there is the merest suspicion of drug use. Suspects who appear intoxicated can be detained and forced to urinate under observation for

> **“There was a moment of real opportunity that came about from an alignment of factors – Norway’s high drug death rate, the move by UN agencies in favour of reform and a growing evidence base from countries that have already decriminalised.”**
>
> STEVE ROLLES

Association for Safer Drug Policies (ASDP) Director Ina Roll Spinnangr.

Photo credit: Tommy Strømmen

traces of drugs. Failing a drug test can lead to a fine of up to NZ$1,700, withdrawal of a driving licence and, for parents, the involvement of childcare services. The use of drug sniffer dogs in schools and urine ‘contracts’ for teenagers caught smoking cannabis have also caused controversy.

Most contentious though is the way the country’s 12,000 injecting drug users have been treated. Even though there are provisions in place for substitute prescribing, safer injection facilities and a naloxone distribution strategy, drug users are still dying at an alarming rate. Norway has the third-highest per capita drug death rate in Europe after Sweden and Estonia, with around 250 people dying each year.

Campaigners say this is because the country’s most vulnerable drug users exist largely outside the much-praised health and welfare system. They say the most visible drug users are being arrested and fined as an easy way for Police to boost ‘solved crime’ rates.

“We have a great welfare and health system, but drug users aren’t wanted in that system,” says Arild Knutsen, Head of the Norwegian Association for Humane Drug Policies, one of the most tireless and respected drug user rights campaigners in Norway.

“You can come to a hospital when needed – if you’re not a drug addict. You can get help with your mental health – if you’re not a drug addict.”

It is these policies and their stigmatising effects that ultimately created such a determined and successful campaign for reform in Norway. The question is, how did a group of NGOs achieve this in a country that was on very few people’s lists to become Portugal 2.0?

“There was a moment of real opportunity that came about from an alignment of factors – Norway’s high drug death rate, the move by UN agencies in favour of reform and a growing evidence base from countries that have already decriminalised – that was ‘brilliantly grasped’ by NGOs,” says Steve Rolles, Head of Policy at Transform.

Most observers agree that Norway’s drug NGOs have gained a lot of respect among the public and politicians for helping marginalised drug users and have therefore become an important voice in the debate. Knutsen, for example, is no public pariah for sticking up for heroin users. He was named citizen of the year by readers of the largest newspaper in Oslo and won Amnesty Norway’s annual prize in 2014. But Rolles says one organisation played a central role in persuading the government and general public to rethink the drugs issue.

“It was perhaps a case of cometh the hour, cometh the NGO,” says Rolles about the Association for Safer Drug Policies (ASDP). Formed in early 2016, they managed to convert Høie in record time.

“They are talented, professional and passionate. They’ve synthesised policy and advocacy lessons from across the world and created a highly effective campaign that’s delivered the goods in less than two years.

“I guess it helps that Norway is a small country so it’s perhaps easier to make a splash but, nonetheless, a lot of the international reform groups they’ve claimed to have learned from could probably learn a lot more from them.”

Ina Roll Spinnangr, the 37-year-old ASDP Director, pointed out earlier this year that “while there were already a few active user associations, some academics and older organisations with roots in the temperance movement who dominated the debate, there was a need for a new association that could embrace more voices from all walks of life”.

Spinnangr worked in communication and marketing for various companies before becoming involved in politics because she wanted to improve the mental health and child care systems. She helped set up ASDP after becoming disillusioned with how “policies that where supposed protect the vulnerable from harm actually increases their problems and harm from drugs”.

“We chase people around the city taking their drugs, and they get more drugs. It’s no solution.”

BÅRD DYRDAL

I asked her how she managed to turn the ASDP into such a major influencer.

“In the last couple of years, our organisation and a few other prominent voices have made drug policy reform a much talked-about issue in the media,” she says.

It’s worth noting that Norway is a country with a very high newspaper readership.

“We have changed the perception of the issue from fringe to mainstream. At the same time, we believe we’ve succeeded in reframing the debate from being a question of liberty to one of harm prevention.”

One of her main messages was that the system was essentially using a sledgehammer to crack a nut.

“We wanted to bring to the public’s attention the fact that not all people are vulnerable to becoming dependent; that while current policy may dissuade less-vulnerable individuals from using, it is actually doing more harm than good to the vulnerable minority. In a country that has one of Europe’s highest rates of drug overdose deaths, this is a strong message.”

What is unique is how quickly she managed to persuade Høie. How was this done?

“As for the Health Minister, he seems to have had a personal revelation at some point. To what extent we have directly influenced him is unclear, but he is now using the exact same arguments for decriminalisation we would use against him when he opposed it. Progress would have been much slower without the Health Minister’s change of heart.”

In Norway, the reaction from the media has been very positive to the rerouting of drug reform. Several of the biggest national newspapers have taken a strong standpoint in favour, with some advocating legalisation. Yet, however confident people are that the government will turn drug policy around, there are still concerns the proposals may get watered down because not everyone is sold on the idea of decriminalisation. The biggest opponents are the Narcotics Police Association and the Christian Conservative Party, as well as some NGOs based within the temperance movement. It is the Police, however, that represent the biggest obstacle to a Portuguese style decriminalisation.

Bård Dyrdal, a senior detective in Oslo, formed the Scandinavian branch of LEAP (Law Enforcement Action Partnership), a global network of law enforcement figures opposing the War on Drugs, and says the current strategy is not working.

“We chase people around the city taking their drugs, and they get more drugs. It’s no solution.”

But he has met with a wall of opposition from his colleagues and set up LEAP Scandinavia last year in full knowledge it would mean he would never be promoted again. So far, he has gathered 20 officers to be part of LEAP, but only he and one other have been willing to reveal their identities.

“The national Chief of Police has been very clear in saying he is against decriminalisation, and those who disagree have to stay quiet. It is not surprising the Police are against reform because Police do not like those who take their powers away,” he says.

“The drug laws are a powerful tool and open up all kinds of possibilities for us. If we want to check you for something, suspicion of drugs is a way to search you and your home. If we go into a house and there is cannabis on the table, we can arrest everyone who is there on suspicion of using it.”

One of the key outcomes for many reformers will be the knock-on effect decriminalisation will have on the way authorities, institutions and the public view drug users.

Alleviating taboos is a major part of this for Dyrdal too.

“I think decriminalisation is a start, not an end point. The most important thing is that it will change people’s mindset. If you take away punishment, you reduce stigma.”

Perhaps the Police will be less of a barrier to meaningful reform than people think. Dyrdal says that, since Police started to hold naloxone, their attitude to drug users has improved.

“Police don’t live in a bubble, we can rethink things. We have come a long way from how we used to treat people as ‘junkies’.”

The exact role of Police in any new system, to be decided by the working group, will be key to its success or failure, says John Melhus, a drug law reformer from Norway who has spent many years working in the Netherlands.

“It’s important that the Police do not continue to pursue and detain drug users in order to turn them over to the health authorities. It will mean we will continue to have the same problems – we can still not speak openly about drugs, and the public debate will still be constricted by fear.”

Melhus, who describes Høie as a “very engaged and hard-working minister”, suggests Norway could learn from the Netherlands, where heroin assisted treatment and drug user rooms have reduced drug deaths and visible drug use on the streets.

“They also have one other thing in place and that is that they do not let the Police bother drug users, something which, in my opinion, allows for a freer public debate about drugs, which in turn leads to practical, hands-on solutions.”

