Matters of Substance.
MARCH 2018 | Volume 29 Issue No.1 | www.drugfoundation.org.nz

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

# Step into the light

Hearing from people frankly talking about their everyday experiences with alcohol and other drugs is a privilege. In this issue of the magazine two guest co-editors bring us insights from people whose experiences are often left unheard.

Matters of Substance.
MARCH 2018 | Volume 29 Issue No.1 | www.drugfoundation.org.nz

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

# Step into the light

Hearing from people frankly talking about their everyday experiences with alcohol and other drugs is a privilege. In this issue of the magazine two guest co-editors bring us insights from people whose experiences are often left unheard.

## CONTENTS

# Step into the light

COVER STORY

06

This issue we share the stories of people who are personally affected by drug use – their own and others.

FEATURE: BEING IN RELATIONSHIP

14

FEATURE: WHAT WE CAN LEARN FROM THE PSYCHEDELIC RENAISSANCE?

22

FEATURE: KEEPING SAFER UNDER SUMMER SKIES

28

FEATURE: MENTAL HEALTH INQUIRY

34

## FEATURES



## REGULARS






**MATTERS OF SUBSTANCE**
March 2018
Vol 29 No. 1
ISSN 1177-200X




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


**Brand development/ graphic design**
Insight +64 4 801 6644
talktous@insightcreative.co.nz
www.insightcreative.co.nz



**NZ Drug Foundation**
4th Floor, 265 Wakefield Street
PO Box 3082, Wellington,
New Zealand
p +64 4 801 6303



This report is printed on Advance Laser, an environmentally responsible paper produced using elemental chlorine free (ECF) pulp sourced from sustainable and legally harvested farmed trees. Advance Laser is manufactured under the strict ISO 14001 environmental management system. The ink used in the production of this report is 100% vegetable based, mineral oil free and manufactured from 100% renewable resources.

## CO-EDITORS' CUT

Our kaupapa centres on creating a space for the voices in our communities that are often left unheard. This especially includes those voices most affected by policy and legislative change. We believe Māori should be part of any legislative reform conversation, particularly one that may unintentionally harm Māori communities.

This issue contains true accounts of everyday New Zealanders and their experiences with drugs and alcohol. We explore the ideas that drug use does not always equate to abuse, and conversely, that often those who may not be labelled as 'addicts' may also present problematic use patterns. We have attempted to bring to life some of the more silent and hard-to-reach groups here in Aotearoa with the aim to create awareness and provide a space to share their experiences – both good or bad – with drugs and alcohol.

**EMMA ESPINER**
**ANGUS LINDSAY**
Co-editors

As young people growing up in distinct cultural contexts within New Zealand, Emma and I share the common thread of wanting to create a better future for our society. We have both seen and experienced the effects of problematic drug use within our communities. At the same time, we also understand that the conversation around drug use is more nuanced than what has traditionally came before us. We value sensible, evidenced-based legislation that consults a broad range of voices within the wider community.

As the victors of the 2017 General Election, the Labour-New Zealand First-Green coalition has a duty to take action and acknowledge the impact that legislative change can have on the already vulnerable. The coalition has already taken action on priority areas such as housing, health, education, mental health and the environment – one of these priority areas is the vote on medicinal cannabis.

The Misuse of Drugs (Medicinal Cannabis) Amendment Bill, which aims at improving access to medicinal cannabis for terminally ill patients, passed its first reading in January. The next day, Green MP Chlöe Swarbrick's medicinal cannabis Bill was defeated in a conscience vote 73 to 47. Her Bill sought to allow approved chronic pain sufferers to use, possess and grow cannabis as well as nominate a person to grow cannabis for them.

Why the distinction between need and use? Is New Zealand ready for this discussion? Are we mature enough as a society to examine the scientific evidence, rationalise the pros and the cons, and communicate with a diverse set of groups?

We are in a privileged position to be able to look to other nations such as Canada and the US who have already taken these tense political steps. We should examine their stories to help us make these decisions and how they may or may not work for New Zealand.

**This issue, we're delighted two co-editors set the direction of the magazine. Thanks to Emma Espiner, National Communications Lead, Hāpai Hauora and Angus Lindsay, VUW criminology student and JustSpeak volunteer.**

## SOCIAL

**@etangata** They say we've got a P problem in the Far North. Well, we do. But the P problem is prisons. It's politics ... MAR 18

**@niamhrelease** #Trump just endorsed the use of the #deathpenalty for #drug offences in his speech in Pennsylvania- this is just fucked! ... MAR 11

**@MorganGodfery** if wellington city council approached housing with the same enthusiasm as it approaches "begging", maybe they'd accidentally solve the latter ... MAR 6

**@JulieAnneGenter** Wow, Kim Workman's speech after winning Senior NZer of the Year award. Nailed it. @JustSpeakNZ #prisonscausecrime #timetochange ... FEB 22

**@dbseymour** Jonathan Coleman calls cannabis legislation half baked. Just saying ... JAN 30

## KEY EVENTS & DATES

| | |
|---|---|
| 16–18 MAY 2018 | **12th International Society for the Study of Drug Policy conference, Vancouver, Canada, issdp.org** |
| 28–29 MAY 2018 | **Australian and New Zealand Addiction Conference, Gold Coast, Australia, addictionaustralia.org.au** |
| 13–15 AUGUST 2018 | **Involve: Aotearoa national youth development conference, Wellington. bit.ly/Involve2018** |
| 12–15 SEPTEMBER 2018 | **Cutting Edge, Rotorua. cuttingedgeconference.org.nz** |
| 4–7 NOVEMBER 2018 | **APSAD Scientific Alcohol and Drug Conference, Auckland apsadconference.com.au** |

**Follow us**
Join us online
drugfoundation.org.nz/connect

# NZ.

*In February Medical Cannabis Awareness NZ launched a health policy document at Parliament.*

## 01 YOU CAN HELP IMPROVE ACCESS TO MEDICINAL CANNABIS

Last month, politicians debated two medicinal cannabis Bills, and while the weaker Bill was passed, there's still time to make changes at the select committee stage.

Many people were disappointed that the Government voted against the more robust Bill put forward by Green MP Chlöe Swarbrick, which would have allowed people to grow their own. We are urging MPs to build on the Government's Bill.

When enacted, updated legislation will make it easier to import a wider range of products, and it sets up a framework for New Zealand to develop its own supply. The Bill gives a legal defence for patients with a terminal illness who use raw cannabis, but that doesn't extend to other conditions and it only protects the patient, not their support people.

The Drug Foundation has submitted on the Government's Bill, and to help and encourage others to do the same, we hastily pulled together workshops in Christchurch, Wellington and Auckland. Check out the back page of this magazine for details on how you can help.

## 02 Call for separate Māori voice on cannabis

**WITH THE GOVERNMENT** locked into a referendum on the legal status of cannabis by the next election, one academic has called for a "double majority" vote to give Māori a stonger voice.

Given the disproportionate rates of Māori usage and prosecution, University of Otago law professor Andrew Geddis has raised the question of whether the referendum should have a separate Māori vote, with majorities on both votes required for it to pass.

Drug Foundation Chair Tuari Potiki says it's appropriate for Māori to have a say in cannabis law reform, so the question deserves consideration. While there's an inherent conservatism in Māoridom about the issue, he believes that attitude is slowly changing as the statistics become more widely known.

## 03 Rhythm and calm at Gisborne festival

**RHYTHM AND VINES** music festival entered its 10th anniversary with a relatively well behaved crowd, according to local Police.

Crowds at the December event in Gisborne's Waiohika Estate were reportedly less intoxicated and more well behaved than in previous years. Tairawhiti Police Area Commander Inspector Sam Aberahama said more vigilance and crowd management ensured festival goers knew they would not be allowed in if they were "playing up".

Seventeen people were arrested during the event for minor disorderly offences, including four held overnight, who were all locals. Some drugs were seized at the gate.

## 04 Shaun takes on Goliath in costly local alcohol battle

**A KAIKOHE PENSIONER** has refused to back down in his bid to reduce off-licence opening hours, despite threats to pursue him for legal costs.

The Far North District Council's Local Alcohol Policy went to an appeals hearing in December, after 83-year-old ex-farmer Shaun Reilly refused to give in to pressure from supermarkets. A decision is expected by mid-February in an appeals process that has already cost ratepayers over $160,000 and is expected to cost more before it's over.

Mr Reilly and Progressive Enterprises both appealed the LAP but for different reasons. Progressive says there's no proof the council's plan to reduce supermarket and off-licence hours from 7am–11pm to 9am–10pm will reduce alcohol-related harm, whereas Mr Reilly says it doesn't go far enough.

## 05 Low alcohol – naturally


**TOP WINE BRANDS** could soon be exporting naturally produced, low-alcohol products as a seven-year research project attempts to position New Zealand in a growing international market.

The $17 million Lifestyle Wines project, funded by the New Zealand Government, New Zealand Winegrowers and around 15 individual wineries, has just passed its half-way mark.

To create a point of difference from other low-alcohol wines, which typically use de-alcoholisation methods to lower the alcohol content, manufacturers will use natural techniques such as yeasts less effective at converting sugar to alcohol and restricting exposure to sunlight to slash alcohol content.


## 06 Baby Boomers bingeing more

**OLDER KIWIS** are drinking more heavily here than they are in other countries – four times more than their Russian counterparts and neck and neck with English Baby Boomers.

However, the authors of a new Massey University study have pointed out the surprising results can be explained by the relative affluence in that age bracket as well as a longer life expectancy. "It looks like [older Russians] are drinking less, but it's just they have many more heavy drinkers at a young age who just don't make it through," says co-author Dr Andy Towers.

The report compared drinking patterns of over-50s across nine countries including New Zealand, England, the United States, China and Mexico. "Off the bat, more older adults in New Zealand drink than pretty much every other country in the study," Dr Towers says.

## 07 Last drinks at The Hood

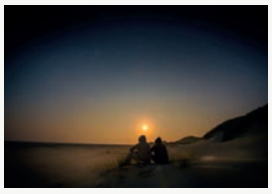



**AFTER YEARS** of Police literally lining up every Saturday night to diffuse trouble outside Hamilton's notorious drinking den The Hood, the bar has had its liquor licence revoked.

The district licensing committee said it was concerned at the number of Police being diverted into the inner city to keep order outside the bar. Police released data that showed a large number of people they arrested had taken their last drink of the night at The Hood.

The decision comes into effect in April, but owners Lawrenson Group have said they are "disappointed" and are likely to appeal.

## 08 New MoH data for drug use trends



**THE MINISTRY OF HEALTH** has just released its latest health statistics for 2016/17, which confirm what we already knew about how many Kiwis have used illicit drugs.

While overall cannabis use in the past year has remained approximately the same (11.6%), Māori are using more often (25.6%, slightly down on last year's figure) and Māori men have the highest use at 30.1%. Youth use also remains high (22.2%), but that's down from the previous year (24.6%).

Similar trends show in amphetamine use in the past year, with Māori still above the general population (2.1% compared to 0.8%) and men much higher than women (1.2% compared to 0.4%).

It should be pointed out that these figures only show whether people have used a drug over the past year. They do not give an indication of how often people are using or the harm being caused.

## 09 Transport Ministry winds back the clock on saliva testing

**IN A SURPRISING** about turn, the Transport Ministry has recommended Police be given the power to conduct random roadside saliva tests for drug use.

However, the Minister in charge, Julie Anne Genter, is not on board. She says saliva testing is intrusive and ineffective, not to mention expensive. Ms Genter says Police can already conduct impairment tests, which are over 90% effective and usually backed up by 100% accurate blood tests.

Drug Foundation Executive Director Ross Bell says very few countries are using saliva testing because the devices are slow and unreliable. "These were the same officials that gave advice to the previous National Government that saliva testing technology was not up to scratch … I'm surprised to see they're now saying it is up to scratch, because we don't think the technology has improved."

# World.


## 01 NEW GLOBAL COMMISSION FOR DRUG POLICY REPORT

Since being appointed to the Global Commission on Drug Policy late last year, former Prime Minister Helen Clark has voiced her opinion that decriminalising drugs is the "hardest of all issues".

The Commission released a report in January that seeks to overturn the negative perception that drug use is immoral. Speaking at the report's release, Ms Clark said the common narrative that "bad people" use drugs makes it harder to implement change. "Actually the use of drugs requires a health and safety approach, a social policy approach, a safe spaces approach."

**RESOURCE**

See nzdrug.org/GCDP-report-2018

## 02 Norway heading for Portugal-style decriminalisation

**NORWAY'S PARLIAMENT** has voted to decriminalise all drug use and will now begin developing a plan for reform.

A recent report from the European Monitoring Centre for Drugs and Drug Addiction found that Norway has a relatively low rate of drug use compared with other European countries. However, there is a small group of high-risk (injecting) drug users, and 266 people died from drug overdoses in 2014.

Based on the Portugal model, it's likely that people caught with a small quantity of drugs would be offered treatment instead of punishment.

## 03 Samoa reviewing the status of narcotics

**THE SAMOAN** Government is considering a review of their current "outdated" Narcotics Act, which has been in place since 1967.

The Samoa Law Reform Commission's recommendations are now before Cabinet for approval. A post on the Commission's Facebook page says, in addition to the issue of medicinal drugs, "other matters including offences and penalties for drug offending, exemptions to prohibition, enforcement, rehabilitation and treatment ... as well as the role of the village community are also being considered".

Ministry of Health Director Leausa Dr Take Naseri says the health sector has "always entertained" the idea of legalising medicinal cannabis, although he does not personally believe there is enough evidence of its efficacy.

## 04 £3.99 wine banned: Scotland wins battle of the booze

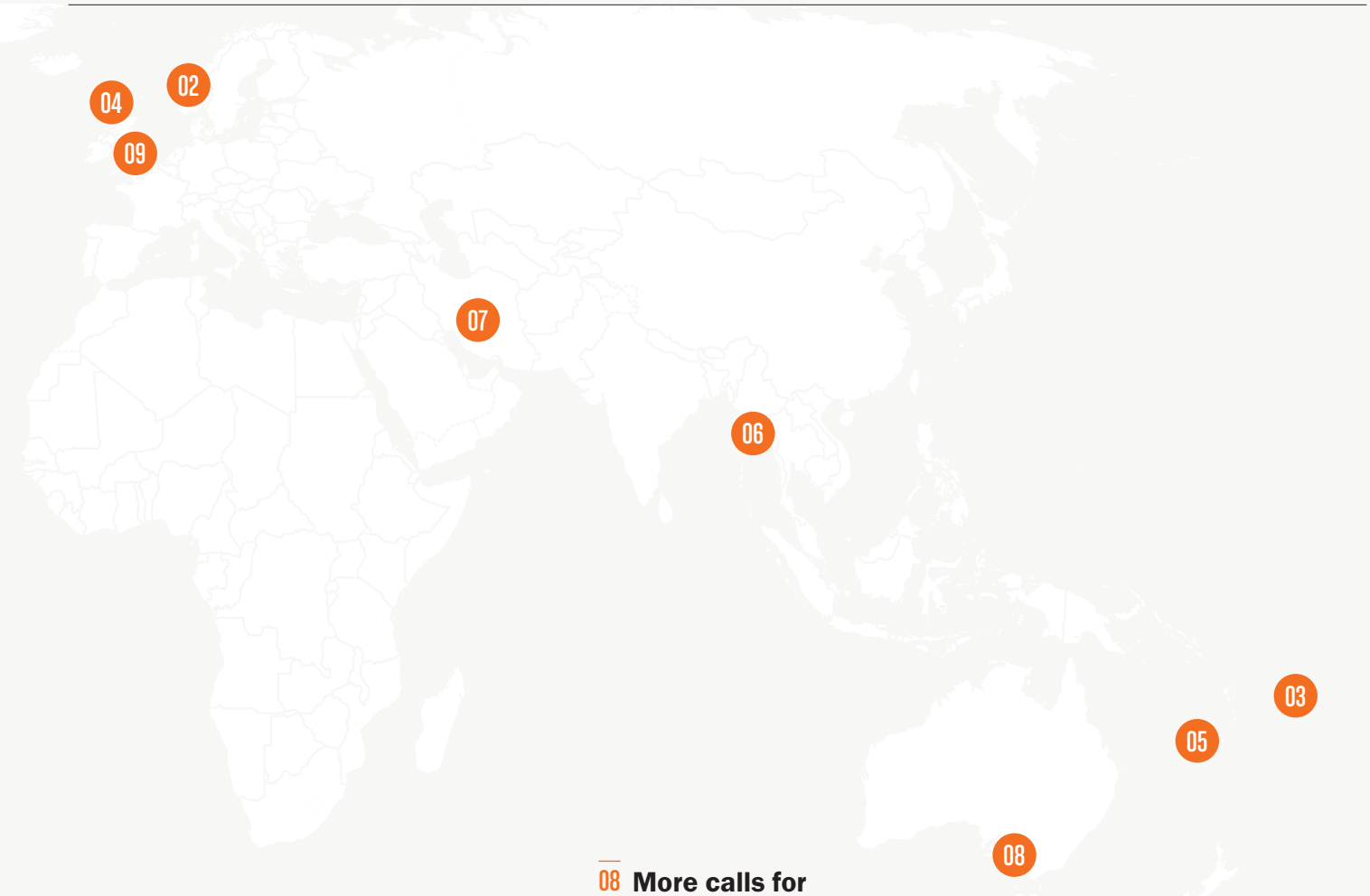
**CHEAP BOOZE** is about to get more expensive in Scotland, despite the best efforts of industry lobbyists to stop it. In a bid to curb Scotland's binge drinking culture, the government passed legislation five years ago to raise the minimum price of alcohol – but it's taken since then to overcome a legal challenge from the Scotch Whisky Association. The Supreme Court finally ruled the policy does not breach EU law, and the new 50p-per-unit minimum will be introduced in May.

