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LAW·COMMISSION
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April 2011, Wellington, New Zealand | REPORT 122

CONTROLLING AND REGULATING DRUGS

A REVIEW OF THE MISUSE OF DRUGS ACT 1975

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The Law Commission is an independent, publicly funded, central advisory body established by statute to undertake the systematic review, reform and development of the law of New Zealand. Its purpose is to help achieve law that is just, principled, and accessible, and that reflects the heritage and aspirations of the peoples of New Zealand.

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The Hon Simon Power
Minister Responsible for the Law Commission
Parliament Buildings
WELLINGTON

26 April 2011

Dear Minister,

NZLC R122 – CONTROLLING AND REGULATING DRUGS – A REVIEW OF THE MISUSE OF DRUGS ACT 1975

I am pleased to submit to you Law Commission Report 122, *Controlling and Regulating Drugs – A Review of the Misuse of Drugs Act 1975*, which we submit under section 16 of the Law Commission Act 1985.

Yours sincerely

Hon Justice Grant Hammond
President

FOREWORD

In 2007, the Government asked the Law Commission to comprehensively review New Zealand's drug law. There are at least five fundamental reasons why reform of New Zealand's drug law is required.

First, the recreational use of illegal psychoactive substances is regulated by the Misuse of Drugs Act 1975. At the time that statute was enacted, the illegal drugs of choice were things like cannabis, cocaine, opiates and psychedelics like LSD. While the use of cannabis remains high, new drugs have appeared. In the 2000s party pills like Benzylpiperazine (BZP) and very harmful drugs like methamphetamine have joined cannabis at the forefront of New Zealand's drug scene. In short, the drug landscape has changed.

Second, the 1975 statute is inconsistent with the official drug policy adopted in New Zealand. That policy is based on the principle of harm minimisation and supports a balance of measures under the pillars of supply control, demand reduction and problem limitation. The Misuse of Drugs Act, however, emphasises the supply problem whilst distinctly neglecting these other two important pillars. Much greater legislative recognition of demand reduction and harm reduction strategies is needed.

Third, the existing supply control focussed approach consumes a very considerable resource through demands on detection, enforcement, justice and corrections.

Fourth, there are adverse social consequences from a distinctly punitive approach to lower level offending. Quite large numbers of young New Zealanders receive criminal convictions – which might subsist for life – as a result of minor drug offences. This is a disproportionate response to the harm those offences cause. More can be done through the criminal justice system to achieve better outcomes for those individuals and for society at large.

Fifth, the absence of effective regulatory controls over new psychoactive substances is entirely anomalous when compared with the prohibitionist approach to substances which are covered under the United Nations Conventions – which New Zealand must respect – and represents a serious threat to public health.

This is a wide-ranging Report. Two features of it bear particular emphasis. First, we advance a new regulatory framework for non-convention drugs. This regime would require manufacturers and importers of a new substance to obtain an approval for it before it could be released onto the market. This would effectively reverse what happens now in practice, where a substance can be manufactured, imported and sold until it is proven to be harmful. This is therefore a preventive regulatory regime. Second, we have concluded that there is distinct scope for a more effective approach to personal drug use within the framework of the United Nations Conventions. This would enable more drug users to be directed away from the criminal justice system and into education, assessment and treatment.

Our Issues Paper for this review generated over 3,800 submissions. These ranged from submissions delivered on a "Cannabus" urging a substantial relaxation of New Zealand's cannabis laws, to submissions from individuals and community groups highlighting the harm that "recreational" drug use has caused to their families and communities, to submissions from the treatment sector on ways to improve the delivery of treatment services.

That many of these issues are contentious means that, inevitably, some of the recommendations in this Report will not please everyone. The need for a regulatory regime for dangerous new drugs is hardly controversial. But in other areas – such as how best to respond to personal use of illegal drugs – doubtless strong views will continue to be held.

This Report should also be read in conjunction with another Report that has emanated from this review: *Compulsory Treatment for Substance Dependence: A Review of the Alcoholism and Drug Addiction Act 1966.* The recommendations from that Report are presently being considered by government.

We acknowledge the assistance provided by the New Zealand Drug Foundation in arranging consultation meetings on our behalf, and the invaluable advice and assistance provided to us by the Ministry of Health.

I would also like to acknowledge the significant contribution made to the review by former Law Commissioner, Val Sim. Although Val's term with the Commission finished before this Report could be published, the leadership she provided was critical to our ability to progress the review and develop its recommendations. I also acknowledge the work of the Deputy President, Dr Warren Young, and Senior Legal and Policy Advisers Jo Dinsdale, Andrea King, Cate Honoré Brett and Allison Bennett.

Hon Justice Grant Hammond
President

TERMS OF REFERENCE

The Commission will review the Misuse of Drugs Act 1975 and make proposals for a new legislative regime consistent with New Zealand's international obligations concerning illegal and other drugs.

The issues to be considered by the Commission will include:

(a) whether the legislative regime should reflect the principle of harm minimisation underpinning the National Drug Policy;
(b) the most suitable model or models for the control of drugs;
(c) which substances the statutory regime should cover;
(d) how new psychoactive substances should be treated;
(e) whether drugs should continue to be subject to the current classification system or should be categorised by some alternative process or mechanism;
(f) if a classification system for categorising drugs is retained, whether the current placement of substances is appropriate;
(g) the appropriate offence and penalty structure;
(h) whether the existing statutory dealing presumption should continue to apply in light of the Supreme Court's decision in the *Hansen* case;
(i) whether the enforcement powers proposed by the Commission in its report on *Search and Surveillance Powers* are adequate to investigate drug offences;
(j) what legislative framework provides the most suitable structure to reflect the linkages between drugs and other similar substances;
(k) which agency or agencies should be responsible for the administration of the legislative regime.

It is not intended that the Commission will make recommendations with respect to the regulation of alcohol or tobacco in undertaking this review.

Controlling and Regulating Drugs

A Review of the Misuse of Drugs Act 1975

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Summary

INTRODUCTION

1 The use of illegal psychoactive substances is regulated by the Misuse of Drugs Act 1975. That Act is now 35 years old. Its main components were developed in the 1970s, when the "hippie" counterculture was at its height and the illegal drugs of choice were cannabis, cocaine, opiates and psychedelics like LSD.

2 New Zealand's drug landscape is now vastly different from that which existed in 1975. Moreover, we now know much more about the harms of drug use, and what can be done to reduce them. That knowledge underpins the *National Drug Policy*. However, the Act is poorly aligned with it, and largely treats drug use solely as a matter of criminal policy rather than health policy. It should be the concern of both.

3 Over the years, various ad hoc amendments have also been made to the Act that make it difficult to understand and navigate.

4 In 2007 the Law Commission was invited to review the Act. This invitation arose in response to the emergence of an evolving market in novel psychoactive substances, many of which are promoted as "legal" alternatives to prohibited drugs. In light of concerns about the lack of active regulation of these substances and other fundamental difficulties with the Act, the Government decided that a broad review of the Act was required.

PART 1 – CONTEXT AND PRINCIPLES OF REFORM

Chapter 1 – The context of drug reform

5 The terms of reference for the review require us to make proposals for a new legislative regime that is capable of dealing with the rapidly evolving market in new drugs and is consistent with our international obligations. We are required also to consider what the fundamental objectives of a new regime should be and the extent to which that legal framework should reflect the principles of harm reduction underpinning the *National Drug Policy*.

6 Our review of the Misuse of Drugs Act is underpinned by the following principles:

- The primary justification for regulating or prohibiting the manufacture and use of psychoactive drugs rests upon the potential for their use to result in harm to others. Intervention may also be required to protect the user from harm in circumstances where individuals lack the necessary information, maturity or faculties to accurately assess the risks associated with their decisions and actions.
- The choice between strategies must be consistent with the overriding obligation of all signatory countries to comply with the international drug conventions.
- The choice between strategies needs to be based upon an evaluative judgement, informed by an overall assessment of the costs and benefits, both quantified and unquantifiable.

- The degree of control involved in the regulatory strategy should be the minimum required to achieve its objective. Absolute prohibition should be a last resort.
- Even when prohibition is the preferred response, there should be a range of responses including the possibility, when appropriate, of treatment and rehabilitation. This will reduce the demand for drugs and the social and fiscal costs associated with drug-related offending.
- The abuse of drugs is both a health and criminal public policy problem and, as a matter of principle, drug laws should facilitate a multi-sectoral response designed to minimise drug-related harms.

Chapter 2 – Drug use and harm in New Zealand

7 All psychoactive drugs act on the central nervous system (CNS) to change how people feel, perceive and behave. Most can be roughly categorised as depressants, stimulants or hallucinogens according to their primary effect on the CNS. Depressants, which include alcohol and opiates such as heroin, essentially slow (depress) the CNS and can reduce inhibitions and awareness and produce a temporary sense of relaxation and wellbeing. Stimulants, which include caffeine, nicotine, benzylpiperazine (BZP), cocaine and amphetamines, accelerate the CNS and can produce feelings of euphoria, increased energy, perception and alertness. Hallucinogens, or psychedelics, include naturally occurring organic substances such as mescaline (from the cactus plant) and synthetics such as LSD. They act on the CNS in different ways, altering perceptions, and sometimes inducing hallucinations.

Drug use

8 Surveys show that people take illicit drugs for the same reasons many people drink alcohol: relaxation, fun and a desire to fit in socially are common reasons given.

9 Cannabis is by far the most commonly used illicit recreational drug in New Zealand – as it is throughout the world. Nearly half this country's adult population has used it at some point in their lives and about one in seven, or the equivalent of 385,000 people, were classified as current users in 2006.

10 Until recently New Zealand also had high use rates of the mild synthetic stimulant drug BZP, marketed as "party pills". The most recent estimates are that 13.5 per cent of the adult population had used them at some point in their lifetime. After cannabis and BZP, the percentage of the population who report ever having used illicit drugs falls away steeply.

11 There have been changes in the prevalence of different drugs. New psychoactive substances have also emerged over time, reflecting lifestyle and culture change. There has been a growth in the use of stimulants such as methamphetamine, ecstasy and BZP, which in turn has coincided with the growth of the late night economy and associated club and dance party scene.

Drug harm

12 There are very significant differences in the harms associated with different types and patterns of drug use. This means that generalised discussions of harm are of limited value from a policy perspective. Drug harms are not evenly distributed among the whole population, so it is important to identify the groups most likely to be affected. The *National Drug Policy* identifies the young, Māori and Pacific peoples as being at greatest risk of drug-related harm.

Chapter 3 – The evolution of drug control in New Zealand

13 Just as there is a spectrum of problems associated with illicit drug use, there is also a spectrum of responses available to governments to deal with drug-related harms. Responses range from a laissez faire approach, characterised by minimalist regulation, through to outright prohibition, backed by strong enforcement and criminal penalties.

14 History shows that, although commonplace today, prohibition of drugs is relatively new in historical terms. Drug use itself dates back to the earliest civilisations, but it was not until the late 19th and early 20th centuries that governments sought to intervene in the drugs market. Growing international concern about opium at the beginning of the 20th century prompted New Zealand's first prohibition on drugs: the Opium Prohibition Act 1901.

Current drug laws

15 New Zealand's approach to drug control since then has been shaped by a century of international cooperation designed to restrict the manufacture, trade, possession and use of psychoactive drugs to medical and scientific purposes. This policy is given effect by three international drug conventions that require signatory countries to maintain a system of prohibition for the drugs they cover. The Misuse of Drugs Act translated these international obligations into domestic law. However, the Act also has a local flavour, adopting many of the recommendations of the Blake-Palmer Committee which undertook the last comprehensive review of New Zealand's drug laws between 1968 and 1973.

Chapter 4 – The case for change

National Drug Policy

16 The overarching goal of the National Drug Policy is "to prevent and reduce the health, social, and economic harms that are linked to tobacco, alcohol, illegal and other drug use". The policy therefore views drug use primarily as a health and social issue that should be addressed, at least partially, through health-based responses.

17 While the *National Drug Policy* draws no distinction between legal and illegal drugs in framing its goals and objectives, in practice the legal status of a drug has profound implications for the strategies that are implemented. In the case of strategies aimed at reducing the demand for and supply of illicit drugs, the

potential policy levers are circumscribed by the limits of the criminal law. The primary lever is the use of prosecution and criminal penalties to deter people from using and dealing in controlled drugs.

The efficacy of drug laws

18 Our starting point is that the use of the criminal law, backed by strong sanctions, is required for convention drugs by our international obligations, and is appropriate as a mechanism for reducing their supply and penalising those who profit from their manufacture and sale. However, there are legitimate questions to be asked about the efficacy and appropriateness of a wholly punitive response to the possession and use of illicit drugs. Could a greater range of responses under the criminal law framework be more effective at reducing the demand for drugs and the harm they cause?

19 A number of practical and ethical questions need to be weighed here. These include:

- whether the current balance between conviction and punishment, diversion and treatment is as effective as it might be in reducing drug-related harms;
- whether a more flexible approach to illegal drug use arising from addiction or mental health problems might be both more effective and more humane than the purely punitive approach adopted under the current criminal law;
- whether criminalisation can exacerbate the harms associated with drug use and whether there are ways within the criminal law framework of mitigating these harms;
- whether the particular risks to young people and Māori could be mitigated by a less punitive and more therapeutic approach to drug use offences.

20 In the case of non-convention drugs, where the position is not constrained by international obligations, a more fundamental analysis of a variety of regulatory approaches is possible. Prohibition should be a last resort, used only where regulation is not adequate to manage the risks of harm.

Objectives of reform

21 We believe that the objectives of any new drugs legislation should be closely aligned with the objectives of the *National Drug Policy*. The current Act is poorly aligned with the policy platform of harm minimisation that is at the core of that Policy. The Act is a criminal justice statute focused on controlling the supply of drugs. The use of drugs, even by those who are dependent on them, is largely treated as a matter of criminal policy rather than health policy. We think it should be the concern of both.

22 Accordingly, the objectives of our recommended legislative framework, which should be administered by the Ministry of Health, include ensuring that:

- drug laws actively contribute to demand reduction by providing opportunities for drug treatment and other therapeutic and non-punitive responses to harmful drug use associated with addiction and other mental health issues;
- the harms associated with the criminalisation of drug users are mitigated wherever possible by introducing a wider menu of legal responses to personal drug use offences;

- personal drug offending which does not result in harm to others is met with a consistent, proportionate and just response;
- criminal justice resources are effectively targeted;
- any changes to the sanctions and penalties relating to the use of convention drugs are effective in reducing harm and do not have the perverse effect of increasing drug prevalence; and
- the new regime for the management of non-convention drugs protects public health and prevents the manufacture and sale of un-trialled substances.

PART 2 – NEW DRUGS

Chapter 5 – New psychoactive substances

23 A major impetus for our review was the emergence of a rapidly evolving market in new synthetic psychoactive substances. These new drugs, which are not caught by the Misuse of Drugs Act unless they are analogues of controlled drugs, pose real challenges for regulators and those concerned with protecting public health. Technically the Hazardous Substances and New Organisms Act 1996 (HSNO) already applies to many of these substances, but it has never been used for this purpose and is not entirely suitable.

24 The restricted substances regime in the Misuse of Drugs Amendment Act 2005 was established to deal with new recreational psychoactive substances that are not harmful enough to justify prohibition. But BZP is the only drug ever to have been brought within that regime, and then only briefly. It is now a Class C controlled drug. Problems with the definitions used to determine the scope of the restricted substances regime mean legislative change is required before it could ever be used again.

Current approach fundamentally flawed

25 New psychoactive substances can be manufactured, imported and sold without restriction until they are proven to be harmful and scheduled either as restricted substances or controlled drugs. In practice, there is a significant time lapse between when new substances start to become available for use and when authorities have gathered sufficient evidence on patterns of use and their effects to determine whether they should be scheduled. There is then a further time lapse while scheduling is undertaken. During this period, potentially harmful psychoactive substances are marketed and sold without restriction.

26 The lack of adequate regulation creates an unacceptable level of risk for the public.

New regime proposed

27 We recommend a new regime for regulating new psychoactive substances.

28 The proposed regime would replace the restricted substances regime and the controlled drug analogue provisions. Like HSNO, the regime would require manufacturers and importers of a new substance to obtain an approval for a substance before releasing it onto the market.

29 Like the restricted substances regime, we recommend that there be some minimum requirements on all approved substances. These should include restrictions on their sale or supply to people under 18 years old (or 20 if the age at which alcohol can be purchased increases), advertising restrictions like those imposed on tobacco products under the Smoke-free Environments Act 1990, and a prohibition on where these substances might be sold. The regulator should also have the power to impose additional conditions on individual substances, depending on the particular risks of harms they present.

30 If the regulator decided that a substance was so harmful that it should not be approved, the regulator would refer the substance on to be considered for inclusion in the prohibited drugs regime. Prohibition would also be considered if the regulatory regime proved to be ineffective in minimising the harm of a regulated drug.

The regulator

31 An independent regulatory authority with appropriate expertise would determine applications for approvals. That authority would not need to have its own administrative or corporate structure if it was supported by the Ministry of Health.

Scope of the regime

32 The proposed new regime would cover all psychoactive substances that are manufactured for the primary purpose of being administered, ingested, inhaled, or injected in order to induce a psychoactive response but not substances like paint, glue and other solvents which, though capable of being inhaled for recreational purposes, are primarily used for other purposes. These types of products should continue to be regulated under HSNO for their dominant use. We think that the Environmental Risk Management Authority, when issuing approvals under HSNO, should give consideration to the potential for products containing psychoactive substances to be misused for their psychoactive effects and impose appropriate controls and restrictions that reflect this risk.

PART 3 – CONVENTION DRUGS

33 Our overall approach to convention drugs has been constrained by New Zealand's obligations under the international drugs conventions. At a minimum, these conventions require that the production, manufacture, import, export and supply of drugs listed in the conventions be criminalised. We have not suggested any dilution of New Zealand's prohibition approach in relation to these activities. Nor would we wish to. In particular, we believe that there must continue to be a vigorous law enforcement focus on large-scale commercial dealing in all convention drugs, backed up by strong penalties.

34 However, there is room within the conventions for taking a more flexible approach to small-scale dealing and personal possession and use, particularly where these activities are linked to addiction. Doing so would support the overarching goal of the *National Drug Policy*.

35 While the Misuse of Drugs Act plays a vital role in reducing the supply of illicit drugs in the community, signalling the risks associated with drug use and deterring some sections of the population from experimenting with drugs, it fails to respond appropriately to the health and addiction issues which frequently

underpin illicit drug use. It therefore does little to support demand reduction. For those whose drug use is associated with addiction or other mental health problems, the criminal law's response can in some circumstances *exacerbate* rather than reduce drug-related harms.

36 Crucially too, the illegal status of drugs and the risk of criminal prosecution can create an obstacle to drug users accessing appropriate education and treatment – both of which are critical components of the *National Drug Policy's* strategies. Furthermore, because the current Act does not provide statutory recognition for therapeutic options, it makes it very difficult to achieve the level of cross-sectoral collaboration mandated by the *National Drug Policy*.

Chapter 6 – Drug classification

37 Chapter 6 examines the ABC drug classification system. Under this system, the restrictiveness of controls imposed on a particular drug, and the severity of penalties attached to breaches of those controls, depends upon whether a drug is classified as falling into Class A, B or C. Which class a drug falls into depends on the harm it causes. Since 2000, the Expert Advisory Committee on Drugs has provided advice to the Government on classification decisions. Classifications are then made by Order in Council.

The approach to classification

38 We recommend that a three-tier classification system should be retained.

39 However, the classification system should be kept under regular review to ensure it remains up-to-date with developing scientific knowledge and relevant changes in the drug landscape. Current classifications should also be reviewed. There has been no systematic review of the individual drug classification decisions made before 2000. It is generally accepted that some of the current classifications are anomalous, and do not reflect available scientific evidence about drug harm.

Classification criteria and process

40 We propose a number of important changes to the classification process:

(a) *Criteria used for classification decisions:* The sole purpose of classification is to determine maximum penalties and enforcement powers. The most important consideration for determining these things is how much harm is caused by any particular substance. Unlike now, the criteria used to decide classification should focus solely on assessing a drug's risk of harm, including social harm.

(b) *Assessments of harm should be undertaken by an independent expert advisory committee:* How different types of drug harm are assessed and weighted is in part a value judgement. Nevertheless, there remains a need for a statutory committee of experts to objectively assess the level of harm posed by different drugs and to make recommendations to the Government as to their appropriate classification. We recommend an independent advisory committee of eight or nine people with expertise in pharmacology, toxicology, drug and alcohol treatment, community medicine, neuroscience, emergency medicine, psychiatry, expertise in drug research and evaluation, and knowledge and experience of the nature and context of, and reasons for, drug use.

(c) *Classification process:* The Order in Council procedure used to classify drugs restricts public participation and full parliamentary scrutiny of drug classifications. It should be removed and classification decisions made by Parliament. When introducing legislation proposing new drug classifications or changes to existing classifications, the Government should be required to present a report containing the expert committee's advice and recommendations to the House.

Classifying precursor substances

41 We recommend that precursor substances should not be classified as controlled drugs. Essentially, a substance should only be classified as a controlled drug if it is being used as a psychoactive substance, not if it is being used to manufacture or produce such a substance. Instead, we propose that precursor substances should be separately scheduled as A, B or C precursors depending on the classification of the most harmful drugs that they are potentially used to produce.

Chapter 7 – Dealing

Supply of Class C drugs

42 There is significant potential for the Act's approach to the supply of Class C drugs to be simplified. The current approach is confusing and difficult to understand. In particular, there are currently separate offences with different maximum penalties depending on whether or not the supply of a Class C drug involved a sale or was to a young person. While both factors should aggravate culpability and be reflected in the sentence an offender receives, we do not think them so important that they should be core elements of the offence, while other equally relevant factors (such as the quantity of drugs supplied) are not.

43 We recommend that the approach to the offence of supply of a Class C drug should be the same as that for supply of a Class A or B drug; that is, there should be one offence with a maximum penalty that is sufficiently high to enable all relevant factors to be taken into account at sentencing. These factors include whether the offending involved a sale or a supply, and whether it was to a young person.

Maximum penalties: supply, import, export, produce, manufacture

44 The maximum penalties for dealing offences should continue to differ depending on the class of drug in question. The current maximum penalties for dealing in Class A drugs (life imprisonment) and Class B drugs (14 years imprisonment) should be retained. However, we recommend a new maximum penalty of seven years imprisonment for dealing in Class C drugs. Dealing in Class C drugs is the only offence on the statute book with a maximum penalty of eight years imprisonment. A seven year maximum penalty is appropriate in light of the changes we recommend to the offence of supply of a Class C drug and is relative to other offences of similar seriousness.

Presumption in favour of imprisonment: dealing in Class A drugs

45 We recommend that the current presumption in favour of imprisonment in relation to dealing in Class A drugs be retained (but modified to exclude social dealing). Dealing in Class A drugs is the most serious of all dealing offences and imprisonment in all but the most exceptional cases is appropriate.

Possession for supply/aggravated possession

46 The offence of possession for supply includes a legal presumption that a defendant who possessed a drug in a certain quantity must have possessed that drug for the purposes of supply. There is an onus on the defendant to prove, on the balance of probabilities, that he or she did not possess the drug for supply. Presumption levels for individual drugs are provided in the Act.

47 The presumption is controversial. In 2007, in *R v Hansen*, the Supreme Court held that it is inconsistent with section 25(c) of the New Zealand Bill of Rights Act 1990 and is not a justified limitation under section 5 of that Act. Section 25(c) affirms the long-standing right of those charged with an offence to be presumed innocent until proven guilty according to law.

48 We do not believe that the arguments that can be made for retaining the presumption are sufficient to justify its retention. We therefore recommend that the possession for supply offence be repealed and replaced with an offence of aggravated possession. The offence would be defined by reference to quantity, which would be set on a drug-by-drug basis. A higher maximum penalty would apply to the "aggravated" possession offence than to "simple" possession. Since the aggravated possession offence would be indicative of supply, the fact that possession was for personal use rather than for supply would become a mitigating factor on sentence.

Social dealing

49 We consider that the supply by drug users of small amounts of drugs with no significant element of commerciality ("social dealing") is entirely different from commercial dealing.

50 The current offence of supply of Class C drugs to adults is effectively a social dealing offence. That offence is treated as equivalent in seriousness to a possession offence. We believe there is scope to go further.

51 We recommend that there should be a statutory presumption against imprisonment in any case of social dealing. The presumption should apply to all drug classes and all dealing offences (whether import, export, production, manufacture or cultivation). It would essentially replace, on a much broader basis, the current presumption against imprisonment that exists in relation to the supply of Class C drugs to adults.

52 The presumption should only apply when the offending is not motivated by profit (as that term is commonly understood). The quantity of drugs and whether or not the offender was also using the drugs should be identified as secondary factors to be taken into account in determining whether there was a profit

motive. In all cases, the sentencing judge would retain overall sentencing discretion to determine the most appropriate sentence in light of all the circumstances of the offence and the offender.

Administering

53 The Act currently treats administering a drug to another person as a dealing offence. We recommend that it should be a separate offence with its own maximum penalty. Such an offence is qualitatively different from supply or other dealing offences and should not be lumped together with them. We recommend a new maximum penalty of two years imprisonment, which better reflects the relative culpability of that offence compared to other offences.

Chapter 8 – Personal possession and use

Possession of utensils

54 Under section 13 of the Misuse of Drugs Act, it is an offence to possess any pipe or other utensil (other than a needle or syringe that has been obtained from an authorised outlet) for the purpose of committing an offence against the Act.

55 We recommend that it no longer be an offence to possess utensils for the purpose of using drugs. We are not aware of any evidence that existence of the offence itself deters drug use. The range of drugs that may be taken without the assistance of utensils, or with utensils that are widely and legally available, also makes this aim difficult to achieve, if not irrelevant, for some drugs. Nor does the possession of utensils usually reflect any additional culpability on the individual's part; statistics indicate that most users found with utensils will also have drugs in their possession or will be committing other offences at the same time.

56 We are also concerned about the impact of the offence on reducing drug-related harm. We consider that, to the extent that the offence deters safer drug use, it causes harm rather than prevents it. We are particularly concerned about its potential impact on the Needle and Syringe Exchange Programme, which has had demonstrated success in reducing the prevalence and/or incidence of HIV infection in injecting drug users. Although the possession of needles and syringes that have been obtained from the Needle Exchange Programme are exempted from the offence, concerns have still been raised with us that the offence compromises the Programme's effectiveness.

57 It is important to note that this recommendation relates only to the possession of utensils and not their supply. We propose in chapter 9 that the supply of utensils (with some exceptions to allow for the secondary distribution of clean needles obtained from the Needle and Syringe Exchange Programme) should remain an offence.

New approach to personal possession and use offences

58 Responding to the possession and use of drugs occupies a significant amount of police and court time and attention. In many cases, police detection of these offences is likely to be incidental to the detection of other offences. In addition, the police and courts often take a low-level and diversionary response to personal use offences, particularly when these offences are not accompanied by any other offending.

59 However, we have a number of concerns about the current approach. These include questions about the effectiveness of criminal sanctions for responding to people whose drug use may be resulting in no serious harm to others or may be associated with underlying health and other problems, including mental health disorders and drug dependence. In addition, while the exercise of police discretion might increase the likelihood of a proportionate and appropriate response to minor drug offences in practice, the existence of this discretion also provides an opportunity for unfairness, discrimination and uncertainty. We prefer an approach that:

(a) provides a more proportionate response to the harm that drug use causes;
(b) enables law enforcement resources and activity to focus on more harmful drug-related offending like commercial dealing;
(c) addresses or mitigates some of the harms and costs that inevitably result from drug prohibition;
(d) provides greater opportunities in the criminal justice system to divert drug users into drug education, assessment and treatment;
(e) is in line with the approach taken in all Australian states and territories, the United Kingdom and many European countries.