What is fascinating about Norway’s move is that it is happening at a time when drug policy reform is firmly on the global agenda, even more so than it was for Portugal in 2001, and most notably currently in the US and Canada.

There is a long way to go before change comes about in Norway, but Spinnangr remains confident that Scandinavia’s drug laws can be taken out of the deep freeze.

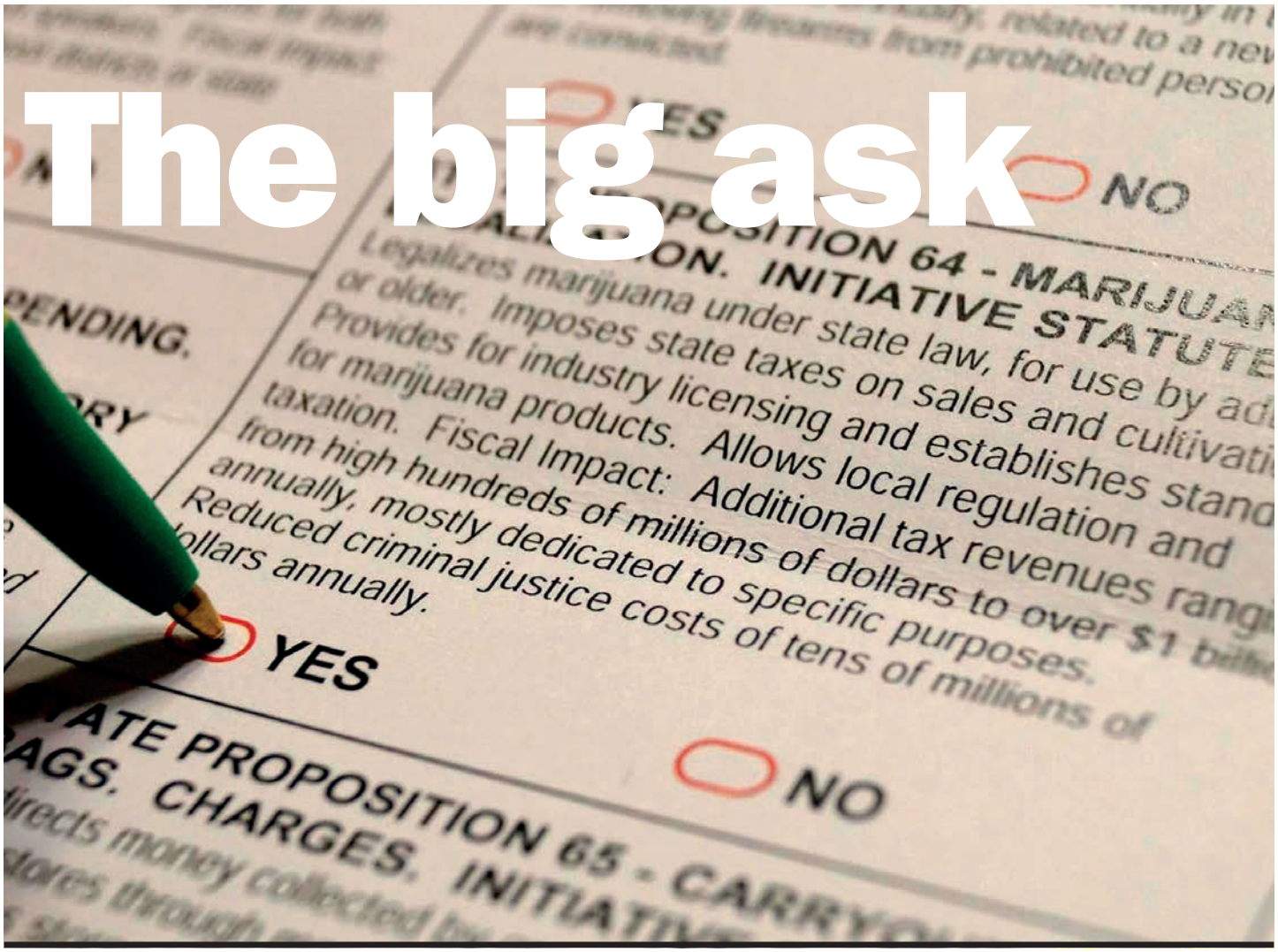
“It is very likely that Norway will see a Portuguese-style decriminalisation of use, purchase and possession of smaller amounts by 2021/22,” she told me. But Norway is not enough. Spinnangr’s next stop could be Sweden.

“Sweden needs an effective community to advocate for changes in drug policy,” she said earlier this year.

“Unfortunately, the biggest user organisation in Sweden has succumbed to bankruptcy, and their web page is down. Currently, there are no real organisations to address issues of progressive drug policy reform in Sweden. We believe we can establish such a group, and we are planning an event about decriminalisation in Stockholm. But we will need all the help we can get, many more members and more resources to succeed.”

Who would have thought, even five years ago, that Scandinavia could become the unlikely catalyst for a fresh wave of drug policy reform that could transform the way the world treats people who use drugs? ■

Max Daly is UK-based journalist specialising in illegal drugs. He is author of *Narcomania: How Britain Got Hooked on Drugs* (Windmill, 2013).



Ensuring the best legalisation referendum question

Next year, or perhaps the year after, New Zealanders will vote in the first government referendum anywhere in the world on legalising cannabis. Right now, however, there is no clear picture of what question will appear on the ballot or how that question might be arrived at. That's going to be important, and really, that's just the start of the complexities we're going to have to work through. **Russell Brown** tells us more.

RUSSELL BROWN

Justice Minister Andrew Little told *Matters of Substance* that deciding on the question put to the public in the impending cannabis legalisation referendum is obviously going to be very important.

But does he have any views about what a good question would look like?

"I haven't really given it any depth of thought at all," he says

The irony is that the art and science of using direct democracy to reform cannabis law is now well established – in America at least. But in US states, ballot questions have been composed by their proponents who design them for a winning outcome. California's bullet-pointed question only reached state voters after it had been repeatedly tested and refined through polling, with the aim of crafting a proposal acceptable to the greatest possible number of voters.

That process can't be applied to a referendum in which it is the government that writes the question and where the goal is not to push a result one way or the other but to provide for a fair vote. Nonetheless, there are lessons that might apply. And the first is that it's not just the question but *how it's asked* that has an impact.

"In general, 'regulation' sells much better than 'legalisation' since the latter allows opponents to claim it will lead to anarchy," observes Sanho Tree, who directs the Drug Policy Project at the Institute for Policy Studies in Washington.

"It's clear that how you ask the question can have a measurable impact on the outcomes," agrees Steve Rolles, Senior Policy Analyst for the Transform Drug Policy Foundation in the UK.

"And in a tight contest, it could easily swing it one way or another. There will, for example, be a natural bias towards a position framed in the positive rather than the negative, so 'Should we legalise YES/NO?' or 'Should cannabis remain illegal YES/NO?' might produce marginally different outcomes, even though they are essentially the same question.

"We know from polling research that more people say yes if asked if they support the legalisation and regulation of cannabis than merely the legalisation of cannabis. And support rises further if you ask 'Do you support the legalisation and regulation of cannabis in the same way as alcohol?'."

> **"The risk is that, without having a legal blueprint in place before people vote, everyone can impose their fears – and their hopes – on the outcome."**
>
> ANDREW GEDDIS

Alison Holcomb, Director of Strategy for the Washington State branch of the American Civil Liberties Union, helped design the successful I-502 legalisation initiative in Washington where she saw a desire for reassurance.