Minimum pricing has been broadly welcomed by health bodies and alcohol awareness groups, who say it will target the kind of drinking that leads to the greatest harm.

## 05 New Caledonia tackles alcohol issues

**ALCOHOL AND TOBACCO** have just undergone hefty tax increases in New Caledonia, as part of a long-term plan to reduce alcohol-related crime and improve health outcomes, especially among the young.

The price of alcohol has gone up by 20%, while tobacco will cost 40% more – that's on top of a 30% hike three years ago. The extra revenue will be used to counter growing health costs related to excessive drinking in the French republic, where per capita consumption has risen by almost 30% over the past decade.




## 06 Myanmar opium production drops, but meth on the rise

**PROGRAMMES TO** find alternative livelihoods for opium-growing communities in Myanmar have helped reduce heroin production, but many young drug users are reportedly shifting to methamphetamine.

The UN Office on Drugs and Crime reports that regional demand for heroin has stabilised or decreased in Southeast Asia, but demand for methamphetamine has risen. Myanmar is now the main source of methamphetamine, which is mostly produced in lawless border regions outside the government's control.

## 07 Iran halts executions for some drug traffickers

**THOUSANDS OF** Iranian prisoners facing death could have their lives spared under a law change to abolish capital punishment for some drug-trafficking offences.

Almost 3 million Iranians are thought to have a problem with high-risk drug use, and the government had resorted to hardline punitive methods to control the problem. The change came after some European countries threatened to stop funding Iran's counter-narcotics programme unless the government stopped using the death penalty. Human rights groups have welcomed the news but want to ensure prisoners are aware of their rights and receive legal aid.

## 08 More calls for drug checking after disaster strikes at Melbourne rave


**SUPPORTERS OF** drug checking were outraged after multiple people were hospitalised at a Melbourne rave in January. Many pointed out that it was a year since three people had died and over 20 were hospitalised at similar events, asking how this could be allowed to continue.

Australia's first attempt to implement a legitimate drug-checking service failed last year, after organisers of the Spilt Milk Festival in October claimed the service provider, STA-Safe, had not supplied the necessary paperwork. STA-Safe denied this, saying the organisers had bowed to political pressure. Interestingly, the Liberal Party claimed it as a victory for their hardline stance against drugs.

## 09 UK Police back cannabis 'social club'

**ONCE AGAIN,** the Durham constabulary are showing a more progressive stance towards cannabis use, publicly backing the Teesside Cannabis Club, which allows members to use cannabis in a "safe and controlled space".

Durham is one of five Police districts in the UK to have stopped actively pursuing cannabis users. North Wales Police and Crime Commissioner Arfon Jones visited the Middlemore club and voiced his approval – even recommending the scheme be replicated across the UK. "Then ... we would have a strong evidence base to take to government and show them how this model works."

## 10 Vermont legislates for recreational weed


**IN A MOVE** seen by some as a deliberate slight against Attorney General Jeff Sessions' tough anti-drugs stance, Vermont has become the ninth US state to legalise cannabis – and the first to do it through the legislative process.

The move has been touted as setting a precedent for other states, as all previous cannabis legislation has been pushed through by public ballot rather than the lawmakers themselves.

There won't be any commercial market at this stage, but Governor Phil Scott has created a commission to research the pros and cons.

# Step into the light

Our three cover stories are deeply personal reflections about drug use. We chose to focus on the lived experiences of real people to highlight the critical role of consumer perspectives in shaping addiction, health and social policy. This year, more than ever, it is essential that we ensure those who will be most affected by any change in the way things are done are represented.

The biggest challenge in finding and hearing these critical voices lies in creating a space for them to share their stories safely. We know that those who expose themselves as having had mental health, addiction or drug use problems open themselves to employment, social and legal risks. In light of this, we wish to acknowledge the bravery of our authors in sharing their stories so that others might benefit. We wrap a korowai of support around them in the form of this magazine and our gratitude. We extend this support to others who might have an untold story to share. Ngā mihi nui ki a koutou.

# Cannabidiol

## A better treatment option than my tiny pink pills?

Using medication to cope with anxiety comes with negative side effects. **Denise Carter-Bennett** shares the realities of living with her clinically diagnosed condition and how she is optimistic that, one day, access to cannabidiol as a treatment will be an option legally available.

DENISE CARTER-BENNETT

It's a Thursday morning, and I have just dropped my son off to school. I calculate in my head I have about five hours to get the rest of my Christmas shopping done before I have to pick him up again. I get to the shopping mall with a list in my hand carefully listing which shops to go to and what I need to buy. I step inside the mall, and my senses are overloaded with fluorescent lights, loud Christmas music and the sickly, sweet smell of perfume. My head starts to spin, and my hands feel tingly. I look down at my list and quickly walk to the first shop, determined to get this shopping done, determined to get this shopping done.

Three hours later, I start to feel the beginnings of an anxiety attack. My central and peripheral nervous systems are overloaded, and it feels as if my spine is on fire. My hands are shaking, and my heart is beating at a million miles per second. I fumble around in my handbag, trying to find the small bottle that contains my clonazepam tablets (I call these "the tiny pink pills"), which will help me feel better.

I also realise I should have taken my second dose of ADHD medication about an hour and a half ago, and my mind quickly jolts to a thought about which sparkling wine to get from the supermarket and then that I need to get some more sunscreen onto my face. Someone comes up and asks if I am OK, and I realise

**"Three hours later, I start to feel the beginnings of an anxiety attack. My central and peripheral nervous systems are overloaded, and it feels as if my spine is on fire."**

I really need to find those tiny pink pills. I mumble back, "Yeah, I am OK, thank you for asking," even though my hands are trembling and my eyes are darting all over.

I find the bottle, take out a pink pill and break it into quarters. One tiny quarter is ingested, and I have to wait 25 minutes for it to start working its magic, which is 25 minutes too long for me. I start doing every breathing technique I have been taught in therapy to try and keep my anxiety under control, slowly drifting off into random thoughts about Christmas cake, my lemon tree and the mountains of washing I have at home. After 25 minutes of random thoughts, I feel the medication kicking in, a wave of relaxation hits my body and my thoughts calm down. I calmly get up and complete the rest of my shopping, remembering I will suffer the consequences of having an anxiety

**“Having an anxiety attack is a typical part of my life as someone who has autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) ...”**

attack and the side effects of taking that tiny pink pill when I get back home.

Having an anxiety attack is a typical part of my life as someone who has autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) – two conditions that signal I am part of the neurodiverse community. Neurodiversity, as defined in the *Oxford Dictionary*, is “the range of differences in individual brain function and behavioural traits, regarded as part of normal variation in the human population (used especially in the context of autistic spectrum disorders)”. Both ASD and ADHD are classified as neurodevelopmental disorders in the *Diagnostic and Statistical Manual of Mental Disorders* 5th edition (DSM-5), which affect the structure and development of the brain, and these differences have an effect on behaviour and the processing of sensory input from various sources.

As someone who is neurodiverse, I explore ways I can better handle the side effects of these conditions, such as depression and anxiety. I am constantly altering my diet and taking various supplements to see if they have any effect, but the only thing in my life that has any noticeable positive effect is the medication prescribed by my psychiatrist and GP. One pharmacological treatment that may be effective for anxiety in neurodiverse people is the use of medicinal cannabis, specifically cannabidiol (CBD) compounds without the presence of psychoactive tetrahydrocannabinol (THC).

I watch a video on YouTube by Candace Lowry – a former Buzzfeed employee – where she explores the use of medicinal cannabis to help with her anxiety issues. Unlike myself, she can legally purchase CBD products as she lives in California and has a valid prescription card.

The video starts with her recording an anxiety attack and how she wants to try medicinal CBD. Due to her personality and openness, you get pulled in to her story and the journey she takes. I feel jealous that she has access to these products, and I think back to that tiny pink pill I took earlier. The consequences of taking it are disturbed sleep and waking up the next day feeling very groggy and unable to achieve much, apart from staying in bed and binge watching *Downton Abbey* on Netflix. It comes across in the video that Candace doesn’t seem to have similar side effects to me taking a tiny bit of clonazepam, and I feel a tear streaming down my face. I have to really limit how often I take clonazepam due to the side effects and often go through anxiety attacks without taking it, which has a negative flow-on effect on my everyday life.

After watching the video, I chat to a friend who is neurodiverse like me, and we talk about how great it would be to have access to medicinal cannabis. We also talk about whether the new government will make medicinal cannabis legally accessible to people like us, when this friend mentions she uses cannabis every now and then to help manage her anxiety.

“I can’t take prescription medication for it, Denise, as the side effects are too much. I only use cannabis maybe once every two months when my anxiety is really bad,” she says, and I verbally express my empathy for what she has to do to handle her anxiety. I will not judge her for using something that helps her function in everyday life, and she exclaims, “Oh, but it would be great if I could access cannabis without the THC stuff in it, as it makes me feel a bit spaced out.” I nod in agreement.

Later that day, I ask in a Facebook group for ADHD what people’s views are on the use of medicinal cannabis to help treat and manage the severe anxiety we all seem to suffer from. I get a couple of positive replies before the post is deleted by an administrator of the group. I feel deflated when I get a message that the discussion of illegal drugs is not permitted in the group.

**“Currently, the process to access CBD products is tangled up in red tape and requires ministerial approval, with those getting it needing to have very specific and life-threatening medical conditions.”**

With a new government and a new Bill being introduced to legalise use of medicinal cannabis in New Zealand, it is an exciting time to see whether people like myself may be able to access and use CBD to help manage our conditions. Currently, the process to access CBD products is tangled up in red tape and requires ministerial approval, with those getting it needing to have very specific and life-threatening medical conditions.

Public approval for the legalisation of medicinal cannabis increases each year, with MP Chlöe Swarbrick saying that 78 percent of New Zealanders agree with the premise of her Bill, which relates to her recently defeated Bill to allow New Zealanders who are unwell to grow and use cannabis.

While I agree that access to medicinal cannabis needs to be expanded, I believe that prescribing guidelines need to be established for doctors and that the CBD used must be of a standardised, pharmaceutical grade. I feel optimistic that, with increasing pressure from the New Zealand public, people who are neurodiverse will benefit from what Candace has access to, and I may not have to rely on those tiny pink pills. ■

**Denise Carter-Bennett is of Ngāpuhi descent and does graduate studies in business at AUT. She lives in Auckland with her son and cat.**

# Mixed messages

## Finding a way through the drugs minefield

**Angus Lindsay** talks us through his upbringing where he was constantly surrounded by both the positives and negatives of drug and alcohol use. Based on his experience and a few hard-learned lessons, he concludes with some observations about how, as a society, we deal with substances and the people who use them.

ANGUS LINDSAY

It was a blistering hot, early summer's afternoon. Tūī were singing in the trees overhead, and all the kids in the neighbourhood were crowded around the pool doing bombs and splashing. The sounds, smells and sights of a classic Kiwi summer were in full force.

Nearby, inside a dimly lit room, adults were huddled around the table coughing, laughing and sharing their stories from the past week. They were having fantastic conversations I just wanted to be a part of.

"I don't want to be out here with these kids!" I thought to myself. But heading inside, I was promptly stopped by an authoritative voice: "Kids outside today. The adults are having alone time!"

Begrudgingly, I walked back outside and began plotting how to re-enter the forbidden darkness of my elders.

The mood inside the dimly lit house grew cold. Something was up. I knew this was my opportunity to get in on the adults' conversation. I thought back to something I had learned earlier in the day. Running into the room, I proudly announced, "Did you know the Amazon rainforest is the largest in the world and is home to over 40,000 plant species?"

The feeling of the room immediately lifted! Several of the adults further questioned my knowledge of rainforest ecology, and the rest started laughing and talking. I was successful – I had made them happy!

I had a great childhood, filled with love, affection and the odd summer holiday away with my grandparents. We never went hungry (even if our mum had to sometimes) and were given everything we could ever need.

But my childhood was not without its challenges. My parents divorced when I was eight years old, which placed a huge strain on my family's and my own mental health. I was moved to a smaller school and was beaten up and bullied most days. I often faked illnesses to stay home from school and contemplated ending my life. No one else knew this, but I didn't know who to talk to. I came to see the world as a dark place and, for the first time, began to realise some of the negative consequences of the drug use around me.

Heavy drug and alcohol use was common where I'm from. Looking back, I remember hard-working, unhappy people who did what they could to provide for their families. Their release was cannabis and alcohol. I remember this is when I started to feel anxious and scared that the people close to me would be taken away by the Police – or worse.

As a teenager, I realised drug use was a fairly common thing even outside my family circle. We had been told by Harold the Giraffe that drugs were bad, but I could see drug use in a positive light. I experienced the effects alcohol and cannabis had when

> **“I was involved in great conversations with family and friends while they were high, discussing ‘adult’ topics and expanding my mind ...”**

> **“Our teachers told us any use of illegal drugs was bad and that the only acceptable drug was good old alcohol.”**

people were socialising. I was involved in great conversations with family and friends while they were high, discussing ‘adult’ topics and expanding my mind with ideas that may not have flowed so easily without some help from Mary-Jane. What was Harold to say to that?

In my teens, I developed a passion for playing music. I joined a band and slaved away for hour upon hour, perfecting my craft. I become obsessed. I started to play gigs and was invited to parties. This is where I began my own experiments with alcohol and drugs.

I was surprised to discover that cannabis helped my creative side and made me more caring and empathetic to the people around me. Alcohol allowed my shy teenage self to become more confident and sociable. So for the first time in years, I was making friends! This started my teenage love affair with these substances.

The extent of my drug and alcohol education at school was rooted in a clear way: use = misuse. Our teachers told us any use of illegal drugs was bad and that the only acceptable drug was good old alcohol. At home, I was lucky to see both positive and negative sides of drug and alcohol use, but being stubborn, it took me years to learn for myself.