A mandatory cautioning scheme

60 We have concluded that a mandatory cautioning scheme is the most appropriate response to personal possession and use offences that come to the attention of the police. This option provides a formal opportunity, at the earliest stages of the criminal justice process, to consider the drug treatment needs of low-level drug offenders. It is also consistent with the direction of the Government's 2009 Methamphetamine Action Plan, which notes that "sending users to prison rather than diverting users to [alcohol and other drug treatment] can make the problem worse" and includes proposals to divert users from the criminal justice system at an early stage.

61 The key objectives of the proposed cautioning scheme are twofold:

- to remove minor drug offences from the criminal justice system; and
- to provide greater opportunities for those in need of treatment to access it.

62 The police would be required to issue a specified number of cautions to a user depending on the drugs involved. On his or her final caution, a user would be required to attend a brief intervention session as a caution condition or face prosecution for the offence. Users of Class A drugs would be required to attend a brief intervention on their first caution; users of Class B drugs on their second caution; and users of Class C drugs on their third caution. A user who came to police attention after receiving a final caution would be prosecuted. The earlier

cautions would be accompanied by information on the legal and health consequences of drug use, and the contact details of support services and treatment providers. No other enforcement action would be taken.

63 Not all drug users who are apprehended are in need of drug treatment. To avoid "over-intervening", our approach uses drug class as a proxy for the likely risk of harm that the drug poses to a user. If drugs are appropriately classified, those in Class A will be the most addictive and harmful. An approach based on drug class also limits the amount of police discretion in the scheme.

64 A caution notice should be issued in respect of any "simple" possession offence and, if they are retained, the offences of drug use and the possession of utensils. It is important to note that the cautioning scheme will not change the legal status of these offences. They will remain criminal offences that are subject to criminal penalties.

Approach by the courts to personal possession and use offences

65 We recommend that a presumption against imprisonment should apply whenever the circumstances indicate that a drug offence was committed in a personal use context. It would be inconsistent to have a presumption against imprisonment apply in cases of social dealing, but not in cases of personal use. As a matter of principle, we cannot see how the purposes and principles of sentencing in these cases could ever be met by the use of imprisonment.

66 We also recommend that personal possession and use offences be excluded from the scope of the Police Adult Diversion Scheme following the implementation of a cautioning scheme. Doing otherwise risks confusion between the two schemes.

Offending by youth

67 On balance, we consider that the cautioning scheme should not apply to youth offenders. This is primarily because of the significant difficulties that would be caused by trying to integrate that scheme with the key features of the youth justice system, including its emphasis on family and whānau involvement in the response to youth offending via family group conferences.

Chapter 9 – Other offences and penalties and procedural provisions

68 In addition to offences of dealing and personal use, the Misuse of Drugs Act contains a range of offences targeting other drug-related activities. These include offences related to precursor substances used to produce, manufacture or cultivate a controlled drug and offences in relation to drug-related activities that are committed outside New Zealand.

69 The Act also includes procedural and other provisions that apply, broadly, when a charge is being contemplated or laid. These include legal onuses of proof which, like the presumption of supply in respect of dealing, place a burden on the defendant to prove certain matters instead of the prosecution.

Precursor substances

70 The Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 (the 1988 Convention) requires that controls be imposed over specified substances that are used to produce, manufacture or cultivate a controlled drug ("precursor substances"). Precursor substances are defined by their inclusion in Schedule 4 of the Act.

71 In chapter 6 we recommend that precursor substances should be separately scheduled as A, B or C precursors depending on the classification of the most harmful drugs that they are potentially used to produce. If this approach is taken, the maximum penalties for precursor offences should differ depending on a substance's scheduling as an A, B or C precursor and should reflect each substance's potential for harm. We recommend that the maximum penalties should be set at approximately half the tariff for the relevant offences involving controlled drugs. This would treat these offences in the same way as attempt offences.

Pipes, utensils and other equipment

72 We consider that there should continue to be restrictions on the supply and import of utensils. Such restrictions are consistent with our overall approach to direct enforcement away from users and towards those who are in the business of, and are making a profit from, supporting drug use. However, the relevant offences should be in primary legislation, rather than established via regulations as they are now.

73 We also recommend that a new offence be established that prohibits the import or export of pill presses or other equipment that is to be used to produce or manufacture controlled drugs.

Limitation periods

74 The Act provides that charges in relation to most offences committed under the Act must be laid within four years of their commission. There is no time limit for the offences of dealing, cultivation of a prohibited plant or aiding offences against the corresponding law of another country. We see no need for specific limitation periods for drug offences. Instead, we recommend that the general limitation periods that apply more generally to criminal offences should apply.

Legal onuses of proof on defendant

75 The Supreme Court's decision in *R v Hansen* has put into question the other three reverse onuses of proof currently in the Misuse of Drugs Act. We recommend the abolition of the following legal onuses:

- the legal onus in section 30, which requires a defendant to prove that he or she was acting in accordance with an exemption, licence or regulation;
- the legal onus in section 29C, which relates to the possession of controlled drug analogues; and
- the legal onus in section 29C, which requires a defendant to prove that a seed, fruit or plant which he or she possessed was not of the species Papaver somniferum.

Forfeiture

76 Despite the Criminal Proceeds (Recovery) Act 2009 covering the same ground, we think that the separate profit forfeiture regime currently in the Misuse of Drugs Act should be retained. That regime enables the court to forfeit dealing proceeds at the time an offender is sentenced for a dealing offence and avoids the need for a separate application under the Criminal Proceeds (Recovery) Act. However, the provisions in the Misuse of Drugs Amendment Act 1978, which authorise the court to recover the proceeds of drug dealing without requiring a conviction, are redundant and inappropriate and should be repealed.

77 We also recommend that, following a conviction for any drug offence, the judge should be required to order the forfeiture and destruction of any unlawful items relating to the conviction (for example, drugs). The forfeiture of these unlawful items should not be taken into account in an offender's sentence. Forfeiture of lawful items used to commit the offence (for example, a vehicle) should be dealt with under the forfeiture provisions in the Sentencing Act 2002. Finally, we recommend that enforcement agencies should be given statutory authorisation to retain a representative sample of seized items and to dispose of the remainder.

Chapter 10 – Exemptions from prohibition

78 In the main, we do not propose much substantive change to the scope of the current exemptions that allow the supply and use of controlled drugs as medicines. In practice, these appear to be working relatively well.

79 However, identifying what the exemptions are requires a detailed consideration of both the Misuse of Drugs Act and the Medicines Act 1981 as well as the regulations made under them. A number of important exemptions are in the regulations rather than in primary legislation. This lack of transparency and accessibility is unsatisfactory.

80 We recommend that the exemptions currently in regulation be moved to primary legislation. The regulation-making powers should be much more limited.

81 We recommend also that all the exemptions that apply to controlled drugs should be consolidated in the Medicines Act (with appropriate cross-references) and made subject to one consolidated set of conditions that is also contained in that Act. This would result in one set of rules governing the supply and use of all medicines (including controlled drugs).

Restrictions on the exemptions

82 Sections 20, 22, 23, 24 and 25 of the Misuse of Drugs Act and regulations 22 and 26 of the Misuse of Drugs Regulations 1977 contain the most significant restrictions that limit the scope of the statutory exemptions authorising the use of controlled drugs as medicines.

83 We have recommended a number of changes to these provisions to ensure that the restrictions imposed on the exemptions are appropriate and also clear. The most significant changes proposed are:

(a) The provision (section 20) that enables a medical officer of health to publish

statements about any person the officer believes is likely to become dependent on any controlled drug is unnecessary and should be repealed. The transfer or disclosure of relevant health information within the health sector should always be undertaken in compliance with the Privacy Act 1991 and the Health Information Privacy Code 1994 issued under it.

(b) The provision (section 22) that authorises the Minister of Health to prohibit the production, distribution and use of any controlled drug should be retained as a reserve power to deal with unanticipated and urgent safety issues.

(c) The provision (section 23) that authorises the Minister to prohibit any prescriber or other person from exercising any of the rights conferred by an exemption should be repealed. Registration authorities should instead have powers to take appropriate disciplinary action when prescribers or pharmacists abuse their privileges under the exemptions.

(d) The provision (section 24) that makes it an offence for anyone other than an authorised addiction specialist to prescribe or supply controlled drugs solely to maintain someone's dependence should be retained. We recommend also that any prescriber who is not authorised to treat drug dependence should consult an authorised addiction specialist before prescription of controlled drugs as treatment for another condition to a person who may be addicted to controlled drugs. Better provision also needs to be made for monitoring the prescription of controlled drugs within primary care and within other specialist disciplines.

(e) The provision (section 25) that allows a medical officer of health to issue a notice that imposes restrictions on the supply of any controlled drug to a "restricted person" should be retained. It should also be combined with the similar provision in section 49 of the Medicines Act.

(f) The offence (section 25) of supplying to a restricted person in contravention of a notice should be retained. It should also continue to be an offence for a restricted person (where he or she knows he or she is restricted) to procure or attempt to procure a prescription or supply of controlled drugs or prescription medicines in contravention of the notice.

(g) The restriction (regulation 26) that prohibits any person who obtains multiple prescriptions for controlled drugs from relying on the exemption for patients who have been prescribed such drugs should be in primary legislation.

(h) The requirement (regulation 22) for the Minister's approval before a prescriber can prescribe, or a patient can use, any of the drugs specified in that regulation should be repealed.

Licensing scheme

84 We recommend some changes to the current approach taken to licensing the production and distribution of prohibited drugs. These include:

- establishing the main components of the licensing scheme in primary legislation, rather than leaving them to be dealt with in regulations as currently;
- appointing, in the primary legislation, the Director-General of Health as the licensing authority;
- abolishing the Minister of Health's role in approving and revoking licences, because these decisions should be the sole responsibility of the licensing authority.

Use of cannabis for medicinal purposes

85 Cannabis and cannabis-based products have historically been used for medicinal purposes. There is continuing debate about the nature and extent of their therapeutic benefits. However, a number of jurisdictions, particularly in North America, now authorise the use of cannabis for some therapeutic purposes.

86 In New Zealand, the current licensing scheme and exemptions from prohibition appear to adequately deal with cannabis-based medicines. The more difficult issue is whether there should be greater access to unprocessed cannabis for therapeutic uses. Cannabis-based medicines can be expensive (if they are not publicly funded) and may not be considered effective for all those who could benefit medically from cannabis use.

87 There are significant differences of opinion on whether unprocessed cannabis should be available for therapeutic use. Until randomised control trials are undertaken we do not think it will be possible to resolve the differences of view about the safety or efficacy of raw cannabis. As a matter of principle, we take the view that cannabis should not be a special case, but should be treated in the same way as other controlled drugs that can be used medicinally. It should therefore be subject to the same evidence-based testing as other controlled drugs before being made available to the public as a medicine.

88 Given the strong belief of those who already use cannabis for medicinal purposes that it is an effective form of pain relief with fewer harmful side effects than other legally available drugs, we think that the proper moral position is to promote clinical trials as soon as practicable. We recommend that the Government consider doing this.

89 In the meantime, while trials are being conducted, we think that it would be appropriate for the police to adopt a policy of not prosecuting in cases where they are satisfied that cannabis use is directed towards pain relief or managing the symptoms of chronic or debilitating illness.

Chapter 11 – Enforcement

90 The Search and Surveillance Bill 2009 currently before Parliament implements an earlier Law Commission report on search and surveillance powers. It brings together in one place all core police powers of search, including the search powers currently located in the Misuse of Drugs Act, and establishes a new generic surveillance regime to replace the current law.

Changes to warrantless search powers

91 One important change to the Bill's warrantless search powers will be necessary as a consequence of the changes we have proposed to the classification system in this report. Our proposal (in chapter 6) to remove subparts from the drug classification structure means that, if nothing is done, the warrantless search powers will be broader than currently – that is, they will apply to all controlled drugs and potentially all precursor substances.

92 We consider that a power to search places, vehicles and people without a warrant can be justified for all Class A and B drugs (and their precursors). Drugs in these classes, assuming appropriate classification decisions have been made, will pose a very high or high risk of harm. It is appropriate that immediate action can be taken without the need to obtain a warrant when an offence involving one of these drugs is suspected.

93 The approach that should be taken to Class C drugs is more difficult. We consider that the current warrantless search power in relation to Class C drugs also needs to stay broadly intact – that is, that a warrantless search power should at least be retained in relation to people and vehicles if there is reasonable cause to suspect an offence involving a Class C drug. However, the current ability to search a *place* without a warrant when a Class C drug offence is suspected should be limited to instances where there is reasonable cause to suspect a dealing offence. Searches of premises generally occur as a result of information received or a period of surveillance. That not only provides the opportunity for a warrant to be obtained but it is also likely to indicate whether dealing is involved.

Powers in relation to internal concealment

94 An issue that was not addressed in the Commission's search and surveillance report is whether changes are required to the Act's internal concealment powers. These powers enable police or customs officers to detain a person for up to 21 days if there is reasonable cause to believe that a person has any Class A or Class B drug secreted within his or her body for any unlawful purpose.

95 We recommend two changes to the existing powers. The first is to limit the powers to situations where the person is suspected of concealing drugs for the purposes of committing a drug dealing offence. The second is to enable the use of a wider range of medical imaging techniques and technologies if an examination is carried out to determine whether or not drugs are secreted. Currently, these examinations are limited to a physical examination, an x-ray or an ultrasound scan.

Chapter 12 – Drug treatment

96 Treatment services provided to treat alcohol and drug addiction or dependence are a key component of the *National Drug Policy*.

97 There is clear evidence that treatment can be cost-effective. Most reviews consistently find that addiction treatment yields net economic benefits to society. The National Committee for Addiction Treatment has cited studies that estimate that for every $1 spent on addiction treatment, there is a $4 to $7 reduction in the cost associated with drug-related crimes, and that for some non-residential programmes, total savings can exceed costs by a ratio of 12:1.

98 More weight should therefore be placed on treatment as a harm minimisation strategy, particularly in the criminal justice sector.

A coherent framework for delivery

99 We strongly support the need for a more effective structure and a coherent framework for alcohol and drug treatment services, and believe that this would plug some of the current gaps in those services and improve their delivery. The Commission's report on alcohol recommended that the Ministry of Health and the Mental Health Commission be supported to develop a blueprint for addiction service delivery for the next five years. Until such time as a blueprint has been completed, and specific gaps in existing services determined, it is difficult to identify where further resources may be required.

Dealing with offenders' drug and alcohol treatment needs

100 A significant portion of defendants currently appearing before the criminal courts have alcohol or other drug dependence or abuse issues. The drug involved is usually alcohol. Department of Corrections' research in 2008 found that 65 per cent of New Zealand prisoners had ongoing drug or alcohol problems.

101 The criminal justice system has a number of processes and disposition options available to ensure that the treatment needs of offenders are identified and that offenders are directed into treatment. These include a number of pilots and other initiatives being undertaken in the sector to improve access to, and the utilisation of, treatment as a disposition option. However, notwithstanding the many initiatives already in place, in practice there are still real problems in identifying the need for treatment in the criminal justice system and in accessing treatment services for those offenders who need them.

Separate treatment funding for offenders

102 We propose separate treatment funding for offenders through the justice sector.

103 Almost all assessment and treatment services that are accessed by the courts are funded and provided by the health sector. Within the health sector, access to alcohol and drug treatment is prioritised on the basis of clinical need. There can consequently be difficulties and delays in obtaining drug and alcohol assessments in a timely manner and in identifying appropriate treatment programmes. There are significant waiting lists for entry to intensive residential programmes in particular. These difficulties may prevent treatment from being utilised as a disposition option within the criminal justice system.

104 Based on their level of alcohol or drug dependence, many offenders, whose offending is driven by that dependence, will have lower priority for treatment than non-offenders. However, there is a wider public interest in ensuring that those offenders (for example, the recidivist drunk driver) receive treatment, so that the harms caused by their associated offending are reduced. Unless there is additional funding for treatment from the justice sector, better access to treatment services by offenders as a consequence of their conviction will inevitably reduce the availability of treatment to non-offenders. That would be unfair and contrary to the public interest.

105 To be cost-effective, an appropriate range of treatment interventions (based on an understanding of the relationship between criminal behaviour and alcohol and drug use) should be funded and made available to the courts.

Drug courts – pilot proposed for New Zealand

106 There is growing interest in New Zealand in the development of drug courts.

107 Drug courts are perceived as an improvement on other approaches. Active supervision of treatment by the judge and regular interaction between the judge and the offender is believed to increase the likelihood that the offender will successfully undertake the treatment programme. Because of the judge's status within the court system, he or she can also bring together and focus the efforts of the relevant agencies on each offender's specific problems.

108 The international evidence of drug court effectiveness, however, is somewhat mixed. Evaluations tend to indicate that drug courts can reduce drug use by participants and have a positive impact on participants' general health and wellbeing. Drug courts' impact on rates of reoffending is less clear.

109 We consider that there is enough evidence from the international experience with drug courts thus far to justify further exploration of the approach in New Zealand, if funding is available for a pilot. The pilot should utilise a pre-sentence model by way of adjournment and deferral of sentencing. The pilot should be evaluated.

110 In the New Zealand context, given the unified nature of the treatment sector and the relatively low number of people with dependence only on drugs other than alcohol, it would be artificial and unhelpful to try to exclude alcohol dependence from the pilot. We therefore propose that it should include offenders with both alcohol and other drug dependence.

111 The resourcing implications of the pilot will be significant. However, the offenders who are likely to meet the eligibility criteria for the pilot are a high risk and high needs group. In the absence of a drug court, substantial costs would still be incurred under alternative options in addressing the needs of this group, either through the Community Probation Service or otherwise. Notwithstanding that, we propose that a full cost benefit analysis be undertaken on the preferred model before the pilot proceeds.

Summary of recommendations

CHAPTER 4

R1 The Misuse of Drugs Act 1975 should be repealed and replaced by a new Act, which should be administered by the Ministry of Health.

CHAPTER 5

R2 There should be a new regime with its own criteria and approval process for regulating new psychoactive substances.

R3 The coverage of the new regime should be restricted to psychoactive substances that are manufactured for the primary purpose of being administered, ingested, inhaled, or injected in order to induce a psychoactive response.

R4 Products that contain psychoactive substances, but are primarily for other purposes, should continue to be regulated under HSNO for their dominant use and ERMA should, when issuing approvals under HSNO, give consideration to the potential for products containing psychoactive substances to be misused for their psychoactive effects.

R5 The Government should consider whether the new regime for psychoactive substances should, at a future date, be expanded to include a wider range of non-therapeutic lifestyle and recreational substances intended for human consumption.

R6 The regulator for the new regime should be required to facilitate regular consultation with the regulatory bodies under other related regimes, including HSNO, to address any issues that arise at the boundaries of the regime.

R7 The new regime should require anyone who wishes to manufacture, import or distribute a new psychoactive substance to apply for an approval for the substance before doing so.

R8 The following criteria should be applied by the regulator when deciding whether a psychoactive substance should be issued an approval under the new regime:

(a) the nature of the harm caused by the substance and any benefits associated with its use;

(b) whether that harm can be effectively managed by the imposition of regulatory controls (including considering any research into the impact of different regulatory controls on minimising harm generally and also specifically (if available) for that substance);

(c) the likely consequences of any proposed regulation or prohibition of the substance (including the cost of different regulatory options); and

(d) any possible displacement effects that might occur because of the way other substances are regulated.

R9 The regulator should consider all applications and determine whether to:

(a) issue an approval on appropriate conditions; or
(b) decline the application for an approval; or
(c) decline the application for an approval and refer the substance for classification as a prohibited drug.

R10 If an approval is issued, the approved substance should be able to be legally manufactured, imported and supplied subject to the regulatory controls imposed by the regime.

R11 All manufacturers and importers of approved substances should be required to report to the regulator any new information they acquire on the adverse effects of the substances they deal in.

R12 If a substance is assessed and not approved, because it appears from the available evidence that it has such significant adverse effects that these cannot be adequately managed with conditions, the regulator should refer the substance to the body responsible for classifying prohibited drugs so that the substance can be considered for inclusion in the prohibited drugs regime.

R13 Where a new substance is not approved, but the substance is not classified as a prohibited drug, it should be illegal to manufacture, import or distribute it, but not illegal to possess or use it.

R14 Each distinct combination of psychoactive ingredients should be considered a separate substance and should require an approval.

R15 Any person should be able to apply to the regulator requesting a reassessment of a substance, and the regulator should grant an application for a reassessment if:

(a) significant new information relating to the effects of the substance becomes available; or
(b) other substances with similar benefits, but less adverse effects, have become available and these could be approved in substitution.

R16 The regulator should be able to initiate a reassessment where satisfied that one of the grounds in R15 above applies.

R17 The regulator should be a separate regulatory authority with the appropriate expertise to determine applications for approvals.

R18 There should be a number of generic statutory conditions in primary legislation that apply to all approved substances.

R19 The regulator should have the power to impose additional more tailored substance-specific conditions as a condition of an approval.

R20 The age at which new psychoactive substances can be purchased should be the same age as that at which alcohol can be purchased from an off-licence.

R21 The advertising of substances approved under the regime should be prohibited except at the point of sale, either within premises where they are sold or supplied, or on internet sites from which they are sold or supplied.

R22 Point of sale advertising should be confined to material that communicates objective product information, including the characteristics of the substance, the manner of its production and its price. This restriction should also apply to advertising on websites selling these products.

R23 The promotion of new psychoactive substances, including sponsorship, should be prohibited in all media.

R24 Incentives to encourage people to purchase approved substances, such as promotional gifts or free-of-charge supply by retailers, should be prohibited.

R25 The sale or supply of approved substances should be prohibited from:

(a) places where alcohol is sold;
(b) petrol stations;
(c) pharmacies;
(d) non-fixed premises such as vehicles, tents and mobile street cars; and
(e) places where children gather (such as schools, recreational facilities and sports facilities).

R26 When a person is convicted of an offence relating to an approved substance, the sentencing court should have the power to prohibit that person from selling or manufacturing approved substances for a period of time.

R27 Any person under the age of 18 should be prohibited from manufacturing, importing or selling approved substances under the regime. However, this age restriction should increase to 20 if the legal purchase age is set at 20.

R28 Any person who has been convicted within the previous five years of a dealing offence under the Misuse of Drugs Act 1975 or an offence under the Crimes Act 1961 with a maximum penalty of seven years or more should also be prohibited from manufacturing or selling any approved substance under the regime.

R29 Approved substances should be packaged and stored in child-proof and tamper-proof containers.

R30 Approved substances should be accurately labelled with a full list of ingredients and the phone number and address of the National Poisons Centre should be included on all labels.

R31 The regulator should have the power to impose additional specific conditions as part of an approval relating to any or all of the following matters:

(a) additional place of sale restrictions;
(b) labelling restrictions and requirements;
(c) packaging restrictions and requirements;
(d) health warning requirements;
(e) signage requirements;
(f) quantity, dosage, form and serving requirements;
(g) storage and display restrictions;
(h) record-keeping requirements;
(i) any other requirements considered necessary or desirable to minimise the harm that might occur as a result of use of the substance.

R32 Any person selling or supplying a psychoactive substance, as well as the manufacturer or importer, should be required to comply with any specific conditions relating to the matters that have been specified in the manufacturing or importing approval for a substance.

R33 The regulator should have the power to issue binding codes of manufacturing practice governing the production, manufacture and preparation of substances, requirements for laboratory practice and for sampling and testing of substances.

R34 The conditions of approval for any approved substance should stipulate the applicable code or parts of a code of manufacturing practice that must be complied with by the manufacturer.

R35 The regulator should have the power to recall any approved substance at any time if it considers that the substance is:

(a) unsound or unfit for human consumption;

(b) damaged, deteriorated or perished;

(c) contaminated with any poisonous, deleterious or injurious substance.

R36 The Government should investigate the option of using excise tax as a mechanism for regulating the retail price of new psychoactive substances in a similar way to alcohol and tobacco.

R37 Manufacturers and importers should be required to file annual returns and reports, similar to those required in respect of tobacco products under section 35 of the Smoke-free Environments Act 1990, to provide data on the quantities of each approved product sold by the manufacturer or importer each year and the recommended retail price.

R38 Responsibility for enforcing the proposed regime should fall to police, New Zealand Customs Service and the Ministry of Health.

R39 The Director-General of Health should have a power to appoint enforcement officers for the regime.

R40 There should be a power to enter premises (other than a private dwelling house) and to inspect documents and take samples of substances for the purposes of monitoring compliance with any approval issued under the regime and with any of the statutory requirements or conditions attached to that approval.

R41 A warrant should be required to authorise entry to a private dwelling house.

R42 When enacted, Part 4 of the Search and Surveillance Bill should apply to the exercise of the search powers provided for the new regulatory regime, with the exclusion of provisions relating to the detention of persons found on the premises.

R43 There should be a power to search places, vehicles or people without a warrant in circumstances where there is reasonable cause to suspect a person is committing the offence of dealing in a substance that has not received regulatory approval.

R44 Where any substance covered by the regime is imported without an approval, it should become a prohibited import under section 54 of the Customs and Excise Act 1996 and section 209 of that Act should apply.

R45 The following offences and maximum penalties should be established:

(a) knowingly or recklessly manufacturing, importing, or supplying any unapproved psychoactive substance – maximum penalty three months imprisonment for an individual and a fine not exceeding $500,000 for a body corporate;

(b) manufacturing, importing, or supplying any psychoactive substance in breach of the generic or specific terms and conditions of an approval – maximum penalty three months imprisonment for an individual and a fine not exceeding $500,000 for a body corporate;

(c) knowingly including false or misleading information in an application for an approval or omitting any adverse information concerning the substance from an application – maximum penalty three months imprisonment for an individual and a fine not exceeding $125,000 for a body corporate;

(d) a manufacturer or importer knowingly failing to report any significant new information of any adverse effects of any substance they deal in – maximum penalty three months imprisonment for an individual and a fine not exceeding $125,000 for a body corporate;

(e) a manufacturer or importer failing to file an annual return and report or knowingly providing false or misleading information in an annual return and report – maximum penalty three months imprisonment for an individual and a fine not exceeding $125,000 for body corporate; and

(f) wilfully obstructing an enforcement officer undertaking functions or exercising powers under the regime – maximum penalty a fine not exceeding $5,000 for an individual and a fine not exceeding $10,000 for a body corporate.

CHAPTER 6

R46 The ABC classification system should be retained.

R47 The following factors should be incorporated in statutory classification criteria for assessing the risk of harm posed by any substance:

(a) the risk of physical harm posed by the substance's acute and chronic toxicity (including the risk of death);

(b) the capacity for a substance to be ingested by the more dangerous means of injection rather than swallowing;

(c) the likelihood of a substance causing dependence (including the intensity of pleasure derived from the substance and the psychological and physical withdrawal symptoms);

(d) the likely health care costs of substance misuse;

(e) the risk of damage to others posed by drug users' intoxication;

(f) the loss of public amenity value attributable to the use of the substance; and

(g) other social harms (such as child neglect, acquisitive crime and the erosion of family relationships).

R48 All the criteria, including those which measure social harm, should be applied and considered at the individual level and not at the aggregate level to better reflect the intrinsic harm of each substance rather than the prevalence of their use.

R49 A statutory committee of experts should be retained to assess the level of harm posed by a particular drug using the statutory criteria listed above, and to make recommendations to the Minister of Health as to its appropriate classification. The committee should consider assessments of drug harm undertaken in both New Zealand and other jurisdictions.

R50 The committee should be able to determine its assessment process and the appropriate weightings it applies to different harms. These may change over time as better information becomes available.