"Seven years ago, in Washington State, voters responded strongly [in polling] to messages that reassured them about tight control of this novel policy experiment," she says.

"Messages about freedom and individual rights fell flat. I'm not sure how relevant those insights may or may not be today, but I continue to believe that acknowledging basic human nervousness about change is always important."

Drug Policy Alliance Legal Director Tamar Todd, who helped write California's successful Proposition 64 in 2016, says that even where voters there were "on board" for legalisation, they still wanted to know what it meant.

"Who gets the licences, who grows it, how big are the companies? It's not so much of an issue in the US, but should the government itself be the producer or seller? What should be the legal age to use? What products should be made legal? What should the legal allowable amount be? Should people be able to grow it at their homes non-commercially and share it?

"It's not necessarily good for the voters in a referendum to answer all those specific policy details – but at the same time, if the government itself and the policy makers and regulators and law makers aren't on board with the concept, there's a lot of ways they can obstruct the will of the voters."

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The two New Zealand constitutional lawyers consulted by *Matters of Substance*, Graeme Edgeler and Andrew Geddis, strongly believe that New Zealand voters should be presented with a specific proposal as an alternative to the status quo. Indeed, Edgeler believes the proposal should take the form of a law to be triggered by a vote in favour and that it should be "a fully worked-through proposal of exactly what a regulated cannabis market would look like".

Geddis agrees and says, "The ideal way to proceed would be for a Bill to already have been drafted and passed by the House, with the referendum result then automatically deciding whether or not that Bill becomes law. This is how the vote to introduce MMP proceeded. The benefit of this approach is that it would allow everyone to know what it is they are voting on. We can all see in advance what form of reform we are talking about. Is it decriminalisation? Is it legalisation? Would it permit grow-your-own or a full market regime?

"The risk is that, without having a legal blueprint in place before people vote, everyone can impose their fears – and their hopes – on the outcome. Consequently, we have not previously had binding referenda on issues in the abstract without the public actually getting to decide the precise outcome. So, for example, we didn't just vote on the question 'Do you want to change the flag?', then leave it to Parliament to decide what a new flag would look like. We instead got to choose between a bunch of different possible options, knowing that a vote one way or the other would produce a certain result."

Both the electoral reform and flag referenda were two-step processes, which seems an unlikely – and in Edgeler's view, undesirable – prospect in this case.

"A two-step referendum process doesn't seem like a good idea," he says. "We'd be voting in a vacuum. If there are concerns about there being support for one type of regulation but not another, then the pre-legislative process and select committee process should tease that out – public meetings, focus groups, market research."

"I think if you have a very clear, simple question, there will be no doubt what the will of the people is," says former Prime Minister Helen Clark, a self-declared 'friend of reform' who is now a member of the Global Commission on Drug Policy.

"And you should prepare legislation to reflect that. In an ideal world, you might go to the people with the legislation to be triggered, but that in itself might introduce a lot more complexity into the debate about the Bill. And complexity is always confusing."

Confusing or not, the signs are that there won't be a law to be voted on. Andrew Little acknowledges that "the reality is people are going to want to know

> **"... the reality is people are going to want to know what it means in practice if you change the status quo. There are legitimate questions around that."**
>
> ANDREW LITTLE

what it means in practice if you change the status quo. There are legitimate questions around that. Whether you'd go to the extent of having a law ready to go, that's something we will have to think through. There is no question that we will have to have answers to the obvious questions about what it will look like if you decriminalise, legalise, do whatever."

Rolles believes a referendum without a worked-up law is viable, but "at a minimum, the government should have a clear statement of guiding principles for any proposed regulated market model and at least a framework policy document that described the broad contours of how the system would work. It would also usefully spell out the detail of the process by which the model would be fully developed, implemented, evaluated and reviewed. This wouldn't have to be a fully drafted piece of legislation that could follow later. But it would need to be something credible and accessible to the voting public to form the basis of an informed and focused debate."

Rolles says the perils of a status-quo-versus-unspecified-change question have been highlighted by Britain's Brexit referendum.

"The Remain option was simple, but the Leave option is actually a fiendishly complex spectrum of options relating to a vast array of legal frameworks, agencies and institutions. This meant that, before the vote, advocates on both sides made wildly conflicting claims about what Leave involved, horribly confusing the debate. And then, since the vote, there's been profound conflict over what it actually means in practice and what people were voting for."

But another recent referendum, Rolles says, could provide a model for New Zealand. Ireland's abortion referendum was foreshadowed by a Citizens' Assembly of 99 randomly chosen (but demographically representative) voters.

"They gave up their weekends to listen to experts, affected women and a variety of advocacy groups before making their recommendations on which the draft reform Bill was shaped. A process of deliberative democracy such as this – even on a smaller scale – would, I think, be a brilliant model for New Zealand. It would give the people of New Zealand a sense of ownership of the reform proposals and would acknowledge the obvious fact no one understands what New Zealanders think better than New Zealanders. The debate could only be the richer for it."

Green MP Chlöe Swarbrick, who fronted the members' Bill on medical cannabis originally drafted by her colleague Julie Anne Genter, also believes an innovative approach is required in the run-up to a vote.

"I think we can't continue to do it the way we've always done it – trying to do the consultations at fancy hotels or conference venues at ridiculous times of the day, which nobody with a family or a job or study can get to. We need to ensure it's accessible but also that the tone of the debate is raised. I think it should be a balanced discussion in that way and not be co-opted by either moral panic or people saying that everything's going to be fine. Because we are going to need to have regulations."

One key challenge in getting the question right is the time available. Little says that the government has begun thinking through the issues. But the referendum process was not funded in this year's Budget, and nothing can really be done until that happens – which means May 2019 at the earliest.

Could reforms from somewhere else be adopted to speed up the process of giving the people something to vote on? The highly commercial models adopted in most legalised US states may turn off even supporters of reform in New Zealand – and the state distribution model in Uruguay could be seen as too restrictive. The closest match is probably Canada, whose cannabis reform will be completed this year.

But even that's not straightforward. Individual Canadian provinces have been given the freedom to go quite different ways. Alberta, for example, will license private retailers, while Ontario will allow only a limited number of state-run stores. But other elements of the Canadian reform – package labelling, control of advertising, possession limits, permission for home growing, a ban on licensed commerce, relationship to existing anti-smoking regulations and, most fraught of all, a drug-driving limit – could be picked up in a New Zealand proposal.

> **"I think it should be a balanced discussion in that way and not be co-opted by either moral panic or people saying that everything's going to be fine."**
>
> CHLÖE SWARBRICK

And one element of the Canadian reforms, the clear signal that past cannabis convictions would not be a barrier to entering the new, legal cannabis industry, would be a game-changer for Māori voters, says Khylee Quince, Associate Head of School and Director of Māori and Pacific Advancement at AUT.

"We're going to have to go there," says Quince. "That's going to be key to a yes vote from Māori, because if we maintain that collateral consequence of conviction, then that shuts Māori out altogether."

There's a further complication. Little indicated to *Matters of Substance* that the referendum would probably not be binding – meaning Parliament could be in the position of interpreting the will of the people. So even if the engagement process is top notch and voters were presented with clear choices, it is possible they might not get what they voted for.

Having agreed to a referendum that was the policy of only one governing party – New Zealand First, although to say its idea lacked detail would be kind – the government has a lot of thinking to do.