Every Friday and Saturday night, my friends and I would drink hard and fast – the New Zealand way, right? We slept where we dropped, then snoozed long into the afternoon, relieving our sore heads with a diet of greasy pies and bongs for breakfast. At times, friends’ parents even encouraged us to drink. It was a ‘coming of age’ ritual – it’s what teenagers do. It was accepted.

I wasn’t sure how to deal with my angst when I was a teenager. Major life changes, being bullied, being poor at communication and feeling a lack of direction all made life seem not worth living at times. All regular teenage problems, right? Around me in my home, there were good, fun and happy times but also a lot of sadness. Looking back, this was no doubt made worse by my own and others’ drug and alcohol use.

Our patriarchal culture expects us as men to harden up or ‘handle our shit’ to suppress sadness. Real men don’t show negative feelings, unless they’re rooted in anger or aggression. It’s socially entrenched, and writing this, I still feel its pull. When things felt like they were falling down around me, alcohol and drugs seemed to offer an easier, more reliable form of counselling than talking to someone about my problems.

After high school, I decided to stop using all drugs and change my life. I began to learn Muay Thai, and a year later, I began competing around the world, later becoming a New Zealand champion. Little by little, day by day I literally fought my demons inside and outside the ring. After two years of abstinence, I decided to begin a long journey of working out how to use drugs safely. I remembered the positive effects that some substances offer. I wanted to have drugs back in my life.

Tragedy struck with my coach and mentor passing away. I starting drinking a lot to numb the feelings I was experiencing. Success in competition had taught me that I had to keep trying to be better. I worked at it and fought my demons once again, but I now had a new goal: to be the first in my family to go to university. I began studying with the intention of helping other people like me – those who were either too proud, too shy or just not sure how to ask for help.

In 2016, my stepfather was taken early from harms related to lifelong drug and alcohol use. Even then, seeking help was difficult. Eventually, I began seeing a counsellor who helped me work through my fight with anxiety and depression, teaching me that it’s OK and normal for people, including men, to feel this way sometimes and that talking was far better medicine than drugs or alcohol.

Many of us in New Zealand (like myself) are taught problematic drinking practices from an early age, and we are not very good at talking about our issues. Instead, it’s easier to find the solution at the bottom of a bottle. This is directly linked to our stoic, colonial predecessors and the culture we have inherited. As a society, we often demonise certain drugs and the people who use them. Many of the laws and societal attitudes we have around legal and illegal drugs are rooted in archaic, puritanical ideals that have no medical or scientific rationale.

I truly believe we need to look at the ways we teach young people (and ourselves) to use alcohol and other drugs. We should take responsibility and encourage people to use them in a responsible, evidence-based manner, and we should avoid demonising these substances and people who choose to use them.

I wish I had had more support and had known where to turn when things looked dark. Identifying and supporting our at-risk rangatahi is of utmost importance. I also wish we had much wider access to resources and knowledge so people can find alternative ways of coping with life’s stressors, especially for people like my past self who may not have a severe addiction but whose use is borderline problematic.

Finally, we need to destigmatise seeking help for mental illness – we need to treat people with more love and compassion. Due to my past experiences, education and efforts at combating my own mental health problems, I have discovered why my teenage self turned to drugs and alcohol to escape. These days, I’ve got a choice if I use drugs or not. I am more in tune with ‘why’. While I’m thankful for my experiences, as they have helped create who I am today, I’m hoping others find support early on when they need it most. There’s a way forward for drug legislation in New Zealand too, but we need to be brave and try something different. ■

**Angus Lindsay is a Victoria University of Wellington BA graduate now studying criminology for an honour’s degree, and he volunteers for JustSpeak’s policy team.**

# Alcohol
## and the illusion of coping

Photo by Tanaphong Toochinda on Unsplash

**Nadine Anne Hura's** personal reflection on her bitter-sweet relationship with alcohol is one many people can probably relate to. Here, she explains how alcohol slowly turned from being a source of strength and calm to a debilitating accuser. But it is also a story of great hope.

NADINE HURA

I never hit rock bottom. There wasn't any great reckoning or moment of truth – just a series of low-bottoms and near misses culminating in the urge to just be done with it.

When I look back, I can see that almost all my early drinking habits were intricately linked to or woven around the routines of parenthood. Cooking dinner, bath time, story time. It was infinitely easier to negotiate sibling spats or to read *The Enormous Crocodile* one more time with a few glasses of wine on board. Thanks to alcohol, I was patient and kind and funny and loving. In that sweet, golden moment between tipsy and drunk, I was the mother I wanted to be.

It didn't matter that sometimes I fell asleep on the beanbag before I managed to get the kids into bed or that I woke up every other morning with a splitting headache. I was a working mother raising three children. Exhaustion was normal. A drink or two in the evenings was my reward, a helping hand to transition from the stress of deadlines to the demands of domesticity. I could turn a stir fry in my high heels, reading out spelling lists as I went. With a chilled bottle of wine on the bench, everything was manageable.

In the early days, I could stop after the second glass, and I only drank a few nights of the week. I didn't notice how gradual the slide was until I found I preferred to finish the whole bottle than to leave a tiny smidgen in the bottom to stare at me accusingly the next morning.

> **"Mornings were spent reviewing everything I did or said the night before. Had I talked too much? Did I say something stupid? Why did I tell that stranger all those personal things?"**

I'd binge at the weekends, but this didn't ring any alarm bells. I'd conveniently filled my social circle with other mums who enjoyed a drink or two. We'd gravitated towards each other at kindy and school BBQs – sociable, funny and irreverent women who also happened to be mums. Our mutual appreciation for alcohol manifested in dry humour and witty one-liners that gave us permission to be our perfectly flawed selves. It was a sisterhood that kept a part of our former identities alive while simultaneously carrying each other through the trials of motherhood.

More than once, I wondered if I had a problem, but if I ever voiced these

thoughts, my mates were quick to assure me I didn't. I couldn't possibly have a problem, because they didn't have a problem.

But behind closed doors, I was struggling. It wasn't just the headaches and the nausea. It was the voice in my head getting louder and more persistent as the years passed. I had become intensely self-critical. Mornings were spent reviewing everything I did or said the night before. Had I talked too much? Did I say something stupid? Why did I tell that stranger all those personal things?

On the one hand, alcohol was a salve. It relaxed me and made me feel better about myself. Parenting decisions seemed less daunting with the calming effects of alcohol. When there was strain in my relationship or I faced family dramas, alcohol helped me process things in a way that felt briefly reassuring – as if I was coping.

At the same time, alcohol was my accuser, magnifying – in the wee hours of the morning – all the worst parts of myself. It was like having a best friend who often treated me like shit. I knew my health was suffering, too – not just emotionally, but physically. My doctor had warned me I had the blood pressure of someone twice my age.

The illusion that I was coping didn't so much shatter as lightly make itself known. I'd begun to conceal alcohol. I'd started scheduling my drinking so I started early and finished early to ensure I'd be sober to drive the kids to school in the morning.

Unable to sleep one night, I got up and went to my computer and spent hours trawling the internet. Around dawn, I stumbled upon the personal blogs of a group of American women sharing in their own words the very same struggles I was going through. As the sun came up, I lay my head on the keyboard and felt a weight come off me. I wasn't alone.

The first time I quit, I was sober for 13 months. I remember that period as wonderful and surprising and not nearly as difficult as I thought it would be. The self-critical voice had softened and even become kind and encouraging. I took up knitting. I threw myself into learning te reo. The decision to start drinking again was to satisfy a curiosity. Could I be a moderate drinker? I desperately wanted to know. I longed to live without the stigma of identifying as 'an alcoholic'.

It didn't last long. The enjoyment had all but gone out of alcohol. When I wasn't drinking, I was thinking about drinking. My brain was constantly in a state of negotiation. Could I have two glasses or three? In the end, I just got sick of it. I wanted to be doing other things with my life. I wanted to be writing or learning guitar or reading one of the books that lay for months on my beside table. I had also started to think seriously about the kinds of treasures I wanted to pass on to my children. My love of drinking wasn't one of them.

In the nearly two years I've been completely alcohol-free, I've come to see that drinking is actually a pretty solitary exercise. We tell ourselves drinking is social, but beyond a couple of glasses, it's really just about us. Often, it's about our pain as much as our pleasure. Alcohol is a way of masking and self-medicating – a way of living with the ups and downs and stresses of everyday life and with the emotional baggage that can be too difficult to bear sober.

Nowadays, when I refuse a drink, people will often press me on my reasons. The simple answer is that it's easier to have no alcohol at all than to resist the urge to have another. But really, why should anyone have to justify why they choose not to drink? It's frustrating having to explain that there isn't a label for my relationship with alcohol. I'm not an alcoholic, but alcohol isn't good for me. It's pretty simple, and there's no guilt or shame associated with that. In fact, I can laugh about it. People will say, "Don't you like a drink?" and I reply "Oh, trust me, I really do!"

Too often, the stigma of labels distorts our conversations and stop us talking about all the space that lies between 'alcoholic' and 'sober'. I think this is particularly true for women, and mothers. We're judged if we don't drink and judged if we drink too much. Humorous greeting cards and memes that normalise unhealthy drinking habits are shared on social media as if alcohol is a benign influence in life. It's always women, and often mothers. We're depicted as people who 'need' alcohol to cope.

What I know is that alcohol didn't help me cope at all. In fact, it concealed the fact that I wasn't coping. When I drank, I didn't do much else. Books I wanted to read piled up. Knitting projects gathered dust. Words I longed to write never left my head.

In the end, quitting wasn't a grand event. I didn't mark it on the calendar or tell anyone. I just emptied the last of the bottles down the sink and put them into the recycling. I was determined, in a quiet way, not to focus on what I was losing or giving up but on what I was gaining.

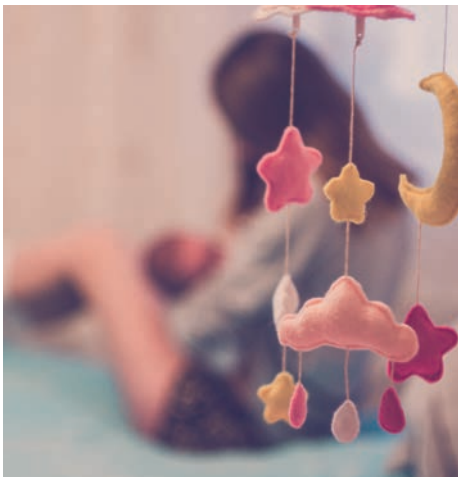


Photo credit: Nikolay osmachko flickr.com

**"Now, when I wake up, no matter what other drama or stress is going on in my life, my head is clear and my stomach is settled. I never take that for granted."**

Now, when I wake up, no matter what other drama or stress is going on in my life, my head is clear and my stomach is settled. I never take that for granted. I marvel at the freshness of every new day, the energy in my step and the sharpness of my mind. It doesn't mean my life is sorted, not by any stretch. But I've seen more sober sunrises now than I can count, and each one holds more meaning for me than any cocktail hour.

I'm not always a patient mother or as kind or funny as I would like to be, but I hear my kids and I see them. I can embrace them without guilt. I am not a perfect mother, but I am present. I am awake.

The thing is, alcohol can mask the pain, but it also masks the joy. Parenting is hard. Never will we be so vulnerable, so turned inside out or so busy. It's a beautiful thing and even more mighty sober. ■

**Nadine Anne Hura (Ngāti Hine, Ngāpuhi) has a background in journalism, education policy and kaupapa Māori research. Her essays explore themes of identity, biculturalism, politics and parenting.**

# BEING IN RELATIONSHIP

## Reimagining our addiction sector

An inquiry into the mental health and addiction sector has recently been announced, and conversations about how these services might look in the future are now urgent. Fundamental to this will be how we might meet our obligations under Te Tiriti o Waitangi and, in doing so, meet the needs of Māori communities.

KURA RUTHERFORD

**Kura Rutherford** talked with people who offer and receive help with addictions and asked them about their experiences. Woven together, these stories highlight diverse aspects of tikanga and te ao Māori and envision a future approach that will place identity, connectedness and partnership firmly at the core of the healthcare system in Aotearoa New Zealand.

## CRYING OUT LOUD – FRANCINE (NGĀPUHI)

First it was Valium, then Rohypnol, nitrazepam and pinkies. It was Wellington and the world of drag queens, Cuba Street nightclubs and getting high.

Francine was taken to another world when she discovered drugs.

"These things gave me a voice, landed me back in my skin, so I felt grown up and connected to others," she says.

And they also helped disguise feelings of disassociation that began during a hospital visit as a two-year-old.

"I remember sobbing for hours [in hospital] wanting to be held or heard but no one came … Somewhere in my child-size mind and brain, I felt completely abandoned and unlovable."

But life got hard. Really hard. After several suicide attempts, hospital stays and severed relationships, Francine was desperate for help.

A core part this came from the kaupapa Māori elements of the addiction services she found at Lifewise in Rotorua, at Higher Ground and at Narcotics Anonymous.

"Te reo, pepeha, waiata, spiritual dimensions – [they were] collective, holistic and whānau-oriented. That was the element that healed my spirit. Karakia keeps me connected to spirit and allows me to let things go and trust in the process of things. Today I have the peace of mind I've searched for my whole life."

"I started my journey towards whakapapa, and I sang again after a voiceless 10 years."

Having public figures like Rob Mokaraka being brave and speaking out about mental illness also helped. Rob advocates being vulnerable, talking, letting people in – reminding her "crying is better than dying".

"I learned I am worthy of love through the kindness of those who have stood by me. When I wanted to quit or give up, someone would share their story, and I felt understood, that I was not alone and I would make it through that day without picking up." ✖

**"I learned I am worthy of love through the kindness of those who have stood by me. When I wanted to quit or give up, someone would share their story, and I felt understood, that I was not alone and I would make it through that day without picking up."**

*Pipi Rutherford with Maioha*

Photo credit: Rosa-May Rutherford.

> **“It’s OK in hospital. It’s at home where you’ve got the problem. You go back, and you’re faced with it again. I had a grubby house, a big empty house. I had no family living nearby. I was kinda up against it.”**

## MOKO POWER – PIPI RUTHERFORD

Pipi Rutherford was a young Kiwi hippy in Paris when he first smoked cannabis-laced cigarettes. It was the least of the drugs he had been experimenting with, but the habit stuck and he kept up the combination for the next 45 years.

Back in New Zealand, Pipi, his then partner and some friends set up a hippy commune in the hills behind Opononi, Hokianga. It was isolated, tucked away from mainstream New Zealand – just what he was looking for.

Though the commune is long gone, he still lives in the board and batten house he built for his family 34 years ago. People like to visit Pipi for a cup of tea on his front step. He’s articulate and deeply switched on to politics and the state of the world.

But he doesn’t travel further than Opononi to get the paper or to the little village of Waimamaku to visit the local doctor’s clinic for check-ups – he has chronic obstructive pulmonary disease (COPD).

Two years ago, when he was out working in the garden, his lung collapsed. His trip to Whangārei hospital (a two-and-a-half hour drive) by ambulance was hell.

Pipi’s admission to hospital was a crisis point. In the shared ward of the busy Northland hospital, he quit smoking.

“You want to stop. There’s like 30 percent of you wants to stop all the time, but the 70 percent is stronger.”

But this time it was 100 percent that wanted to stop, and he did.

Pipi didn’t feel up to reaching out to health services. He couldn’t shake the feeling of being judged, and he was scared. But his family gathered around, staying in a motel nearby while he was in hospital.

“I had a new moko, Maioha. He was six months old then, and when I was in the hospital, he spent most of the time on the bed beside me. That helped a lot.”

The family drove him home and kept close during those early days of withdrawal. And every time the urge to roll a cigarette got strong, he hopped in his car and drove over the hill to take Maioha for a walk around the garden.