R51 The committee should be an independent advisory committee comprising up to nine people with expertise in pharmacology, toxicology, drug and alcohol treatment, community medicine, neuroscience, emergency medicine, psychiatry, expertise in drug research and evaluation, and knowledge and experience of the nature and context of, and reasons for, drug use.

R52 The Minister should be required to consider the committee's recommendations and to present a report containing the committee's advice and recommendations to Parliament at the time legislation proposing new drug classifications or changes to existing classifications is introduced.

R53 Classification decisions should be made by Parliament and the executive's power to prohibit and classify drugs by Order in Council should be removed.

R54 If the Order in Council process is retained, it should also allow downward classifications and the removal of substances.

R55 Substances should be classified and scheduled as either precursor substances or as controlled drugs, but not as both.

R56 Precursors should be separately scheduled as A, B or C precursors depending on the classification of the most harmful drugs they are potentially used to produce.

R57 The tiered ABC classification system should only be used for the purposes of determining penalties for offending and the ancillary purpose of applying law enforcement powers. Classifications should not be sub-divided and utilised for regulatory purposes.

R58 A full scale review should be undertaken to determine the appropriate classification of all drugs currently scheduled in order to address existing inconsistencies.

R59 There should be a requirement for regular review of classification decisions to ensure that drug classifications continue to reflect the developing scientific knowledge and relevant changes in the drug landscape.

CHAPTER 7

R60 The offence of supply of a Class C drug should be simplified so that there is one offence with a maximum penalty that is sufficiently high to enable all relevant factors to be taken into account in sentencing, including whether the supply involved a sale and/or supply to a young person.

R61 The maximum penalty for the offence of supply of a Class C drug should be seven years imprisonment.

R62 The offence of possession for supply, which includes a reverse onus of proof, should be replaced with an aggravated possession offence.

R63 The aggravated possession offence should be defined by reference to the quantity of drugs possessed, which should be set on a drug-by-drug basis.

R64 The expert advisory committee recommended in chapter 6 should be required to advise government on the quantity of drugs that would comprise "aggravated" possession (and, by default, "simple" possession).

R65 The maximum penalties for the aggravated possession offence should differ by class and should reflect the principle that aggravated possession is, at best, an attempted supply.

R66 There should be a statutory presumption against imprisonment in cases of social dealing.

R67 The presumption should only apply when the offending is not motivated by profit (as that term is commonly understood). The quantity of drugs and whether or not the offender was also using the drugs should be identified as secondary factors to be taken into account in determining whether there was a profit motive.

R68 The presumption should apply to all dealing offences and all drug classes, but should not apply when the dealing is to a person under the age of 18 years.

R69 Administering or offering to administer a controlled drug should be a separate offence with a maximum penalty of two years imprisonment.

R70 The offences and maximum penalties for dealing and related activities should be as follows:

DEALING AND RELATED ACTIVITIES – PROPOSED OFFENCES AND MAXIMUM PENALTIES

OFFENCE	CLASS	MAXIMUM PENALTY	SENTENCING
Supply, import, export, produce, manufacture	A	Life imprisonment	· Presumption in favour of imprisonment for Class A dealing (excluding social dealing) · Presumption against imprisonment for social dealing to adults
	B	14 years imprisonment	
	C	7 years imprisonment	
Aggravated possession	A	10 years imprisonment	
	B	7 years imprisonment	
	C	3 years imprisonment	
Cultivation of any prohibited plant	All classes	7 years imprisonment	
Administering controlled drug to another	All classes	2 years imprisonment	

CHAPTER 8

R71 It should no longer be an offence to possess utensils for the purpose of using drugs.

R72 If the possession of utensils offence remains:

(a) the legal position in respect of the distribution of clean needles and syringes by a person who has obtained them from an authorised source ("secondary distribution") should be clarified;

(b) consideration should be given to exempting from the offence other utensils and equipment that are harm reducing;

(c) the maximum penalty for possessing a utensil should be reviewed to ensure there is appropriate relativity with the maximum penalty for possessing or using a drug.

R73 A mandatory cautioning scheme should be established for personal possession and use offences.

R74 The key components of the cautioning scheme should be that:

(a) Police would be required to issue a caution notice when a personal possession and use offence was detected, with limited exceptions.

(b) The drugs in the user's possession would be confiscated whenever a caution notice was issued.

(c) A caution notice would only be issued with the user's consent and when the user acknowledged responsibility for the offence. Otherwise, the user would be prosecuted.

(d) A user would receive a specified number of caution notices. On his or her final caution, he or she would be required to attend a brief intervention session as a caution condition or face prosecution for the offence. The earlier caution notices would be accompanied by information on the legal and health consequences of drug use, and the contact details of support services and treatment providers. No other enforcement action would be taken.

(e) The number of cautions a user would receive would vary depending on the class of drug concerned:

  (i) a user apprehended for a Class A drug offence would be cautioned on the first occasion that he or she came to police attention and would be required to attend a brief intervention session on that occasion;

  (ii) a user apprehended for a Class B drug offence would be cautioned on the first two occasions that he or she came to police attention, and would be required to attend a brief intervention session on the second occasion;

  (iii) a user apprehended for a Class C drug offence would be cautioned on the first three occasions that he or she came to police attention, and would be required to attend a brief intervention session on the third occasion.

(f) A user who came to police attention for a personal possession and use offence for the second time for a Class A drug, the third time for a Class B drug, or the fourth time for a Class C drug, would be prosecuted.

(g) There would be no requirement as part of the caution conditions for the user to attend any specialist drug treatment that was identified as being required as a result of the brief intervention session.

(h) The caution notice would "expire" after a certain period of time, so that a user who received one or more cautions but then did not come to police attention for a significant period of time (for example, five years) would begin again at the first level of a caution.

R75 A caution notice should be able to be issued for:

(a) any "simple" possession offence;

(b) the offences of drug use and the possession of utensils (if those offences remain criminal offences);

(c) the offence of a restricted person procuring or attempting to procure a prescription or supply of a controlled drug.

R76 The cautioning scheme should not be available to youth offenders who are dealt with in the youth justice system.

R77 A presumption against imprisonment should apply in any case of personal use offending (including where an offender was convicted of a dealing offence but where the offence was committed to generate drugs solely for the offender's own use).

R78 If the cautioning scheme is implemented, the Police Adult Diversion Scheme should not be available for personal possession and use offences.

R79 If the cautioning scheme is not implemented, further consideration should be given to widening the application of the Diversion Scheme to a greater range of personal possession and use offences, including those for Class A and B drugs.

CHAPTER 9

R80 The following offences and maximum penalties should apply to precursor substances:

PRECURSOR SUBSTANCES – PROPOSED OFFENCES AND MAXIMUM PENALTIES			
OFFENCE	MAXIMUM PENALTY		
	A	B	C
Supply, produce or manufacture any precursor substance knowing that the substance is to be used in, or for, the production or manufacture of any controlled drug or cultivation of a prohibited plant	10 years imprisonment	7 years imprisonment	3 years imprisonment
Import or export any precursor substance knowing that it will be used to produce or manufacture any controlled drug	10 years imprisonment	7 years imprisonment	3 years imprisonment
Possess any precursor substance with the intention that the substance be used in, or for, the production or manufacture of any controlled drug or cultivation of a prohibited plant	5 years imprisonment	3 years imprisonment	2 years imprisonment
Import or export any precursor substance without a reasonable excuse	12 months	6 months imprisonment	3 months imprisonment

R81 The offence in section 13, which prohibits the possession of utensils for the purpose of committing an offence against the Act, should be abolished.

R82 The ability for the Minister of Health to prohibit the import, supply etc of utensils via a *Gazette* notice should be replaced by the necessary offences in primary legislation.

R83 An offence should be established to prohibit the import or export of pill presses or other equipment that is to be used to produce or manufacture controlled drugs.

R84 The offence in section 10, relating to the aiding, inciting, counselling or procuring of an act or omission in another country, should be retained but should be redrafted for clarity.

R85 The maximum penalties for the offence in section 10 should be revised so that they are the same for offences where the equivalent act or omission is aided, incited, counselled or procured in New Zealand.

R86 The offence in section 15, which prohibits the making of false statements for the purpose of obtaining a licence or for any other purpose under the Act, should be retained but narrowed in scope so that it only applies to a false statement that is made for the purpose of obtaining a licence.

R87 There should be a maximum penalty of three months imprisonment for the following offences:

(a) obstruction of those exercising powers under the Act (section 16);
(b) prescribing, supplying or administering a controlled drug to a person dependent on that drug, in contravention of the Act (section 24(1) and (1A));
(c) prescribing or supplying a controlled drug to a restricted person (section 25(2)(a));
(d) being a restricted person, procuring or attempting to procure a controlled drug (section 25(2)(b)).

R88 An offence's maximum penalty should appear alongside the offence to which it relates (the general maximum penalty in section 27 of the Act should be repealed).

R89 Maximum penalties for drug offences that specify a maximum term of imprisonment should not specify a maximum fine.

R90 The limitation periods in the Misuse of Drugs Act should be abolished so that drug offences are subject to the same limitation periods as other criminal offences.

R91 If it remains an offence to possess utensils for the purpose of using drugs, the limitation period for that offence should be the same as the limitation period for the possession and use of drugs.

R92 A principal should continue to be liable for an offence committed by his or her agent, but the relevant provision (section 17(1)) should be redrafted to remove any ambiguity in its application.

R93 A company director or manager should continue to be liable for the actions of a body corporate.

R94 When due to his or her negligence, a principal is liable for an offence committed by an agent, or a company director or manager is liable for an offence committed by a body corporate, the applicable maximum penalty should be half that which applies to the agent or body corporate.

R95 The evidential onus in section 12AC(4), which requires a defendant who is charged with importing or exporting a precursor substance to point to evidence of a reasonable excuse, should not be explicitly stated.

R96 The evidential onus in section 29A, which requires a defendant in summary proceedings, who is charged with an offence that has possession as an element, to point to evidence that the drug possessed was not of a usable quantity, should not be explicitly stated.

R97 The legal onus in section 30, which requires a defendant to prove that he or she was acting in accordance with an exemption, licence or regulation, should be removed.

R98 The legal onus in section 29C relating to the possession of controlled drug analogues should be removed.

R99 The legal onus in section 9, which requires a defendant to prove that a seed, fruit or plant which he or she possessed was not of the species Papaver somniferum, should be abolished.

R100 Section 29, which provides that a defendant remains liable for an offence even if he or she makes a mistake about the nature of the controlled drug or precursor substance, should be retained but redrafted to make clear that the prosecution must prove that the defendant knew that the drug or substance was a controlled drug or precursor.

R101 The profit forfeiture regime in the Misuse of Drugs Act should be retained and should enable the forfeiture of any dealing proceeds.

R102 The provisions in the Misuse of Drugs Amendment Act 1978, which enable the court to indirectly recover the proceeds of drug dealing, are redundant and inappropriate and should be repealed.

R103 There should be a statutory requirement that, following a conviction for any drug offence, a judge must order the forfeiture and destruction of any unlawful items to which the conviction relates.

R104 The forfeiture of unlawful items should not be taken into account in an offender's sentence.

R105 Enforcement agencies should have statutory authorisation to retain a representative sample of seized items and to dispose of the remainder.

R106 The forfeiture regime in the Misuse of Drugs Act, which enables the forfeiture of vehicles or conveyances used to commit a dealing offence, has been superseded by the Sentencing Act 2002 forfeiture regime and should be abolished.

R107 Section 33, which requires a court to send the particulars of a conviction against the Act to a offender's professional body, should be repealed.

R108 The Veterinarians Act 2005 should be amended to include a requirement that a court registrar must notify the Veterinary Council of New Zealand if a veterinarian is convicted of an offence against the Act.

R109 Section 21, which enables a court or coroner to suppress the name of a controlled drug, should be repealed.

CHAPTER 10

R110 All the current statutory exemptions in section 8 of the Misuse of Drugs Act and in regulations made under the Act should be retained, but they should, to the extent this is possible, be amalgamated into a shorter, simpler and clearer list of exemptions.

R111 The statutory exemptions currently in regulations made under the Misuse of Drugs Act should be included in primary legislation.

R112 The scope of the exemption in section 8 that allows District Health Boards, other certified hospitals, and institutions with the care of patients to possess those controlled drugs needed to treat their patients should be clarified. In particular, a clear definition of institution is needed.

R113 There should be a new statutory exemption for drug testing kits and other diagnostic test kits to authorise the importation, distribution, possession and use of such kits without a licence.

R114 The statutory exemptions and all the other provisions in the Misuse of Drugs Act that regulate access to and the use of controlled drugs as medicines should be moved into the Medicines Act 1981. However, because that may require a broader review of the Medicines Act, as an interim measure, the exemptions for controlled drugs should be consolidated within new legislation to replace the Misuse of Drugs Act.

R115 The provision in section 20 of the Act, which allows a medical officer of health to publish statements about any person the medical officer believes is or is likely to become dependent on controlled drugs, should be repealed. More explicit provision should instead be made for medical officers to provide information to relevant health care professionals on people who are subject to restriction notices issued under section 25 of the Act.

R116 The power in section 22 of the Act, which allows the Minister of Health to prohibit the production, distribution and use of any controlled drug, should be retained as a reserve power to deal with unanticipated and urgent safety issues. However, the power should have a higher threshold than the current provision and should be in the Medicines Act.

R117 The power in section 23, which allows the Minister of Health to prohibit any prescriber or other person from exercising any of the rights conferred by an exemption, should be repealed. The powers of registration authorities to take appropriate disciplinary action under the Health Practitioners Competence Assurance Act 2003 should be used instead to deal with cases where individual prescribers or pharmacists are found to be abusing their prescribing privileges under the exemptions.

R118 The restriction in section 24, which makes it an offence for a medical practitioner or other prescriber to administer, prescribe or supply controlled drugs solely to maintain someone's dependence unless the prescriber or the hospital or clinic in which he or she works is expressly authorised to treat drug dependence, should be retained.

R119 A new provision should be included to require that, where any medical practitioner other than one expressly authorised to treat drug dependence is prescribing or supplying controlled drugs as treatment for another condition to a person who the practitioner believes may be addicted, the practitioner must consult with an addiction specialist who has been authorised to treat drug dependence with controlled drugs.

R120 There should be better systems for effectively monitoring and then managing the level and nature of prescribing of controlled drugs within primary care and in other specialist disciplines where these drugs are used.

R121 The provision in section 25, which allows a medical officer of health to impose restrictions on the supply of any controlled drug to a "restricted person", should be retained but combined with the similar provision in section 49 of the Medicines Act.

R122 The medical officer of health should be authorised to provide details of restricted persons to all health practitioners and other people authorised to supply controlled drugs or prescription medicines. This information should be able to be communicated by any practicable means (including electronic communication) and should be provided regularly and kept up to date.

R123 The offence of supplying to a restricted person in contravention of a notice should be retained.

R124 It should continue to be an offence for a restricted person (where he or she knows he or she is restricted) to procure or attempt to procure a prescription or supply of controlled drugs or prescription medicines in contravention of the notice. The new enforcement approach recommended for personal use offences (with its emphasis on therapeutic interventions and treatment) should apply.

R125 The restriction in regulation 26, which prohibits any person who obtains multiple prescriptions for controlled drugs from relying on the exemption for patients who have been prescribed such drugs, should be in primary legislation.

R126 The restriction imposed by regulation 22, requiring the approval of the Minister of Health before a prescriber can prescribe or a patient can use any of the drugs specified in that regulation, should be repealed.

R127 The Director-General of Health should be the licensing authority for controlled drugs and in that role should determine all licensing matters.

R128 The Director-General should have the power to revoke licences where the conditions of the licence are breached or where the licence-holder is convicted of a serious offence.

R129 Offending that would disqualify a person from retaining his or her licence should include a conviction for serious offences under the Crimes Act 1961 or the Medicines Act.

R130 The current requirement for the licensing authority to obtain ministerial approval before issuing licences to certain categories of people or in relation to certain drugs should be repealed.

R131 All important aspects of the licensing regime should be included in primary legislation, including:

(a) the establishment or appointment of the licensing authority;
(b) the monitoring and enforcement powers of the licensing authority;
(c) the categories of licence that may be granted;
(d) any limitations or restrictions on the purposes for which different categories of licence may be granted or the types of activities licences may authorise;
(e) the criteria against which licence applications are to be assessed;
(f) the grounds and the process the licensing authority must follow if it wishes to revoke a licence;
(g) rights of review and appeal;
(h) the offence of making a false statement for the purposes of obtaining a licence; and
(i) the offence of breaching or failing to comply with the conditions of any licence.

R132 Primary legislation will need to contain appropriate regulation-making powers so that regulations can provide for other more detailed aspects of the licensing scheme.

R133 To give effect to our broader recommendation of having one regulatory regime governing access to all medicines (including controlled drugs), the licensing regime should be combined with that for other medicines and included in the Medicines Act.

R134 The Government should consider undertaking or supporting clinical trials into the efficacy of raw cannabis by comparison to synthetic cannabis-based products as a treatment for pain relief.

CHAPTER 11

R135 There should be a warrantless power to search places, vehicles or people if there is reasonable cause to suspect an offence involving any Class A or B drug (or its precursors).

R136 There should be a warrantless power to search vehicles or people if there is reasonable cause to suspect an offence involving any Class C drug (or its precursors).

R137 The current warrantless power to search places if there is reasonable cause to suspect an offence involving a Class C drug should be limited to dealing offences.

R138 The circumstances in which a person may be detained under the internal concealment regime should be restricted to situations where there is reasonable cause to believe that a person is concealing a Class A or B drug to commit a dealing offence.

R139 The internal concealment regime should be amended to permit the use of a wider range of medical imaging techniques and technologies.

R140 The inspection power in section 19 should be retained and made subject to the generic regime in the Search and Surveillance Bill.

CHAPTER 12

R141 There should be separate funding through the justice sector for the treatment of offenders with alcohol and drug problems.

R142 Subject to a fuller analysis of the likely cost-effectiveness and the availability of funding, the Government should consider establishing a drug court pilot.

R143 A monitoring and evaluation methodology should be developed and implemented as part of any drug court pilot.

R144 Any pilot should utilise a pre-sentence model by way of adjournment and deferral of sentencing.

Part 1
CONTEXT AND PRINCIPLES OF REFORM

Chapter 1

The context of drug reform

INTRODUCTION

1.1 Few adult New Zealanders would get through a day without using a drug of some sort: a jolt of caffeine to kick start the morning; a painkiller to dull a headache or a decongestant for hay fever; perhaps a covert cigarette on the way home from work; a beer or a glass of wine to help unwind at the end of the day; and for some a herbal or synthetic sedative before bed. Each week an estimated 147,800 New Zealanders use cannabis, alone or in combination with alcohol, to help them relax and, in some cases, cope with chronic pain or sleep problems.[1] Roughly half of adult New Zealanders – the equivalent of 1.3 million people – have used a prohibited drug recreationally at some point in their lives.[2] Many more take daily prescription drugs for an array of chronic conditions from blood pressure to arthritis and depression.

1.2 This is neither new nor surprising behaviour. Human beings have been using psychoactive substances (substances that affect mood and behaviour) for thousands of years. Some researchers have gone so far as to suggest that "there has never been a society that has not had some form of psychoactive drug or drugs used by at least some of its members".[3] Other social historians have claimed that pre-European Māori were one of the few known societies in the world not to have manufactured or used psychoactive substances."[4] Drug use has for a long time been regarded as a routine and beneficial part of life.

1.3 That said, our attitudes towards drug taking, and the social mores and legal controls surrounding drug use, have differed markedly over time – and continue to differ depending on the substance in question and context of use.

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1 Ministry of Health *Drug Use in New Zealand: Key Results of the 2007/08 New Zealand Alcohol and Drug Use Survey* (Ministry of Health, Wellington, 2010) at 47 [*Drug Use in New Zealand*].

2 Ibid, at xix.

3 David Ryder, Noni Walker and Alison Salmon *Drug Use and Drug-Related Harm – A Delicate Balance* (2nd ed, IP Communications Ltd, Melbourne, 2006) at 5.

4 M Hutt *Te Iwi Māori me te Inu Waipiro: He Tuhituhinga Hitori Māori & Alcohol: A History* (The Printing Press, Wellington, 1999) at 3.

1.4 For example, a century ago, New Zealanders could lawfully purchase quite large quantities of opium from licensed vendors without prescription.[5] Remedies containing opium and morphine were marketed and routinely prescribed to children and adults alike for a range of ailments from insomnia to colds. It was not until the 1920s, when the serious risks of addiction were better understood, that more stringent restrictions were legally enforced and drugs like heroin, cocaine and cannabis began to be regulated.

1.5 Half a century later, in the late 1960s and early 1970s when New Zealand's drug laws were last systematically reviewed, it was estimated that 11 per cent of all married women in the country took a daily hypnotic or tranquilliser prescribed by their family doctor.[6]

1.6 While this type of routine prescription of tranquillisers is largely a thing of the past, the range of psychoactive drugs available on prescription, or self-administered without prescription, has expanded exponentially in the ensuing 40 years. However, the laws used to regulate the use of psychoactive drugs in different contexts have struggled to keep pace and as a consequence can be both incoherent and inconsistent.

1.7 So, for example, the menu of drugs referred to in paragraph 1.1 is subject to a bewildering range of controls. The stimulant caffeine is not regarded as a drug at all (unless incorporated in a medicine) and is regulated under the Food Act 1981; codeine-based painkillers are regulated under the Medicines Act 1981, but some can be purchased freely over the counter; sedatives are also regulated by the Medicines Act, but must be prescribed by a medical practitioner. Meanwhile herbal sleeping "remedies", based on plants such as Valerian or Corydalis, can be sold without any controls at all provided no therapeutic claims about their effects are made. However, anyone choosing another herbal remedy, Cannabis sativa, as an aid to sleep – or as an alternative to prescription painkillers – commits an offence under the Misuse of Drugs Act 1975, while some synthetic alternatives to cannabis, marketed as "herbal highs", can currently be legally obtained from niche retailers without any restriction.[7]

1.8 And while most Western nations prohibit the recreational use of a wide range of psychoactive drugs, many, including New Zealand, have until recently permitted the aggressive sale and promotion of two highly toxic drugs for recreational purposes: ethyl alcohol and nicotine.

5 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand First Report (NZ Board of Health Report Series, No 14, Wellington, 1970) at Appendix VIII [*First Report*].

6 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report* (NZ Board of Health Report Series, No 18, Wellington, 1973) Appendix XII at 172 [*Second Report*].

7 On 30 March 2011 the Government announced its intention to include these substances in the restricted substances regime; see Peter Dunne, Associate Minister of Health. "Dunne Signals R18 Ban on Synthetic Cannabinoid Substances" (press release, 30 March 2011) < www.beehive.govt.nz > .

1.9 This short discussion illustrates the divergent and at times inconsistent regulatory responses to drug use in this and most other Western democracies. Some drugs are freely available to anyone; some are available subject to certain legal restrictions; and others are prohibited altogether unless under medical prescription.

1.10 At its most simplistic level, the explanation for these different regulatory approaches reflects the fact that the use of drugs can be both beneficial and harmful depending on the context in which they are used. However, such bright-line distinctions between benefit and harm are often far more nuanced in practice and are not always reflected in the strength of the regulatory response we adopt.

1.11 In part, the explanation for the more liberal approach to the control of alcohol and tobacco (the two most prevalent drugs) lies in the deeply entrenched positions they have had in the economic and cultural fabric of many nations. As noted in the Law Commission's recent report on the reform of alcohol regulation, New Zealanders have developed a high tolerance of alcohol-related harms as a result of the customary practices associated with heavy drinking in this country.[8]

1.12 Many of the illegal psychoactive drugs that are the focus of this report are frequently used in combination with other psychoactive drugs, including alcohol and tobacco. There is therefore a strong argument for adopting a consistent, evidence-based and holistic approach to the regulation of all psychoactive drugs.

1.13 However, the terms of reference for this review require us to focus primarily on a legislative regime to control illegal psychoactive drugs and the rapidly expanding range of so-called designer drugs that have so far escaped regulatory controls. Moreover, drug policy is not an empirical science evolving consistently from an evidence base. Rather, it is a dynamic process influenced by historical, moral, cultural and social expectations and norms and mediated by important economic and political considerations – including international treaties and conventions.

1.14 In light of this it is important to consider the social context of the current review of New Zealand's drug laws and to consider the changes which have occurred since these laws were last reviewed some 40 years ago.

THE CONTEXT OF DRUG REFORM

The Blake-Palmer Review 1968–1973

1.15 The last systematic review of this country's drug laws took place between 1968 and 1973 against the backdrop of the emergent youth counterculture. The use of drugs, particularly cannabis, heroin and the newer psychedelics such as LSD, went hand in hand with a spirit of social, cultural and sexual experimentation. In 1968, in response to what was perceived as a growing problem of drug use and dependence in New Zealand, the government appointed a Committee, chaired by the Deputy Director-General of Health, Geoffrey Blake-Palmer, to:[9]

> [E]nquire into and report on drug dependency and drug abuse in New Zealand and matters relating thereto and make recommendations.

8 Law Commission *Alcohol in Our Lives: Curbing the Harm* (NZLC R114, 2010) at ch 3 [*Alcohol in Our Lives: Curbing the Harm*].

9 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*, above n 5, at 3.

1.16 The Committee's investigations coincided with increasingly aggressive measures to combat the illicit traffic and abuse of drugs internationally. In 1961, under the auspices of the United Nations, all previous drug treaties had been consolidated under the Single Convention on Narcotic Drugs (the 1961 Convention). A decade later, in response to the rapid growth in the production and use of hallucinogens (such as LSD and mescaline), stimulants (such as amphetamines) and depressants (such as barbiturates, sleeping pills and tranquillisers), the Convention on Psychotropic Substances (the 1971 Convention) was signed.

1.17 Like any international convention that New Zealand signs, the Conventions were not self-executing. An important objective of the Blake-Palmer review was therefore to ensure New Zealand's drug laws complied with the additional requirements of these international treaties.

1.18 Within this context the Committee undertook a comprehensive review of drug laws and policies in New Zealand, consulting widely and commissioning reports on various aspects of drug use and offending. The Committee also commissioned an analysis of drug prescribing habits among the nation's General Practitioners. Its final report and recommendations to government, published in 1973, formed the basis of the current Misuse of Drugs Act which was enacted in 1975 and came into force in July 1977.

1.19 While public concern and political sensitivity was firmly focused on the so-called "hippie" culture and the perceived risks to a generation of pill-popping youth, the Blake-Palmer Committee adopted a more holistic approach to its review, tackling both the inconsistencies in the regulation of drugs such as cannabis and alcohol, as well as the potential misuse and abuse of prescription medicines.

1.20 The Committee was particularly concerned at the growing reliance on a range of new hypnotics and tranquillisers marketed as Mogadon, Valium and Librium. A detailed analysis of the prescribing of hypnotics and stimulants by New Zealand doctors between 1958 and 1971, revealed that the use of these drugs doubled over this 13 year period. The analysis also revealed that "married women" (a category which included women who had been divorced or widowed) were by far the largest consumers of hypnotics and stimulants. As highlighted earlier, the researchers estimated that on a typical day in New Zealand in 1971, 8.3 per cent of "married women" took a tranquilliser and 11.6 per cent took a hypnotic, a tranquilliser, or both.[10]

1.21 The risk of addiction associated with the prolonged use of benzodiazepines such as Valium and Librium was not well understood at the time of the Blake-Palmer review, but the Committee was concerned about both the cost to the health budget and the potential for doctors to be influenced by the "overzealous promotion" of new prescription drugs by competing pharmacological companies.[11]

10 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report*, above n 6, at 172.