And it's coming from a standing start. When *Matters of Substance* asked Little about looking at international examples, he said the government would "see how other countries like Canada have done it most recently, how they conducted their campaign leading up to their referendum".

Canada, of course, did not have a referendum – although its pre-legislative Task Force, headed by former Deputy Prime Minister Anne McLellan, might be an idea worth copying.

One thing is clear, however. The road to The Question is itself littered with many questions. Addressing cannabis reform via a referendum may not turn out to be the easy option at all. ■

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

What happens to criminal records?

A feature of California's Proposition 64 was that it provided for anyone with a conviction for an offence that would not exist after legalisation to zhave that conviction erased. Given that a key argument for cannabis law reform is the harm caused by criminal convictions, could it be part of the question here?

Justice Minister Andrew Little isn't sure. "I haven't really thought about that," he says. "We recently did the law on expunging historical homosexual offences, because in an enlightened age, that law was immoral. Whether Parliament would take the same view about old drug laws, I'm not sure. Certainly Parliament changes its mind on laws, but it doesn't necessarily overturn convictions on historical laws."

He says the question hadn't come up before *Matters of Substance* raised it, "but if it comes up, I guess we'll have to have a response to it".

International experts were largely in favour of an expungement provision as a component of legalisation.

Tamar Todd says the provision was crucial in California because of the historical racial disparity in arrests, prosecutions and convictions – but also because of the consequences of a drug conviction in the state. "It's carried forward on their criminal record, and that prevents them from doing anything. Getting any kind of professional licence, becoming a firefighter, getting loans to go to school … all aspects of people's lives."

"I think expungement of convictions for crimes that are no longer crimes under a new framework is essential on basic legal and ethical principles and should form part of any proposal," says Steve Rolles. "I can't see any possible arguments against this."

He notes that, in parts of California and in Massachusetts, attempts to redress past wrongs have gone beyond "mere expungement".

"They are giving people with former convictions, as well as people from designated socially deprived communities – groups who have carried the greatest burden of cannabis enforcement harms – priority access to the market in terms of licensing applications for production and retail.

"In Massachusetts, they are additionally offering training – in management, accountancy, marketing, horticulture – to support these groups' entry into the industry and even have a budget to publicise the equity programme amongst affected communities. I would love to see something like this in New Zealand – which like most places, has its own legacy of discriminatory policing and iniquitous impacts of drug enforcement."

AUT's Khylee Quince, a specialist in Māori and the justice system, agrees.

"That would be a meaningful step in terms of restorative justice," she says. "A really significant step."

It might not be an easy sell first up, acknowledges Alison Holcomb. Washington State voters were being asked to make "an historic, unprecedented" break with the past in her state's 2012 initiative. Adding such a provision to I-502 would have added to the risk of failure.

"California had the benefit of following us four years later."

California cannabis ballot text

The full text of Proposition 64, the 2016 ballot initiative that legalised and regulated cannabis in California, runs to well over 100,000 words. It's safe to assume that almost no one who voted on it read it.

But what people did read when they went to vote is worth looking at. The long-form ballot summary was this:

- "Legalizes marijuana under state law, for use by adults 21 or older."
- "Designates state agencies to license and regulate marijuana industry."
- "Imposes state excise tax of 15% on retail sales of marijuana, and state cultivation taxes on marijuana of $9.25 per ounce of flowers and $2.75 per ounce of leaves."
- "Exempts medical marijuana from some taxation."
- "Establishes packaging, labelling, advertising, and marketing standards and restrictions for marijuana products."
- "Prohibits marketing and advertising marijuana directly to minors."
- "Allows local regulation and taxation of marijuana."
- "Authorizes resentencing and destruction of records for prior marijuana convictions."

The initiative regulations also require a shorter "ballot label" summary, which includes the assessment of the state's Legislative Analyst's Office:

"Legalizes marijuana under state law, for use by adults 21 or older. Imposes state taxes on sales and cultivation. Provides for industry licensing and establishes standards for marijuana products. Allows local regulation and taxation. Fiscal Impact: Additional tax revenues ranging from high hundreds of millions of dollars to over $1 billion annually, mostly dedicated to specific purposes. Reduced criminal justice costs of tens of millions of dollars annually."

Different again was the wording on the petition that exceeded the 365,880 signatures required for inclusion on the ballot. Even after passing the threshold, it was shaped and amended in response to polling.

"One of the things that we learned in the polling was that people actually wanted a lot of the answers to those questions upfront," says Tamar Todd, Legal Director of the Drug Policy Alliance, who jointly authored the initiative. "What would be allowed and what the system would look like. It was more of a comfort level, they wanted to see detail.

"They also wanted to know about taxation – because people also like the idea of regulated products being taxed."

Groups to be persuaded included participants in the illicit cannabis market – some of them families who had relied on that income for a generation or more. And, of course, people who were against cannabis per se. They, too, had to be listened to, says Todd.

"You need to be able to convince people who don't like cannabis at all that legalisation of cannabis is a better policy than criminalisation of it."

What to expect when Canada legalises

This October, recreational cannabis use will become legal in Canada, making it only the second country in the world, after Uruguay, to permit a nationwide cannabis market. Canadian Centre on Substance Use and Addiction CEO **Rita Notarandrea** explains just what this might mean for the country's society, young people and public health.

RITA NOTARANDREA

Photo credit: flickr.com/photos/cannabisculture

When Bill C-45 comes into effect, adults will be able to legally possess and use small amounts of recreational cannabis, with strict rules in place governing production, possession, safety standards, distribution and sale.

The law will also create new criminal offences for selling to anyone under the age of 18 but will allow provinces and territories to set a higher minimum age. Alongside this is another Bill that deals specifically with impaired driving.

The overall objectives of the law are to prevent youth from accessing cannabis, protect public health by establishing strict product safety requirements, deter criminal activity and reduce the burden on the criminal justice system in relation to cannabis.

The ultimate objective is to protect Canadian youth and keep the profits out of the hands of organised crime.

Starting the conversation

With legalisation, we can begin talking openly about the risks, harms and benefits of cannabis use. We can dispel the misinformation young people have and make cannabis part of the substance use programmes in the Canadian workplace.

We can also do more research on the impact of cannabis, promote lower-risk use and monitor product quality with standards for pesticides, moulds and other contaminants. We can label cannabis packaging with tetrahydrocannabinol (THC) and cannabidiol (CBD) levels.

Legalisation also presents new economic opportunities, but these will need to be carefully monitored to ensure economic interests don't trump public health interests.

While opinion polls indicate most Canadians approve of the plan to legalise cannabis, there are still mixed views about some of the provisions. There is scepticism that the new law will actually succeed in keeping cannabis out of the hands of Canadian youth.

The Canadian Centre on Substance Use and Addiction (CCSA) perspective is simple and pragmatic. Canadian youth consume cannabis and will continue to do so. In fact, Canadian youth are among the top users of cannabis in the developed world. Despite a decrease in use in recent years, cannabis remains the most commonly used illegal drug among Canadians aged 15 to 24 years.

If that's the case, we need to ensure youth have all the correct information to make informed decisions.

For example, science tells us that the adolescent brain is still undergoing rapid and extensive development, which puts them at particular risk for cannabis-related harms.

Research also shows that *chronic* cannabis use is associated with memory and attention difficulties, particularly for those who began using in early adolescence, not to mention the increased risk of psychosis, depression and anxiety, respiratory conditions and possibly lung cancer. That goes for adults as well.