For Pipi, hospital visits were critical moments. Ten years earlier, he had been admitted to hospital – that was when he found out he had COPD. He tried to stop smoking then, but it was too hard.

“It’s OK in hospital. It’s at home where you’ve got the problem. You go back, and you’re faced with it again. I had a grubby house, a big empty house. I had no family living nearby. I was kinda up against it.”

He is certain that if someone – a community worker or district nurse – had knocked on his door after his first visit to hospital, it would have helped. Someone who said, “No pressure, but make us a cup of tea and let’s talk.” Someone who could have helped him work out his triggers and take those first steps to community services.

If this had happened early it’s likely he would have arrived at a positive place 10 years sooner. ✖

*Pam Kupa-Sheeran, drug and addiction clinician at Hawke's Bay District Health Board.*

Photo credit: Sarah Horn.

> **"You want to make people feel like it's possible, and you want to create hope. That's what we are trying to do – create hope that things can be different, things can be better and things can change."**

## TAKING YOUR TOOLKIT TO THE JOB – PAM KUPA-SHEERAN

*Ko Tākitimu te waka*
*Ko Ngāti Kahungunu te iwi*
*Ko Kauahehei te maunga*
*Ko Tukituki te awa*
*Ko Whatuiapiti te marae*
*Ko Whatuiapiti te hapū*

For Pam Kupa-Sheeran, it's not just what you do in your job that's important, it's also about the kete you bring with you – your toolkit of life experience.

Pam is a drug and addiction clinician at Hawke's Bay District Health Board, working with clients with moderate to severe mental health and addictions in both Waipukurau and Hastings.

For her, life experience is a vital part of being an effective counsellor. Pam's experience includes study, connections and a diverse career path.

"You've got to be good at researching what's gone on, you've got be good at engagement, you've got to be good at lots of things … connection, you've got to be good at connection," she says

"If you miss the boat on what it is [your client] connects to, you probably won't get good engagement. It's maybe talking about whakapapa – and sometimes not. You've got to be quite sensitive around that."

You can hear Pam's passion in her voice. It would be hard not to be buoyed by her optimism.

"You want to make people feel like it's possible, and you want to create hope. That's what we are trying to do – create hope that things can be different, things can be better and things can change."

Part of working holistically, Pam believes, is calling in resources and networks.

"I really think that, as a collective, you get better results, and I mean networking, and I mean family and whoever it is you need in that package of care.

"You're kind of looking for people [your client] might connect with. It might be an opportunity to bring in whānau. It can be a powerful tool having the family there. It is often also about finding links within the wider community.

"If you don't have networks, you are not doing your clients a service. It's balancing out all your links and networks and wrapping around a model of care that is quite holistic."

These networks might include group services, home care, financial care, housing, work and training.

When bringing families of clients into the therapeutic process, Pam's focus is not just on support but also on education.

"Where I find we have the most success is when the family is educated as well … We're not around for ever and a day, but whānau are. They need to know the support networks and what to look out for if their loved one needs more help. So, if you educate someone they can carry that on."

Pam believes more addiction education is sorely needed.

"I don't think addiction is really understood by a lot of people … We need to talk to people generally about addiction. It needs to happen more, because it's so much part of our lives now."

And if that education was able to be extended out into education packages in schools, Pam believes we would be seeing massive changes.

"If I had a magic wand, I would ask every school to educate our children about addiction and emotional regulation. Honestly, I don't mean to sound simplistic, but I do kind of think it's as basic as that." ✖

> **“One of the big effects of addiction – be it alcohol, whatever – is the lowering of your self-esteem and feeling that you are worthless in the eyes of the people you care about … and actually ending up doing the wrong things by them. Addiction is very powerful, it sort of defies self-preservation.”**

*Steve Hughes*


Photo credit: Kura Rutherford

## BEING IN RELATIONSHIP – STEVE HUGHES

Relationships are a critical part of every dimension of Steve Hughes’s work – the relationship between him and his clients, the relationship between his clients with each other and their families, the crucial professional collaboration needed to provide effective client care and also the relationship society has with addiction.

Steve has been an addiction counsellor for the last 10 years at Hawke’s Bay District Health Board. He works out of the modern, bustling premises of Napier Health, doing specialised opioid substitution treatment (OST) work under the broader umbrella of the mental health team. He’s the kind of person you would want on your side in a crisis. He’s approachable, solid, not fazed by much.

The first meeting Steve has with his clients is defining.

“Quite often when someone does present, that’s the window – the moment – when there’s been a coalescing of factors that has led them to come through the door. My ultimate aim is that they come back again. They kinda have a window of time for us to meet them, to get them engaged.”

Catching people in time, Steve believes, should be a key consideration in future planning in the mental health and addiction sector.

“The more someone has to wait, the more that can go wrong. People become entrenched in behaviour that makes it hard to come through the door again. It’s about hope, and waiting for too long diminishes hope.”

And easy access to good resources is also essential.

“When we are supporting someone’s identity ... whatever it takes, we will consider it. [At Hawke’s Bay District Health Board], we have access to really good kaupapa Māori resources, team members who know what we do [in opioid substitution]. We can call on them, and they will support directly with clients, with the whānau of the client, with Māori medicine, working alongside us.”

Steve believes taking time to foster family relationships is something that adds significantly to the success of the OST programme. But it’s not always an easy road.

“Family can be a very fraught thing. One of the big effects of addiction – be it alcohol, whatever – is the lowering of your self-esteem and feeling that you are worthless in the eyes of the people you care about … and actually ending up doing the wrong things by them. Addiction is very powerful, it sort of defies self-preservation.”

But family can sometimes be the thing that makes all the difference.

“Sometimes it’s the critical factor that gets them onto a programme – that support from family or wanting to do well by their kids. We are social creatures, aren’t we?”

Outside of the ‘traditional’ family unit, Steve sees another really strong tight-knit community who support the treatment process – the community that has formed around their addiction. Many of his clients have long allegiances. These relationships can be complex and at times unproductive, but there are often also whānau principles at work.

“They do help each other out – getting on the programme, getting to the pharmacy, getting jobs. There’s some empathy there. They are part of something ... and they know what it is to be hanging out.”

Community support coming from other quarters, especially in response to the rising levels of methamphetamine use, is something Steve would like to see more of.

“A lot of what has actually happened is self-help as a response to an epidemic – parents, grandmothers, people who see what’s going on – trying to address it. We need to give support to those who are stepping up, who are under-resourced. It needs proactive things, and working with young people, [providing] information.”

Steve sees a lot of complexities in his work – things like poly-drug use, high rates of hepatitis C and unmet dental needs (a biggie that he would love to see addressed

> **“A te ao Māori point of view of mental health for working with people who are hearing voices is saying, ‘This is what’s happening with you, we recognise that, it’s actually a gift and this is how you can manage it.’”**

with funding). But the biggest obstacle he sees is all about relationships – society’s relationship to drug use.

“The whole public perception thing gets in the way. Quite a lot of people want to get back into employment or studies. Some of them have criminal records, which makes it hard. Being on methadone, there is a stigma attached.” ✖

## WHEN THE LIGHTS GO ON – TIPENE PICKETT

*Nga ngaru a te Huki te maunga*
*Waihua te awa*
*Kahungunu te iwi*
*Kurahikakawa te hapū*
*Waihua te marae*

Tipene Pickett brings two world views to the work he does – the clinical skills he is trained in and a knowledge of tikanga that informs his work. Like many in the sector, he juggles multiple roles. He is a trainer, group facilitator and a clinician at Waitemata Health’s Whitiki Maurea, Te Atea Marino alcohol and drug services and MOKO mental health services.

From his kete, Tipene draws on motivational interviewing – the practice of “helping people talk themselves into change” – alongside wisdoms gleaned from Māori wellness models, such as Pōwhiri Poutama, Te Whare Tapa Whā, the Rangi Matrix and the Pūtangitangi model.

When meeting clients, Tipene has “an overarching process that guides the whole thing”, and it is proving to be a successful approach.

He starts with a cup of tea, a karakia and a mihimihi to acknowledge their mana and tapu, their inherent right to be here, the influence they have in their world. Then he acknowledges any goals they’ve had, what’s brought them in the door.

“I always acknowledge their journey. There’s an affirmation that goes on, it’s a process of affirmation.”

And next is whanaungatanga.

“I would introduce me and give them a sense of me, so they have an idea of the container they are going to place their trust into.”

And woven into all that would be an exploration of whakapapa and tikanga, and if the client wants, the whole process can all be conducted in te reo Māori.

“You just see the lights go on, see them having their awakening moments and the motivation for change just … moves from maybe a sense of feeling pressured from the outside, from feeling like their partner or other services are pressuring them to change, to moving to an internal state of motivation where they feel thirsty for more … change just tends to follow on from that. They feel much more connected to themselves culturally with that knowledge … boom, you’re away.”

Tipene is seeing amazing results for Māori and non-Māori alike, so it’s no big surprise that, when asked what a future service might look like, his answers were not about process. Rather, they point to ways we need to think about recentring our services.

“Rather than being asked at the point of entry by someone who is not Māori would they like a cultural service, [I would like to see Māori clients] automatically go to the cultural service … that would change the outcomes.”

Tipene would also like to see services being located alongside other services, such as education.

“There is real value in considering co-location of resources – Māori services literally on site within education services so that pathway becomes a whole lot easier.”

But there are two crucial things that affect all the communities Tipene serves – poverty and the traumatisation of colonisation that goes unrecognised.

”When people have had childhood trauma, what’s often forgotten is that it’s an experience they’re born into, so they are doubly traumatised and poverty is the result. That’s the biggest, biggest block I come up against.

“Lack of cultural connection, lack of finances at times, disconnection from cultural identity and how that manifests – it manifests in all the behaviours that Māori are well over-represented in.” ✖

> **“You just see the lights go on, see them having their awakening moments and the motivation for change just … moves from maybe a sense of feeling pressured from the outside ... They feel much more connected to themselves culturally with that knowledge … boom, you’re away.”**

*Simon Waigth*

Photo credit: Peter Meecham.

## ALL IN THIS TOGETHER – SIMON WAIGTH

*Ko Matawhaura te maunga*
*Ko Rotoehu te roto*
*Ko Waitaha me Ohau ngā awa*
*Ko Ngāti Makino me Ngāti Pikiao ngā iwi*
*Ko Te Arawa te waka*

The day Simon Waigth handed in his doctorate thesis was a celebration for him and his whānau. But even if people working in addiction weren’t entirely aware of it, it was also a significant day for the sector.

Simon’s research, *Mā te Whānau, ka Ora ai te Tangata: Māori Experiences in Recovery from Addiction,* completed through the University of Auckland, is the first PhD research to focus on the recovery process in Māori addiction services.

The research followed a group of clients who had been part of the whānau group at the Higher Ground treatment centre in Auckland and were reintegrating into the community.

One of the most wide-ranging and evident findings from Simon’s research was the importance of helping Māori work through any identity issues they had in treatment and post-treatment.

“It was extremely validating for a lot of people to be able to address their Māori identity. The number of ways they were able to do that was huge, there were just so many unique experiences of that. [Within the research], there was a common experience of being distanced in some way from their Māori identity,” Simon says.

Within the Higher Ground treatment process itself, he saw participants reconnecting to their whakapapa, learning more about te ao Māori, tikanga, kaupapa, developing routines, benefiting from tuakana/teina relationships, all in the safety of a whānau group environment.

What happened out in the community afterwards was significant.

“The way the facilitators of the whānau group intentionally help the whaiora [clients] carry over into the community, the things they had learned from treatment – it’s pretty unique to them and what they do, but they put a lot of effort into maintaining the whānau group more broadly in their own time. They’ve set up their house as a sort of half-way home between treatment and full independence.

“The facilitators organised activities like hāngī fundraisers, parents’ nights, parenting advice sessions and music nights. It was really an organic process, quite natural for Māori, but it was so pronounced … that level of ongoing connection would be hard to come by.

“I am hearing a lot more people talking about community reintegration, and this is what that is, but in a Māori context – Māori principles and tikanga. These people didn’t have the funding, they didn’t have any extra resourcing to do this. It’s just something they did because they believed in it … and it really helped in the recovery process.”

Simon believes what is needed in planning for future addiction programmes is funding for the recovery aspect of treatment.

“It seems to be such a gap. It’s understandable there’s a gap, it’s expensive … [but] funding is a consequence of priority.”

He also believes an ideal model would include significant resourcing to support community participation in after-care initiatives.

“It needs to be more than just previous addicts participating in the reintegration. It needs to be people from all walks of life.”

The hidden benefit to this would be an opportunity to disrupt the stigma and prejudice surrounding addiction.

Simon references the work of Peter Adams – a University of Auckland professor who also works for the Kina Foundation – who saw successful groups being run in Italy.

“There were community groups, a lot like AA support groups but more, because they included people from the community who hadn’t been through addiction issues helping people with addiction issues.”

And part of that picture is to have more research, like Simon's, that focuses on the addiction field.

"We don't have any research in New Zealand showing the outcomes of treatment. There's a complete absence of it. We need a huge focus on evidence-based practice for an Aotearoa New Zealand population that absolutely includes Māori models of working with Māori and non-Māori." ✖

## FINDING THE WAY FORWARD – BOYD BROUGHTON

*Ko Ngātokimatawhaorua te waka*
*Ko Ramaroa te maunga*
*Ko Whirinaki te awa, te whenua tapu hoki*
*Ko Te Hikutū te hapū*
*Ko Mātai Ara Nui te marae*

As programme manager for Action on Smoking and Health, Boyd Broughton is no stranger to thinking about societal perceptions of addiction, the shifts that stem from policies and health initiatives and how these impact a population.

In his work, he has come to see the need for a fundamental shift in the way we perceive addiction.

"We need to move away from the idea that people are broken and focus on the individual, with all their trauma and all the gifts they have. A te ao Māori point of view of mental health for working with people who are hearing voices is saying, 'This is what's happening with you, we recognise that, it's actually a gift and this is how you can manage it.'"

"Tohunga were renowned for eating different leaves to put them in a state so they could come to a place to be able to manage their voices. Hearing voices for some people was considered normal – there wasn't negative stigma.

"When you apply that to addiction services, people who take drugs because they're feeling stress and feeling sad, [it's about saying] 'Sadness is normal, feeling unhappy is normal, and this is how we can manage it,' so you can operate in all the other spheres of life. That is the key conversation that needs to happen."

In relation to smoking tobacco, "While there have been some gains, there's a stigma about smoking tobacco that we really didn't want to happen. We have sidelined a whole lot of people. We wanted to make smoking not cool, but we've also made the person smoking it feel not cool."

However, Boyd points to some positive shifts that have occurred in the way communities interact with alcohol and drugs, and he puts these changes down to a concerted effort a decade ago "where the focus was on sharing information about the use of drugs, the harms and pros and cons. That's been as a result of some really good information and a change in the workforce not to condemn the person."

That initiative, Boyd believes, has led to changes in behaviour and attitude – people smoking outside away from children, not smoking in the car, not drinking on the sidelines of sports games.

"All that sort of behaviour, while it hasn't been legislated, there's been massive change. It's happening among whānau, among community groups, sports groups, sports teams … I've had beer bottles thrown when I was playing – that doesn't happen any more.

"Whānau are openly talking about – without condemning – the use of marijuana. The conversation isn't about 'You're naughty for smoking dope.' The conversation is that their brain is still developing … and adding marijuana to the mix can stunt that growth."

Both policy and health initiatives clearly have a massive part to play in all realms of society. So, what is the path forward in policy development for the addiction sector?

"First of all, there needs to be a plan for all those different areas – for mental health, tobacco control, addiction, suicide – all those services our people need help with. It needs to have realistic timeframes, and the main thing is that the government needs to be accountable in terms of timing, realistic targets and evidence-based strategies."