11 Ibid, at 190.

1.22 But its main conclusion was that in many instances doctors were resorting to prescribing these drugs because they did not have the time or resources to deal with the underlying patient issues:[12]

> Hypnotics being used at double the level of 13 years ago; tranquillisers disappearing down our throats to the tune of $2.3 million a year; what excuse can there be for such a situation in a country like New Zealand? – except shortage of doctors and lack of time to spend on sorting out psychological troubles.
>
> One thing seems to be clear. For many women in New Zealand marriage is a stressful occupation, which is getting worse instead of better. Hypnotics and tranquillisers are not the answer.

1.23 In the Committee's final report, it recommended a single new Act to control all drugs and similar substances (other than alcohol and tobacco) that had a significant potential for misuse. It also recommended a more rational and transparent approach to drug regulation, proposing that all drugs controlled by the Act should be divided into schedules that broadly indicated their relative potential for harm and the degree of controls deemed necessary.

1.24 The Blake-Palmer Committee also made a number of progressive recommendations concerning prevention, treatment and options for the diversion of young offenders away from the criminal justice system. These recommendations, which did not find their way into the 1975 Act, were based on the Committee's firm conviction that without adequate attention to treatment, legislative attempts to control drug harms were unlikely to succeed:[13]

> The Committee has given very careful consideration to the progress which has been made in the control, treatment and alleviation of drug misuse since it commenced preparing its first report in 1969. It is strongly of the opinion that, while commendable progress has been made in some fields, there is little, if any, chance of halting, let alone reversing, the steady escalation in the misuse of drugs unless New Zealanders individually are prepared to meet the considerable cost of providing the broad and essential minima of treatment and research facilities now required and of developing an effective public education programme.

1.25 The Committee also noted the need for "much closer co-ordination of responsibilities and efforts of the many Government departments, social agencies and professional bodies" involved with drug abuse in the community.[14]

The contemporary context

1.26 Four decades on and the volume, patterns and context of drug use have all changed significantly.

12 Ibid.

13 Ibid, at 97.

14 Ibid.

1.27 Criminal justice statistics show that in 2008 there were 12,542 convictions for drug offences in New Zealand – 76 per cent of which related to cannabis offending.[15] This compares with the 700 people charged with drug offences in 1972.[16] In 2008 drug-related hospital admissions (excluding alcohol and tobacco) totalled 3,792,[17] compared with approximately 100 admissions for drug dependency in the late 1960s.[18]

1.28 While New Zealand women may have found alternatives to Valium and Mogadon to cope with relationship stresses, concerns have shifted to the alacrity with which New Zealanders have taken to the new generation of antidepressants, with the number of prescriptions for antidepressants doubling from 1.1 million in 1997 to 2.1 million in 2005.[19]

1.29 The illicit drug supply market has also changed significantly in the past four decades. As noted by the New Zealand Police Association in its submission to this review:[20]

> During the 1970s, most illicit drug use and supply in New Zealand was associated with a 'hippie' counterculture. That is no longer the case. Illicit drug supply is now criminal big business, and characterised by aggressive marketing of products to relatively wealthy, 'mainstream' consumers rather than just those living on society's margins. Suppliers are not always drug users, with profit in almost all cases being the sole motivation at all but the very lowest levels of the supply chain. Market position and debt recovery are enforced through violence and intimidation targeting rival suppliers, lower level dealers and users who leave themselves vulnerable to exploitation.

1.30 While such crude comparisons must be treated with caution, the figures suggest that the use of drugs, both medically prescribed and unsanctioned, is now an entrenched part of life for many New Zealanders.

1.31 This snapshot might suggest that the current legislative framework has been a failure, and that the Blake-Palmer Committee's warnings about the futility of drug laws operating in isolation from comprehensive treatment programmes and a robust multi-sectoral approach, were well founded. However, it would be rash to reach such a strong conclusion, because the efficacy of our laws must be assessed within the radically changed social context within which they now operate.

1.32 In the period since the Misuse of Drugs Act was passed into law New Zealand's population has increased by more than a million and the country has undergone significant economic, social, demographic and technological change.

15 A further 7,767 drug charges were prosecuted and resulted in an outcome other than conviction: 1,896 of these related to cannabis offending.

16 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report*, above n 6, at 240.

17 Provisional data for the period January–December 2008 derived from Ministry of Health Information Services, the National Minimum Dataset (NDMS) (Hospital Events).

18 In 1968 110 people were admitted, but this decreased to 90 in 1969; see Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*, above n 5, at 26.

19 Ministry of Health *Patterns of Antidepressant Drug Prescribing and Intentional Self-harm Outcomes in New Zealand: An Ecological Study – Public Health Intelligence Occasional Bulletin No. 43* (Ministry of Health, Wellington, 2007) at 12.

20 Submission of the New Zealand Police Association (submission dated 12 May 2010) at 4.

Many indicators of wellbeing have improved over this time, including average life expectancy, levels of educational attainment and income, but growing inequality and structural changes to the economy have come at a cost to some sections of society.[21]

1.33 Unemployment rates, which were near zero throughout much of the 1960s and early 1970s, are now around seven per cent (and as high as 30 per cent for Māori and Pacific youth). Research shows that the proportion of working-age people receiving a sickness benefit, invalid's benefit or ACC weekly compensation has risen from around one per cent of the adult population in the 1970s to five per cent in June 2002.[22] Mental health disorders, including depression and substance abuse, are believed to partially account for these increases.

1.34 Undoubtedly these and other social changes have made a significant contribution to patterns in drug use. Without the existence of our current drug laws the patterns in drug use may have been subject to even greater change. Nevertheless, it is reasonable to conclude that, while our current laws may well have had a significant impact upon the types of drugs that are used and the way in which they are consumed, they have had only a marginal impact upon the nature and extent of the overall problem.

New psychoactive substances

1.35 Alongside changes in the illicit drug market, modern technology has facilitated the emergence of a rapidly evolving market in novel psychoactive substances, many of which are promoted as "legal" alternatives to prohibited drugs. This poses real challenges for regulators and those concerned with protecting public health and is a major impetus for this review.

1.36 Recently, bodies such as the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) have noted rapid increases in the number of new psychoactive substances emerging in different markets around the world. In 2009, for example, EMCDDA was officially notified of 24 new psychoactive substances.[23] These included new, smokable herbal products laced with synthetic cannabinometic substances and a range of synthetic cathinones.[24] As noted by EMCDDA, the internet plays an important role in promoting and marketing many of these new substances as "legal highs" and "presents a growing challenge for monitoring, responding to and controlling the use of new psychoactive substances".[25]

21 The New Zealand Institute *NZahead: A Report Card of New Zealand Social, Economic and Environmental Wellbeing* (New Zealand Institute, March 2010).

22 Moira Wilson and Keith McLeod "Understanding the Growth in Invalid's Benefit Receipt in New Zealand" (2006) 29 Social Policy Journal of New Zealand Te Puna Whakaaro 127 at 129.

23 European Monitoring Centre for Drugs and Drug Addiction "Record Number of New Drugs Reported in 2009, says Report" (press release, 23 April 2010).

24 Synthetic cannabinometic substances mimic the effects of tetrahydrocannabinol (THC), the active ingredient contained in the cannabis plant. Cathinones are alkaloids which can be extracted from the leaves of Catha edulis (khat).

25 European Monitoring Centre for Drugs and Drug Addiction, above n 23.

1.37 As different countries assess these substances and their effects, some may be brought under existing legislative regimes. In New Zealand, for example, an amendment to the Misuse of Drugs Act in 1996 meant drugs that had a substantially similar chemical structure to an existing controlled drug were defined as drug analogues and automatically classified as Class C drugs.

1.38 However, the potential for rapid adaptation of a compound's chemical structure during manufacture means the analogue provision can often be side-stepped. This has led to a situation in New Zealand whereby a synthetic cannabinometic substance (marketed as "Spice") has been deemed by experts to be an analogue of THC, while another synthetic cannabinometic substance which has similar effects on users has been deemed to be sufficiently different in structure to avoid being classed as an analogue. Substances which avoid being classified as analogues currently escape effective regulation regardless of their potential for harm.[26]

1.39 This regulatory loophole saw the widespread sale of "party pills" in New Zealand during the first half of this decade. Because these pills' core chemical component, benzylpiperazine (BZP), was a novel synthetic compound which fell outside the drug categories covered by the Misuse of Drugs Act, it was possible for them to be manufactured and sold in New Zealand for five years without any regulatory controls or consumer safeguards.[27]

1.40 New Zealand's experience with BZP, and more recently with cannabinometic substances and cathinones, illustrates the potential risks in the current regime which allows non-analogue drugs effectively to be trialled on consumers without any regulatory controls. Devising a new regulatory scheme specifically for uncontrolled psychoactive drugs is a major focus of this report.

PRINCIPLES UNDERLYING THIS REVIEW

1.41 The terms of reference for this review require us to make proposals for a new legislative regime that is capable of dealing with the rapidly evolving market in new unregulated drugs described above and is consistent with our international obligations. They also require us to consider what the fundamental objectives of such a regime should be and the extent to which the legal framework for the regulation of drugs should reflect the principles of harm reduction which underpin this country's overarching drug policy.

1.42 The Government's framework for tackling the harms associated with the use of both legal and illegal drugs in New Zealand is set out in a document known as the *National Drug Policy*. The overarching goal of the *National Drug Policy* is to "prevent and reduce the health, social and economic harms that are linked to tobacco, alcohol, illegal and other drug use".[28]

26 Technically harmful substances which fall outside the analogue provision are covered by the hazardous substances regime in the Hazardous Substances and New Organism Act 2003. Since 2005 the Misuse of Drugs Act has also contained a provision allowing for substances which are not so harmful as to justify prohibition to be classified as restricted substances and subjected to regulatory controls. However, as discussed in paragraphs 5.16 – 5.32 in ch 5 of this report, neither of these alternatives is currently being used to regulate new substances.

27 Most of the first generation of party pills contained benzylpiperazine (BZP) often used in combination with trifluromethylpenylpiperazine (TFMPP). BZP has been found to have effects similar to low potency amphetamine and TFMPP to have similar effects to ecstasy.

28 Ministerial Committee on Drug Policy *National Drug Policy 2007 – 2012* (Ministry of Health, Wellington, 2007) at 4.

1.43 The use of regulation and prohibition, of course, is only one means of achieving this overarching goal. Other non-legislative measures, notably education and voluntary treatment, are recognised in the *Policy* itself as core complementary strategies. The key question is when regulation and prohibition, in addition to these complementary strategies, are justified.

1.44 As noted in the Law Commission's review of alcohol regulation,[29] our starting point in answering this question is that New Zealanders live in a free and democratic society and are at liberty to behave as they choose, provided that their actions respect the rights of others. Regulation and prohibition restrict that freedom of choice and must therefore be based on the need to protect others from harm and reduce the costs imposed on society as a whole as a result of an individual's choices. It is not generally appropriate for the State to intervene coercively to prevent individual citizens from harming themselves.

1.45 There are exceptions to this general rule. In particular, as the Commission recognised in its alcohol review, regulation or prohibition may be justified to prevent individuals from harming themselves in circumstances where they lack the necessary information, maturity or faculties to accurately assess the risks associated with their decisions and actions. For example, it may be appropriate to prohibit supply to those aged under 18 or to regulate advertising that artificially stimulates demand. Similarly, because individuals do not have the ability (due to a lack of information, time or otherwise) to assess the safety of every drug they use, it may be appropriate that regulation is in place to ensure that this assessment is made on behalf of us all.

1.46 In any case, the distinction between harm to drug users themselves and harm to others is in this context a somewhat artificial one. The use of psychoactive substances almost invariably carries the potential to harm others.[30] Family members and intimates may be harmed by risky or violent behaviour attributable to drug use, as well as emotional distress and financial hardship. Employers are affected by absenteeism and lost productivity. Other people are affected by activities such as driving under the influence of drugs or causing drug-related property damage and disorder. Drug use may also lead users to commit crime, either due to the immediate result of drug intoxication, the longer-term effects of drug use on the brain, or the need to finance a drug habit.[31] Society more generally must meet the cost to the health system of responding to drug-related injuries and conditions, and providing rehabilitative and treatment services. This suggests that some degree of regulation will almost always be justified.

1.47 The choice of regulatory strategy needs to take into account the costs associated with it, including the costs arising from the restrictions it imposes on individual freedom of choice. However, neither the benefits that arise from a particular strategy, nor the costs associated with it, can always be quantified. An economic cost/benefit analysis is therefore likely to be partial, biased in its coverage and

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29 Law Commission *Alcohol in Our Lives: Curbing the Harm*, above n 8.

30 Some commentators argue that most drug-related harms are borne by someone other than the user; see Robert J MacCoun and Peter Reuter *Drug War Heresies: Learning from Other Vices, Times and Places* (Cambridge University Press, New York, 2001) at 106.

31 The link between drug use and crime is contested. See Alex Stevens, Mike Trace and Dave Bewley-Taylor *Reducing Drug-Related Crime: An Overview of the Global Evidence* (Report 5, Beckley Foundation Drug Policy Programme, Beckley (UK), 2005).

accordingly inadequate. Rather, policy choices need to be based upon evaluative judgements informed by an overall assessment of the costs and benefits, both quantified and unquantifiable.

1.48 The degree of control involved in the regulatory strategy should also be the minimum required to achieve its objective. Absolute prohibition should be a last resort and reserved for those substances and activities which are so injurious that no lesser regulatory intervention will suffice.

1.49 This is the approach we have adopted with respect to designing a regulatory regime for the control of new psychoactive drugs. In an ideal world it is also the approach we would adopt to the control of drugs that are currently prohibited. However, with respect to these substances we are bound to modify this approach to some degree.

1.50 This is a consequence of the very significant obligations New Zealand has as a signatory to the United Nations' international drug conventions. These conventions commit signatory nations to prohibit the manufacture, distribution, possession, use and trade of all convention drugs except for medical or scientific purposes or under lawful authority.[32] These drugs, which include cannabis, are specified in a three-tier schedule of prohibited substances listed in the Misuse of Drugs Act.

1.51 Ensuring our recommendations are consistent with these international obligations is not only a requirement of our terms of reference but also an absolute and overriding principle in itself. For this review does not take place in a policy vacuum but rather within the context of the international effort to reduce the impact of drug abuse on humankind:[33]

> The Conventions have been signed and ratified by most UN Member States. This is a remarkable diplomatic achievement. It shows a high level of international consensus on a complex policy issue that impacts on different societies in different ways. There is near universal recognition of the gravity of the 'drug problem' and a shared recognition that it has an irreducibly global dimension.

1.52 Hence, while a very substantial body of public submissions to this review argued persuasively for a reassessment of the legal status of cannabis on the grounds that the evidence suggests moderate cannabis use by adults is no riskier (and is possibly less risky) than the use of the legal drugs, alcohol and tobacco,[34] this was not a policy position open to us to recommend.

1.53 Even if decriminalisation of cannabis were an option open to us, it is by no means clear that the benefits of such a policy would outweigh the harms associated with adding another potentially harmful substance to the list of legally

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32 See the detailed analysis in ch 6 of our issues paper; Law Commission *Controlling and Regulating Drugs* (NZLC IP 16, 2010) and the summary of country obligations and how they should be interpreted below in ch 3 of this report (paragraphs 3.53 – 3.57).

33 Marcus Roberts, Axel Klein and Mike Trace *Towards a Review of Global Policies on Illegal Drugs* (Report 1, The Beckley Foundation Drug Policy Programme, Beckley (UK), 2004) at 1.

34 For an assessment of the relative harmfulness of different drugs see, for example, David Nutt and others "Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse" (2007) 369 The Lancet 1051 and David Nutt, Leslie King, Lawrence Phillips, on behalf of the Independent Scientific Committee on Drugs "Drug Harms in the UK: A Multicriteria Decision Analysis" in (2010) 376 The Lancet 1558.

available drugs. As discussed in chapter 2, cannabis use can be associated with significant health risks, including a possibly greater potential than tobacco smoking to cause lung cancer. Any increase in the already high prevalence of cannabis use in the population is therefore likely to add to drug-related harms.[35]

1.54 However, proportionality is an important principle underpinning our approach to the sanctions and penalties that apply to illicit drug use and there is strong evidence to support the submitters' view that the abuse of alcohol and tobacco imposes greater costs on individuals and society than the use of cannabis.[36] There is therefore a strong argument for revisiting the criminal law's response to and penalties associated with the possession and use of cannabis to ensure that these consequences are not disproportionate to the harms cannabis use itself causes. At a more fundamental level this is also required to reflect our conclusion that the criminal law can be most effective when it adopts a more holistic approach to drug control rather than a purely punitive response.

1.55 In this report we argue that as a matter of principle the contemporary legislative framework for regulating drugs in New Zealand should not only be consistent with the overarching goals of harm reduction enunciated in the *National Drug Policy* but should also positively contribute to its realisation. Specifically, we support the stance adopted in recent years by the United Nations Office on Drugs and Crime (UNODC), which has warned against a narrow focus on the enforcement of prohibition and supply control measures at the expense of strategies aimed at reducing demand and treating drug dependency and addiction.

1.56 UNODC's Executive Director, Antonio Maria Costa, has argued that there has been an imbalance in both resourcing and policy priorities between measures designed to eliminate drugs and those designed to reduce demand. He has argued that this imbalance should be redressed so that more resources are put into prevention and treatment, as well as measures aimed at reducing the adverse health and social consequences of drug use.[37]

1.57 Recognising that drug control is *both* a criminal justice and a health and social policy concern is fundamental to our approach to this review, as is the view that adequately resourced drug treatment is fundamental to reducing the demand for drugs in the community and the harms resulting from drug abuse.

1.58 This is based on the rationale that substance abuse and dependence are fundamentally social and health problems. For individual users they become criminal problems when the substance in question is prohibited. But the legal status of the substance should not, of itself, inhibit or prevent a person from obtaining help – or worse, it should not exacerbate a user's problems through incarceration.

1.59 The importance of treatment in reducing drug offending was acknowledged by government agencies in their submissions to this review:

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35 S Aldington and others, "Cannabis Use and the Risk of Lung Cancer: A Case-control Study" (2008) 31 European Respiratory Journal 280 at 286.

36 See the discussion on attempts to measure the relative harm of different drugs in paragraphs 2.63–2.70 in ch 2.

37 Antonio Maria Costa "Health: The First Principle of Drug Policy" (18 March 2008) Costa's Corner < www.unodc.org > ; see also United Nations Office on Drugs and Crime *Reducing the Adverse Health and Social Consequences of Drug Abuse: A Comprehensive Approach* (UNODC, New York, 2008) at 5.

> Police acknowledges that increased access to drug and alcohol treatment services is likely to contribute to a reduction of people who repeatedly commit offences as a result of their addiction problems. People are frequently processed through the criminal justice system without having their underlying issues of drug and alcohol addiction addressed.[38]

> …the Ministry [of Health] would support an approach which allows the provision of information to users and assists them to access brief interventions and treatment… The Ministry also considers the likely impact of a drug conviction on the future employment, accommodation and travel prospects of a young person to be disproportionate to the offence, particularly if no opportunity is taken to provide the person with information, help and possible treatment.[39]

1.60 By placing a greater legal emphasis on diversion and treatment we also seek to reduce the very considerable harms that can arise from the criminalisation of those who use illicit substances. As highlighted in the Ministry of Health's submission above, and outlined in many other submissions to this review, individuals who receive criminal convictions as a result of their possession or use of prohibited substances often experience levels of harm quite disproportionate to their offending. A drug conviction can derail young lives, curtailing educational and work opportunities, making it difficult to access a range of services from housing to finance and insurance and hurting family and dependants. Minimising these harms for users is an important objective of policy reform.

1.61 In summary, then, our review of the Misuse of Drugs Act is underpinned by the following principles:

- The primary justification for regulating or prohibiting the manufacture and use of psychoactive drugs rests upon the potential for their use to result in harm to others. Intervention may also be required to protect the user from harm in circumstances where individuals lack the necessary information, maturity or faculties to accurately assess the risks associated with their decisions and actions.
- The choice between strategies must be consistent with the overriding obligation of all signatory countries to comply with the international drug conventions.
- The choice between strategies needs to be based upon an evaluative judgement, informed by an overall assessment of the costs and benefits, both quantified and unquantifiable.
- The degree of control involved in the regulatory strategy should be the minimum required to achieve its objective. Absolute prohibition should be a last resort.
- Even when prohibition is the preferred response, there should be a range of responses including the possibility, when appropriate, of treatment and rehabilitation. This will reduce the demand for drugs and the social and fiscal costs associated with drug-related offending.
- The abuse of drugs is both a health and criminal public policy problem and, as a matter of principle, drug laws should facilitate a multi-sectoral response designed to minimise drug-related harms.

38 Submission of the New Zealand Police (submission dated 18 June 2010) at 8.

39 Submission of the Ministry of Health (submission dated 30 April 2010) at 14.

REPORT'S STRUCTURE

1.62 Our recommendations are based on the principles outlined in this chapter. While these principles apply equally to prohibited drugs covered by the international conventions and to new unregulated psychoactive substances, the parameters applying to the two are different. The report is therefore structured to reflect the different legal starting points for the treatment of convention drugs and new psychoactive substances.

1.63 Part 1 of the report provides the broad context within which we have formulated our recommendations.

1.64 In chapter 2 we provide an overview of illicit drug use in New Zealand and set out the benefits and harms drug users experience as a consequence of their drug use. Chapter 3 describes in broad terms the evolution of drug control in New Zealand and summarises the key features of the Misuse of Drugs Act. It also reviews the extent of New Zealand's obligations under the international drug conventions. Chapter 4 explains how the law sits within the overarching framework of New Zealand's *National Drug Policy* and makes the case for a new approach.

1.65 Part 2 of the report, which consists of a single chapter (chapter 5), proposes a new regulatory scheme for the control of new psychoactive substances. The proposed regime would effectively reverse what happens now in practice because it would require manufacturers and importers to obtain an approval before releasing new substances onto the market.

1.66 Part 3 of the report addresses the approach to convention drugs. In chapter 6 we examine the ABC classification used for fixing penalties for drug offending and make recommendations for how that approach can be improved. Chapter 7 proposes a number of changes to the current law as it applies to dealing in illegal drugs.

1.67 In chapter 8 we examine personal possession and use offences. We believe there is scope in this area for a more effective approach to these offences that would direct drug users away from the criminal justice system and into health-based interventions. Chapter 9 examines all the other offences and penalties and procedural provisions contained in the Misuse of Drugs Act.

1.68 Chapter 10 considers the exemptions that are needed from the overall prohibition framework to enable controlled drugs to be lawfully used for legitimate medical, scientific and industrial purposes. In chapter 11 we examine the issue of enforcement. Finally, chapter 12 considers drug treatment and the options, including drug courts, for increasing the emphasis given to treatment as a disposition option within the criminal justice system.

Chapter 2

Drug use and harm in New Zealand

INTRODUCTION

2.1 All psychoactive drugs act on the central nervous system (CNS) to change how we feel, perceive and behave. They can be naturally occurring or synthetic. Most can be roughly categorised as depressants, stimulants or hallucinogens according to their primary effect on the CNS. Depressants, which include alcohol and opiates such as heroin, essentially slow (depress) the CNS and can have the effect of reducing inhibitions and awareness and producing a temporary sense of relaxation and wellbeing. Stimulants, which include caffeine, nicotine, BZP, cocaine and amphetamines, accelerate the CNS and can produce feelings of euphoria, increased energy, perception and alertness. Hallucinogens, or psychedelics, include naturally occurring organic substances such as mescaline (from the cactus plant) and synthetics such as LSD (Lysergic acid diethylamide). They act on the CNS in different ways, altering perceptions and sometimes inducing hallucinations.

2.2 But the effects of drug taking can differ markedly depending on the particular substance, the mode and pattern of use, the characteristics of the user and the context in which he or she is using. Alongside the sought-after effects of drug use, there can also be a range of unwanted and potentially harmful effects on the individual user and others with whom he or she lives and associates. Costs associated with these harms may be borne by publicly-funded services.

2.3 In this chapter we provide an overview of some of the important features of drug use in New Zealand, drawing on a range of data and surveys. We also rely on research and public submissions to provide an understanding of the scope and nature of drug-related harm.

2.4 However, the very significant differences in the harms associated with different types and patterns of drug use mean generalised discussions of this sort can be of limited value from a policy perspective. Similarly, drug harms are not evenly distributed among the whole population, so that it is important to identify the groups most likely to be affected. In order to illustrate the spectrum of harm associated with different types of drug use, this chapter includes a comparative analysis of the harms associated with two high profile recreational drugs in New Zealand, cannabis and methamphetamine.

CHAPTER 1 CHAPTER 2 CHAPTER 3 CHAPTER 4 CHAPTER 5 CHAPTER 6 CHAPTER 7 CHAPTER 8 CHAPTER 9 CHAPTER 10 CHAPTER 11 CHAPTER 12

What we use

2.5 Cannabis is by far the most commonly used illicit recreational drug in New Zealand – as it is throughout the world. Nearly half this country's adult population has used it at some point in their lives and about one in seven, or the equivalent of 385,000 people, were classified as current users in 2006.[40]

2.6 International comparisons compiled by the United Nations Office on Drugs and Crime (UNODC) suggest that at 13.3 per cent the annual prevalence (i.e. the percentage of the adult population who have used the drug in the past year) of cannabis use in New Zealand is among the highest in the world, behind Papua New Guinea (29.5 per cent), Micronesia (29.1 per cent), Ghana (21.5 per cent), Zambia (17.7 per cent), Canada (17 per cent) and Sierra Leone (16.1 per cent).[41]

2.7 Until recently New Zealand also had high use rates of the mild synthetic stimulant drug BZP (benzylpiperazine) marketed as "party pills". Initially available without restriction, the Ministry of Health estimates a total of 20 million doses of party pills were sold in New Zealand between 2002 and 2006.[42] The Ministry of Health's 2007–2008 drug use survey (subsequently referred to as *Drug Use in New Zealand*) estimates that 13.5 per cent of the adult population had used party pills at some point in their lifetime and 5.6 per cent were current users at the time they were made illegal in April 2008.[43]

2.8 But, as the following two graphs indicate, after cannabis and BZP, the percentage of the population who report ever having used illicit drugs, or who were using them at the time of the Ministry of Health's survey, falls away steeply: 7.3 per cent had used the hallucinogen LSD at some point in their lives and 1.3 per cent had used LSD in 2006; 7.2 per cent had used an amphetamine stimulant and 2.1 per cent had used one in 2006; 6.3 per cent had used ecstasy (MDMA), a drug which has both amphetamine and hallucinogenic effects, and 2.6 per cent had used it in 2006; and 6.3 per cent had used kava and 0.9 per cent had used it in 2006.[44]

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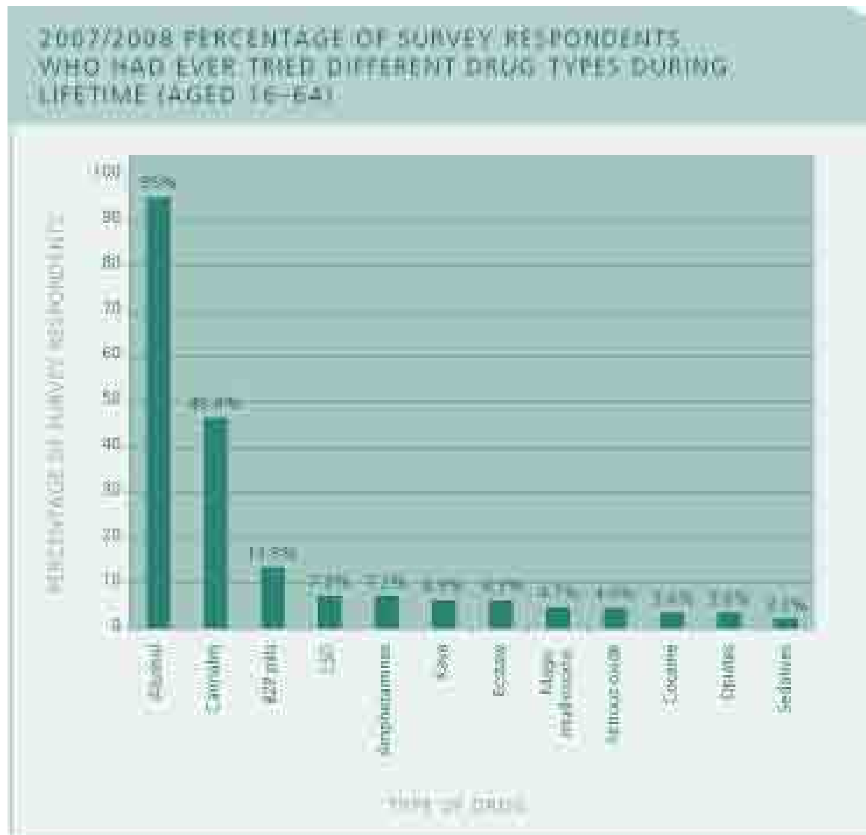
40 Ministry of Health *Drug Use in New Zealand: Key Results of the 2007/08 New Zealand Alcohol and Drug Use Survey* (Ministry of Health, Wellington, 2010) at 43 [*Drug Use in New Zealand*]. The survey measured past-year (2006) drug and alcohol use behaviours among over 6,500 New Zealanders aged 16–64. These surveys have been carried out regularly since 1998 and, while possibly underestimating illicit drug use, they provide an indication of the prevalence of use among the general population.