We also know that youth is a time of significant growth and change, when risk taking and substance use most commonly begins. They might use substances to produce feelings of euphoria or relaxation, but there can also be negative consequences such as injuries, car crashes, difficulties at school and problems with relationships and the law.

This is why the CCSA understands that adolescence is also the best time to begin prevention efforts – free of judgement or scare tactics – to ensure young people have the information they need to make healthy, informed decisions.

Education is key

To that effect, the CCSA will soon be releasing a guide for youth allies to talk to young people about cannabis use. This *Cannabis Communications Guide* will combine our knowledge and independent research with what young people told us they want to know – with the most effective ways to tell them.

And our research shows that, more and more, young people want *unbiased*, evidence-based information on everything from the dangers of impaired driving to the harms of cannabis use and support services for substance use disorders. We will use this information to inform and develop new products aimed at educating children and youth and dispelling any misconceptions they have.

Ultimately, we hope to see a delay in the onset of use for as long as possible, an increase in the quality of cannabis products consumed and a decrease in overall rates of use.

We also hope to see an *equitable* enforcement of laws and regulations across the country. For example, restrictions on use in rental housing can disproportionately affect students and lower-income populations, including indigenous communities.

Some indigenous communities are taking the initiative and developing their own regulations over production, processing, sales and use, which could lead to questions of jurisdictional rights where there are inconsistencies with provincial, territorial or federal regulations.

In fact, provinces and territories having different policies and regulations brings up potential concerns and opportunities.

Finally, there are lingering concerns about cannabis-impaired driving – specifically an increase in auto accidents among young drivers who are already at the highest risk. In fact, 16 to 34-year-olds represent only 32 percent of the Canadian population but 61 percent of the cannabis-attributable fatalities, according to a 2017 CCSA-led study.*

Other concerns involve the ability to detect cannabis impairment, potential issues at the US border, a shortage of officers trained in behavioural roadside detection and a lack of research establishing a clear link between the level of THC in the blood and the level of impairment. And certainly, more public education is needed on the interaction of cannabis and alcohol.

Will societal cost go up or down?

A recent study published by the CCSA, *Canadian Substance Use Costs and Harms*, determined that cannabis contributes about $2.8 billion to the total cost of substance use, which was $38.4 billion in 2014. Cannabis was also responsible for the third-highest substance-related criminal justice costs at $1.8 billion.

Which begs the question – when legal cannabis comes into effect, will the overall cost to society go up or down? Only time will tell. The cost of policing and prosecuting simple possession will go down, but this could be offset by increased health costs if use goes up. Only time will tell.

So, there are still some wrinkles to iron out, but the good news is we can now have these conversations.

Fundamentally, the CCSA strives to mobilise the evidence to minimise the harms and maximise the benefits. Moving forward, the CCSA will continue to ensure that public health remains the priority when it comes to decision making and that these decisions are informed by science and evidence. ■

RESOURCE

ccsa.ca

Medicinal cannabis paradigms

For this edition of Viewpoints, we provide contrasting perspectives from two medical professionals on the merits of medicinal cannabis. It's a timely issue considering the current Bill before Parliament that would amend the Misuse of Drugs Act to improving access for people to possess and use cannabis.

DR DAVID CALDICOTT

DR SAM McBRIDE

Part 1 – Medicinal cannabis seems to work, let's get on and explore its uses

Dr David Caldicott

Associate Professor David Caldicott argues that the evidence for its effectiveness seems real and that we should get on with exploring a medicinal regime in the interests of patient wellbeing.

When I first got involved in the medicinal cannabis debate several years ago, I had no idea how big a skunk I was about to poke.

It started when I accepted an invitation from Lucy Haslam to speak about the potential risks versus the benefits of cannabinoids used medicinally. This staunch mum, a now near-venerable Australian institution, became an advocate after she saw the symptomatic relief from a terminal illness her son Dan was getting.

Innocently, I suggested that, by any known metrics – therapeutic ratios, margins of exposure, etc. – cannabinoids seemed to be considerably safer than most recreational drugs and even the medicinal compounds for which they were informally and increasingly being substituted.

At the time, for many in the medical profession, these sorts of statements verged on heresy, and they still do for some. We are a conservative bunch in medicine, and there is an unspoken 'party line' expected of all of us – drugs that have a traditionally illicit provenance are strictly 'verboten'.

For nearly a century, humanity has been fed a line regarding the harms of recreational cannabis, and more recently, those arguments have been extrapolated to medicinal use. Initially naïve on the medicinal applications, it soon struck me that these arguments were disingenuous and intellectually flawed, if not frankly dishonest.

There is a vast human experience with the use of medicinal cannabis that pre-dates even the written word. That human randomised controlled trials (RCTs) are only now emerging is more a reflection of the interdiction on research on the subject than there not being anything to know. There is an enormous amount that is

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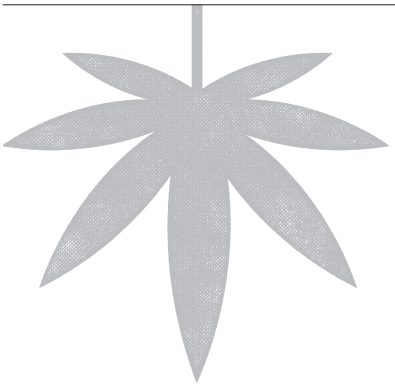
> **Taking a middle road between those who believe that medicinal cannabis should be as available as oregano and those who believe our very souls are threatened by it has gained us the disapproval of both sides of the divide.**



known in this field – just not by clinicians. Most physicians have never been taught anything about the endocannabinoid system in their medical training, so why should they reasonably be expected to know about how it might be modified for therapeutic gain?

There is also considerable contemporary experience about how to use medicinal cannabis – just not in Australia or New Zealand. The global leader is probably Israel, where over 30,000 patients are enrolled in a tightly regulated medical system. There they have codified treatment in the form of *The Green Book*, perhaps the world's first medicinal cannabis prescribing manual. They have been generous enough to share it with numerous countries, using a term that perhaps we could all embrace – the 'medicalisation of cannabis'.

At a meeting of all of the major global medicinal cannabis regulators in Sydney last year, they explained their position. Given the very low risk from a medically supervised programme, they consider it unethical to withhold a treatment that showed clear benefit for some. How it works could be elucidated in parallel to allowing patients to benefit from compassionate access. Similarly, they have none of the qualms that have been locally expressed about the requirement to avoid the use of a botanical product. If, as they have demonstrated by achieving Good Agricultural and Good Manufacturing Practice certification, one can produce a consistent product, then dosing becomes easily achievable.

They have now produced a 3D printed, thermal metered-dose inhaler, light years ahead of our own technology and philosophy. Again, their position is that it doesn't make any sense to withhold treatment with a botanical product if it seems to work and no one is getting hurt. Using a botanical product in this way, albeit under the strictest of global production criteria, considerably reduces cost when compared to pharmaceutical cannabinoids.

This concept has been best articulated by the highly distinguished Australian health economist Professor Simon Eckenmann, who refers to the "net health benefit" of botanical product for an ageing global demographic.[2]

Within the Israeli framework, there have been none of the catastrophes so many local naysayers appear to fear. Neither have they been seen in Canada, where nearly a quarter of a million patients are using medicinal cannabis to therapeutic benefit under medical supervision. This is so mundane that, in both countries, it is considered entirely appropriate for nurse practitioners to supervise and administer medicinal cannabis within the community.