And within that planning, there needs to be room to hear the people who, up until now, haven't had a voice.

"[Some lesser-recognised] services do have the researchers. They say, 'This is the evidence, and this is what needs to happen based on the evidence to get good inroads,' but they don't get as listened to because they either don't have the right voice, don't have the right language or just don't look right."

To Boyd's mind, these discussions will need to place the individual and their complex group of needs, not the addiction, at the forefront. The discussions will need to consider where and how services are provided to best meet the needs of communities – things like working outside 9am–5pm hours and visiting people in their own homes are just some of the ideas he has – and they will need to place more trust in the people doing the work on the ground.

> **"It needs to be more than just previous addicts participating in the reintegration. It needs to be people from all walks of life."**

But essentially, the planning needs to be about taking action.

"There are always going to be disagreements on paths forward. The focus needs to be on what is agreed … then we'll have to have intelligent discussion, research and evidence on what we don't agree on to come to a sensible conclusion." ✖

## DREAMING BIG

All these conversations identify different facets of a wide-ranging topic, but when seen as a whole, they remind us that many of the answers are already evident, deep within our communities, within tikanga practices and models of health and within te ao Māori.

It is a critical time to listen to those doing the groundwork, to resource the initiatives that are already successful, to analyse the dynamics that underpin our services and to reimagine a healthcare system that firmly puts identity, relationships, community and Te Tiriti o Waitangi at the centre. This is time to reflect, plan and dream big. ■

**Kura Rutherford is a Hawke's Bay-based health and educator editor. She is of Scottish, English and Māori descent (Ngāpuhi, Te Rarawa).**

# What can we learn from the psychedelic renaissance?

Research into the therapeutic use of psychedelics, stymied by War on Drugs thinking in the 60s, is enjoying a significant comeback, thanks to recent studies about their efficacy for treating addiction and mental illness. But how might these drugs be used in a real-world situation, and what are the implications for recreational users? **Max Daly** reports.

MAX DALY

*After being suppressed for decades, research into psychedelics is making a comeback.*


In 1967, after the release of the Beatles' album *Sgt Pepper's Lonely Hearts Club Band*, Paul McCartney became the first British pop star to admit taking LSD.

"It opened my eyes," he told fashion magazine Queen at the time.

"We only use one-tenth of our brain. Just think of what we could accomplish if we could only tap that hidden part. It would mean a whole new world, if the politicians would take LSD, there wouldn't be any more war or poverty or famine."

The rest is history, because McCartney's hippy dream was swiftly suffocated. Amid rising 1960s recreational drug use, the authorities got paranoid and clamped down on the blossoming world of psychedelic science and culture. A huge body of promising research into the medical uses of these drugs was mothballed, and the drugs were reconfigured as an undesirable social poison or, in President Lyndon B Johnson's words in his 1968 State of the Union address, "a threat to our nation's health, vitality and self-respect". Psychedelics became just another banned high alongside cannabis, cocaine and heroin.

Yet now, after decades of being forsaken by the authorities, psychedelic drugs find themselves ushered in from the cold as potential saviours in the battle to address spiralling global depression and entrenched addiction.

For many scientists and drug researchers, the core idea that psychedelics may be clinically useful is not new. Research into the use of LSD in treating mental illnesses and alcoholism dates back to around 1950, 12 years after Swiss scientist Albert Hofmann first synthesised the drug.

A huge number of studies of varying degrees of quality and ethics were conducted, so much so that, by 1958, scientists were writing literature reviews on the existing research into LSD for psychotherapy treatments. Many of the trials showed promise – an early convert was Bill Wilson, the co-founder of Alcoholics Anonymous – although some of the them were questionable. LSD was tested on children as a cure for autism and given to soldiers as part of mind control experiments conducted by the British secret intelligence service MI6.

Despite some of the more extreme research carried out and allegations of pro-LSD bias levelled against some clinicians, the research was nevertheless ground-breaking. By the mid-1960s, more than 40,000 patients had been

**"... in the 1960s and 1970s, psychedelic drugs were not just about white coats – they were about having a good time."**

*The use of ecstasy to combat post-traumatic stress disorder is gaining momentum.*


**"Psilocybin, the active ingredient in illegal magic mushrooms, is showing promise for the treatment of depression, addiction to nicotine and alcohol and in reducing anxiety in people with cancer."**

administered LSD as part of their psychiatric treatment, and psychedelic research had produced more than 1,000 scientific papers.

Of course, in the 1960s and 1970s, psychedelic drugs were not just about white coats – they were about having a good time. When the recreational use of LSD and magic mushrooms began to grow in the US and in Europe – and these drugs became synonymous with rebellion and counter culture – the authorities banned them and shut the gates on scientific research. By the end of the 1960s, studies were severely curtailed, although on the other side of the Iron Curtain in the Soviet-controlled Czechoslovak Socialist Republic, research at five centres for psychedelic research continued until the mid-70s.

Fast forward to 2018, and the ability of psychedelic drugs to treat depression, addiction and trauma is again being measured along with their effects on the human brain, but this time under modern scientific conditions. As a scientific area of investigation, psychedelics are snowballing.

Ecstasy, the banned psychedelic stimulant used as a therapy tool in the late 1970s before sparking a revolution in dance and club culture a decade later, could become a legal medicine for the treatment of post-traumatic stress disorder (PTSD) by 2021. Psilocybin, the active ingredient in illegal magic mushrooms, is showing promise for the treatment of depression, addiction to nicotine and alcohol and in reducing anxiety in people with cancer.

Meanwhile, ketamine, the hallucinogenic anaesthetic that gives users the power to become – according to 1970s K-hole explorer John C Lilly – "peeping toms at the keyhole of eternity", is being trialled as a treatment for heavy drinking and as a rapid-acting alternative to pills such as Prozac for treating depression. There has also been research into the use of ayahuasca, a hallucinogenic brew containing DMT used by indigenous people in Amazonia, for depression.

In many of the studies, psychedelics are proving effective in situations where conventional treatments have failed. It is likely this is because of their ability to 'unlock' the human mind. Scientists have shown that taking psychedelic drugs can reroute the way the brain talks to itself by bypassing its default mode network. Taking psychedelic drugs can temporarily switch the brain off autopilot by connecting parts that do not usually communicate with each other, enabling people to overcome entrenched perceptions and to see things from a fresh perspective.

"What we see under psilocybin and other psychedelics is an ability to step back, like an astronaut who goes up into space," explains Dr Robin Carhart-Harris, Head of Psychedelic Research at Imperial College London, in a promotional video for Compass Pathways, a British start-up that is preparing an extensive trial for treating 400 patients who have treatment-resistant depression with psilocybin.

"All of a sudden, you can see the whole of the Earth. It allows the mind and the brain to operate in a more expansive way."

Psychedelics are not being used as a magic bullet but as an adjunct to other treatment, such as talking therapy. For example, psilocybin is not stopping smoking in some patients through a biological reaction as other medicines that directly affect nicotine receptors might do. Instead, the drug is being shown to work by shifting patients into periods of deep reflection, then engendering change.

Clinical studies have found LSD can enhance music because of its effects on the brain, and this works both ways – music can influence the way people trip. Magic mushrooms have been found to produce "sustained changes in outlook and even political perspective", for example, an increased "nature-relatedness and decreased authoritarianism". Moreover, research is showing that hallucinogens are way less likely to cause long-term mental

*Harry Sumnall*


Photo credit: Addaction UK (addaction.org.uk).

damage – and far less than other drugs – than the fear-mongering has suggested.

So what has prompted this renaissance? Brad Burge is Director of Communications at California-based Multidisciplinary Association for Psychedelic Studies (MAPS), founded by Rick Doblin in 1986. Alongside the Heffter Research Institute in Zurich and the UK-based psychedelic research funding group the Beckley Foundation, MAPS has driven what Burge describes as an "unprecedented" rise in psychedelic research in the last 15 years.

"It is the work of a widespread, international network of scientists, doctors, therapists and patients who want to see better treatments developed for a variety of mental illnesses."

This has occurred, Burge says, within the context of "declining public confidence in currently available pharmaceutical treatments for PTSD, anxiety, addiction and other mental illnesses" as well as the "failed War on Drugs, which uniformly categorises all psychedelics as drugs of abuse despite scientific evidence to the contrary".

As with the burgeoning legal cannabis industry in America, money men are becoming increasingly attracted to the idea of investing in the potential of psychoactive substances to improve people's health. Compass Pathways has seed funding from a host of high-profile investors including PayPal founder Peter Thiel for its psilocybin trials. If MAPS is able to conduct its crucial but highly expensive phase three trials of MDMA-assisted psychotherapy for PTSD, it will be down to funding from an anonymous bitcoin millionaire.

**"It is the work of a widespread, international network of scientists, doctors, therapists and patients who want to see better treatments developed for a variety of mental illnesses."**

It is clear there has been a rebirth in research alongside a fresh willingness by financiers to fund it, but what of psychedelia and the cultural landscape of these drugs? Is this changing too, or is this renaissance all about labs and money?

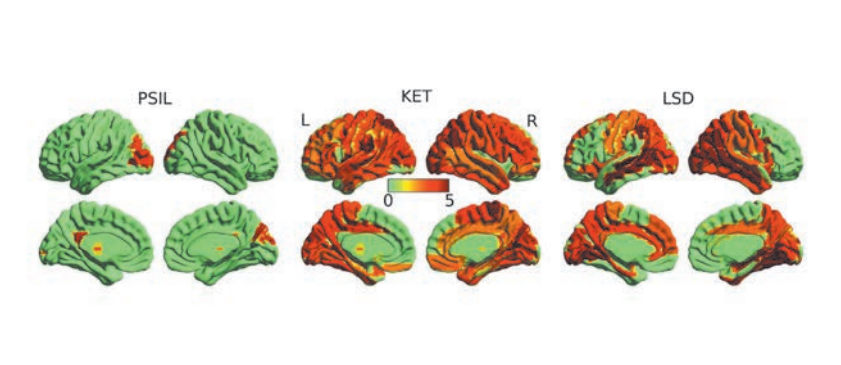
The apparently counter-intuitive story about how 'mind-bending' drugs can improve our mental health has become a staple for the mainstream media. They love it. Scare stories about children's tattoos impregnated with LSD are being replaced by a steady stream of positive articles about the psychological benefits of LSD, ecstasy and magic mushrooms. This is not to say ignorance and stigma has vanished – far from it – but this coverage has improved the image of psychedelics.

"These days, I increasingly smile at how mainstream psychedelic-assisted psychotherapy is becoming," wrote Doblin in the latest MAPS bulletin.

"It's profoundly satisfying to see this occurring, about half a century after the backlash to the psychedelic 1960s."

Prompted by media coverage, the public seems to be warming to the idea

# Local research unlocking new treatment potentials




In 2016, a kiwi scientist was part of an international research team that released the results of a study into the possible therapeutic benefits of LSD.

At the time the research was carried out, Dr Suresh Muthukumaraswamy was working at Cardiff University's Brain Research Imaging Centre. The research team got approval to carry out trials on 20 healthy volunteers who had used psychedelic drugs before.

These trials revealed that activity in certain areas of the brain, which are overactive in depression and potentially in addiction, can be altered to create different patterns of communication. This was a breakthrough in the possible therapeutic use of psychedelics.

"The results were very promising," says Dr Muthukumaraswamy. "But there's a lot still to be done."

Dr Muthukumaraswamy returned to NZ on a Rutherford Discovery Fellowship to continue his studies closer to home and family. However, so far it's proved impossible to secure any funding for local trials of LSD. He says the technique they used, called magnetoencephalography, is very expensive and there are no MEG scanners in New Zealand.

The illicit status of most psychedelics also makes funding difficult to obtain.

These days, Dr Muthukumaraswamy is a senior lecturer and researcher in the Faculty of Medical and Health Sciences at Auckland University. He and his team use brain-scanning techniques to measure both blood flow and electrical activity. The research involves testing how a range of drugs, particularly ketamine, can alter brain activity in both healthy individuals and patient groups.

In 2015, they discovered that fast-acting ketamine (once popular in the clubbing scene, and known colloquially as "Special K") can be used to treat depression. This research is ongoing; however, the therapeutic potential of ketamine is limited because the effects, while fast acting, are also short-lived.

He says clinical trials of drugs are vital. "For a long time, in psychiatry, what we've done is to give a patient drugs, close our eyes and hope it works. And to some extent it has… but not with a good understanding of why and how it works."

Dr Muthukumaraswamy hopes that with a bit more insight, they can develop new drugs which may be faster acting than conventional antidepressants, but more long-lasting than ketamine.

of psychedelics as medicines. Last year, a survey by YouGov found nearly two-thirds of American adults said they would be willing to try MDMA, ketamine or psilocybin if it was proven safe to treat a condition they have. Last year's Psychedelic Science 2017 conference in California attracted 3,000 attendees.

But the rise in scientific, professional and intellectual interest in psychedelics is not reflected in any softening of the law or rise in the recreational use of these drugs. In Britain, while the minor psychedelic ecstasy remains a prevalent drug and ketamine has been added to the menu, the use of LSD and magic mushrooms by both young people and adults has fallen by around two-thirds over the last 20 years. The picture in America is the same.

Compared to most recreational drugs, the use of LSD and magic mushrooms has always been a niche pursuit, largely limited to subcultures and intellectuals, from the hippies and punks of past generations to today's dark web psychonauts and 21st century new agers. Even during the 1960s, 1970s and 1980s – seen as being the golden age of acid – the drug was only ever popular with a very small proportion of the population.

However, there are signs psychedelic users are becoming more diverse. Micro-dosing of LSD, most notably in Silicon Valley, has been on the rise – a trend that Rosalind Stone, an expert in psychedelics and a director at the harm reduction group Drugs and Me, says "fits very neatly into the changing social perception" of psychedelics.

"People have always taken psychedelics, and they did not stop when the research stopped, but their use goes way beyond the hippy stereotype."

She points out that the #psychedelicsbecause social activism campaign shows people from all age groups and professions using these drugs for a wide array of therapeutic, recreational and medicinal purposes.

Despite all the publicity and interest, the number of dedicated LSD and magic mushroom users is unlikely to rise, says Rob Dickins from the Psychedelic Press.

"Most people never try them. Even if they do find them fascinating, most will take drugs like LSD only a few times. For me, 'psychedelic culture' is just a bunch of wyrd enthusiasts. It's very unlikely, therefore, we'll see a sudden and major spark in numbers taking them regularly. The nature of the experiences they elicit precludes this."

**“It’s refreshing that, in 2018, you are as likely to read about psychedelics in a clinical trial as you are a criminal one.”**

There is a feeling among some psychedelic drug users that the widening distinction between mainstream scientific research and broader cultural use of psychedelics is somehow leaving them behind, while their own use remains a criminal and stigmatised act.

For example, ayahuasca, which has for centuries been used in spiritual ceremonies by indigenous tribes of the Amazon basin, is showing promise in treating depression. However, due to the rise in interest from Western tourists in the drug, indigenous people have seen a steep rise in the cost of the brew and are increasingly likely to be prosecuted over the drug. Constanza Sanchez of the International Center for Ethnobotanical Education, Research & Service says communities in Colombian Amazonia see the appropriation of ayahuasca as being indicative of wider and more pressing threats to their way of life, such as armed conflict and mining companies taking over their land.

Even though scientists are trying to find a way of developing new pills that have the medicinal properties of psychedelics minus the trippy effects, research has shown that the emotional, spiritual side of taking psychedelics is a crucial part of their effectiveness. Severing the mystical side of psychedelics from the science, whether in the lab or in wider society, may prove difficult.

The use of psychedelic drugs for medicinal purposes may be fast approaching. But where will that leave those people who are using the exact same drugs for recreational use? Amanda Feilding is currently working on a report looking into how to regulate psychedelic drugs. One of the options she identifies is based on the cannabis club model, allowing the creation of non-profit collectives that produce and supply psychedelic substances to their members for consumption on site. Yet she can’t envisage any form of regulation any time soon.