41 United Nations Office on Drugs and Crime (UNODC) *World Drug Report 2008* (United Nations, New York, 2008) at 276.

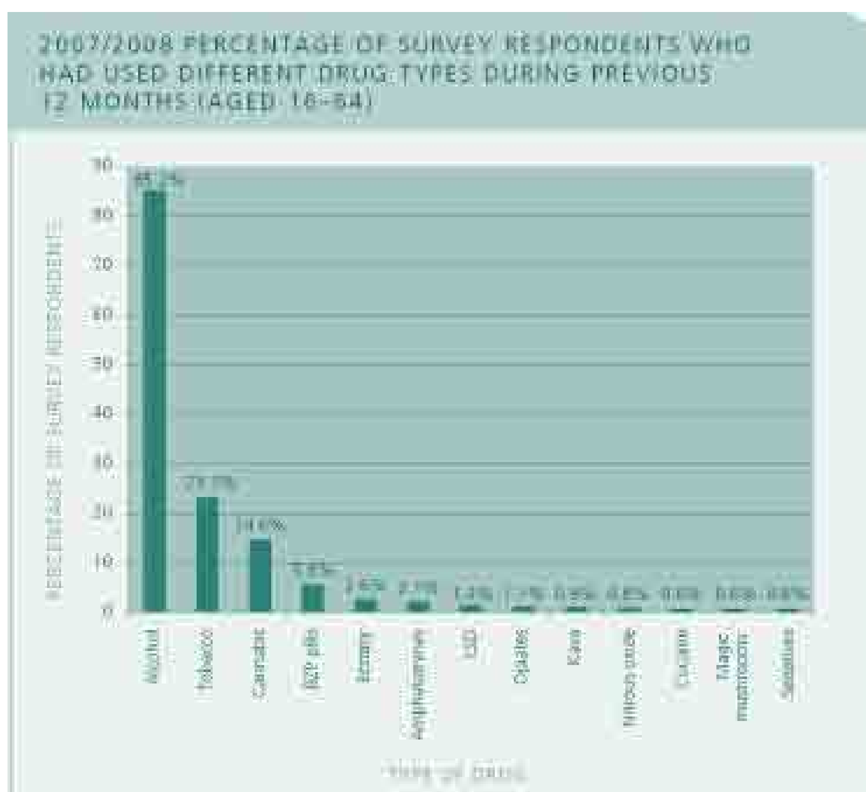
42 Beasley and others *Report for the Ministry of Health – The Benzylpiperazine* (BZP)/*Trifluoromethylphenylpiperazine (TFMPP) and Alcohol Safety Study* (Medical Research Institute of New Zealand, Wellington, 2006) at 2.

43 Ministry of Health *Drug Use in New Zealand*, above n 40, at 15.

44 All figures used here and in the graphs are taken from Ministry of Health *Drug Use in New Zealand*, above n 1, except that current tobacco use was reported in Ministry of Health *Tobacco Trends 2008: A Brief Update of Tobacco Use in New Zealand* (Ministry of Health, Wellington, 2009).



Amphetamines include amphetamine sulphate, methamphetamine (commonly called P) and crystal methamphetamine. **BZP** (benzylpiperazine) is a synthetic stimulant that induces effects similar to ecstasy. **Nitrous oxide** is more commonly known as laughing or happy gas. **Opiates** include diverted prescription drugs like morphine, codeine, or methadone; all forms of "homebake" derived from poppies or prescription opiates; and heroin.



2.9 At just over one per cent, the current use of opiates, which includes heroin and diverted prescription drugs like morphine, codeine or methadone, is low by international standards. Cocaine use is also rare in New Zealand with an annual prevalence of 0.6 per cent. This compares with Australia (2 per cent), the United Kingdom (2.6 per cent) and the United States (3 per cent).[45]

2.10 So while nearly half the population has tried illicit drugs at some point in their lives, a much smaller proportion – one in six or 16.6 per cent – of the adult population aged 16 to 64 could be considered current users of illegal drugs.[46] While this is three times the percentage of the world's population aged 15 to 64 that UNODC estimates used illegal drugs in 2006/07,[47] it is largely explained by our high rates of cannabis use.

2.11 After cannabis, the survey data shows the most commonly used type of drug in New Zealand are stimulants, which include amphetamines, ecstasy and diverted prescription stimulants such as Ritalin. *Drug Use in New Zealand* showed that just under four per cent, equating to 104,000 people, reported using some form of stimulant in 2006, excluding BZP. This was down from five per cent in the previous survey period but is still reasonably high by comparison with other countries such as the United States (1.6 per cent), Canada (1 per cent), England and Wales (1.3 per cent) and the Netherlands (0.3 per cent).[48]

2.12 Half of those who used stimulants, or the equivalent of 54,900 adults, used some form of amphetamines (excluding ecstasy). The most commonly used variety of the drug was speed (typically of a lower purity) followed by methamphetamine, often described as "P" (Pure) and ice or crystal methamphetamine. In 2006 an estimated 2.5 per cent of the adult population used an amphetamine and 1.6 per cent used "P" or crystal methamphetamine.[49]

2.13 Critically, from the perspective of health harms, New Zealand has low rates of intravenous drug use with only 0.3 per cent of the population, or the equivalent of 6,700 people, estimated to have injected drugs for recreational purposes in 2006.[50] This compares with 1.9 per cent in Australia.[51]

2.14 It is also important to note that illicit drugs are frequently used in combination with each other and with the legal drugs, alcohol and tobacco. For example, 76 per cent of cannabis users reported using alcohol with cannabis in the past year and 60 per cent said they had used cannabis and tobacco together. Over 11 per cent said they had used cannabis in combination with ecstasy, amphetamines, cocaine or heroin. It is also not uncommon for prescription drugs (obtained either legitimately or illegitimately) to be mixed with non-prescription drugs, including alcohol and cannabis.

45 United Nations Office on Drugs and Crime, above n 41, at [3.5.1.2].

46 Ministry of Health *Drug Use in New Zealand*, above n 40, at 15.

47 United Nations Office on Drugs and Crime, above n 41, at 30.

48 Ibid, at 278.

49 Ministry of Health *Drug Use in New Zealand*, above n 40, at 84.

50 Ibid, at 181.

51 The Australian Institute of Health and Welfare (AIHW) *2007 National Drug Strategy Household Survey: Detailed Findings* (AIHW, Canberra, 2009) at 83.

Drug trends

> Speed is the forerunner of methamphetamine. It was interesting because I was thinking that in the '60s the scourge of New Zealand was LSD, in the '70s the scourge of New Zealand was cannabis, in the '80s and early '90s the scourge was ecstasy, now we've got methamphetamine. All these drugs have been around and available for more than 50 years. (Auckland, parents, Year 9–13 students, male)[52]

2.15 This quotation from a 2009 research report on New Zealanders' knowledge of and attitudes towards illegal drugs (subsequently referred to as the *UMR Drug Research*), illustrates the cyclic nature of illicit drug use and our changing perceptions of drug harms. Although drug markets are distorted by the illegality of the product, they are nonetheless influenced by the laws of supply and demand, changing social trends and the emergence of new products. And as with many other commodities, the price and availability of drugs will impact on demand and will in turn be influenced by factors such as where and how the drugs are manufactured, the costs and risks in sourcing raw materials, and the complexities and risks of managing distribution and supply chains.

2.16 For example, New Zealand's geographic isolation, ocean borders and relatively small population base are likely to make it a less lucrative and more difficult market for international drug sellers to penetrate and have probably contributed to the relatively low use of heroin and cocaine. Conversely, our comparatively high rate of cannabis use is likely to be linked to climate and ready access to remote growing sites throughout New Zealand.

2.17 The rapid establishment of a methamphetamine market in New Zealand since the late 1990s may also be explained by the relative ease with which the drug can be manufactured locally using mobile laboratories and easily obtained chemicals, including illegally imported precursors and diverted domestic medicines. Police drug intelligence suggests the expansion of the methamphetamine market was initially fuelled by a small number of gang associates and visiting "cooks" who passed their manufacturing methods onto others.[53]

2.18 Changes in the prevalence of different drugs and the emergence of new psychoactive substances also reflect lifestyle and culture change. For example, the prevalence of cannabis has declined from 20 per cent in 2001 to 18 per cent in 2006. This has coincided with the growth in the use of stimulants such as methamphetamine, ecstasy and BZP, which in turn coincided with the growth of the late night economy and associated club and dance party scene.

52 Acqument Ltd and UMR Ltd *Research into Knowledge and Attitudes to Illegal Drugs: A Study Among the General Public and People With Experience of Illegal Drug Use* (Ministry of Health, Wellington, 2009) at 30.

53 Department of the Prime Minister and Cabinet Methamphetamine Working Group *Research Synthesis – Review of Best Practice on Interventions to Reduce Methamphetamine Use and Associated Harm* (unpublished paper, Department of the Prime Minister and Cabinet Methamphetamine Working Group, Wellington, 2010) at 20.

2.19 Since 2005 changes in the availability, price and patterns of drug use in New Zealand have been regularly monitored via a nationwide survey of frequent drug users. The surveys, known as the Illicit Drug Monitoring System (IDMS), are conducted annually as part of the *National Drug Policy*.[54]

2.20 The most recent IDMS survey, published in September 2010, noted the addition of ketamine (a drug used in anaesthesia) and oxycodone (a semi-synthetic opioid used for pain relief) to the menu of drugs being used by interviewees and the re-emergence of LSD, possibly in response to a perceived lessening in the potency of ecstasy.

2.21 Researchers have also been closely monitoring changes in the use and availability of methamphetamine since the epidemic growth noted in the early 2000s. Since that peak prevalence has reduced and is now considered to be in a "more stable endemic phase".[55] The IDMS survey also noted "a steady rise in the wholesale price of a gram of methamphetamine over the past four years from $610 in 2006 to $738 in 2009, indicating that law enforcement agencies are imposing significant costs on those trafficking in methamphetamine in New Zealand".[56]

2.22 Alongside this changing market for prohibited drugs, there now also exists a rapidly expanding market for synthetic substances which mimic many of the effects of controlled drugs but have a sufficiently different chemical structure so they escape regulation. This potential for infinite adaptation has very significant implications for regulators attempting to protect public health and minimise harms in the face of constant change.

Why we use drugs

2.23 Relaxation, a heightened sense of well-being, a social lubricant: these are some of the most common benefits New Zealanders cited when surveyed by the Alcohol Advisory Council (ALAC) about their use of alcohol.[57] Others sought the "buzz" associated with drinking and the sense of escape that comes with intoxication.

2.24 Broadly similar motivations were reflected in the very large number of recreational cannabis users who made submissions to this review. Submitters cited a wide range of benefits they associated with use of the drug, including a heightened sense of wellbeing, enhanced sociability, stress reduction, an aid to sleep and relaxation, and a palliative for chronic pain.

54 C Wilkins, R Giffiths and P Sweetsur *Recent Trends in Illegal Drug Use in New Zealand 2006–2009: Findings from the 2006, 2007, 2008 and 2009 Illicit Drug Monitoring System* (Centre for Social and Health Outcomes Research and Evaluation, Massey University, Auckland, 2010) [IDMS 2009]. The IDMS report drew on interviews with 315 frequent drug users in the three main urban centres, Auckland, Wellington and Christchurch and included 105 frequent methamphetamine users, 99 frequent injecting users and 111 frequent ecstasy users. (To be categorised as a "frequent user" the individual had to have used their primary drug of choice at least monthly in the past six months. All three groups also used cannabis and many used other drugs in combination with their drug of choice.)

55 Ibid, at 21.

56 Ibid.

57 BRC Marketing and Social Research "The Way We Drink: The Current Attitudes and Behaviours of New Zealanders (Aged 12 plus) Towards Drinking Alcohol" (2004) Alcohol Advisory Council of New Zealand <www.alcohol.org.nz>.

2.25 Relaxation, fun and a desire to fit in socially also featured strongly in the list of motivations cited by New Zealanders participating in the *UMR Drug Research*.[58] Researchers noted some differences between the motivations of young, novice drug users and older users: while "relaxing" and "having fun" featured high on the motivations of both groups, the most commonly cited reason for older users was "to cope with and block out personal problems". The report noted that for some in this group illegal drug use was a strategy to escape or help cope with personal and emotional "pain" and problems:[59]

> [P]eople gave examples from their own childhood experiences of sexual, physical and emotional abuse and dysfunctional family relationships. Some said they preferred to use illegal drugs and to 'self-medicate' rather than use drugs available from their doctor.

2.26 For others, drugs were a source of income and a way of life, particularly for those living in rural and low socio-economic communities where there were fewer legitimate employment and business opportunities.

2.27 Motivations for drug use also differ between substances and types of users. These differences are reflected in the responses of a sample of frequent methamphetamine, ecstasy and intravenous drug users surveyed as part of the IDMS.

2.28 Given its focus on frequent users of harder drugs, the survey findings cannot be treated as representative of the wider population of recreational drug users. However, the report provides some interesting insights into the self-reported reasons for drug use across the three groups. The most common and almost universal (and self-evident) motivations were simply "to get high", "socialise" and "have fun".

2.29 But there were also clear differences in motivations between drug users. For example, 67 per cent of ecstasy users said they used the drug to "stay awake to party", while only 13 per cent said they used it to "cope with unhappiness or everyday problems" and only 23 per cent because they considered themselves to be addicted. In contrast, about half of the frequent primary methamphetamine users reported using the drug to "cope with everyday problems, unhappiness and depression" and 72 per cent felt they were addicted. Among intravenous drug users, 84 per cent said they used because they were addicted and over 50 per cent said that they used to cope with depression and/or physical pain.[60]

2.30 Motivations for drug use can also change, sometimes rapidly, from experimental or recreational use to dependency.

2.31 The researchers summarised their findings in this way:[61]

> The most obvious reason why people use drugs is for their immediate pleasurable effects and to enhance social interaction. However, there are often a range of deeper motivations for drug use including coping with depression, stress, economic

58 Acqument Ltd and UMR Ltd, above n 52.

59 Ibid, at 95.

60 IDMS 2009, above n 54, at 193.

61 C Wilkins, R Giffiths and P Sweetsur *Recent Trends in Illegal Drug Use in New Zealand 2006–2008: Findings from the 2006, 2007 and 2008 Illicit Drug Monitoring System* (Centre for Social and Health Outcomes Research and Evaluation, Massey University, Auckland, 2009) at 157 [IDMS 2008].

deprivation, social exclusion and mental health problems (Hough 1996). Some people also use drugs to self medicate for chronic physical pain or to alleviate physical and psychological dependency (St.George et al. 2004, Inciardi et al. 2007).

2.32 Against this it is important to remember, as one submitter to this review stressed in his submission, that for many young people drug use is a rational and relatively uncomplicated personal choice, closely associated with contemporary lifestyles and culture:[62]

> I have been working in the nightclub industry for a long time and have had many experiences with people under the influence of drugs, while not dabbling myself. These are not depressed, renegade, idiotic or addicted people. They are bored. The drugs are for fun. The need for fun in one's life is a stronger addiction than any drug, strong enough that no amount of prohibition or punishment, or knowledge of health risks will drive it out. If we are to address these issues we need to figure out why our young people are so disenchanted, so bored with our churned up commercial world, with our lack of ambition and meaning in life.

2.33 As this discussion demonstrates, the human motivations for using intoxicants vary from individual to individual and between different substances and within different contexts. Alongside the genuinely recreational users is a subset for whom drug use is a palliative or a form of self-medication.

DRUG USE AND HARM

2.34 Just as the motivations for drug use differ between user groups and drug type, so too do drug harms. The factors which determine the extent and nature of drug-related harm include the pharmacological characteristics of the drug itself (including the substance's toxicity and propensity to cause addiction); the characteristics of the individual user (including their underlying health status and genetic predispositions, personality traits, motivation for use, age, ethnicity, gender and socio-economic status) and the context in which drug use occurs including factors such as the manner and frequency of use, the social and cultural norms and expectations associated with use and the legal sanctions, if any, attached to use.

2.35 Drug harms include both the immediate and longer-term health risks associated with drug use and a range of social harms. These social harms include the tangible effects of drug abuse on crime and public safety, and the less tangible effects on employment, productivity, educational attainment, personal relationships and general wellbeing.

2.36 In New Zealand three groups in the population have been identified as being at greatest risk from alcohol and drug-related harm: the young, Māori, and Pacific peoples.[63] In part this is explained by the higher rates of harmful alcohol and drug use among these groups – although the prevalence of illicit drug use is lower among Pacific peoples than the general population. Illicit drug use, like many

62 Submitter 7 (submission dated 12 February 2010). Submitters who are individuals and who have not made a submission on behalf of an organisation or in a professional capacity are identified by their submission number rather than by name.

63 Ministerial Committee on Drug Policy *National Drug Policy 2007–2012* (Ministry of Health, Wellington, 2007) at 7.

risky behaviours, is most common in the 18–24 year age group. Over one in three men and about one in three females in this age group reported using illegal drugs in the past year.[64]

2.37 New Zealand research has found that early exposure to alcohol and illicit drugs is associated with a range of poor adult outcomes including substance dependence, criminal convictions, sexually transmitted infections and failure to achieve educational qualifications.[65] This finding challenges the conventional view that adolescents who developed substance dependence problems could be distinguished from "normal" risk taking adolescents by the pre-existence of other conduct problems or disorders. Instead the authors of the Otago study concluded:[66]

> Approximately 50% of adolescents exposed to alcohol and illicit drugs prior to age 15 had no conduct-problem history, yet were still at an increased risk for adult substance dependence, herpes infection, early pregnancy and crime. Efforts to reduce or delay early substance exposure may prevent a wide range of adult health problems and should not be restricted to adolescents who are already at risk.

2.38 However, there are a number of challenges in describing the overall harms arising from drug use and reliably quantifying their costs.

2.39 In the first place, the harms arising from the use of some particular drugs (for example, the long-term health effects) may be unknown, or at best only partially understood.

2.40 Secondly, drug use may be associated with a range of harms without there being a proven causal link. In some cases, where causation is suggested, it may be bi-directional. So, for example, while social and economic disadvantage is often associated with higher rates of drug-related harm, the research suggests that drug abuse both *reflects* and *exacerbates* health and socio-economic disadvantage. Similarly, while substance abuse is an underlying risk factor for some mental health disorders, mental health disorders can also increase the risk of substance abuse – as illustrated in the preceding discussion about motivations for drug use.

2.41 Finally, even when particular harms can be identified and a causal link established, there may be great difficulties in describing the extent of the harm in quantifiable terms; many harms are intangible and relate to evaluations of quality of life which are difficult to translate into economic terms.

Health harms

2.42 All drugs, licit and illicit, have the potential to harm if taken in sufficiently high doses or for a prolonged period. The mechanisms by which drugs may harm the user relate primarily to the substance's toxicity and to its potential to cause addiction. In the longer term, repeated exposure to some drugs can cause damage to body organs and can contribute to a range of diseases including cancer and respiratory diseases.

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64 Ministry of Health *Drug Use in New Zealand*, above n 40, at 37.

65 Candice L Odgers and others "Is it Important to Prevent Early Exposure to Drugs and Alcohol Among Adolescents?" (2008) 19 Psychological Science 1037.

66 Ibid.

2.43 At a population level we do not have a complete picture of drug-related health harms because of the limited data available. Data on hospital admissions does not capture drug-related presentations to emergency departments that do not result in admissions, or those enrolled in private or public drug treatment programmes. Nor will this data necessarily capture when drug use is an underlying contributory cause of the presenting condition.

2.44 Crude public hospital admission data shows that in each of the years between 2004–2008 about 2,000 people were admitted into hospital with either a primary or secondary diagnosis related to cannabis use; about 1,200 with a diagnosis relating to opiate use; 650 with a diagnosis relating to stimulant use; less than 100 for hallucinogen use and fewer than 20 for cocaine use.[67] These diagnoses included mental and behavioural disorders relating to withdrawal, harmful use, acute intoxication and poisoning as a result of overdose and psychotic disorders.

2.45 This data does not, however, capture the prevalence of substance use disorders relating to illicit drug use – a major cause of drug-related harm. Dependence can be mild or severe and involve psychological and physical symptoms. Typically, addiction occurs after frequent use as the body and brain become habituated to exposure to the drug, leading to metabolic and cellular adaptations. These adaptations lead to increased tolerance as the body and brain accommodate the drug's effects. As a result, when drug use stops, the user will experience a range of withdrawal symptoms that will generally be the opposite of the sought-after effects associated with the drug's use. Tolerance and withdrawal are not the only indicators of addiction; others include craving for the substance, dyscontrol concerning use, and continued use despite harmful consequences.

2.46 The risk of dependence relates not just to the pharmacological makeup and purity of the substance but also to the manner in which the drug is administered (injecting and inhaling drugs, for example, produces a more intense and rapid effect than oral ingestion). It also relates to the characteristics of the user including underlying mental health issues or a genetic predisposition for dependence.

2.47 A major survey of New Zealanders' mental health published in 2006 estimated that 3.5 per cent of the adult population met the diagnostic criteria for a substance abuse disorder. Alcohol use disorders were most prevalent at 2.6 per cent, followed by drug abuse and dependence at 1.2 per cent and 0.7 per cent respectively.[68] The survey also found substance use disorders most common in the 16–24 age group (9.6 per cent) and among Māori (8.6 per cent).[69]

67 Ministry of Health Information Services, National Minimum Dataset (NMDS) (Hospital Events).

68 MA Oakley Browne, JE Wells and KM Scott (eds) *Te Rau Hinengaro: The New Zealand Mental Health Survey 2006* (Ministry of Health, Wellington, 2006) at 41.

69 Ibid, at 150.

Social harms and harms to others

2.48 Drug use does not occur in isolation but in a wider social context, and the knock-on effects are seldom limited to the individual. In the preceding chapter we argued that, with some limited exceptions, the primary justification for controlling drug use must be the harm and costs borne by others, including the state as the funder and provider of core health and justice services.

2.49 Direct harm may arise as a result of the actions, or inactions, of someone whose judgement or reactions are impaired or distorted by drug use or withdrawal. People may engage in a number of risky or abusive behaviours while under the influence of drugs, placing themselves and others at risk of harm.

2.50 The most common example is the drug or alcohol impaired driver who injures others in a road accident. Analysis by the Ministry of Transport has shown than for every 100 alcohol or drug impaired drivers killed in crashes, 54 of their passengers and 42 sober road users die with them.[70] A five-year study examining the extent to which drug use contributed to the deaths of 1,046 drivers killed on New Zealand roads between 2004 and 2009 found 48 per cent (500 drivers) tested positive for drugs or alcohol. The study, conducted for the New Zealand Police by the Institute of Environment, Science and Research Ltd (ESR), found that just under half of the 500 who tested positive had more than one drug in their system at the time of the fatality. The most common combination among the fatalities was alcohol and cannabis (28 per cent) while those who used cannabis alone accounted for 19 per cent of the fatalities and alcohol alone 27 per cent. Only 29 of the 500 drivers (six per cent) who had used a drug had not used either cannabis or alcohol.[71]

2.51 In addition to such highly visible and measurable drug-related harms are the harms experienced by families, friends and colleagues as a result of someone else's drug use. In *Drug Use in New Zealand*, about one in five, or 18.6 per cent of past year drug users, reported that their use had harmful effects, the most common of which were harm to the individual's financial position (11 per cent) followed by harm to friendships and home life (8.5 per cent).[72]

2.52 Employment and education were also affected, with 6.5 per cent of past year drug users reporting that their drug use had had a harmful effect on their work, study or employment opportunities and 5.6 per cent believing their drug use had resulted in learning difficulties. Drug use also impacts on productivity, with 7.2 per cent reporting they had had one or more days off work in the past year due to their drug use. This equates to about 34,700 New Zealanders.

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70 Ministry of Transport *Alcohol and Drug Crash Factsheet* (2008).

71 H Poulson *Alcohol and Other Drug Use in New Zealand Drivers 2004–2009* (Environmental Science Research Ltd, Wellington, 2010) at i.

72 Ministry of Health *Drug Use in New Zealand*, above n 40, at 196.

2.53 Critically, the abuse of alcohol and other drugs has been identified as an important contributory factor in the high rates of family violence and child injury and assault in New Zealand. The particular vulnerability of children who are dependent on adults who are intoxicated or who have a substance use disorder was emphasised in the submission of Children's Commissioner Dr John Angus:[73]

> The potential for a child to be harmed as a consequence of their parent or caregiver's drug use is obvious from even a cursory examination of the common effects of drug use [reference omitted]. The misuse of drugs can contribute to the following types of harm to children, including abuse and neglect:
>
> - physical abuse due to diminished self-control or violence
> - lack of proper supervision leaving children vulnerable to unintentional injuries and abuse by others [reference omitted]
> - leaving or putting children in unsafe situations (driving while under the influence of drugs, bed sharing between an infant and an adult under the influence of drugs risking smothering)
> - failure to ensure a child is prepared for their own day (such as being dressed appropriately or getting to school on time, and ensuring they've completed homework and have enough to eat)
> - emotional abuse and distress caused by changes in a parent's mood, perception, cognition and behaviour
> - family stress and financial hardship caused by spending on drugs
> - risk of child consuming drugs either directly (toddler putting a tablet in their mouth) or indirectly (secondhand cannabis smoke).

2.54 The submission cited a 2008 literature review prepared for the Ministry of Social Development (MSD) which found a "large body of evidence linking parental alcohol and substance abuse with all types of maltreatment and with the likelihood that a child will be exposed to inter-parent violence". Addressing adult alcohol and substance abuse was identified as a priority prevention strategy.

2.55 The Commissioner also cited a recent working paper prepared for MSD which found that in 17 of the 35 cases of child homicide within families between 2002 and 2006 there was:[74]

> [E]ither a history of drug and alcohol use by the perpetrator/s or drug and alcohol use associated with the event, or both. The substances used include alcohol, cannabis and methamphetamine. In some events the perpetrators were or had been clients of drug and alcohol services, but this was the exception rather than the rule.

2.56 The Commissioner concluded:[75]

> Work currently underway in my office has found that factors that increase vulnerability to child neglect include:
>
> - substance abuse by a parent or caregiver
> - family involvement with criminal activity
> - a local drug trade

73 Submission of the Office of the Children's Commissioner (submission dated 1 June 2010) at 3.

74 Ministry of Social Development (MSD) *Learning from Tragedy: Homicide within Families in New Zealand 2002–2006* (MSD, Wellington, 2009).