When it became obvious that Australia would be embracing medicinal cannabis in some form, we at the Australian National University in Canberra decided to consider what we could contribute to the emerging market. We deliberately avoided clinical trials, which we knew would be dogged by controversy, and instead focused on the infrastructure that might be required – namely a registry of users, a way of determining the provenance of allegedly medicinal cannabis and a system for educating medical practitioners about the endocannabinoid system and how it might be beneficially modified by phytocannabinoids. And so the Australian Medicinal Cannabis Course was born – an independent academic programme free from the sponsorship of Pharma or the growing influence of cannabinoid medication manufacturers.

RCTs that may reassure the mainstream medical community are beginning to emerge, as we predicted several years ago. But it is not clear that RCTs are the best way to evaluate a product like cannabinoids. There is great interest in n=1 trials, which may be a more appropriate way to evaluate their utility.

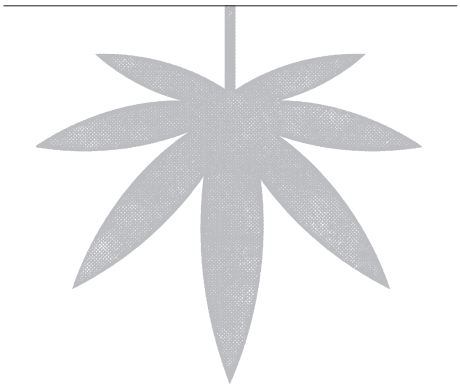
As doctors await publications that corroborate the clinical practice already in place, local practitioners can be reassured by two types of surrogate markers in the interim. The demographic evidence demonstrates that, in jurisdictions in the US that have a medicinal cannabis programme in place, significant reductions in mortality associated with opiates are consistently described. Prescribing evidence demonstrates that patients are taking themselves off opiates, benzodiazepines and anxiolytics in swathes, saving billions of dollars in taxpayer dollars and going some ways to explain the antipathy shown by the pharmaceutical industry (and its beneficiaries) towards medicinal cannabis.

Taking a middle road between those who believe that medicinal cannabis should be as available as oregano and those who believe our very souls are threatened by it has gained us the disapproval of both sides of the divide. While it's nice to be a unifying influence, it has on occasion been a rocky road. We remain committed to the concept of putting patients before profit and educating to the science. We try to do so with kindness and humour in the knowledge that we are on the right side of history. ■

Associate Professor David Caldicott is Emergency Physician, ED, Calvary Hospital; Clinical Lead, Australian Drug Observatory; and Clinical Senior Lecturer in the Faculty of Medicine at the Australian National University.

Part 2 – The evidence is not quite there, and the risks are yet to be defined

Dr Sam McBride



Dr Sam McBride counters that the evidence isn't all that compelling and that the risks are not yet fully clear – despite the naïve naturalist claims of some of its proponents.

The debate over medicinal cannabis, like many relating to prohibited drugs, is polarised and prone to hyperbole. Medical professionals have been criticised for being "prejudiced": reluctant to embrace the perceived benefits, narrow in their thinking and subject to vested interests. This is countered by the argument that cannabis is a "complex slush of chemicals" lacking evidence for use and proposed by those prone to naturalistic fallacy: a naïve belief that natural products are inherently good. This debate confuses the prohibited status of cannabis as an excuse for trying to force a product that largely fails to conform to medical standards into a clinical framework.

Cannabis has been used medicinally for thousands of years, with many of the described uses similar to those for which it is promoted today. Morphine, the main active ingredient of opium, was isolated in the 19th century, allowing provision of a purified, quantified product and development of synthetic medications. Development of cannabinoid products, however, remains in its infancy. Prohibition and lack of the motivating intellectual property rights have contributed to lack of knowledge regarding the body's endocannabinoid system and development of specific medications. The current expanding knowledge of this system rarely finds its way into the medical curriculum. Medical students will learn more about the harms of cannabis related to recreational use.

These factors have contributed to cannabis as medicine being a consumer-driven – not doctor-driven – phenomenon. The tension between a consumer and medical paradigm is illustrated by the dismay expressed in the *Journal of the American Medical Association* at the way medicinal cannabis had been introduced to various North American States through "low quality scientific evidence, anecdotal reports, individual testimonials, legislative inquiries, and public opinion" (De Souza, 2015).

Medical commentators have argued that the debate serves as a Trojan horse by which legalisation can be smuggled through society's bastions – sanitising the moral overtones related to recreational drug use. Certainly, frameworks for medicinal cannabis preceded legalisation in Canada, Colorado and California. Here, the medical profession became disingenuous gatekeepers for a variety of cannabis products whose relationship to medicines was often spurious (medicinal cannabis gummy bears?!) and provided the framework for a ready commercial market. The conjoined nature of much of the industry catering for both recreational and medical use is rightly treated with suspicion.

Recent New Zealand legislation illustrates how access to medicinal cannabis appears as an effort to sidestep the awkward issue of prohibition. While allowing those expected to die within a year to use cannabis without fear of prosecution may be compassionate, as a proposed amendment to the Misuse of Drugs Act, it is practically and philosophically fraught. Medically, it relies on the ability of doctors to accurately make such judgements and raises issues of equity. (Why exclude those suffering from debilitating illnesses or longer timeframes, and where does the threshold for deciding sit?) Doctors are being delegated the duty of deciding who can worthily access cannabis while politicians deride them for lack of leadership on the issue.

There is also a yawning chasm between the claims made for medicinal cannabis and those supported in medical literature with no clear unifying biological premise. Recent extensive summaries of the evidence for cannabinoids as medicine have concluded that there is evidence of moderate quality to support use in chronic pain and spasticity with less to support use in a handful of other indications including nausea and vomiting due to chemotherapy, weight gain in HIV infection, sleep disorders and Tourette syndrome. With improved medications for nausea and the ability to halt the progression of HIV, the need for alternatives seems less obvious. The evidence that doctors expect to rely upon for decision making stands in marked contrast to the claims made for cannabis by advocates, which seem to cover every medical complaint possible including curing cancer. Surveys of people using cannabis for "medicinal" reasons indicate that, while use in the context of

“Medical commentators have argued that the debate serves as a Trojan horse by which legalisation can be smuggled through society’s bastions – sanitising the moral overtones related to recreational drug use.”

“There is also a yawning chasm between the claims made for medicinal cannabis and those supported in medical literature with no clear unifying biological premise.”

pain is high, so too is use where there are no diagnosable symptoms.

Clinical frameworks rely upon a reproducible medication and consistent dosing along with evidence of efficacy and licensed indications. Only one medication meeting these standards is licensed in New Zealand: nabiximols (trade name Sativex). Pharmaceutical grade products in New Zealand can also be accessed, though they are unable to be licensed as medications. The Ministry of Health requires monitoring of use and processes to reduce diversion of these products. This need is inconsistent with probable risks and not required for some medications where these risks are greater.

Insufficient evidence, products that sit outside usual processes, highly invested consumers and a potentially lucrative market mean that a niche medicinal cannabis service appears likely to develop. This will further distance medicinal cannabis from mainstream medicine and an evidence-based approach.

Regardless of the ability to access standardised cannabinoid products, debate often centres around plant material – another example of the confluence of medicinal and recreational use. Overseas surveys indicate a preference for botanical cannabis even when alternatives exist. Doctors with expectations of standardised medications are faced with a material that is subject to environmental influences in production, degrades over time with altered properties and is often smoked. Proposed regimes giving medical approval for patients to grow their own similarly confuses the boundaries between prohibition and medical sanction.