It’s refreshing that, in 2018, you are as likely to read about psychedelics in a clinical trial as you are a criminal one. Ultimately, the psychedelic renaissance is a welcome, long-overdue re-examination of how these drugs can be used for the good of mankind. But their utility must be grounded not just in scientific trials but real-world practicality.

“We have countless examples of interventions and therapies that showed great promise in efficacy trials but that failed to deliver in larger trials, or it simply wasn’t feasible to deliver the intervention to scale,” says Harry Sumnall, Professor in Substance Use at the Public Health Institute, John Moores University, Liverpool.

“Outside private practice, for example, we struggle with the funding and delivery of even basic psychosocial therapies for mental health disorders. We need to start thinking about the next steps for utilisation of these therapeutic approaches in universal healthcare systems to see if they’re cost-effective, if they’re acceptable to patients and healthcare professionals or indeed if there is even a role for them in routine healthcare.

“Whether administration of a psychedelic drug can reduce the intake of another drug is largely irrelevant if we haven’t also developed strategies to reduce social and structural stigma, help overcome social isolation or ensure people can get access to decent jobs and homes.”

The people for whom psychedelic drugs will prove most useful – those suffering depression, addiction and trauma – are also society’s most excluded. The focus has to be on how these substances can effectively be used to change the lives of the socially excluded rather than being a bespoke treatment for a select few. ■

**Max Daly is a freelance journalist and author living in London. He was shortlisted for Specialist Journalist of the Year at the 2017 British Journalism Awards.**

## QUOTES OF SUBSTANCE

**“If we care about the harms of drugs to the point where people are dying then you’ve got to do something about alcohol.”**

Eminent Professor of Neuropsychopharmacology **DAVID NUTT** is not letting up on his appeal to the multicriteria decision analysis that got him fired.

**“The war on drugs had devastating impacts on people, especially people of color and their families. People’s lives were ruined for misdemeanor marijuana offenses. This action is a necessary first step in righting the wrongs of the past.”**

**SEATTLE MUNICIPAL COURTS** are being asked to vacate convictions and dismiss charges for misdemeanour cannabis offences by Mayor Jenny Durkan and City Attorney Pete Holmes.

# Keeping safer under summer skies


Come festival season, everybody wants to have a good time and experience the breadth of human experience. This can be risky, but it's why volunteers from KnowYourStuffNZ freely dispense credible information and a dose of science at festivals around New Zealand. The Drug Foundation has been helping out and sent photographer **Josiah Pasikale** along to capture what happened at the harm reduction tent over one 2018 summer festival weekend.

1

## Easy to find but discreet.

When New Zealanders gather at various festivals to enjoy music, dance, sun, nature and each other's company, some will choose to use drugs.

For most, this will be a positive experience, but due to the nature of the black market, it can be a gamble. People have to trust their cousin's friend of a friend that they have 'the good stuff'.

Because the current law does not offer legal protection to event organisers who host harm reduction services offering drug safety checking, the existence of the service isn't shouted loudly.

However it doesn't take long for people to find the service. Word of mouth soon gets around that there's a tent where there is some state-of-the-art testing technology providing a service people have been wanting for years.

The testing and advice is free and confidential. As with any harm reduction approach, the aim is to provide reliable information so that people can make more-informed decisions. No tut-tutting here.

**NO TUT-TUTTING HERE.**

THE TESTING AND ADVICE IS FREE AND CONFIDENTIAL.

## 2

### Two steps.

Testing of substances is a two-part process. Once the client prepares a small amount of their sample to be tested, an initial screen is done using reagents, then a full screen using an infrared spectrometer. Each has its place, and festival goers get to watch the whole process.

Only the most significant components in a substance can be identified – keeping a look out for anything nasty or unexpected. The testing can't indicate purity or potency. Any unwanted substances can be destroyed.

ANY UNWANTED SUBSTANCES CAN BE DESTROYED.

## 3

### Getting the results.

While the substance is being checked, the KnowYourStuffNZ team will provide advice around what substance someone has, what to look out for and how to be safer if someone decides to use it. The whole process takes around 15 minutes.

THE WHOLE PROCESS TAKES AROUND 15 MINUTES.

## 4

### For the record.

A log is kept of substances that are tested. Information of this kind is rare and has many uses: tracking trends, identifying new substances and the basis for issuing warnings if there are dangerous substances circulating.

When people receive the results of their sample, they're asked if they still intend to take the drug. This is the only personal piece of information that is collected to show the impact of the service and how it changes behaviour. When the drug is not what people were expecting, more than half say they don't intend to use it. For those who do still plan to use it, many say they are more informed and often comment on being more careful with the new information they have.

The data is aggregated at the end of the season and made publicly available.

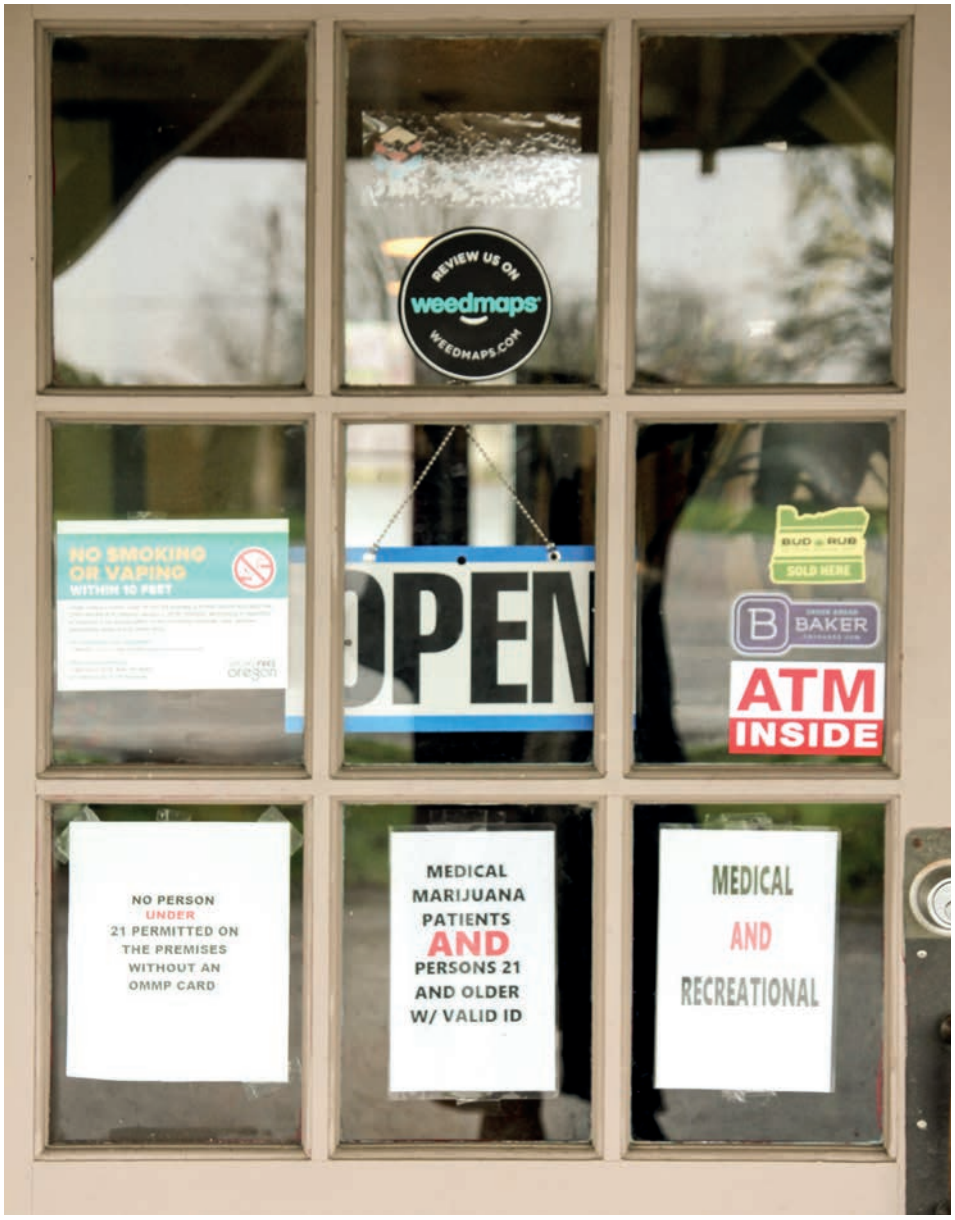
WHEN THE DRUG IS NOT WHAT PEOPLE WERE EXPECTING, MORE THAN HALF SAY THEY DON'T INTEND TO USE IT.

**Testing is currently not funded due to the legal grey area it inhabits. A change to the Misuse of Drugs Act would enable this service to be available at many more festivals and other nightlife events.**

**RESOURCE:** knowyourstuff.nz

# Are you old enough?

## The legal cannabis purchase age explored




If recreational cannabis becomes legal in New Zealand, one thorny problem we'll need to deal with is the legal purchasing age. How do we settle on an age that will reduce harm for the most young people and what are other countries doing? **Rob Zorn** explores a few of the issues and makes a tentative case for 18.

ROB ZORN

At or by the time of the next election, New Zealanders will vote on whether to legalise cannabis for recreational use. If we do legalise (or if we start by decriminalising), we'll be joining a good number of other developed countries. So far, at least 23 jurisdictions have adopted some form of legalisation or decriminalisation. The last was Vermont. The next will probably be Canada.

Legalisation or decriminalisation in a progressive country like New Zealand almost looks inevitable – if not as a result of this referendum then soon. Governments and Ministers appear to be catching on that prohibition and the War on Drugs have failed and that the sky hasn't fallen where cannabis laws have been relaxed.

The fact is, most New Zealanders now seem to accept that prohibition has not only failed to stop cannabis use but has also fared poorly at protecting both individuals and communities from the harms cannabis can cause. An August 2017 Drug Foundation poll revealed 65 percent of us favour either legalisation or decriminalisation.

If we took the legalisation route, moving from a prohibitionist model to a regulated market would not be without its challenges, and one issue we would need to tackle is the legal purchase age. Just when is a person old enough to responsibly decide to buy and use a psychoactive substance?

**What about 18?**

In *Whakawātea te Huarahi – A model drug law to 2020 and beyond*, the Drug Foundation proposes a legal purchase age of 18. Its reasoning is that 18–25-year olds are already the largest cannabis-consuming group in New Zealand. According to the last New Zealand Health Survey (2012/13), 24 percent of young people aged 15–24 used cannabis in the last year, and 7 percent used it at least weekly. It would be far preferable that these young people use the drug in a legal, controlled and harm reductionist environment.

It's a significant part of the Drug Foundation's proposed model that all cannabis sales are accompanied by evidence-based harm reduction messages. For young people, this could include information about the damage cannabis does to developing adolescent brains, the potential for addiction and where to go for help when use becomes problematic. Controls on potency could also mean that young people who purchase cannabis legally would have reduced risk of harming their brains or mental health.

Another compelling argument for setting the legal purchase age as low as 18 is the impact it should have on the black market cannabis industry – often controlled by gangs. People who buy black market cannabis are participating in an illegal activity where there are no controls over potency and contaminants and, probably, little regard for customer health and wellbeing. A lot of harms can result from all these things, not least of which is the access that purchasers may gain to more dangerous drugs through contact with dealers.

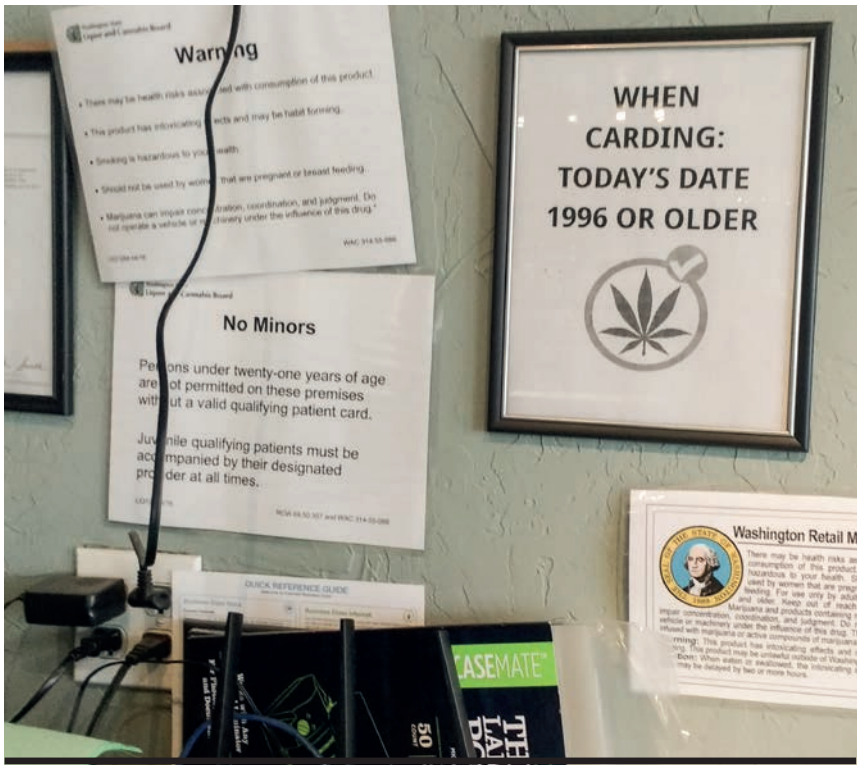
We can be fairly certain that many young people, whatever age we set, will continue to use the black market if they can't purchase cannabis legally. So, the argument goes, the higher we set the purchase age, the more potential customers we leave in the hands of gangs and outlaws. The lower we set it, the more 'adults' will turn to legitimate and legal sources. With a diminished market and reduced profitability, there is less incentive, and the hope is black marketeers will close their nefarious businesses and go out and get real jobs.

Lastly, there's the human rights issue. At 18, you can go to war, vote in elections and, importantly, purchase alcohol. It doesn't seem right then that cannabis – on the face of it a less-harmful drug than alcohol – remains off limits. And 18 does seem to be the default age of majority in New Zealand. Legally, it's actually 20, but the only things a person under 20 can't lawfully do are enter a casino or drive with any alcohol in their system.

But is 18 really a sensible choice from a health perspective given the emerging and burgeoning evidence about the effects of cannabis on the adolescent brain? Studies suggest regular cannabis use can disrupt the development of the brain's neurochemistry and that this brain development doesn't stop until a person is in their mid-20s. Resulting cognitive impairments can include diminished attention spans, memory and verbal learning skills. A 2008 New Zealand study published in *Addiction* has further linked higher cannabis use in people aged 14–25 with lower educational attainment, income and employment.

Research has also linked adolescent cannabis use with psychosis onset, where

**"We can be fairly certain that many young people, whatever age we set, will continue to use the black market if they can't purchase cannabis legally. So, the argument goes, the higher we set the purchase age, the more potential customers we leave in the hands of gangs and outlaws."**





a pre-existing vulnerability exists, and a 2014 New Zealand and Australian longitudinal study published in *The Lancet Psychology* reported high rates of suicide attempts later in life for those who used cannabis daily before 17 years.

Concerns around these health effects on young people have led the Canadian Medical Association (CMA) to firmly oppose a legal age of 18. They advocate for 21 as a practical minimum, though ideally, they'd like the age set even higher.

"In a perfect world what we would recommend based solely on the scientific evidence is an age of legalisation of 25," CMA Vice President of Medical Professionalism told the *Canadian Medical Association Journal* last year.