75 Submission of the Office of the Children's Commissioner (submission dated 1 June 2010) at 4.

In my view drug regulation must look beyond the individual user to his or her children and the impact the drug taking, and the legal response to it, will have on their lives. I strongly support a move towards a health policy response rather than drug use being solely dealt with by the criminal justice system.

Drug use and crime

2.57 The association between drug use and crime is complicated by the illegal status of most of the substances themselves. Whereas alcohol-related crime is limited to the actions of those whose behaviour is affected by their drinking, drug-related crime encompasses not just the actions of those affected by drugs, but also a range of offences stemming simply from the possession or use of the substance, irrespective of whether that use has resulted in harmful behaviour. The extent to which the illegal status of drugs contributes to the harms associated with drug use is discussed further in paragraphs 4.41 to 4.52 in chapter 4 of this report.

2.58 However, there is no doubt that drug use can contribute significantly to criminal offending. Because psychoactive substances can alter perceptions, distort judgement, and have a disinhibiting effect on behaviour, their use may result in accidental or deliberate injury to the user or others. Drug users, particularly those with a dependency, may also commit crime – including drug dealing – to finance their own drug use.

2.59 The New Zealand Arrestee Drug Abuse Monitoring programme (NZ-ADAM), which measures drug and alcohol use amongst those apprehended by police, indicates high levels of drug and alcohol use by offenders prior to arrest. However, while the evidence suggests a causal relationship between alcohol intoxication and aggression in some contexts, the nature of the association between various types of offending and the use of other drugs needs to be analysed carefully. For example, the same factors which predispose people to commit crime may also predispose them to use drugs.

2.60 Drug and alcohol intoxication have also been identified as risk factors in coercive and violent sexual behaviour. This may be associated with the disinhibiting effects of intoxication or the specific effects of some psychoactive substances on libido and sexual stamina. The New Zealand National Survey of Crime Victims (NZNSCV) 2001 reported that just under half (46 per cent) of victims of sexual violence thought the offender was affected by alcohol and/or drugs.[76] A 2008 Ministry of Justice review of sexual violence cases involving alcohol or drugs found that 50 of the 61 offenders were reported or suspected to have been drinking, sometimes in combination with other drugs, which were primarily marijuana but also Ritalin and "P".[77]

76 A Morris and others *The New Zealand National Survey of Crime Victims 2001* (Ministry of Justice, Wellington, 2003).

77 Ministry of Justice Case Law *Summary of New Zealand Sentencing Notes* (SVAD), (unpublished, 2008).

2.61 Similarly, the high prevalence of drug- and alcohol-related problems among New Zealand's prison population is likely to reflect the complex associations between criminal offending, socio-economic and social disadvantage, mental health issues and substance abuse.[78]

2.62 Alongside these relationships between individual offending and drug use is the overarching issue of illegal drug importation, manufacture, distribution and sale. In its submission to this review the New Zealand Police Association described these networks in the following terms:[79]

> The major supply chains…are to all intents and purposes entirely controlled by serious, trans-national organised crime networks. Even the supply of New Zealand's largest domestically produced illicit drug (cannabis) is, at a commercial level, dominated by New Zealand based, but globally-linked organised crime groups. Those realities mean the drugs trade is inextricably linked to a myriad of other types of criminal offending in New Zealand and elsewhere.

Counting the costs

2.63 As discussed in our Issues Paper, a recent paper by the Business and Economic Research Limited (BERL) estimated that the annual total social costs resulting from the harmful consumption of illegal drugs in New Zealand was $1,585 billion.[80] These costs comprised:

- costs for tangible (monetary) harms ($1,191.7 billion) borne by individuals (for example, lost wages, reduced productivity, medical treatment) and government (for example, crime costs, police and justice resources, healthcare costs, accident compensation, road crashes); and
- intangible (non-monetary) harms ($393.6 million) (for example, pain and suffering as a result of accident, loss of life).

2.64 Other tools have been developed to demonstrate the benefits of a particular enforcement approach. For example, BERL has also developed a Drug Harm Index for the New Zealand Police which provides a numerical estimate of the potential drug harm avoided annually due to drug seizures from 2000 to 2006 – in essence, the potential economic value to the community of drug seizures. That Index estimated that illegal drug seizures potentially avoided $458 million of drug harm in 2006.[81] A similar index has been developed for the Australian Federal Police.

2.65 However, while such studies provide one global view of the cost of drug harms, the overall picture they paint is deficient for a number of reasons.

78 The Department of Corrections estimates that 65% of sentenced prisoners in 2008 had on-going drug or alcohol-related problems; see Department of Corrections *Drug and Alcohol Treatment Strategy 2009–2014* (Department of Corrections, Wellington, 2009) at 3.

79 Submission of the New Zealand Police Association (submission dated 12 May 2010) at 5.

80 Business and Economic Research Limited (BERL) *Costs of Harmful Alcohol and Other Drug Use* (prepared for Ministers of Health and ACC, BERL, Wellington, July 2009) at 64. The study estimated the total social costs for the 2005/06 year, but expressed its findings in 2008 dollars.

81 Adrian Slack and others *New Zealand Drug Harm Index* (prepared for the New Zealand Police, BERL, Wellington, 2008) at 47. Note that whether or not this level of harm is actually avoided depends on a variety of factors, including the ability of drug users to access drugs from other sources.

2.66 First, they often conflate the harm arising from drug use (for example, offending that takes place while a person is under the influence of a drug) with the harm arising from drug prohibition (the consequences that arise simply from the illegal status of the drug itself). This gives a misleading picture of drug harm. The development of a criminal black market in a prohibited drug (and the crime that goes with it), the impact on a drug user of a criminal conviction, and the cost to the State of enforcing drug prohibition are costs and harms of drug prohibition, not drug use.

2.67 Secondly, attempts to measure and quantify those costs are fraught with ideological and methodological problems. Studies are inconsistent about whether and how they count intangible costs, such as those arising from the pain and suffering of those who witness the effects of dependence or disability on a loved one. As noted above, these are evaluative judgements about the quality of life which cannot have a dollar value readily attached to them.

2.68 Thirdly, the costs are typically confined to the harms arising from the use of illegal drugs. They do not take account of the equivalent harms arising from legal use – for example, the harms that follow an addiction to a controlled drug that was originally prescribed as a medicine and subsequently dealt with as a medical rather than criminal problem.

2.69 Finally, discussions of the harm that arises from illegal drugs tend to ignore the benefits that may arise from their use. As outlined earlier in this chapter, these benefits may include the pleasurable effects of an altered state of consciousness (ranging from increased relaxation to increased energy), better social bonding with peers or an escape from the realities of everyday life. Many of these benefits have parallels with the social benefits of alcohol (although those from alcohol are more readily acknowledged than those from illegal drugs).

2.70 We are therefore sceptical of the value of overarching attempts to quantify the costs of all drug use. In our view, it is more helpful to illustrate the extent and costs of harms from drug use by providing a more detailed and nuanced picture in relation to specific drugs.

TWO CASE STUDIES

2.71 The preceding discussion provides a very broad overview of the extent of recreational drug use in New Zealand and the potential harms associated with it. However, as explained, the risks and nature of drug-related harms vary greatly depending on the substance being used, the manner in which it is used and the characteristics of the users themselves.

2.72 If drug policies are to be effective, therefore, they must be based on an analysis of the patterns of drug use and drug harms in this country. As discussed, New Zealand has high rates of cannabis experimentation and use compared with many other countries. The past decade has also seen the growth of amphetamine use supported by the local manufacture of high grade methamphetamine. Understanding the different risks and harms associated with the use of these two drugs is therefore important.

2.73 The following discussion attempts to summarise the key research regarding the risks and harms associated with the use of cannabis and methamphetamine, with a particular emphasis on their impact on the young and Māori.

Cannabis

> I was somewhat older when I first tried it, by this stage my peers were binge drinking, partying and generally being obnoxious young Kiwis, I quickly found that alcohol made me sick, very easily and cannabis became my intoxicant of choice. There was no hangover, no aggressiveness, no black outs and best of all, it was a plant, completely natural and no risk of overdose, over-intoxication and/or death.[82]

2.74 The sentiments expressed in this submission from a "law abiding, tax paying, honest citizen" were echoed in many submissions to this review. Many also drew comparisons between the respective harms associated with the use of cannabis, alcohol and nicotine, challenging the justification for their different legal status:[83]

> I am a father of two adult children, a caring husband and have been a teaching Principal of a small rural school since 1991. I try to lead a respectable and law abiding life. I have also been smoking cannabis since 1979. I choose to smoke cannabis (rather than drink alcohol) and I grow my own plants because buying from criminal elements is unacceptable to me. ... Research is clear that smoking cannabis is less harmful than drinking alcohol or smoking cigarettes so therefore why should I be discriminated against.

2.75 And this from an occasional cannabis user:[84]

> [C]annabis itself, as far as I can see – and I speak as someone who has partaken from time to time, and who continues to be acquainted with many others, of all social ranks, who still use the wonderful substance – cannabis use, certainly in moderation, does not seem to me to have many, or perhaps even any, ill-effects. (Alcohol is a different story. Ah, the hypocrisy!)

2.76 The view that cannabis use is less harmful than the use of either of the two main legal drugs is supported by a number of international studies which rank drugs according to their potential to cause physical harm, dependence and social harms. A notable British study in 2007, headed by Professor David Nutt, ranked alcohol fifth and cannabis eleventh in a list of 20 psychoactive substances assessed for their potential to cause harm across a matrix of nine different health and social measures.[85] More recently Professor Nutt and others have taken part in another exercise scoring the same 20 substances against a broader range of 16 different health and social measures. Under this matrix alcohol is ranked first and cannabis eighth.[86] Both studies are discussed in more detail in paragraphs 6.26 to 6.34 in chapter 6.

82 Submitter 69 (submission dated 26 March 2010).

83 Submitter 117 (submission dated 15 April 2010).

84 Submitter 183 (submission dated 27 April 2010).

85 David Nutt and others "Development of a Rational Scale to Assess the Harms of Drugs of Potential Misuse" (2007) 369 The Lancet 1047.

86 David Nutt, Leslie King and Lawrence Phillips, on behalf of the Independent Scientific Committee on Drugs "Drug Harms in the UK: A Multicriteria Decision Analysis" in (2010) 376 The Lancet 1558.

Short-term effects

2.77 The primary psychoactive agent in cannabis is THC (or delta-9 tetrahyrocannabinol). The drug's potency varies according to the relative proportions of THC and cannabidiol (CBD), a non-psychoactive substance found in most cannabis products that moderates the THC effect. There is some concern that the THC content has increased in recent years as growing methods have become more refined. A study by ESR scientists in 2008 found the average THC value of seized cannabis plants from indoor and outdoor sites was 10.9 per cent, compared with an average of 3.4 per cent detected in 1998.[87]

2.78 High doses of THC can have hypnotic or hallucinogenic effects. However, because of its relatively low toxicity, the short-term risks of any serious health conditions arising from cannabis intoxication, such as poisoning, are much lower than for many other psychoactive drugs, including alcohol.

2.79 Like alcohol intoxication, cannabis intoxication can affect reaction time, short-term memory, judgement, concentration and motor skills, including driving. In its submission to this review, the Child and Youth Mortality Review Committee (a body which reviews the cause of death of any New Zealander who dies before the age of 25) said its case reviews show a trend in motor vehicle deaths involving cannabis or cannabis and alcohol as a causal factor.[88] *Drugs in New Zealand* found that more than a third of all past-year cannabis users report driving while feeling under the influence of cannabis, compared with one in five past-year drinkers. Among young male cannabis users, aged 18–24, 52 per cent admitted driving under the influence of cannabis, compared with 33 per cent of young male drinkers who reported driving under the influence of alcohol.[89] As discussed earlier, recent ESR research has revealed that a high proportion of alcohol and drug impaired drivers killed in road accidents in New Zealand between 2005 and 2009 had consumed cannabis (either on its own or with alcohol).[90]

Longer-term effects

2.80 Just as the risks of long-term alcohol-related harms increase with frequency and dosage, so too do the risks associated with cannabis use. International research suggests that approximately nine per cent of all those who have ever used cannabis, and one in six of those who begin using cannabis in adolescence, become cannabis dependent.[91] New Zealand longitudinal studies suggest the rate of dependence may be twice as high among current young users.[92]

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87 G Knight and others "The Results of an Experimental Indoor Cannabis Growing Study" (Institute of Environmental Science and Research Journal of the Clandestine Laboratory Chemists Association, Wellington, 2009).

88 Submission of the Child and Youth Mortality Review Committee (submission dated 30 April 2010) at [7.01].

89 Ministry of Health *Drug Use in New Zealand*, above n 40, at 197.

90 Poulson, above n 71, at i.

91 Robin Room and others *The Global Cannabis Commission Report – Cannabis Policy: Moving Beyond Stalemate* (The Beckley Foundation Global Cannabis Commission, Beckley (UK), September 2008). Compared to 32 % for nicotine, 15 % for alcohol, and 11 % for stimulants.

92 R Poulton and others "Persistence and Perceived Consequences of Cannabis Use and Dependence among Young Adults: Implications for Policy" (2001) 114 New Zealand Medical Journal 544. Dependence was assessed as meeting the criteria for cannabis dependence on the DSM-IV.

2.81 There is also increasing evidence suggesting a causal link between cannabis use and mental health disorders, particularly psychosis and schizophrenia.[93] Cannabis use by those with a mental health disorder may also exacerbate the disorder and make it more difficult to manage.[94]

2.82 Regular cannabis smokers, like tobacco smokers, are at increased risk of chronic bronchitis, respiratory infections and pneumonia when compared to non-smokers. Cannabis smoke contains carcinogens and may cause cancers of the lung and aero-digestive tract.[95] A recent New Zealand study found cannabis may have a greater potential than tobacco to cause lung cancer. The population-based, case-control study found for each joint-year of cannabis exposure the risk of lung cancer was estimated to increase by eight per cent. A major differential risk between cannabis and cigarette smoking was observed, with one joint of cannabis being similar to 20 cigarettes for risk of lung cancer.[96] While the researchers cautioned about the limitations of epidemiological research in determining the effects of cannabis, they concluded that given the increasing prevalence and mortality of lung cancer, public health initiatives needed to include cannabis reduction initiatives alongside smoking cessation campaigns.

2.83 And while many cannabis advocates regard its use as more socially benign than the use of alcohol, the *Drug Use in New Zealand* survey indicates broadly similar rates of harmful effects on friendships (cannabis seven per cent: alcohol 7.8 per cent) and home life (cannabis 6.8 per cent: alcohol 6.2 per cent). Cannabis users reported higher rates of harmful effects on work, study or employment opportunities (5.6 per cent compared with 3.6 per cent) and significantly higher rates of learning difficulties (five per cent compared with one per cent).[97] These harmful effects, as discussed in more detail below, are particularly felt by young people.

2.84 Notwithstanding this catalogue of harms, they must be put in context. There are risks associated with the use of all psychoactive substances; whether or not they materialise depends upon the characteristics of the user, the circumstances of use and, perhaps most importantly, the extent of use. If cannabis is used occasionally and in small quantities, the risk of harm is likely to be low. If it is used frequently and to excess, the risk is likely to be high. But even when the risk does materialise, as will be discussed in more detail in chapter 6, the resulting harms are often of a much lower order than those arising from most other prohibited psychoactive substances.

93 Room and others, above n 91, at 56.

94 Wayne Hall and Rosalie Liccardo Pacula *Cannabis Use and Dependence: Public Health and Public Policy* (Cambridge University Press, Cambridge (UK), 2003) at 97.

95 Room and others, above n 91, at 5–37. Cannabis smoke contains many of the same carcinogens as tobacco smoke.

96 S Aldington and others, Cannabis and Respiratory Disease Research Group "Cannabis Use and Risk of Lung Cancer: A Case-Control Study" (2008) 31 European Respiratory Journal 280 at 286.

97 Ministry of Health *Drug Use in New Zealand*, above n 40.

Cannabis use and young people

2.85 As with alcohol, there is a growing body of research suggesting the risks associated with cannabis use in young people may be much greater than previously understood.[98]

2.86 Rates of cannabis use and experimentation are high among young people in this country, with more than a third (35 per cent) of males and just under a third (27 per cent) of females aged 18–24 classified as current users. In this cohort, 44.9 per cent of the males and 32.4 per cent of the females used cannabis at least weekly.[99] Given this high prevalence, it is important to understand how cannabis use may be impacting on the life course of young people.

2.87 In New Zealand, much of the evidence on the effects of cannabis on young people has been derived from two large South Island longitudinal studies: the Christchurch Health and Development Study involving 1,265 children born in that urban region in 1977; and the Dunedin Multidisciplinary Health and Development Study involving 1,037 children born in Dunedin between 1972 and 1973.

2.88 The Christchurch study, under the aegis of the University of Otago's Department of Psychological Medicine and headed by Professor David Fergusson, has allowed researchers to study numerous variables affecting the life course of over 1,000 young people from birth through adolescence and into adulthood. Among the 300 plus scientific papers based on the study has been a significant body of research revealing associations between cannabis use and a range of negative life outcomes including mental health problems, poor educational and employment outcomes, welfare dependence, interpersonal violence and criminal offending.

2.89 Using complex statistical modelling the researchers have been able to isolate the contribution cannabis use has made to these harms, independent of other confounding factors such as family dysfunction or socio-economic disadvantage. Among the most significant findings arising from the research on this cohort were:

- Daily cannabis users faced significantly increased risks of psychosis. The evidence suggested the association between cannabis use and psychosis was both causal and dose-responsive. The researchers concluded "the weight of the evidence clearly suggests that the use of cannabis (and particularly the heavy use of cannabis) may alter underlying brain chemistry and precipitate the onset of psychosis/psychotic symptoms in vulnerable individuals".[100]
- Increasing use of cannabis amongst 14–25 year olds was associated with the increasing use of, and abuse of or dependence on, other illegal drugs. The association between cannabis use and use of other illegal drugs was strongest for teenagers aged 14–15 who were using cannabis at least weekly, with the strength of this association declining markedly with increasing age and lower levels of use.[101]

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98 DM Fergusson and JM Boden "Cannabis Use and Later Life Outcomes" (2008) 103 Addiction 969 at 974.

99 Ministry of Health *Drug Use in New Zealand*, above n 40, at 44 and 49.

100 DM Fergusson, LJ Horwood and EM Ridder "Tests of Causal Linkages between Cannabis Use and Psychotic Symptoms" (2005) 100 Addiction 354 at 364.

101 DM Fergusson, JM Boden and LJ Horwood "Cannabis Use and Other Illicit Drug Use: Testing the Cannabis Gateway Hypothesis" (2006) 101 Addiction 445.

- Increasing cannabis use was associated with declining educational achievement; reduced income at 25; increased welfare dependence; reduced relationship satisfaction and reduced life satisfaction – even following extensive control for factors present prior to and during adolescence.[102]
- The early use of cannabis in adolescence is strongly associated with lower educational achievement. Findings based on the Christchurch Health and Development study combined with three large Australasian cohort studies suggest that the early use of cannabis "may contribute up to 17 per cent of the rate of failure to obtain the educational milestones of high school completion, university enrolment and degree completion".[103]
- For this cohort, rates of driving under the influence of cannabis were 2.5 times higher than rates of driving under the influence of alcohol. An analysis of the rates of self-reported active motor vehicle collisions (that is, those for which the driver would be held accountable in law) showed "the risks posed by driving under the influence of cannabis exceeded the risk of driving under the influence of alcohol".[104]

2.90 In the researchers' view, these findings provide strong evidence of the risks the early onset of frequent cannabis use poses to young New Zealanders and point to the need to carefully consider these risks in any policy decisions regarding the regulation of the drug.[105] This view was supported in a number of submissions from organisations and individuals working in various capacities with young people in New Zealand. A counsellor with a Wellington-based organisation providing outpatient treatment to adolescents (10–19 years) with alcohol and drug problems, stressed the importance of reducing the prevalence of cannabis use in adolescence:[106]

> As a drug and alcohol counsellor, working in secondary schools in the Wellington region, I see the direct effects of cannabis on young people are serious. Although the effects of harder drugs such as "P" are more severe, and not every young person exhibits addiction symptoms, cannabis is a huge problem for many youth. The effects of heavy use by youth that our service see include reduced capacity to learn, concentrate and achieve academically. Invariably there are behavioural issues, often criminal and marked decreases in motivation.

102 LJ Horwood and others "Cannabis Use and Educational Achievement: Findings from Three Australasian Cohort Studies" (2010) 110 Journal of Drug and Alcohol Dependence 247; and DM Fergusson and JM Boden above n 98 at 969.

103 Fergusson and Boden, above n 98; and Fergusson, Boden and Horwood, above n 101, at 470–476.

104 Horwood and others, above n 102; and DM Fergusson, JM Boden and LJ Horwood "Is Driving Under the Influence of Cannabis Becoming a Greater Risk to Driver Safety than Drink Driving? Findings from a Longitudinal Study" (2008) 40 Accident Analysis and Prevention 1345 at 1350; and DM Fergusson, NR Swain-Campbell and LJ Horwood "Arrests and Convictions for Cannabis Related Offence in a New Zealand Birth Cohort" (2003) 70 Drug and Alcohol Dependence 53 at 63.

105 Fergusson and Boden, above n 98.

106 Submission from Robert Nawalowalo of WellTrust – Youth Alcohol and Drug Service (submission dated 26 April 2010).

Cannabis and Māori

2.91 Māori are twice as likely to use cannabis as non-Māori.[107] In *Drug Use in New Zealand*, for Māori youth aged 13–17 years, approximately one in four (26.4 per cent) had used cannabis in the last 12 months. Significantly, given the heightened risks associated with early drug use discussed above, nearly 30 per cent of Māori who had used cannabis began using at 14 years or younger, compared with 16.2 per cent of non-Māori.[108] As with alcohol, Māori were also more likely to use cannabis in a hazardous way. *Drug Use in New Zealand* showed Māori consumed more potent forms of cannabis and were more likely than other ethnic groups to engage in either frequent (10 times or more per month) or daily use.

2.92 Māori past-year cannabis users were significantly more likely to report harmful effects from cannabis on many areas of life, including energy and vitality, health, financial position, outlook on life, friendships and social life, home life and work or work opportunities.

2.93 A landmark survey of mental health disorders in the New Zealand population, published in 2006, reported that "marijuana disorders (which are a subgroup of drug disorders) contribute strongly to the overall drug disorder prevalence in Māori, with lifetime marijuana abuse in 12.8 % of Māori and marijuana dependence in 5.3 %".[109] It also found that there were complex associations between substance use disorders and other mental and physical disorders. For example, among Māori with any substance use disorder, 39.7 % also had an anxiety disorder and 26.4 % also had a mood disorder. Over 11 % suffered from chronic pain conditions including arthritis and 9.3 % had a respiratory illness. The report suggested that an increase in alcohol and other substance use disorders is likely to have contributed to the overall increase in mental health disorders among Māori.

2.94 It is possible that the differences between Māori and non-Māori in the prevalence of substance use disorders are attributable to differences in age distribution, socio-economic status or other adverse life circumstances. The 2006 survey did not find any support for this; even after adjusting for age, sex and socio-economic factors, the differences remained. In contrast, a study examining the factors that place Māori at greater risk of cannabis use and dependence found that the higher rate of cannabis use by Māori were largely explained by the greater exposure of young Māori to "socio-economic disadvantage and childhood/family adversity";[110] the use of cannabis made a small but detectable contribution to rates of Māori disadvantage, with this contribution being most evident in the areas of crime, education and unemployment.

2.95 Concern about the extent to which cannabis abuse and dependence is undermining the potential of Māori and young people in this country was reflected in a small number of submissions advocating a cautious approach to

107 Ministry of Health *Drug Use in New Zealand*, above n 40, at 44.

108 Ibid, at 43.

109 Oakley Browne, Wells and Scott, above n 68, at 152.

110 D Marie, DM Fergusson and JM Boden "The Links Between Ethnic Identification, Cannabis Use and Dependence, and Life Outcomes in a New Zealand Birth Cohort" (2008) 42 Australian and New Zealand Journal of Psychiatry 780 at 788.

the liberalisation of cannabis laws. These included submissions from a number of organisations working in predominantly low socio-economic communities with high proportions of young people and Māori.

2.96 One such example came from the small Bay of Plenty community of Murupara, a former forestry town battling high levels of unemployment, poverty and drug-related crime. The submission made on behalf of the local community board was informed by a series of community meetings in Murupara and reflected that community's ongoing struggle to establish an economic and employment base that is not dependent on drugs. While the Murupara submission favoured many of the therapeutic approaches proposed in our Issues Paper, it did not favour relaxing rules around social supply or personal cultivation, importation or possession because it did not wish to dilute the message that drug use was to be actively discouraged rather than tolerated:[111]

> Our community has suffered from the effects of illict drug abuse. We have experienced first hand, the negative effects of drug abuse.

2.97 A submission from members of the Te Tai Tokerau CAYAD group also wished cannabis to remain prohibited with "no dilution of the prohibition response":[112]

> The population of Te Tai Tokerau is predominantly Māori and the misuse of drugs causes significant harm throughout Te Tai Tokerau. Drug use has become normalized within whanau and consequently embedded within our tai tamariki/youth culture. The notion of drug and alcohol-free celebrations is alien to many and early drug and alcohol use seen as a rite of passage to peer acceptance and adulthood.

2.98 However, when considering the options for drug policy reform and its impact on Māori in particular, it is important to consider the disproportionate rate at which Māori are arrested and prosecuted for cannabis offending. While we estimate that fewer than one per cent of all users in 2006 were prosecuted for their cannabis use, a study by Fergusson and others found that Māori with the same use levels as non-Māori had rates of arrest and conviction that were over three times higher than for non-Māori.[113]

Methamphetamine

> It's the kinda drug that makes you feel 10 feet tall and super-confident. It makes you feel like you're someone else.[114]

2.99 This description of methamphetamine's effects on the user helps explain why this synthetic stimulant gained such rapid popularity with a segment of recreational drug users after first becoming widely available in New Zealand a decade ago.

111 Submission of Murupara Community Board (submission dated 30 April 2010).

112 Submission of Te Tai Tokerau Community Action on Youth and Drugs (submission dated 29 April 2010) at 2.

113 Fergusson, Swain-Campbell and Horwood, above n 104, at 63.

114 Acqument Ltd and UMR Ltd, above n 52, at 92.

2.100 However, the drug credited with making its users feel "bullet proof" has also come to be associated in the public's mind with psychotic and violent behaviour and crippling addiction. This perception has been fostered in no small part by a spate of much publicised criminal cases involving, on the one hand, notorious violent offenders, and on the other, members of a number of high profile New Zealand families.

2.101 The *UMR Drug Research* clearly illustrates the popular distinctions many people draw between so-called "soft" drugs such as cannabis, and a drug like methamphetamine. While harms resulting from cannabis use were perceived to be minimal and restricted to the user and his or her immediate family, methamphetamine use was "linked with more serious harms including changes in personality, addiction, poor health, mental illness, violence, gangs and criminal activity".[115]

2.102 This positioning of cannabis and methamphetamine at polar ends of the harm spectrum reflects the relative prevalence and acceptability of cannabis in New Zealand. While cannabis is widely used, the most recent drug use survey indicates only 2.1 per cent of adults had used any amphetamines (including methamphetamine) in the past year and only 0.4 per cent reported using an amphetamine at least monthly.[116] This suggests there may be only about 13,000 frequent or semi-frequent amphetamine users in New Zealand.

2.103 In part this relatively low usage reflects the much higher costs and risks associated with methamphetamine production and use. Since its introduction a decade ago, methamphetamine is estimated to have doubled the value of New Zealand's illicit drugs market.[117] A "point bag" of methamphetamine, sufficient for 3 "hits", costs $80–$120 compared with $20–$25 for three cannabis joints.