Compromise is needed. It is certain that cannabinoids have medical potential, but the limits and risks have yet to be defined and are unlikely to fulfil the promise advocates hope for. There is a need for doctors to clarify the role of medicinal cannabinoids while juggling the reality that products conforming to typical medicinal standards are likely to be several years away – while the demand for informed access was yesterday. Medical education needs to include the role of the endocannabinoid system and the potential role of cannabinoids as a medicine, and research and development of medical cannabinoids guidelines should be prioritised in universities and hospitals.

Likewise, medicine should be allowed to continue without having to compromise practice because society remains conflicted over prohibition. It is this, not doctors, that is at the heart of the issue. ■

Dr Sam McBride is a consultant psychiatrist specialising in addictions.

QUOTES OF SUBSTANCE

“The status quo is not tenable. It’s getting worse. Drugs are getting cheaper, stronger, more readily available and more dangerous. I have come reluctantly over the years to the conclusion that we need to regulate the market. If you can regulate the market, you can make sure it’s old-fashioned cannabis – not skunk or spice.”

CHIEF CONSTABLE OF DURHAM POLICE MIKE BARTON, a 28-year veteran of the Lancashire Constabulary, is again calling for law change. He made the same call five years ago.

“While our government is trying to legalise marijuana, there are no preventative measures or supports. This is very critical. There are no resources, there are no healing centres and there are no shelters for elders. Please be aware that, in Nunavut, there is no support system for those people who will need help.”

ISAAC SHOOYOOK, an Inuit elder, raises concerns about what will happen once cannabis is legalised in Nunavut Territory.

Are we truly set up to support whaiora?

Tangi Noomotu, Operations Manager at Addiction Services, Salvation Army, Wellington, believes that sometimes, when we engage in conversations about the issues we are facing in the addiction field, we can lose sight of the people we are working with and for – the tangata whaiora. In this opinion piece, he suggests we need to take a good hard look at just how much we are asking of people with addiction in treatment.

TANGI NOOMOTU

When I presented at the Addiction Leadership Day in April 2018, I wanted to ensure I brought whaiora to the fore, so I talked about a young man I have had the privilege to walk alongside in my work. Tāne* (not his real name) summarised my intention well, saying people need "to hear a real story, from a real person, with real experiences".

There were two key moments in our work together that I will summarise, and in telling the story of this young man, I ask you to hold in your mind a loved one, someone you care for deeply and with whom you feel emotionally connected.

Tāne is an 18-year-old Māori male. He is extremely likeable and determined, has ample resilience and is always keen to share his opinion. He had bounced around a range of different services already and came to our service carrying a number of diagnoses and labels, including ADHD, conduct disorder and anxiety. He also had polysubstance use and met the criteria for severe cannabis and synthetic cannabis use disorders and was experimenting with IV opiates.

“However, there were barriers to him being able to fully and meaningfully participate in society. He had made substantial efforts to make these changes with the limited resources he had, and one has to wonder, what was the point?”

When Tāne was a child, his mum died from an accidental overdose, which occurred after she had completed residential treatment for addiction. His dad was on the methadone programme, and, although he was doing well, he smoked cannabis daily and was not that freely available. Tāne was in a relationship with a young woman he loved. However, he often displayed elements of power and control in their relationship. I worked with Tāne in a community-based service. It was long-term work, and the focus throughout was on harm reduction.

The first key moment came when he started experimenting with IV methamphetamine. He was aware this drug use was causing him harm, was displaying features of drug-induced psychosis and wanted to stop his use. Amazingly, he did.

Dean Rangihuna, who also spoke at the Addiction Leadership Day, referred to methamphetamine use as a taniwha that whaiora are faced with, and this young man faced this particular taniwha and came out the other side, demonstrating his strength and resilience. As a result, he was functioning better and feeling happier, and his psychotic symptoms ceased. There was also a major reduction in secondary harm from IV use, namely hepatitis C.

But also present were some not so good things. In particular, his cannabis use increased to daily, and he still carried with him labels from our health and social systems, such as ‘druggy’, ‘addict’, ‘dole bludger’ and even ‘no-hoper’. He was also still at risk of being criminalised for his use of cannabis, and he could not pass a drug screen in order to secure work.

Looking at this through a harm reduction lens, he had made significant changes in his life. However, there were barriers to him being able to fully and meaningfully participate in society. He had made substantial efforts to make these changes with the limited resources he had, and one has to wonder, what was the point? What are we as practitioners and as community and government organisations offering when whaiora like him make such significant changes? Moving forward, how might we socially and systemically recognise and reinforce major reductions in harm such as this?

Key moment number two came when Tāne decided he also wanted to give up cannabis use. He was determined to get a job at the meatworks, and he needed to pass a drug screen to do so. We came up with a plan together to work towards this, and then he accessed all the support available to him and ran with it. He passed the drug screen, he got the job and he was great at it.

So, the good things that came with this situation were that he gained employment, had an income, had a sense of hope and was feeling good about himself. He was interacting with people who were not using drugs, he had a reason to get up in the morning and he was not at risk of being criminalised for cannabis use.

But again, there were some not so good things. As we often see in this work, he started drinking because that is what is socially acceptable, despite alcohol being a more harmful drug than cannabis. This gradually increased, which came with an increase in alcohol-related harm, his power and control behaviour in his relationship was increasing, his risk of violent behaviour was increasing and he posed a significant harm to himself because of the way he was drinking.

What are our priorities when it comes to reducing harm? Would we say that, actually, this young man is doing well in these circumstances because alcohol use is legal and he is a contributing member of society? How do you think his partner would feel about that? Or should we say, maybe there is another way to do this in terms of our policies and what we promote. Maybe we should ask whether we are truly set up to support whaiora.

Before delivering my presentation, I sent it through to Tāne to look over, to make sure he was OK with it and to reinforce his hard work in making changes.

In his response, he said, “I just want to work hard during the week and smoke a bit of weed in the weekends maybe, like, it’s me and I’m happy being me. The way the system is makes someone like me feel [messed] up, it’s a huge waste of resources and money and for what? For me not to work means having to try and find another source of income or bludge more money off the government.”

Reflecting on Tāne’s experiences, I believe the greatest unmet need in the addiction field is access to meaningful work and activity. Whaiora want and need a reason to get up in the morning, and we have a responsibility to put in place policies and practices that support this. We all have an opportunity to engage in prevention and response, but major systemic changes are required to enable this. Unfortunately, Tāne’s story is all too common, and we have to head towards something better, which we cannot do alone. It requires a collective effort across government and community sectors and organisations.

Tāne gave me hope for positive change, that others can make changes too. I want to highlight some of the expectations we have of people with addiction in terms of what they have to give up, because perhaps as practitioners we could be more upfront and honest with whaiora about how much they will be giving up.

In order for him to achieve his goals and work toward wellness, he had to give up almost everything he knew. He gave up his identity, he gave up coping strategies for dealing with mental distress that he had relied on for years, he gave up his friends and social network because their lifestyles were no longer compatible and, for a period of time, he gave up his family because they did not know how to be around the new version of him.