It's not hard to find similar concerns closer to home, even amongst those supporting legalisation as a public health good. In the Summer 2017 edition of *Addiction Standard*, National Addiction Sector Director Doug Sellman called nonsense on the argument that if you're old enough to vote and fight for your country, you're old enough to buy a beer "and a bong".

"[Our 18-year-old soldiers and voters] don't fight or vote independently, but rather are exposed to a considerable amount of adult influence and guidance in their killing and voting," he wrote.

He argues that lowering the drinking age has encouraged a youth drinking culture to thrive and that this would also be the case with cannabis under a legal, regulated market. He points out there is "substantial literature" showing the damage to young people from reducing the drinking age from 20 to 18 years.

And there is. For example, in its 2010 report *Alcohol in Our Lives: Curbing the harm*, the Law Commission cited a number of studies to back its recommendation to return the legal age for purchasing alcohol to 20. It said lowering the purchase age to 18 saw an increase in drink driving, car crashes, injuries and deaths and other health and social harms among young people.

But I am not so sure we can extrapolate so neatly and assume that what happened with the alcohol purchase age is exactly what will happen with cannabis. Alcohol is used at a vastly higher rate and is much more widely available than any other drug. It's also already part of mainstream culture, has always been legal to purchase and is heavily advertised. Cannabis use is much less widespread, and cannabis would be moving from an illegal to legal status. The cultures and behaviours around the use of these two substances are also significantly different, and all this could lead to quite different and perhaps unexpected outcomes.

**"Concerns around these health effects on young people have led the Canadian Medical Association (CMA) to firmly oppose a legal age of 18. They advocate for 21 as a practical minimum, though ideally, they'd like the age set even higher."**

It could also be pointed out that, since legalisation, according to studies and news reports, cannabis use by adolescents in Colorado, including high school students, has declined by at least four percentage points to its lowest level in more than a decade.

Cannabis use by high school students in Washington has remained stable or declined slightly since legalisation depending on the county, according to a recent report by the Washington State Institute for Public Policy. However, the report also concedes that there is no evidence that legalisation has directly caused any decline. It's just too early to tell.

"Without more data we don't know if the decline would be greater if marijuana remained illegal," said report author Adam Darnell.

And it's hard to tell whether the same declines occurring in Washington and Colorado would occur in New Zealand. Our situations are quite different in that the cannabis markets in these states are a little less regulated than we would probably like to see, and the legal purchase age in both states is 21 not 18.

### Canada and other jurisdictions

What is noticeable is that just about every jurisdiction that has legalised recreational cannabis use has tied the legal age of purchase to the age for purchasing alcohol and tobacco – no doubt for the same human rights and consistency reasons we touched on earlier.

The next country to tie the two will be Canada, which is on track to fully legalise recreational cannabis by July this year. This will make it just the second country to allow the drug nationwide after Uruguay.

Canada's cannabis usage is similar to New Zealand's. There, 8 percent of adults over the age of 25 reported past-year use in 2013, whereas 25 percent of youth aged 15–24 reported past-year use.

Canada will be a country to watch as it seeks to set up a regulated cannabis supply system that will be similar in many ways to the model proposed for New Zealand by the Drug Foundation. In November 2016, Canada's Task Force on Cannabis Legalization and Regulation published its report, *A framework for the legalization and regulation of cannabis in Canada*, which the Canadian Federal Government considered while developing its legalisation legislation.

The Task Force recommended the Federal Government set a national minimum purchase age at 18 and suggested provinces and territories should be free to raise (but not lower) it to harmonise it with their minimum age for alcohol purchase. This was despite advice from some public health sources that this could lead to "border shopping" by young people seeking to purchase cannabis in a neighbouring province or territory where the age is lower – which currently happens with alcohol.

It should be noted, however, that a primary reason for the suggested age of 18 was that "setting the bar for legal access too high could result in a range of unintended consequences, such as leading those consumers to continue to purchase cannabis on the illicit market".

> **"... we should be doing what we can to empower our young people to make decisions about and for themselves."**

Other details such as who can sell cannabis will also be largely left up to the country's provinces. So far, five of Canada's 10 provinces have come forward with frameworks for retail sale. In Ontario, Quebec and New Brunswick, sales will be run by provincial government-owned entities. The western provinces of Manitoba and Alberta have said they will license private retailers. In most provinces, the legal purchase age will be set at 18. In Ontario, Canada's most populous province, it will be 19. The Federal Government's proposed legislation will also permit adults to grow up to four cannabis plants at home, although Quebec has announced it will allow no such thing.

A number of things in the Task Force's report will ring some bells for those who have read *Whakawātea te Huarahi*.

The Task Force acknowledged that age restrictions on their own would not dissuade use by young people. Other actions including prevention, education, treatment and advertising restrictions will be required to achieve this objective.

It also said the young people it consulted did not believe setting a minimum age alone would prevent their peers from using cannabis. However, the report said there was a general recognition that a minimum age would have value as a "societal marker", establishing cannabis use as an activity for adults only – at an age at which responsible and individual decision making is expected and respected. It also suggested 18 was a well-established milestone in Canadian society marking adulthood.

The same could be said for New Zealand, and we should be doing what we can to empower our young people to make decisions about and for themselves. They are generally competent enough, and reported worldwide declines in risky behaviours by youth suggest they are listening to health and harm reduction messages.

### Bringing it all back home

Whether we like it or not, it seems we are stuck with 18 as the legal purchase age for alcohol into the foreseeable future. In the past, the Drug Foundation has backed the Law Commission's call for this age to be returned to 20, but that ship has well and truly sailed for now.

Given this, it just doesn't seem sensible to tell our young people it's fine for them to purchase and drink alcohol at 18 but that buying cannabis is illegal for them until they're 20. That would inherently suggest alcohol is safer than cannabis, and do we really want to be saying that at a time when honesty and credibility from those leading the legalisation debate will be needed more than ever?

In *How to regulate cannabis: a practical guide*, the Transform Drug Policy Foundation says, "Where [the age] threshold should lie for a given drug product will depend on a range of pragmatic choices … informed by objective risk assessments … balanced in accordance with priorities …".

Pragmatically, 18 seems the most sensible choice as we balance the risk of under-the-radar black market use against the priorities of consistency, safer use and harm reduction opportunities. It's not a perfect solution because there isn't one. It's not about encouraging young people to use cannabis. It's about finding a balance that will result in the least harm to the greatest number.

Granted, our young people are not a homogeneous group, and if we don't get the regulatory framework right, there are some who will more likely bear the brunt of that failure, such as Māori who are disproportionately targeted under current law. But bringing young people's use out into the open where we can monitor it and provide help where needed will reduce harm generally and be a great leap forward. We may not know exactly what will happen, but anything would be better than the prohibitionist approach we're taking now. ■

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

# Mental health inquiry –line in the sand

The government's inquiry into mental health and addiction is being welcomed with excitement and hope by a sector that is ready for change. *Matters of Substance* asked four sector leaders what outcomes they'd most like to see from the inquiry.

**Matua Raki Consumer Leadership Group Chair Sheridan Pooley** wants to see some "blue sky thinking" from the inquiry.

"We should be helping people to make the changes they want to make, when they want to make them, with a much more diverse range of options available. At the moment, if you're not comfortable with the principles of AA or Narcotics Anonymous, there's not much else in the community.

We have to meet the whole continuum of needs, from the person who thinks they might have a problem through to someone whose life has fallen apart. Let's get creative – a shop front on K Road, social media apps for teens – whatever it takes. Helping people earlier is more cost-effective too.

We need to ensure all the services are connected and have a map of what's available because it's really difficult for people to navigate their way through the system. The amount of people who say, "I wish I'd known about your service, I would've come sooner". If you tried to draw that map now, it would look like a maze.

Currently, our services are set up to deal with acute episodes, but addictions require a chronic care model to provide cushioning in between.

I believe it's crucial that we take a behavioural health approach to recovery. More important than finding out, 'Why am I like this?' is learning practical tools to change our behaviour. That's the hard part.

So much of what we have in place is about accountability and compliance. Recovery needs to be the focus. The inquiry should investigate how our systems support or stymie that so we can refocus our efforts."

**Psychotherapist Kyle McDonald**, Nutter's Club host and a key instigator of Action Station's *People's Mental Health Report*, says improved access is the key outcome for the inquiry.

"People should be able to access treatment when and where they need it. Our inquiry found the first problem people faced was getting into the system. Then they weren't able to access the right or preferred kind of treatment. Lack of availability was the main problem, with wait times of up to 12 months.

The mental health system is so fragmented that access really depends on where you live. There's huge variability nationwide and even within Auckland where community mental health services are divided into four areas. Some provide clinical psychologists; some don't or have fewer. Access literally depends on which street you live in. If you move, you're expected to transfer to a different team. Nationally, the picture gets even more fragmented, and it's just as bleak in the addiction sector.

The inquiry needs to look at how the entire system is structured, the number of DHBs, how they interact with each other and how they contract out services to NGOs. A comprehensive map and plan as to how services are going to be provided would be a huge step forward.

The commitment to reinstate the Mental Health Commission, disbanded in 2012, is actually going to be the biggest factor that creates change, because it will mean an independent body, outside of the political system, will oversee and ensure the recommendations are implemented."

**Matua Raki National Manager Dr Vanessa Caldwell** says the national addiction workforce development centre welcomes the inquiry and is geared for change.

"The outcome I'd most like to see is that we eliminate the barriers to treatment. As a community, we need to do a better job of letting people know where to go for help. Our care systems need better integration. At the moment, we've got 20 different systems depending on which district health board area you live in.

Care needs to be consumer focused, based on what people are seeking help for rather than a clinical diagnosis dictating the pathway of care.

Addiction treatment should not be seen as a tack-on to mental health. We treat addiction as a behavioural health issue and have a recovery focus. As part of someone's care we assist them with all the components that contribute to overall wellness such as safe housing and building community networks. A multi-disciplinary team approach is the way to go.

I'd also like to see the scope of treatments extended to include low-threshold interventions. A huge number of people with mild addictions or anxiety can, with the right information and tools, treat themselves.

We urgently need a larger workforce. Our nationwide workforce of 1,500 has a capacity of 45,000 people a year, and that's constantly maxed out. The estimated demand is 150,000, so people have to wait until crisis level for help. Crisis intervention is being done by Police who are doing a brilliant job, but it's unacceptable they're in that position."

**Phyllis Tangitu, General Manager of Māori Health at Lakes District Health Board** in Rotorua, says better leadership is needed around reducing inequalities in a system that is failing Māori.

"There has been significant development of kaupapa Māori mental health services in the 30 years I've worked in the sector. The changes have been driven by Māori wanting to develop their own solutions for Māori, but in recent years, we've lost leadership support and kaupapa Māori has dwindled. Given how highly Māori figure in the statistics, it should be a priority.

I believe we can develop a community mental health service model that is embedded within a kaupapa philosophy that will meet the needs of all. The Māori way of doing things works well for everyone because it isn't just about the mental and physical issues that may be occurring for the individual. We acknowledge them alongside their whānau and within their wider community, culture and environment. We recognise the importance of spirituality, rituals like karakia, our environment and how we exist within it.

We've got to weave whānau ora into all that we do, empowering our iwi to work within whānau and hapū to build resilience, particularly around suicide, where there is much more work to be done.

We need to listen to the voices of our service users and whānau and ask them, 'Are we doing OK for you? Are we respecting what it is you need to recover?'

The Mental Health Commission developed the blueprint of what the mental health service need was per 100,000 population and how it was going to be funded. That blueprint was the catalyst for change. I hope that happens again with this inquiry." ■

# Helping build a healthy and supportive society

Housing New Zealand has re-evaluated what they do when someone is found using drugs in their homes. Chief Executive **Andrew McKenzie** explains why more support will now be available and what the corporation is now doing to ensure people have all the tools they need to sustain a successful tenancy.

ANDREW McKENZIE

It's worthwhile starting this column by highlighting the government's direction when it comes to housing. It's very clear: it is in the best interests of the country that all Kiwis should have access to housing. It is also important that we and others acknowledge that Housing New Zealand will focus on providing homes for people who cannot secure other housing due to their health and support needs. New Zealand will be better off socially and financially overall when people with complex needs are given the right support. That starts with a stable home.

There is a great deal of research by social service and health professionals from overseas and here in New Zealand that points to the benefits of helping people recover from addiction and mental health issues by properly housing them first. A stable, warm and safe home is a platform for access and delivery of wraparound services that help people deal with complex issues. This has a positive flow-on effect on health and social sector spending.

Housing New Zealand's vision is "building lives and communities by housing New Zealanders". It means we understand a cornerstone of what we do is giving people a safe, secure place to call their own, even if they do not own it, and providing them a sense of community, of belonging. We're much more than landlords, even though that is our main role. Our job is multi-faceted. Our tenants are people who have been assessed as having priority housing, health and social support needs, and they will typically be in receipt of a range of public services from other government agencies.

In the last 18 months, we've taken a long, hard look at the way we work with our tenants, particularly how we keep them in housing. Our staff have always provided a level of care and support that goes beyond a purely landlord role. For many years, we've worked alongside government and community agencies to help our tenants. This has largely been informal, and we are now looking to do this systematically by developing formal partnerships and designing operational procedures that focus on sustaining tenancies.

Tenants will be provided with support that will ensure they have all the tools they need to sustain a successful tenancy for the time they need it. Achieving life skills and housing independence are key planks of this approach. That includes tenants who need a stable home to have the best chance of working through any addiction issues. While our tenants need us, we'll be there for them.

**"A stable, warm and safe home is a platform for access and delivery of wraparound services that help people deal with complex issues."**

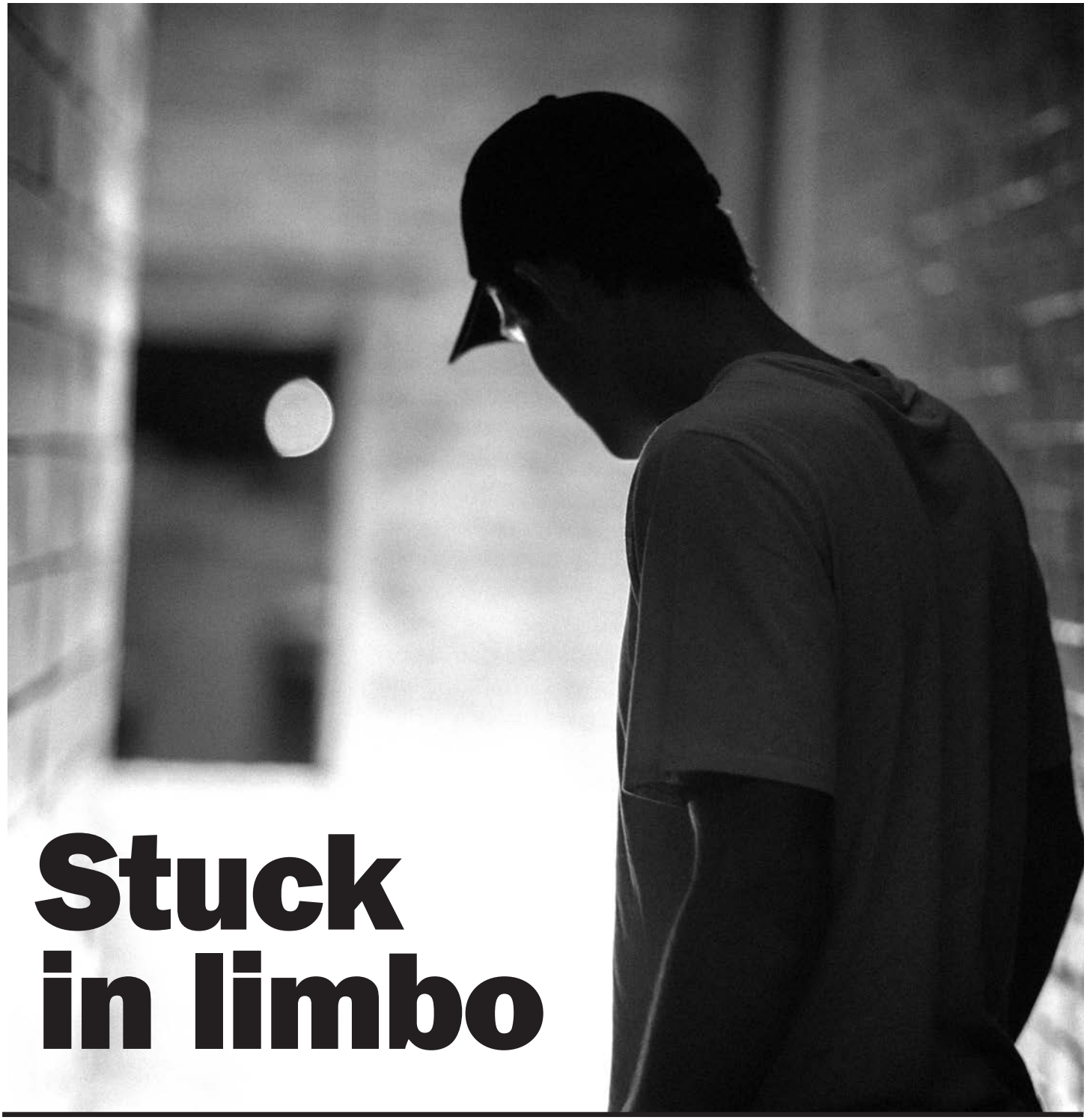
We have been talking with and learning from tenants, tenant support organisations and key stakeholders such as health and social service providers both here in New Zealand and in comparable countries such as Canada and Australia. There will be a focus on making sure people in our homes who experience addiction or have family members living with them who struggle with addiction to get the wraparound support services they need. Those conversations are ongoing. The next step is for us to devise and then implement a range of measures to enable us to handle situations such as methamphetamine use in our properties. We have been planning this for a number of months and are aiming to complete it over the next three months.