2.104 Gangs have been major players in the development of New Zealand's methamphetamine market. NZ-ADAM participants identified the amphetamine black market (including methamphetamine) as being more violent or risky than the other drug markets covered (cannabis, ecstasy and heroin).[118]

2.105 Methamphetamine production is risky, both in terms of the physical dangers associated with "cooking" and the risks of detection and prosecution. The chemicals used to manufacture methamphetamine are generally highly flammable, corrosive and explosive.[119] The risk of explosion, chemical burns or poisoning is high. This creates a dangerous situation for those involved in the manufacturing process, others living in or near the clan lab (including children), law enforcement officials, emergency service personnel and medical practitioners treating those exposed to toxic chemicals.

115 Ibid.

116 Ministry of Health *Drug Use in New Zealand*, above n 40, at 84.

117 C Wilkins and others *The Socio-Economic Impact of Amphetamine Type Stimulants in New Zealand: Final Report* (Centre for Social and Health Research Outcomes Massey University, Wellington, 2004) at 7.

118 Jim Hales, Jennie Bowen and Jane Manser *NZ-ADAM: Annual Report 2006* (prepared for NZ Police, Health Outcomes International, Adelaide, 2006) at 57.

119 The Expert Advisory Committee on Drugs (EACD) *Advice to the Minister on: Methamphetamine* (2002) at 13 [EACD Report].

2.106 But while criminality and cost will have played a part in stemming the growth in methamphetamine use, the risks associated with the drug itself are also likely to have deterred some users. As discussed below, the immediate and long-term risks associated with methamphetamine use, including the risk of addiction, in many respects justify the level of public concern.

Methamphetamine use and effects

2.107 The initial euphoria and rush of energy experienced by methamphetamine users is caused by increased levels of the neurotransmitters dopamine and adrenaline acting on the CNS. Immediate effects include increased heart rate and blood pressure, increased alertness and energy and a reduced need for sleep and food. The heightened arousal of the CNS can also produce a range of symptoms such as sweating, tremors and anxiety. Large doses can cause potentially life-threatening conditions, such as hyperthermia, renal and liver failure, cardiac arrhythmias, heart attacks, cerebrovascular haemorrhages, strokes and seizures.[120] Toxic reactions can occur irrespective of "dose, frequency of use or route of administration, and have been reported with small amounts and on the first occasion of use".[121]

2.108 The intensity and duration of the effects associated with methamphetamine use are determined both by the purity/potency of the substance and by the mode by which it is taken. Injecting or smoking the drug provides the fastest and most intense rush.

2.109 One of the important characteristics of the New Zealand methamphetamine market is the potency of the locally produced drug which has earned it the street name "P" – pure. Typically, imported crystal methamphetamine, known as ice or crystal meth, would be thought of as the highest priced and purest product on the market, but analysis of the locally manufactured product suggests there is little difference between the two.

Long-term effects

2.110 As with other psychoactive substances, dose and frequency are important determinants of harm. *Drug Use in New Zealand* suggests over 60 per cent of current methamphetamine users take the drug 11 or fewer times a year. Nearly a third (32 per cent) use at least monthly and 18.7 per cent use at least weekly.[122]

2.111 Frequent methamphetamine users may be at increased risk of adverse impacts to their physical health, including respiratory problems, stroke, irregular heartbeat, extreme anorexia and neurotoxicity.[123] Cardiovascular health may also be affected, even after use has stopped.[124] There is evidence that

120 Irina N Krasnova and Jean Lud Cadet "Methamphetamine Toxicity and Messengers of Death" (2009) 60 Brain Research Reviews 379 at 380. See also EACD Report, above n 119, at 9–10; and Shane Darke and others "Major Physical and Psychological Harms of Methamphetamine Use" (2008) 27 Drug and Alcohol Review 253 at 255.

121 Darke and others, above n 120, at 255.

122 Ministry of Health *Drug Use in New Zealand*, above n 40, at 44.

123 EACD Report, above n 119, at 9.

124 Darke and others, above n 120, at 255; and Christopher C Cruickshank and Kyle R Dyer "A Review of the Clinical Pharmacology of Methamphetamine" (2009) 104 Addiction 1085 at 1091.

methamphetamine use causes changes to the brain,[125] and this may impair cognitive functioning.[126] In addition, methamphetamine use may often lead to teeth and skin problems.[127]

2.112 There is evidence that methamphetamine users are at increased risk of transmission of communicable diseases. Injecting users who share needles are at a high risk of HIV/AIDS and Hepatitis B and C.[128] Methamphetamine has also been found to increase sexual arousal and this can lead to risky sexual behaviour and disease transmission.[129]

2.113 The regular use of methamphetamine can also cause a number of psychological harms. The 2009 IDMS survey found that the most common psychological problems reported by frequent methamphetamine users were short temper (70 per cent), strange thoughts (66 per cent), anxiety (74 per cent) and paranoia (61 per cent).[130] Long-term users of methamphetamine may also experience a number of psychotic symptoms including paranoia, auditory hallucinations, mood disturbances and delusions.[131] These symptoms can last from hours up to days,[132] with those who have pre-existing psychotic disorders at greater risk of experiencing them.[133] Methamphetamine can also cause depressive symptoms, suicidal thoughts and anxiety disorders.[134]

Binge use

2.114 As with alcohol, bingeing on methamphetamine exacerbates many of the physical, psychological and social problems associated with its use. *Drug Use in New Zealand* suggests the prolonged use of methamphetamine (defined as continuous use in New Zealand for 24 hours or more) is relatively common among users, with 28 per cent reporting having binged in the past year.[135]

2.115 Extended binges tend to be followed by a pronounced crash where the user may experience deep depression, fatigue, difficulty in sleeping, headaches, decreased energy and strong cravings to use again.[136]

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125 Krasanova and Cadet, above n 79; Linda Chang and others "Structural and Metabolic Brain Changes in the Stratum Associated with Methamphetamine Abuse" (2007) 102 Addiction 16.

126 Darke and others, above n 120, at 259.

127 IDMS 2009, above n 54, at 139.

128 EACD Report, above n 119, at 12 and Shane Darke and others, above n 120, at 256.

129 Ibid.

130 IDMS 2009, above n 54, at 185.

131 EACD Report, above n 119, at 9 and Shane Darke and others, above n 120, at 257 and Christopher C Cruickshank and Kyle R Dyer, above n 124, at 1091.

132 Darke and others, above n 120, at 257; EACD Report, above n 119, at 9.

133 Darke and others, above n 120, at 257.

134 Ibid.

135 Ministry of Health *Drug Use in New Zealand*, above n 40, at 44 and 49.

136 Darke and others, above n 120, at 256.

2.116 Experts believe that some of the most harmful behaviour associated with methamphetamine use actually arises during this period of withdrawal from the drug when the abuser is severely sleep deprived, suffering a range of distressing withdrawal symptoms and experiencing drug craving. This can produce unstable, erratic and at times violent or abusive behaviour.[137]

Addiction

2.117 Compared with cannabis, methamphetamine poses a greater risk of both physical and psychological addiction because of the drug's potency and the intensity and duration of its effects. Over 70 per cent of frequent methamphetamine users who took part in the most recent IDMS survey felt they were addicted to the drug.[138]

2.118 As with other drugs, addiction is marked by increased tolerance, problems controlling drug use and a range of physical and psychological withdrawal symptoms. There is evidence to suggest that methamphetamine addiction has a faster progression than addiction to other stimulants such as cocaine.[139]

2.119 There are no national estimates of the number of New Zealanders with a primary diagnosis of methamphetamine addiction. However, figures from the Auckland District Health Board show that of 10,000 new patients referred to its Community Alcohol and Drug Service, nine per cent related to methamphetamine use. (The figures for alcohol and cannabis were 74 per cent and 18 per cent respectively.) The Alcohol Drug Helpline, which received more than 17,000 calls in 2008, report that methamphetamine-related calls have increased and now account for about nine per cent of all calls.

Social harms

2.120 Given the cost of the drug and the intensity of the effects associated with both its use and withdrawal, it is not surprising that frequent users report high levels of harm to themselves and those around them.

2.121 For example, in the 2008 IDMS survey, frequent methamphetamine users reported that their drug use had harmed their financial position (72 per cent), their health (80 per cent) and their relationships and social life (64 per cent). Frequent methamphetamine users also reported involvement in a range of drug-related harmful incidents including losing their temper (74 per cent), arguing with others (70 per cent), doing something under the influence of drugs that they later regretted (60 per cent), reduced work/study performance (49 per cent) or having unprotected sex (55 per cent).[140]

2.122 As with cannabis users, surveys indicate that a high proportion of methamphetamine users drive while intoxicated. The 2009 IDMS survey also found that 90 per cent of frequent methamphetamine users had driven under

137 EACD Report, above n 119, at 9.

138 IDMS 2009, above n 54, at 193.

139 F Castro and others "Cocaine and Methamphetamine Differential Addiction Rates" (2000) 14 Psychology of Addictive Behaviours 390; A Kalechstein and others "Psychiatric Comorbidity of Methamphetamine Dependence in a Forensic Sample" (2000) 12 Journal of Neuropsychiatry Clinical Neuroscience 480 cited in EACD Report, above n 119, at 11.

140 IDMS 2008, above n 61, at 146–147.

the influence of a drug other than alcohol in the past six months.[141] Research on the effect of methamphetamine use on driving is mixed.[142] However, high proportions of frequent methamphetamine users reported risky driving behaviour while under the influence of drugs, including driving too fast, losing their temper at another driver, losing concentration or nearly hitting something.[143]

Methamphetamine and crime

2.123 In 2006, the NZ-ADAM programme found that methamphetamine was the second most commonly detected illicit drug after cannabis amongst programme participants.[144] Sixty two per cent of methamphetamine users reported that their use of methamphetamine had contributed to some extent to their current criminal activity, with 47 per cent saying it had contributed "all/a lot" and 15 per cent saying it had made "some" contribution.[145]

2.124 Of particular public concern is the perceived link between methamphetamine intoxication and violent crime. There is some evidence to support the assertion that violent behaviour is common among methamphetamine users.[146] In New Zealand, NZ-ADAM identified that methamphetamine was the most likely of all drugs covered to increase users' likelihood of getting angry.[147] The 2009 IDMS survey also identified a high likelihood that methamphetamine use would lead to a short temper.[148]

2.125 According to a 2006 New South Wales study, a connection between methamphetamine use and violent crime is plausible because:[149]

- experimental evidence has shown that methamphetamine may exacerbate hostility in individuals predisposed to violence and increase aggression; and
- methamphetamine increases the risk of psychosis and people suffering from psychosis are more likely than the general population to behave violently.

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141 Ibid, at 192. Frequent methamphetamine users most commonly drove under the influence of cannabis, methamphetamine, methadone, ecstasy, and crystal methamphetamine.

142 New Zealand Drug Foundation "Drug Driving in New Zealand: A Survey of Community Attitudes, Experience and Understanding" (2009) New Zealand Drug Foundation at 51 < www.nzdf.org.nz > .

143 IDMS 2009, above n 54, at 199. Note that these findings cannot be entirely attributed to methamphetamine use; although the drivers were frequent methamphetamine users, they were not necessarily under the effect of methamphetamine when the risky behaviour occurred.

144 Hales, Bowen and Manser, above n 118, at 28. 12 % tested positive to methamphetamine. See page 23 – 23 % of participants reported using methamphetamine in the last 30 days and 9 % in the last 48 hours. See also page 35 – 34 % of participants had used methamphetamine on 11 or more days out of the last 30 days, with 18.1 % using it on 20 or more days.

145 Ibid, at 46–47.

146 Darke and others, above n 120, at 258.

147 Hales, Bowen and Manser, above n 118, at 41. 33.2 % of methamphetamine users said using methamphetamine was more or much more likely to get angry, followed by alcohol (30.1 %) and amphetamines (29.9 %).

148 IDMS 2009, above n 54, at 142. 72 % of frequent methamphetamine users reported that using methamphetamine gave them a short temper.

149 Rebecca McKetin and others "The Relationship between Methamphetamine Use and Violent Behaviour" (2006) 97 Crime and Justice Bulletin at 10. Cited in Darke and others, above n 120, at 258–259. A later study found no evidence that being charged with an amphetamine offence increased the later risk of being charged with a violent offence: Nadine Smith and Laura Rodwell "Does Receiving an Amphetamine Charge Increase the Likelihood of a Future Violent Charge?" (2009) 126 Crime and Justice Bulletin 1 at 7.

2.126 However, it is unclear whether the violence is due to the effects of methamphetamine itself or can be attributed to other factors that relate to methamphetamine use. These factors include, for example, the violence inherent in the drug market, polydrug use or the predisposing personality of the methamphetamine user.[150]

2.127 There is also some evidence that methamphetamine users commit property crimes to fund their drug habit. In the 2009 IDMS study, frequent methamphetamine users mostly paid for their drugs through gifts from friends, paid employment, unemployment/social welfare benefits and selling drugs for cash profit.[151] However, 22 per cent admitted to acquiring drugs through property crime.

Impact on specific populations

2.128 Compared with cannabis, methamphetamine use is relatively rare among New Zealand adolescents. A nationwide survey of secondary school students in the country found only 1.2 per cent of school age students had tried methamphetamine and the majority of these had only used once or twice.[152] In contrast, 60 per cent classified themselves as current drinkers and 14 per cent as current cannabis users. (For students in the areas of highest deprivation cannabis use rates were 18 per cent.)

2.129 Significantly, from a harm perspective, methamphetamine users begin using later in life than cannabis users. *Drug Use in New Zealand* indicates that for those who use amphetamines (including methamphetamine) the median age is 20 compared with 17 for cannabis users. Among current methamphetamine users, only 2.5 per cent had begun using at 14 or younger compared with 16.2 per cent of cannabis users.

2.130 Methamphetamine use, as for cannabis, is most prevalent among males aged 18–24 with 8.4 per cent of males in that cohort reporting current use of amphetamines (compared with 35.8 per cent reporting current cannabis use). For females in this age group, the respective rates are 3.4 per cent (amphetamines) and 27.1 per cent (cannabis).

2.131 The drug use surveys also suggest different demographics associated with the two drugs: the prevalence of cannabis use among males is significantly higher in the lowest socio-economic areas but there is no significant difference in amphetamine use between socio-economic groups.

2.132 With respect to ethnicity, Europeans are significantly more likely to use amphetamines but Māori are more likely to use methamphetamine or “P” than other ethnic groups.

CONCLUSION

2.133 As this discussion illustrates, one in six New Zealand adults use illicit drugs at least occasionally. This is largely explained by this country’s comparatively high rates of cannabis experimentation and use. Recent surveys suggest cannabis use

150 Smith and Rodwell, above n 149, at 10.

151 IDMS 2008, above n 54, at 216.

152 Adolescent Health Research Group *Youth ’07: The Health and Wellbeing of Secondary School Students in New Zealand – A Technical Report* (The University of Auckland, Auckland, 2008) at 120–122.

may have declined slightly in recent years. This may reflect an international trend towards the increased use of stimulants, including BZP (prior to its becoming a controlled substance), amphetamines and ecstasy.

2.134 The recreational drug market is also evolving rapidly as technological innovation leads to the development of a plethora of new and unregulated variants of controlled drugs. The advent of the internet has also opened new avenues for global sales and distribution.

2.135 Like many risk taking behaviours, drug use is most prevalent among the young, with over a third of 18–24 year olds in this country estimated to have used illicit drugs at least occasionally in 2006. Rates of drug use are higher among Māori due to the significantly higher prevalence of cannabis use. Pacific and Asian people are less likely to use recreational drugs than the general population.

2.136 Motivations for and patterns of drug use vary within different segments of the population and over time. Alongside genuinely recreational drug users is a subset of problem drug users who may experience varying degrees of dependence and whose drug use generates harm for themselves and others.

2.137 Problem drug use and addiction can also arise from and be a marker of social, economic, physical and mental health problems. These problems can be compounded by drug use and by its legal consequences. There is therefore a risk that punitive drug laws can exacerbate the harms associated with drug use.

2.138 As the discussion of the respective harms associated with cannabis and methamphetamine illustrates, the nature and severity of drug harms vary greatly between different substances. Drug policies must offer an appropriate and proportionate response to these different risks and harms. Reducing and preventing drug harms also requires a strong policy focus on sectors of the community at greatest risk, including the young and Māori.

Chapter 3

The evolution of drug control in New Zealand

INTRODUCTION

3.1 As the preceding chapter illustrates, a very significant proportion of New Zealanders use illegal drugs at some stage in their lives – typically during late adolescence and early adulthood. Whether this drug taking results in harms to the individual user or others is dependent on the myriad of factors outlined in that discussion.

3.2 The challenge for society in formulating an effective response to illicit drug use is that we are confronting not one problem, but a spectrum of interrelated problems. At one end of this spectrum sits the occasional adult recreational drug user who breaks the law by choosing to use prohibited substances, and whose drug use may harm their own health, but whose actions have little or no impact on others. At the other end of the spectrum sits the organised criminal network which profits from the manufacture and sale of illicit drugs and which may use drug revenues to finance a range of other criminal activity. In the middle sits the dependent drug user, who may be abusing both legal and illegal drugs and whose drug use may be associated with mental or physical health problems. This person may also sell drugs, or commit other crime, to support their addiction.

3.3 In reality, of course, these delineations are likely to be far more nuanced, but the scenarios serve to illustrate the array of policy problems arising from the use of illegal drugs, and in particular the way in which drug harms may straddle the arenas of health, welfare and criminal justice.

3.4 A major challenge for those framing drug policies is how to devise a balanced response capable of addressing the complex health and social issues underpinning much harmful drug use, while also tackling the serious criminality associated with the manufacture and trafficking of illicit drugs.

3.5 Currently, the primary tool for dealing with illegal drug use is the Misuse of Drugs Act 1975 (primarily a criminal justice statute). This Act attempts to eliminate drug harms by prohibiting the manufacture, importation, supply,

possession and use of all controlled drugs except for medical or scientific purposes. The Act provides for a graduated response to different types of drug offending, but its approach is primarily punitive.

3.6 In this chapter we begin with a brief history of drug regulation and the origins of the international approach to drug control which has been influential in shaping New Zealand's domestic drug laws. We then describe the key features of the Misuse of Drugs Act and the scale of offending associated with its enforcement over the past three decades.

3.7 Finally, we outline in broad terms some of the different approaches to the regulation of convention drugs adopted by other countries and in particular the scope for a variety of responses to personal use offences.

THE EVOLUTION OF DRUG CONTROL

From free trade to prohibition

3.8 Just as there is a spectrum of problems associated with recreational drug use, there is also a spectrum of responses available to governments to deal with drug-related harms. These range from a laissez faire approach, characterised by minimalist regulation, through to outright prohibition, backed by strong enforcement and criminal penalties.

3.9 In reality there are many policy gradients between these two extremes, which can, in practice, soften the bright line distinctions between "legalised" and "prohibited" substances. For example, many countries are imposing increasingly stringent regulatory controls on the sale and use of the legalised drug, tobacco, including outright prohibitions on its use in public places. In contrast, some countries have adopted a tolerant attitude towards the personal use of the prohibited drug cannabis, leading, in practice, to de-facto decriminalisation.

3.10 The objective of any form of intervention, whether regulation or prohibition, is to reduce the harms arising from drug use in the population, by controlling or restricting the supply of, and demand for, drugs and by influencing the way in which they are used. In theory, outright prohibition is reserved for the substances judged to pose the greatest risk to users and society and is intended to eliminate drug harms by eliminating drug supplies and use. Lesser regulatory controls, such as licensing regimes and age restrictions, are applied to lower risk substances.

3.11 As discussed in chapter 1, although commonplace today, the idea that the law should proscribe the use or manufacture of certain drugs is in fact relatively new in historical terms. While drug use itself dates back to the earliest civilisations, it was not until the late 19th and early 20th centuries that governments sought to intervene in the drugs market.

3.12 Initially at least, the impetus for these early interventions was the protection of public health, as medical science began to recognise the addictive properties of many popular therapeutic drugs such as opium and its derivatives. However, the approach was to regulate rather than prohibit them. For example, in the second

half of the 19th century New Zealand enacted a number of laws designed to ensure opium and morphine-based products carried appropriate health warnings and, later, that access to them was controlled through a relatively liberal system of licensing and prescription.[153]

3.13 However, by the turn of the 19th century public health concerns were overshadowed by far more pressing global economic and political considerations centred on the international opium trade and its impact on China in particular. In fact, China's opium epidemic of the late 1800s and early 1900s provided much of the impetus for the system of international drug control we know today.[154] It directly led to the first international conference to discuss the problems associated with the world trade in narcotics, which was convened in Shanghai in 1909. A stocktake of the size and value of the global opium market at the time estimated total production to be around 41,600 metric tonnes in 1906/07, almost five times more than global illicit opium production a century later.[155] The meeting, known as the Shanghai Opium Commission, laid the groundwork for the first international drug treaty, the International Opium Convention of The Hague (1912). This marked a decisive moment in the approach to drug control as governments came to recognise the importance of multilateral agreements to tackle the complex economic and political issues implicit in the global drugs market.

3.14 The growing international concern about opium prompted New Zealand's first prohibition on drugs: the Opium Prohibition Act 1901. This was directed primarily at Chinese immigrants and explicitly discriminated against them. At first it banned only the smoking of opium and the importation of opium in a form that was suitable for smoking. However, it was amended in 1910 to prohibit a Chinese person from buying any opium at all without a doctor's prescription or an authority from the Minister of Customs, while other people were still free to purchase opium without these restrictions.

3.15 Other drugs that are now prohibited – including heroin, cocaine and other coca-derived products, and cannabis – were not regulated at all at this stage of New Zealand's history. It was not until the 1920s that heroin, cocaine and cannabis began to be regulated.

3.16 The development of that regulation was largely shaped by international drug conventions. In particular, New Zealand acceded to the International Convention relating to Opium and other Dangerous Drugs 1924 and subsequent amending protocols. That Convention required parties to impose controls on the manufacture, import, export, sale and distribution of a growing range of drugs, including (from 1925) cannabis, which was then known as Indian hemp. New Zealand complied with its obligations under that Convention by enacting the Dangerous Drugs Act 1927, which introduced a licensing scheme for a wide range of drugs and made it an offence to import, export or otherwise produce or deal in those drugs except under a licence or some other lawful authority.

153 The Sale of Poisons Act 1866, the Sale of Poisons Act Amendment Act 1871 and the Customs Law Consolidation Act 1882 introduced minimum labelling requirements for opium-based remedies and medicines and required vendors to be registered.

154 A detailed historical account of the development of and response to this epidemic is contained in the United Nations Office on Drugs and Crime (UNODC) *World Drug Report 2008* (United Nations, New York, 2008) at 177.

155 Ibid, at 180.

3.17 Notwithstanding the introduction of a prohibition regime, many of the drugs regulated under the Dangerous Drugs Act were readily available on prescription for medical purposes. Health records from the period suggest that various drugs covered by the Act were liberally prescribed, particularly once prescriptions were publicly funded after 1941.[156] For example, heroin was readily available on prescription in an oral dose form, with regulations made under the Dangerous Drugs Act during the 1940s permitting doctors to prescribe up to 16 oral doses of heroin in one prescription. By the end of the 1940s, New Zealand was one of the highest users of heroin per capita in the world.[157]

3.18 Less restrictive controls than those contained in the Dangerous Drugs Act applied to drugs that were not covered by the international conventions. These were regulated under the poisons regime, which from 1937 included the concept of "prescription poisons" that could only be legally obtained on a doctor's prescription. Barbiturates and lower strength morphine and cocaine preparations were regulated as prescription poisons. Again, health records from the period suggest that liberal prescribing practices were commonplace. For example, doctors wrote prescriptions in broad terms authorising a continuing supply of a prescription poison for an indefinite period of time.[158] Barbiturate use in New Zealand increased markedly during the 1940s. Over time more drugs – for example, amphetamines in 1957 – came to be controlled as prescription poisons.

3.19 In 1946, the task of international drug control passed to the United Nations which in 1961 negotiated the landmark Single Convention on Narcotic Drugs, consolidating and broadening all previous treaties. New Zealand was one of 40 signatories to the 1961 Convention.

3.20 In medical terms "narcotics" refers only to opiates, but the 1961 Convention covered over 100 drugs, including cocaine, cannabis and, later, hallucinogens like LSD. The Convention required signatory countries to establish domestic controls over narcotic drugs. Parties were required to take all necessary measures to limit the use of specified narcotic drugs to medical and scientific purposes, and to cooperate with other nations to maximise the effectiveness of these policies.

3.21 New Zealand implemented the Convention by enacting the Narcotics Act 1965. This Act introduced for the first time a distinction between offenders who dealt in narcotics and those who simply possessed or used them. Significantly higher penalties applied to offences involving dealing than those involving simple possession or use.

3.22 Over the next 40 years New Zealand's drug laws continued to be strongly influenced by the evolving international approach to drug control. Specifically, the original 1961 Convention was supplemented by two further conventions to which New Zealand became party:

156 From 5 May 1941, the Social Security (Pharmaceutical Benefits) Regulations 1941 provided for the free supply of medicines and drugs on the prescription of any registered medical practitioner.

157 The Drug Supervisory Board of the United Nations (the predecessor of the International Narcotics Control Board) asked New Zealand for an explanation of its high level of heroin use, which set in train an investigation and a subsequent campaign to reduce prescribing of heroin. By 1955 prescribing of heroin was virtually eliminated except in hospital practice.

158 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report* (NZ Board of Health Report Series, No 14, Wellington, 1970) at Appendix VIII.

- The 1971 Convention on Psychotropic Substances, which effectively created a parallel control regime for the increasingly popular classes of hallucinogens, stimulants (such as amphetamines) and depressants (such as barbiturates, sleeping pills and sedatives). The Convention recognised the "indispensable" nature of many of these drugs for medical and scientific purposes but determined to combat their illicit trafficking and abuse.
- The 1988 Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances. This Convention looked to strengthen the legal response to drug trafficking and to attack the economic base underpinning the illegal drugs market. At the forefront of the Convention were strengthened legal provisions that expressly required the criminalisation of the organisation and financing of drug crime and associated money laundering.

Lessons from the past

3.23 A number of important points for the current review can be drawn from the evolution of drug control over the past century.

3.24 First, the so called "War on Drugs", formally initiated by United States President Richard Nixon in 1971, and characterised by a rigid prohibitionist stance, marked a distinct departure from a history of unregulated trade in psychoactive drugs that persisted until the early 20th century. During that period a number of world powers actively condoned and economically benefited from exporting large quantities of opium to China and other East Asian countries.

3.25 Secondly, in the decades leading up to the first international convention, governments employed a variety of measures short of prohibition to tackle the opium problem. In the Philippines, state-controlled opium production and supply was deemed to be the most effective strategy for weaning addicts from their dependence on the drug and the government from its dependence on opium revenues. The twin objectives were to gradually detoxify opium addicts while simultaneously winding down opium production to the point where total prohibition was a realistic policy option. While such policies might be regarded as heretical today, they were endorsed by the United States Congress which passed enabling legislation to give effect to this strategy in its occupied territory.

3.26 Finally, attempts by various south-east Asian countries to control the impacts of opium importation on its populations and economies revealed the futility of unilateral action, and underscored the necessity of multinational agreements if nation states were to be effective in controlling the impacts of drugs on their own populations. In the modern age of drug prohibition, governments do not openly sanction or facilitate the illicit drug trade. However, in place of the European traders of last century there are now powerful global criminal networks competing for control of the lucrative trade in illicit drugs. Combatting these criminal trafficking networks requires a high level of international co-operation and a consistent legal approach to drug manufacturing and trafficking.