I want to emphasise that, in the process of working through addiction issues, Tāne and other whaiora like him are giving up a great deal. Surely, if he can give up all of that, we can give up some policies that are no longer working. ■

* ‘Tāne’ gave permission for his story to be shared, and a pseudonym has been used to protect his privacy.

Respect:

Schools teaching critical thinking and harm reduction

A couple of months ago, a sudden scandal broke in the media. A Massey High School parent was outraged to learn their child had been given a brochure that appeared to be teaching students how to use methamphetamine safely.

Without asking why responsible teachers might advocate such a resource, a flurry of uninformed debate followed. Most assumed it was some kind of misguided drug education programme. The hysteria was fuelled by news headlines like "School teaches students how to use meth" and "NZ high school hands out guide to taking meth".

> **"Ignorance resides under the carpet and in the walls."**
>
> GLEN DENHAM, MASSEY HIGH SCHOOL PRINCIPAL

The pamphlet that caused the commotion was a Drug Foundation resource called MethHelp. It's a fairly candid booklet, which is designed for adults who are already struggling with their drug use. It does, unashamedly, teach them how to use meth safely.

So why was it given to high school students? Eventually, a true picture emerged. The MethHelp resource was not being used for drug education at all. It was one small component of a critical evaluation undertaken by students in a specialised health class with five years of training behind them. Their task was to analyse different approaches to reduce methamphetamine harm in New Zealand.

Massey Principal Glen Denham turned media interviews on their head, arguing his "discerning" students are smart enough to confront the issue of drug use in a mature way.

NATALIE BOULD

"Ignorance resides under the carpet and in the walls," he told *Newshub's* Duncan Garner.

"Schools would be ignorant not to teach drug-use safety."

Perhaps it's not surprising that some parents were initially concerned, given the traditional 'scare tactics' they're used to seeing in schools. But those tactics have been proved time and time again to be ineffective.

Ben Birks-Ang is the National Youth Services Adviser for Odyssey and the Drug Foundation. His job is to support communities to help young people based on the best available evidence.

He says young people need to learn how to filter good information from bad.

"There are more than 700 known psychoactive substances and a wealth of conflicting information at the end of a Google search. Just getting students to name information about the risks of taking drugs is outdated and is never going to prepare them for the reality of today's world."

He says that's why Massey High's approach was spot on.

"In today's climate of information overload, we need to help students develop critical thinking. It's the only way to prepare them to discern accurate, healthy information from all the unhealthy information that's out there.

"I'm excited that students are learning how to critique information and critically analyse how to reduce harm. This will set them up well for a great career in our health workforce." ■

Anne Bardsley

As Research Analyst in the Office of the Prime Minister's Chief Science Advisor, Anne Bardsley leads the development of expert reviews of evidence on key issues impacting public health and the environment. She has a PhD in molecular biology from the University of Colorado at Boulder, USA. Anne led development of the Chief Science Advisory's report that says there is no evidence that third-hand exposure from methamphetamine smoking causes adverse health effects.

Q What was the starting point for the report?

A From the outset, we didn't have a view one way or another. We just started from the main question: what do we know about the health risks from the levels of methamphetamine likely to be found in houses in New Zealand? And is the approach being taken reasonable?

Q Is it fair to say you've laid bare the assumptions behind the existing guidelines?

A Yes, we've explained the toxicological principles that were used, the kinds of studies they were based on and the uncertainties and assumptions that went into the calculations so people can understand how they came up with those levels to begin with.

But we also point out that those calculations use very precautionary assumptions and aim to determine a 'no risk' level, which is not actually possible to achieve from a scientific standpoint. But it is also not practical given how the original guidelines were being used to determine the need for testing and decontamination.

We have noted that the original guidelines from the Ministry of Health were completely misused. They were developed to provide guidance on cleaning clandestine meth labs, and it was pretty clear that the triggers for doing a test were finding evidence of a lab or the strong suspicion that meth manufacture had taken place. But that's not how they were used, and that became the issue.

Q Can you share some insights into why there isn't much research on contamination?

A The issue of exposure to methamphetamine contamination in houses is a relatively recent phenomenon. Determining levels of exposure that might affect health is not something you can do a randomised, controlled trial on! So experiments that try to understand how much of the drug might be absorbed in these scenarios have to rely on models, for example, using cadaver skin or gloved hands to try to determine transfer efficiencies, and these have their issues. There are studies of meth exposure in animals, but there are questions on how relevant those are to the human situation.

However, methamphetamine is a therapeutic drug still used in the US for ADHD and obesity, so we do have quite a lot of data on effects from those levels. These are far higher than you're ever going to get from being exposed to household surfaces that might be coated with meth. There is very little information to be found on effects from doses lower than those used for ADHD therapy, but what evidence there is suggests that low doses have some positive effects on brain function. And these doses are still much, much higher than a person could plausibly absorb from surface contamination.

Q What steps did you take to ensure validity for conclusions you reach?

A These types of analysis have to start from knowing what a good source of information is. We reviewed the scientific literature, looked for case studies etc. and followed leads from there. When we couldn't find any cases that were related to exposures resulting from meth smoking (and not to meth labs), we talked to various experts to find out what they knew and whether we might be missing anything. We asked the Ministry of Health and public health services for any reports that might not be in the public domain.

We also talked to experts, both in New Zealand and internationally, about our interpretations of the literature, the exposure studies and the general lack of data on adverse effects. Then, once the review was complete, we sent it to more experts for peer review. We took in their comments and modified some aspects based on what those experts had to say. We also listened to various stakeholders. So in the end, we were very confident that our conclusions were unbiased and sound.

Q Your report follows another one from Standards New Zealand. Why did they reach such different conclusions?

A I don't think we were actually asking the same question. We essentially went back to base questioning – starting with determining whether and at what levels meth contamination on surfaces can cause health effects. Second, how likely is it that those levels (if they can be identified) will be encountered in New Zealand houses? Finally, is the current approach to testing and decontamination commensurate with the risks? Basically, we were asking the big-picture question about the New Zealand situation. The Standards Committee did not look at the situation in this way. It used the toxicological calculations I mentioned earlier and created a standard based on highly precautionary assumptions that did not relate to real-world exposures.

Q Do scientists get a fair hearing in public debates?

A We weren't the first ones to look into this. As you know, Nick Kim from Massey University and Leo Schlepp from the National Poisons Centre have been saying this for a long time, so I wouldn't say in every case the scientists get their views out there in a way that people are listening to all the time.

> **"I actually enjoy the controversial topics where the risks might be misunderstood and where a careful analysis and translation of the technical stuff can provide some clarity."**

It depends on who the voices are on both sides and how that's weighed in the media. In this case, the message was coming from the Chief Science Advisor, a very trusted voice for science, and on the other side, it was basically the meth-testing industry, which has a clear stake in this. We didn't have any stake in this. I certainly didn't. My stake in it is only my own reputation as a trusted analyst – that what I write is completely defensible by the science and the evidence.

Being a trusted voice, an 'honest broker' of the evidence, is what the Chief Science Advisor's Office is meant to be. I think this was a good example of how that worked.

Q Can you talk about the most satisfying work you've done in your career?

A That's a difficult question. I thrive on the variety of topics I get to delve into. I enjoy starting from the base questions and working through further and further levels of detail as I learn more about whatever topic it is. So I am always learning. I actually enjoy the controversial topics where the risks might be misunderstood and where a careful analysis and translation of the technical stuff can provide some clarity. The meth report is one that's had the most impact. It's changing the way things are done, I think in a positive way, and that's very satisfying. ■

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