This is a complex matter requiring considered thought and planning. While on the surface, the answer is simple – to house people experiencing addiction – in fact, it's a many-layered task. We have to take into account the various needs of our tenants, our staff, our contractors, our neighbours, our agency partners, our homes and the general public and to develop operating procedures to meet those different groups' expectations.

**"There will be a focus on making sure people in our homes who experience addiction or have family members living with them who struggle with addiction to get the wraparound support services they need."**

We also need to resource this type of work. We're good at managing people and properties, but the practicalities of managing people using drugs and experiencing associated mental health issues requires ongoing, specialist skills. Our staff will contribute by visiting our tenants' homes more regularly than our current tenant visits programme and liaising directly, and more often, with health and social services.

We are confident Housing New Zealand is engaging with the right people as we develop new policies and procedures, and that includes the New Zealand Drug Foundation. We greatly value the input the Drug Foundation has given us to date. I look forward to updating our partners and stakeholders on our service responses to tenants living with addiction and mental health issues as the next steps in our work are completed. ■



# Stuck in limbo

At least 20 deaths last year were attributed to synthetic chemicals, and Police believe a recent West Auckland death is possibly linked to the drug. But where is the outrage and – more crucially – the action? **Jessica McAllen** shares her perspective.

JESSICA McALLEN

Synthetic substances were sexy. Marketed in flashy packs with bright colours and promises of pineapple or juicy fruit – like the gum! In 2012, I sold them for three weeks during a short-lived stint at Cosmic on Karangahape Road. I was unaware of the damage they were doing at the time. So were a lot of people.

Minus a brief flurry of underground Facebook pages when the drugs were outlawed in 2013, I thought synthetics had all but disappeared. But then, seemingly out of nowhere, Police announced that 20 deaths in 2017 were linked to the chemicals. The problem had reared its head again.

Now that synthetics aren't available on the counters of dairies and edgy clothing/drug paraphernalia stores, fewer people are using, but the deaths last year should be a wake-up call. We're facing a new wave of synthetic users, and it's harder for the authorities to pinpoint blame.

Once when the colourful packets snowballed into mainstream consciousness, they were swiftly outlawed. The lack of action this time around speaks volumes to the out-of-sight out-of-mind aspect of addiction and the lack of concern for marginalised communities in New Zealand.

## The product

Over the past 20 years, hundreds of synthetic cannabinoids have been invented. Synthetic chemicals are designed to mimic drugs like cannabis, MDMA, acid and speed. Some are stimulants that speed up bodily functions, while others are depressants that slow down the body and brain. Others cause hallucinations. The drugs usually come as a bunch of dried leaves sprayed with untested psychoactive substances. They can also come as a liquid that can be used in a vaporiser.

In 2013, the Psychoactive Substances Act was introduced to regulate the availability of synthetics and similar products in order to "protect the health of, and minimise harm to, individuals" using them.

## The people

People using these kinds of drugs often face significant disadvantages such as homelessness or mental health problems, and the stigma surrounding these drugs is so high that telling others about an experience is easier to do once it's over.

**"... it's a positive step that the government is including addictions in the mental health review, but as for meaningful action, we're in limbo."**

You only have to look at last year's headlines to see why: 'Local films synthetic cannabis users drugged up in West Auckland playground, tells them to get lost', 'Synthetic drug user filmed writhing, screaming outside primary school', 'Shocking footage shows two women passed out allegedly after using synthetic 'zombie' drugs in Taupo'.

While there is arguably a case for media publishing such footage to show how dangerous the drug is, it's incredibly discouraging that society's first instinct isn't to help someone struggling but rather to pick up the camera.

Often, we only hear about synthetics from the perspective of family or friends, usually in the context of a recent death. We rarely hear from people who actually use these types of drugs as they feel unable to tell their side of the story. It's a similar problem in mental health, and the two issues have a lot of cross-over.

A friend of mine (who I'll call Harry) used to use synthetics daily. Harry had a full-time job and worked part-time at night to pay for the drugs.

In 2011, he was diagnosed with bipolar disorder, and he found synthetics to be an effective way of controlling his moods, saying he was neither high nor low – just consistently at a baseline.

"For me, that just felt like more of an excuse," he told me. "Because you find out that so many people with bipolar are addicts, then you justify it that way to yourself. Like, I'm allowed to be an addict. I've got bipolar. That was very much a part of it. I felt like I had autonomy because that's what I was choosing to do."

"I think it's important that people get just how addictive it is. It's not a matter of discipline or motivation or values. I grew up in a Christian home with very strong values of health and wellbeing and anti drinking and drugs. As soon as it came up, I was into it. I was working two jobs so that I could do it, so you can't say it's the lazy man's defence. I was extremely motivated as a person, but this was just more important."

## What next?

A Bill sponsored by National MP Simeon Brown was recently drawn from Parliament's lottery, meaning it will be considered this year.

It proposes to increase the maximum penalty on suppliers of illegal psychoactive drugs from two years to eight years. It appears to be more punitive than helpful – echoing the sentiment of people who take exploitative videos of those on synthetics who are writhing in pain. Where are the education campaigns? The healthcare? Locking people away for longer won't fix the problem.

Meanwhile, it's a positive step that the government is including addictions in the mental health review, but as for meaningful action, we're in limbo. No special taskforce seems to have been created, no review of the 2013 Act. It seems like having legal drug-testing facilities so people can at least check what they are consuming would be a worthwhile move.

But last year, after the series of deaths, Bill English told media that it was a Police issue. "That sense of personal responsibility is pretty critical to staying alive. They need to decide they are not going to take these drugs," he said.

We have a new government now, supposedly dedicated to health, and Bill English has gone. With one death already last month possibly linked to synthetics, it is time to ask what is going to change.

Harry thinks politicians pontificating about personal responsibility is ineffective.

"That's what really gets to me. When you get influential people being like, 'Oh people should just stop it, what a bunch of no-hope losers, they should just put it down'. No, it's bigger than emotions or feelings. In the worst of it, when it really, really had me, I stole money off flatmates, from my employer, so I could get it. It's New Zealand's heroin as far as I'm concerned. It's poison. People will always go to it unless there's a safe option available." ■

**Jessica McAllen is a freelance journalist based in Wellington.**

*Behind the scenes production featuring Helen Baxter from Mohawk Media.*

# Getting animated about drug tests

Every employer wants their workers to be safe, and few would disagree that the presence of drugs in the workplace – particularly safety-sensitive environments – can be a hazard.

So, increasingly, many organisations and workplaces – even some schools – are using drug testing to monitor and manage drug use, under the impression they are doing the right thing.

But what if they were told drug testing doesn't always improve workplace safety, that it can be ineffective at managing impairment, that it's highly invasive and, more importantly, that there are far better ways to manage workplace safety?

A new animated video produced by the Drug Foundation with the help of Mohawk Media is attempting to bridge the gap between science and practicality, while making sure workers' rights and privacy are respected.

The Drug Foundation regularly fields calls from employers asking for advice about how to carry out testing and from employees asking about their rights – in fact, it's the number one topic for enquiries.

Our position is that drug testing isn't always the answer. Workplace safety can be improved and impairment can be more effectively monitored through good management and a proactive, supportive workplace culture.

But testing is common practice in some industries and widely accepted as necessary, so advising people against it can seem counter-intuitive. How, then, do you tell people what they may not want to hear?

Samuel Andrews and Ben Birks-Ang are experts in their field. Samuel is the Drug Foundation's Harm Reduction Projects Adviser with an honours degree in sociology, and he fields most of the Drug Foundation's enquiries around workplace testing. Ben is the Foundation's National Youth Services Adviser, has spent over a decade working with young people in the alcohol and drug sector and has helped establish and overseen many community and residential drug and alcohol treatment programmes.

Despite their credentials, they weren't sure that organisations would easily agree to change their processes.

Better to just present them with the facts, says Ben.

**"The Drug Foundation regularly fields calls from employers asking for advice about how to carry out testing and from employees asking about their rights – in fact, it's the number one topic for enquiries."**

"We didn't want to be just another person telling them what to do. They need to work through that process themselves."

So … how do you get people's attention? How do you convey a complicated message in a simple, engaging and shareable way?

Enter Mohawk Media, who are specialists in animation and infographics. Mohawk produced the Did You Know animated series for young people and youth workers, so they already understood the space the Drug Foundation works in.

Director Helen Baxter says helping people understand the science was key. The audience would be wide-ranging – Police, sporting bodies, workplaces – particularly safety-sensitive workplaces like factories, forestry and construction.

It also had to be appealing enough to capture people's interest.

"This needs to go out to anyone in New Zealand, regardless of location, gender – all of that. It needs to be neutral, accessible and flexible. We wanted it to be shareable too – if people are sharing your content, you know you've done your job right."

She says Samuel provided the facts and Ben painted a picture of the audience they were trying to reach. Ideas were bounced around from the first early script to visual storyboard, then as simple animations were fleshed out.

After being immersed in so much science, Helen talks a bit like an expert herself.

"A lot of the work we do is science or health-based. Animation is a fun medium to work in, but it's even better when you know the content has purpose and meaning, is really relevant and will make people's lives better." ■

**Natalie Bould, Communications Adviser**

**RESOURCE**

nzdrug.org/drug-testing

# Chlöe Swarbrick

Green Party MP Chlöe Swarbrick's medicinal cannabis Bill would have allowed people who are debilitated or terminally ill to legally grow cannabis if prescribed it by their doctor.

The Bill lost 47 votes to 73 in the first reading. Here, she tells Q & A about her reaction and what life is like as a new MP.

**Q How did you feel when your medicinal cannabis bill was rejected?**

**A** The hardest thing for me was walking out of the House to face the group of patients and their whānau who had packed out the gallery to witness the reading. A lot of them were crying. I do feel these things deeply personally.

The whole reason I'm in politics is to try to change things. It just felt like cynical politics had won. It wasn't treated as a conscience vote.

The voices of the people who are suffering under archaic laws aren't being heard, and this vote was a roadblock to them being heard. The thing that disappoints me most is that 78 percent of the public are in favour of the Bill's premise, which is access and the ability to grow one's own for medicinal purposes, but only 39 percent of MPs voted for it.

**Q Why does New Zealand need to change how patients access medical cannabis?**

**A** Under the present model, only about 70 people nationwide have access to pharmaceutical medical cannabis. The issue is it's prohibitively expensive – about $1,200 a month. There have also been a handful of prosecutions of people known as 'green fairies'. These otherwise law-abiding citizens are risking jail time in order to provide medical cannabis products to family and friends who are suffering. That indicates the law is unfit for purpose. The government's Bill bizarrely provides a criminal defence for any terminally ill person to be charged with possession, which still means having some very sick people dragged through the criminal system.

**Q Why are you interested in drug policy and law?**

**A** I've always been interested in philosophy and the reasons why we do the things we do. I studied law at university because it's the framework within which we conduct civil society. In recent decades, we've seen a 'War on Drugs' philosophy indoctrinated as law. That approach has proven to be a failure. Criminalising drugs is causing more harm because people who have addiction or abuse problems can't access help, so we just end up with increased harm and incarceration rates.

**Q Can we put better safeguards in place to protect young people from the harms of alcohol and other drugs?**

**A** A health-based approach is increasingly seen as the best way to go. Portugal is often held up as a shining example, but it's important to recognise that, when they decriminalised drugs, they also massively increased funding for mental health and addiction services. Decriminalisation can't happen in isolation. If we take a health-based approach, those services must be in place.

**"Portugal is often held up as a shining example, but it's important to recognise that, when they decriminalised drugs, they also massively increased funding for mental health and addiction services."**

**Q Now that you're on the inside, are you more or less hopeful about democracy?**

**A** Politics has become divorced from democracy for quite a while now. Politics is the games played by politicians. Democracy is engagement with citizens, and right now, that only happens once every three years when we vote in the general election. Hopefully, the voting down of my Bill serves as a wake-up to people that, if we want a proper democracy, we need to engage more regularly.

Since becoming an MP, I've seen evidence that the public have more power than they think. Politicians are comfortable in their jobs and keen to keep them, so when we put all our voices together and make it known that change is wanted, by and large they'll do it.

**Q During last year's election campaign, you spoke publicly about your own battles with alcohol as a teenager. What was the response like?**

**A** I have spoken about my struggles with mental health, particularly around anxiety and depression, when I was 15. Part of that struggle involved abuse of alcohol during those really dark times and was essentially a means of self-harm. That's where drugs and alcohol can be incredibly dangerous.

Fortunately, I was able to work with mental health professionals to get myself to a healthier and happier place. When I was interviewed about this during the election campaign, the response was overwhelmingly positive, but a few people had some nasty things to say. Some suggested I'd chosen to discuss something deeply personal and actually quite traumatic just to win votes. Others said I was crazy, and there was no way I should be allowed in power.

One of the best things to come out of it was I had a great kōrero with Holly Walker, who wrote a book about her struggles with mental health as an MP. We think that, if more politicians felt able to talk about these issues, it would help with normalisation. ■

# Looking Back to Move Forward

## Me hoki whakamuri, kia ahu whakamua, kaneke

In order to improve, evolve, and move forward, we must reflect back to what has been

involve.

## 13–15 August 2018

### **Wellington** | Michael Fowler Centre

INVOLVE has been the national youth development conference in Aotearoa since 2002. It provides a space where the youth sector can come together to connect, share, learn, grow and celebrate our diversity and strengths. This is enabled through a programme rich in contributions from across the sector.

2018 is the first Involve conference since 2010 and is being put on in partnership by **Ara Taiohi**, **New Zealand Youth Mentoring Network**, **Society for Youth Health Professionals Aotearoa New Zealand** and **The Collaborative Trust**.

It will be a time to connect, celebrate and reflect together on where we have come from and where, collectively, we want to go.

FIND OUT MORE OR REGISTER AT

**bit.ly/Involve2018**

Early bird rates are available until 7 May 2018.