3.27 To a very large extent the Misuse of Drugs Act reflects the policies and priorities enunciated in the three major international drug conventions outlined above. However, the Act also has a local flavour, adopting many of the recommendations of the Blake-Palmer Committee.

3.28 As discussed in chapter 1, the Committee, which issued its final report in 1973, concluded that a new Act was needed to update and consolidate New Zealand's drug laws and implement New Zealand's expanded international obligations under the United Nations Convention on Psychotropic Substances 1971.[159] It recommended a single Act to control all drugs and similar substances (other than alcohol and tobacco) that had a significant potential for misuse.

3.29 Recognising the different effects of drug use, the Committee recommended that drugs controlled by the Act should be divided into schedules that broadly indicated their relative potential for harm and the degree of controls deemed necessary.[160] It also considered that the maximum penalties for offences relating to these drugs should differ between schedules to reflect their relative harm.[161] The Committee said that for dealing with offences of illegal distribution and supply of drugs full recourse to the criminal law was appropriate, but that the police should have, and use, discretion in deciding what action to take where people were using rather than dealing in drugs. It considered that an increased use of alternatives to prosecution would be desirable, particularly with younger offenders.[162]

The Misuse of Drugs Act 1975

3.30 Like most statutes of its era, the Misuse of Drugs Act does not contain an explicit objective. Its provisions create a framework for controlling the use of drugs with a potential to cause dependency and harm. In accordance with the obligations created by the international drug conventions, this is done primarily through the vehicle of prohibition, with tightly controlled exemptions for medical and scientific purposes.

Classification based on harm

3.31 As recommended by the Blake-Palmer Committee, drugs controlled by the Misuse of Drugs Act are listed in three schedules and classified A, B or C based on a broad assessment of the risk of harm they pose to individuals, or to society, by their misuse:

- Class A drugs are those that pose a very high risk of harm;
- Class B drugs are those that pose a high risk of harm;
- Class C drugs are those that pose a moderate risk of harm.

3.32 The harm hierarchy established by the classification system currently has two purposes. The primary classifications are used to determine the maximum penalty that applies to a dealing or personal possession or use offence under the

159 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report* (NZ Board of Health Report Series, No 18, Wellington, 1973) at 37 [*Second Report*].

160 Ibid, at 100.

161 Ibid.

162 Ibid, at 52.

Act. However, Class B and C drugs are further divided into a number of sub-classifications which are used to regulate matters such as prescribing, storage and record-keeping by persons authorised to deal in controlled drugs.

3.33 Amendments to the Act in 1988 and 1996 ensured the Act also automatically covers drug analogues, which are substances that have a substantially similar chemical structure to that of a controlled drug but are not themselves specified or described as a controlled drug in the Act's schedules.

3.34 These amendments were made to address the emergence of new synthetic designer drugs that had been developed through subtle chemical changes to prohibited drugs as a way of avoiding the provisions of the Act. New synthetic drugs with distinct chemistry are not caught by the analogue provisions and each one needs to be separately assessed for harm and classified before becoming subject to the Act.

3.35 This task falls to the Expert Advisory Committee on Drugs (EACD). This is a specialist group established by an amendment to the Act in 2000, with statutory responsibility to evaluate substances, assess their potential for harm against criteria set out in the Act and recommend appropriate classifications.[163]

3.36 How to deal with new unclassified drugs in the future is an important question for this review and is addressed in chapter 5.

Offences involving dealing in drugs

3.37 A key feature of the Act is its emphasis on deterrent penalties for offences that involve "dealing" in drugs. Dealing is importing, exporting, manufacturing, selling or otherwise supplying or administering a controlled drug to another person.[164] It also includes the possession of a controlled drug for one of these purposes.[165] The Act has a sliding scale of maximum penalties for unlawful dealing in different classes of controlled drugs. A presumption in favour of imprisonment for offences that involve dealing in Class A drugs reinforces the significance of a drug's classification for determining penalty. The maximum penalties in the Act were increased in 1979 and have not been changed since. The maximum penalty for dealing in a Class A drug is imprisonment for life; a Class B drug imprisonment for 14 years; and a Class C drug imprisonment for eight years.

3.38 A broad range of activities constitute dealing under the Act. This means that the same maximum penalties are set by the Act for activities that involve trafficking for commercial gain and supplying or assisting another to administer a drug in a social situation. Moreover, since the maximum penalty for a dealing offence is determined by the classification of the drug involved, socially supplying a Class A drug appears on the face of the Act to be a more serious offence than importing or manufacturing a Class B drug for commercial gain. However, maximum penalties

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163 Misuse of Drugs Act 1975, s 5AA(2).

164 There is one exception. While selling or offering to sell a Class C drug to another adult is a dealing offence covered by s 6, otherwise supplying or administering a class C drug to an adult is a less serious possession offence covered by s 7 of the Act.

165 Misuse of Drugs Act 1975, s 6 contains the possession and use offences.

are reserved for the worst class of case of an offence.[166] It is therefore common for offence categories to have overlapping seriousness and culpability across the spectrum of conduct that falls within them. The differences in maximum penalty between classes of drugs are intended to reflect their relative degrees of harm when the particular instance of dealing is within the worst class of case.

Presumption of supply

3.39 The Act continues the policy of setting a presumption of supply introduced by the Narcotics Act 1965. Where a person is found in possession of a quantity of a controlled drug equivalent to or exceeding the amount specified in the Act, the presumption that he or she possessed the drug for the purpose of supplying it to others is triggered. The legal burden of proof then shifts to the accused person to prove on the balance of probabilities that he or she was not supplying the drug and that the drug was intended for personal use.

Possession and use of drugs

3.40 As recommended by the Blake-Palmer review, the Act sets much lower maximum penalties for offences of possession and personal use.[167] Penalty levels again reflect the relative harm of the different classes of drug. The maximum penalty for possession or personal use of a Class A drug is six months imprisonment and a fine of $1,000 or both, and a Class B or C drug three months imprisonment or a fine not exceeding $500 or both. The Act also contains a presumption against imprisonment where an offence of possession or use involves only a Class C drug,[168] so in practice the penalties for possession and use of a Class C drug are lower than for a Class B drug. The Act does not incorporate the types of alternatives to prosecution and criminal sanction for drug users suggested by the Blake-Palmer Committee.

Authorisations and licences permitting use of drugs for medical and scientific purposes

3.41 Many drugs controlled by the Act have medical and scientific uses. The Act, like the earlier Narcotics Act, provides for medical and scientific use by creating exemptions to the offence provisions and establishing a licensing and prescription regime for the lawful manufacture, import and distribution of controlled drugs.[169]

3.42 For this purpose the Misuse of Drugs Act interfaces with the Medicines Act 1981 which deals with substances that are manufactured, imported, sold or supplied wholly or principally for administration to a human being for therapeutic purposes. A number of controlled drugs fall within this definition and so are covered by both Acts. Subject to a number of significant restrictions, exemptions allow health professionals and others responsible for the care of patients and patients themselves to lawfully obtain and use controlled drugs as prescribed for therapeutic purposes.

166 See s 8(c) of the Sentencing Act 2002.

167 Misuse of Drugs Act 1975, ss 7(1)(a), (b).

168 Misuse of Drugs Act 1975, s 7(2)(b). This was also a recommendation of the review. See Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report*, above n 159, at 101 [rec 2(j)].

169 Under the Narcotics Act 1961 the exemptions were all contained in regulations made under the Act. In contrast the Misuse of Drugs Act itself contains many of the exemptions that allow for prescribing and other medical use.

The licensing regime established under the Act also allows pharmaceutical companies, pharmacies and other licence holders to manufacture, import and distribute controlled drugs for use as medicines. Scientific research involving controlled drugs and some limited industrial use can be licensed under the Act.

3.43 Under the Misuse of Drugs Regulations 1977[170] none of the following controlled drugs may be prescribed, supplied or administered except to the extent and in the circumstances approved by the Minister of Health:

- any Class A drug other than cocaine;
- any Class B1 drug[171] or Class B2 drug[172] other than morphine or opium; or
- any Class C1 drug.[173]

In practice this means that the availability of some widely used therapeutic drugs, like Methylphenidate (Ritalin) and dexamphetamine, is subject to a Ministerial approval, while the availability for therapeutic purposes of other substances like cocaine, which is now only rarely used therapeutically, is not.

Subsequent amendments

3.44 The Misuse of Drugs Act has been amended many times since its enactment. Amendments that introduced important changes to the legislative framework are considered here briefly.

Search and surveillance powers

3.45 The Narcotics Act had permitted the police to search any premises and any persons inside such premises without first obtaining a warrant where the police had reasonable grounds to suspect an offence was being committed on those premises.[174] Under the Misuse of Drugs Act the power to search without warrant was restricted so that it only applies to offences involving Class A, B1 or C1 drugs.[175] The Act also gave the police a power to search any person without a warrant, regardless of the person's location, where they have reasonable grounds for believing the person is in possession of a drug falling into one of the categories noted above.

3.46 The search powers in the Act were supplemented from 1978 by additional enforcement powers contained in the Misuse of Drugs Amendment Act 1978. New provisions allowed police and customs officers to undertake deliveries of controlled drugs imported into New Zealand. Controlled deliveries allow drugs crossing the border to be tracked to the end recipient. Police and customs officers could also enter premises and conduct searches without warrant in relation to the controlled deliveries. Other provisions authorised the detention of a person for up

170 Regulation 22.

171 Class B1 drugs are those drugs that are listed in Part 1 of sch 2.

172 Class B2 drugs are those drugs that are listed in Part 2 of sch 2.

173 Class C1 drugs are those drugs that are listed in Part 1 of sch 3.

174 Narcotics Act 1965, s 12(2).

175 Later the power to search without warrant was extended to also cover searches for precursor substances listed in Part 3 of sch 4.

to 21 days without being charged where there is reasonable cause to believe the person has concealed a Class A or B controlled drug within his or her body. Powers to intercept private communications were also introduced at this time.

Amendments to facilitate needle and syringe exchange measures

3.47 The Act, like its predecessor, included a provision that made it an offence for any person to have any needle, syringe, pipe or other utensil for the purpose of committing an offence against the Act. However, an exemption in section 13 that took effect from 12 January 1988 permitted the possession of needles and syringes that have been obtained through authorised needle exchange programmes.[176] The exchange programmes were established to try and reduce the risk of blood-borne infection from dirty or shared needles. The amendment was prompted by concern over the risk of the HIV virus spreading among intravenous drug users. Together with opioid substitution treatment, this is one of the few harm reduction measures in the Act.

Money laundering and other trafficking-related amendments

3.48 The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 imposed a number of further obligations in respect of offences, and international cooperation over the enforcement of criminal law. New Zealand ratified the Convention in 1998 and subsequently amended the Misuse of Drugs Act to comply with the Convention. The offence of laundering the proceeds of drug offences was introduced[177] and the interception warrant regime introduced in 1978 was expanded and refined. The extraterritorial jurisdiction of the Act was also extended so that someone in New Zealand could be charged in respect of acts done overseas when those acts constituted an offence in New Zealand.[178] The range of offences under the Act that were subject to extradition was also extended.

Controlling access to precursor substances

3.49 Also as required by the 1988 Convention, New Zealand introduced new measures in 1998 to control precursor substances used in the manufacture of synthetic drugs like methamphetamine. It became an offence to supply, produce or manufacture any equipment or material that was capable of being used for the commission of an offence or any precursor substance knowing that it would be used in, or for, the commission of such an offence.[179] In 2005 the controls on precursor substances were tightened further so that it became an offence to

176 Misuse of Drugs Amendment Act (No 2) 1987 (1987/193) introduced the first amendment that made it lawful to possess any needle and syringe supplied under regulations. Later amendments have further modified and refined the provisions.

177 Misuse of Drugs Act 1975, s 12B.

178 Section 10 of the Act creates offences relating to aiding offences against corresponding laws in other countries. Section 12C, which was added in 1998, made it an offence to do or omit to do outside New Zealand anything that, if done in New Zealand, would be an offence against ss 6, 9, 12A, 12AB or 12B.

179 Misuse of Drugs Act 1975, s 12A(1) covers the offence of supply, production or manufacture and s 12A(2) covers the lesser offence of possession. The maximum penalties are respectively terms of 7 or 5 years imprisonment.

import or export a precursor substance without a reasonable excuse.[180] The objective was to deter the import and export of precursor substances that were being used in the manufacture of methamphetamine.[181]

Restricted substances

3.50 A new type of psychoactive substances in the form of "party pills" became widely available in New Zealand around 2000.[182] Most of this generation of party pills contained benzylpiperazine (BZP) often used in combination with trifluoromethylphenylpiperazine (TFMPP). BZP was a synthetic stimulant that induced effects similar to ecstasy.[183] These new psychoactive substances posed a challenge to the way drugs were classified under the Act because they were not controlled drug analogues and so were not covered by the Act. In response the EACD recommended that provision be made within the Misuse of Drugs Act for the control of substances which had a low risk of harm but needed some degree of control. The Committee proposed that age restrictions and other restrictions on sales should be applied to restrict access to such psychoactive substances.[184]

3.51 The Misuse of Drugs Amendment Act 2005 was subsequently enacted, among other things, to establish a new restricted substances regime to regulate access to psychoactive substances that pose a less than moderate risk of harm. The Expert Advisory Committee on Drugs has a statutory responsibility to evaluate and assess substances and make recommendations to the Minister as to whether any substance should be classified as a restricted substance.[185]

3.52 In April 2008 BZP's classification was changed from that of a restricted substance to a Class C drug and its manufacture, sale and possession became illegal from that point. As a consequence there are currently no restricted substances under the control of the Misuse of Drugs Act.

THE PARAMETERS OF CHANGE

Convention drugs

3.53 The international drug conventions create an overarching obligation on signatory nations to limit the manufacture, trade, import, export, distribution, possession and use of psychoactive drugs to medical and scientific purposes and to enforce these obligations through appropriate domestic law criminalising specific conduct.

180 See Misuse of Drugs Act 1975, s 12AC. A reasonable excuse would include import or export for a legitimate purpose such as a lawful industrial use, or to supply health care professionals who will use it to legally produce a controlled drug. It is also an offence to import or export a precursor substance knowing that it will be used to illegally manufacture or produce a controlled drug. See Misuse of Drugs Act 1975, s 12AB(1).

181 Misuse of Drugs Act 1975, ss 12AB and 12AC.

182 A report prepared for the Ministry of Health estimated that approximately 20 million doses of party pills containing BZP and TFMPP were sold in New Zealand between 2002 and 2006; see Beasley and others *The Benzylpiperazine (BZP)/Trifluromethylphenylpiperazine (TFMPP) and Alcohol Safety Study* (Medical Research Institute of New Zealand, Wellington, 2006) at 3.

183 Expert Advisory Committee on Drugs (EACD) *Advice to the Minister on Benzylpiperazine (BZP)* (2004).

184 Ibid.

185 Misuse of Drugs Amendment Act 2005, s 32.

3.54 Chapter 6 of our Issues Paper contained a detailed analysis of the three main conventions and their implications for domestic law. This discussion highlighted the differing emphases of the successive conventions and in particular the complementary obligations on nations to address the harms associated with drug abuse. The 1961 Convention, for example, requires parties to "take all practicable measures for the prevention of the abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration" of drug users.

3.55 In chapter 6 we drew the following conclusions regarding the implications of the international conventions for New Zealand's domestic drug policies and legislation:

- Trafficking in convention drugs (that is, production, distribution, import and export of drugs, and related conduct including money laundering) must be criminalised. Generally, trafficking is to be punished severely, with imprisonment the norm. Punishment of trafficking must include the ability to confiscate the proceeds and instruments of offending. For minor trafficking offences, however, non-custodial and non-criminal sanctions can be considered and rehabilitative measures are permissible in addition or as an alternative to punishment.
- Parties must co-operate with each other to combat illicit traffic in all convention drugs and prevent the diversion of precursors into illicit traffic. Parties must enable cross-border law enforcement by ensuring trafficking offences are subject to extraterritorial jurisdiction, extradition and mutual legal assistance, including cross-border enforcement of confiscation.
- Convention drugs cannot be legalised. Possession and use of convention drugs for other than medical or scientific purposes must continue to be restricted and unlawful. There is significant uncertainty about the approach that must be taken in relation to possession and cultivation of drugs for personal use, and social sharing at a personal level. It may be open to parties to interpret the conventions as not requiring the establishment of criminal offences for these activities. There is no requirement to establish criminal offences in respect of the use of drugs per se, although it is arguable that offences may be required in relation to obtaining drugs for personal use.
- Where offences are maintained for conduct related to personal use, the permissible responses include:
  - (a) non-prosecution policy and discretion;
  - (b) diversion;
  - (c) treatment and rehabilitation as an alternative to prosecution;
  - (d) civil or administrative sanctions;
  - (e) treatment and rehabilitation as an alternative to punishment;
  - (f) use of non-custodial sentences.
- Parties must take practicable measures to prevent the abuse of drugs and address the treatment and rehabilitation of drug users. For these purposes, it is permissible to consider programmes that allow the use of drugs in controlled circumstances, such as drug maintenance and drug substitution treatment, needle exchange schemes, and drug injection rooms.

3.56 The extent to which the criminal law can – and should – provide an opportunity to help meet these rehabilitative obligations is an important legal and policy question. From a legal perspective the question is how far towards a therapeutic approach the criminal law can go before it has effectively decriminalised behaviour which society wishes to deter and the conventions require to be illegal. From a policy perspective the question is how the criminal law can most effectively reduce drug-related harm.

3.57 A number of signatory countries, including some Australian states, have moved to incorporate non-punitive responses to low level personal drug use as part of their drug laws. Different legal approaches are discussed further in chapter 8.

Non-convention drugs

3.58 The parameters for regulating new drugs, which are not covered by the international conventions, are much wider and include the option of legalisation with regulatory restrictions – the approach currently taken with respect to alcohol and tobacco. A key advantage of this model is that it facilitates a graduated response proportionate to the level of risk associated with the use of different drugs. It also allows policy makers to tailor restrictions to the harm they aim to prevent.

3.59 For example, regulation allows policy makers to target at risk groups through legal restrictions on the sale and supply of legalised drugs (alcohol and tobacco) to young people. It also means governments can use measures such as taxation and advertising restrictions to limit demand for drugs.

3.60 The Misuse of Drugs Amendment Act 2005, discussed above at paragraph 3.51, essentially established a very similar regulatory regime for the control of BZP. Regulations established under this amendment restricted the circumstances under which BZP could be sold and supplied, and to whom, and imposed strict labelling, packaging and display requirements. The Act also provided for manufacturing codes to be issued by the Director-General of Health.

3.61 Although BZP is now a Class C prohibited drug, the potential remains for new drugs to be classified as restricted rather than prohibited substances in the future. The options for regulating new drugs, and the risks and benefits associated with the different approaches, are considered in detail in chapter 5.

CONCLUSION

3.62 New Zealand's approach to drug control has been shaped by a century of international co-operation designed to restrict the manufacture, trade, possession and use of psychoactive drugs to medical and scientific purposes. This policy is given effect by three international drug conventions which require signatory countries to maintain a system of prohibition for the drugs they cover. The Misuse of Drugs Act translates these international obligations into domestic law.

3.63 The Act, like the conventions, distinguishes between the manufacture and trafficking of drugs and personal possession and use offences. While there is an absolute imperative for signatory nations to establish and enforce strong criminal sanctions for trafficking offences, the conventions provide for wider scope in how domestic legislation responds to personal possession and use offences.

3.64 The rationale for a more nuanced legal response to personal use offences relates to the complex causal factors which underpin problematic drug use and in particular the close nexus between mental health problems and drug dependence and addiction.

3.65 While the range of offences and penalties in the Misuse of Drugs Act reflects the different risks associated with the use of different drugs, it does not create a statutory framework for diversionary or therapeutic responses to complement the criminal sanctions. The police and courts do have the power to exercise discretion in how and when they enforce the existing legislation. However, it is clear from reviewing the legal and enforcement practices of a number of signatory countries that there is a much wider range of possible responses *within* the criminal framework demanded by the conventions than New Zealand drug law currently reflects. Whether New Zealand should adopt similar measures is discussed in detail in the following chapter and in chapter 8.

3.66 Finally, with respect to non-convention drugs, New Zealand has the opportunity to design a system of control which draws on the full range of policy options, ranging from prohibition at one end of the spectrum to legalisation at the other. Designing such a system involves a careful evaluation of the costs and benefits associated with the various policy options, including how such a regime would interface with the system of prohibition which applies to convention drugs. These issues and our recommendations for regulating new substances are discussed in chapter 5.

Chapter 4

The case for change

INTRODUCTION

4.1 An important question for this review is whether the Misuse of Drugs Act 1975, which controls drugs covered by the international conventions, is as effective as it might be in reducing the harms caused by those drugs.

4.2 A second and related question is how to regulate new drugs (which are not currently prohibited by the international conventions) so that the public benefits produced by that regulation outweigh its inherent costs.[186]

4.3 As discussed in the preceding chapter, the starting point for considering these two questions is different. Any changes to how the law deals with drugs covered by the international conventions must be consistent with the requirement that such substances are prohibited. With respect to new drugs, however, the policy parameters are wider and include the possibility of the type of regulatory restrictions that currently apply to legalised drugs such as tobacco and alcohol.

4.4 However, despite these different policy parameters, the overarching goal of reducing drug-related harm applies to both convention and non-convention drugs. For this reason, it is important to consider the potential displacement effects of having different forms of regulation: in particular, the extent to which the prohibition or strict regulation of one substance will drive users towards another less regulated but potentially more harmful substance.

4.5 In this chapter we consider the case both for a new approach to the regulation of non-convention drugs and for reform of the laws controlling convention drugs.

THE NATIONAL DRUG POLICY

4.6 The overarching goal of the *National Drug Policy* is "to prevent and reduce the health, social, and economic harms that are linked to tobacco, alcohol, illegal and other drug use".[187] The *Policy* therefore views drug use primarily as a health and social issue which should be addressed, at least partially, through health-based responses.

186 See the discussion of this principle in ch 3, paragraphs 3.58 – 3.66.

187 Ministerial Committee on Drug Policy *National Drug Policy* 2007 – 2012 (Ministry of Health, Wellington, 2007) at [1.2].

4.7 The *Policy* identifies three complementary strategies, or pillars, that are required to achieve the goal:

- supply control – which aims to prevent or reduce harm by restricting the availability of drugs;
- demand reduction – which involves a wide range of activities that aim to reduce an individual's desire to use drugs;
- problem limitation – which seeks to reduce harm from existing drug use.

4.8 For legal drugs supply control measures involve regulatory restrictions on how the substances are sold or supplied and to whom. For illegal drugs they entail the enforcement of the provisions of the Misuse of Drugs Act such as border control, shutting down domestic drug cultivation and manufacture, and interrupting drug supply chains.

4.9 Demand reduction strategies target current drug users by encouraging them to reduce or stop their drug use; and potential drug users by encouraging them not to begin or to delay any use of drugs. They encompass drug education, health promotion, social marketing and community action. Taxation and restrictions on sale and advertising might also be used to reduce the demand for legal drugs.

4.10 Problem limitation measures include emergency services and drug treatment as well as harm reduction services, like needle exchange programmes, which are aimed not at reducing drug use per se but at mitigating specific harms associated with drug use.

4.11 The *National Drug Policy* identifies young people, Māori and Pacific peoples as three priority populations at greatest risk from alcohol- and drug-related harms and outlines specific objectives that will help reduce the social, economic and health harms associated with the use of both legal and illegal drugs. These include:[188]

- preventing or delaying the uptake of tobacco, alcohol, illegal and other drug use, particularly in Māori, Pacific peoples and young people;
- reducing the harm caused by tobacco by reducing the prevalence of tobacco smoking, consumption of tobacco products and exposure to second-hand smoke;
- reducing harm to individuals, families and communities from the risky consumption of alcohol;
- preventing or reducing the supply and use of illegal drugs and other harmful drug use;
- making families and communities safer by reducing the irresponsible and unlawful use of drugs; and
- reducing the cost of drug misuse to individuals, society and government.

188 Ibid, at [1.3].

4.12 The *Policy* is explicit about the need for a whole-of-government approach and close collaboration across a range of agencies (including Justice, Health, Police and Education) in order to achieve these policy objectives:[189]

> All government agencies will be held accountable…for achieving the objectives of the National Drug Policy, delivering effective policies and programmes, and collaborating with other agencies to achieve a co-ordinated approach to reducing drug related harm.

4.13 While the *Policy* draws no distinction between legal and illegal drugs in framing its goals and objectives, in practice the legal status of a drug has profound implications for the strategies that are implemented.

4.14 For example, when addressing the health and social harms associated with the legal drugs alcohol and tobacco, the government has access to a range of policy levers that impact on both the supply of and demand for these drugs. On the supply side these measures have included imposing restrictions on how and where these products can be sold and the minimum age at which they can be purchased. On the demand side they have included measures to make tobacco smoking less affordable through the imposition of taxes, bans on tobacco advertising and sponsorship and a requirement that tobacco products carry graphic health warnings. As a result of growing concerns about the impact of alcohol misuse on health and law and order, a number of less stringent demand reduction measures are also contained in the Alcohol Reform Bill 2010 currently before Parliament.

4.15 Crucially, these policies for reducing the harms associated with the use of tobacco and alcohol have been complemented by high profile social marketing campaigns and supported by well-funded public health initiatives such as the *QuitLine* and addiction treatment programmes.

4.16 However, with respect to strategies aimed at reducing the demand for and supply of illicit drugs, the policy levers are circumscribed by the limits of the criminal law. Given that the supply and use of drugs is prohibited, the primary lever in achieving both supply control and demand reduction is the use of prosecution and criminal penalties as a deterrent. There is comparatively little room for other demand reduction strategies – for example, well-targeted and properly constructed education programmes about the risks of harm associated with excessive use. And, as discussed, responding effectively to the harms associated with illicit drug use is critical to achieving the goals of the *National Drug Policy*. This will often require a multidisciplinary approach allowing mental health, addiction and justice services to interface effectively.

THE EFFICACY OF DRUG LAWS

4.17 Our starting point is that the use of the criminal law, backed by strong sanctions, is required for convention drugs by our international obligations, and is appropriate as a mechanism for reducing their supply and penalising those who profit from their manufacture and sale. However, there are legitimate questions to be asked about the efficacy and appropriateness of a wholly punitive response to the possession and use of such drugs; we must consider whether a greater

189 Ibid, at [2.2.3].

range of responses under the criminal law framework may be more effective at reducing the demand for drugs. Such a consideration involves weighing a number of practical and ethical questions including:

- whether the current balance between conviction and punishment, diversion and treatment is as effective as it might be in reducing drug-related harms;
- whether a more flexible approach to illegal drug use arising from addiction or mental health problems may be both more effective and more humane than the purely punitive approach adopted under the current criminal law;
- whether criminalisation can exacerbate the harms associated with drug use and whether there are ways within the criminal law framework of mitigating these harms;
- whether the particular risks to young people and Māori could be mitigated by a less punitive and more therapeutic approach to drug use offences.

4.18 These questions do not go far enough in relation to non-convention drugs; a more fundamental analysis of a variety of regulatory approaches is required, bearing in mind the principle already outlined in chapter 1 that absolute prohibition ought to be a last resort. That analysis must take into account the respective costs and benefits of available approaches, including the unintended consequences of prohibition. As identified by the United Nations Office on Drugs and Crime (UNODC),[190] these are:

(a) A huge criminal black market "that now thrives in order to get prohibited substances from producers to consumers… There is no shortage of criminals competing to claw out a share of a market in which hundred fold increases in price from production to retail are not uncommon". UNODC considers the violence and corruption associated with the black market to provide the "strongest case" against the global drug control system.[191]

(b) Policy displacement, in which available funds have been drawn into public security and law enforcement and away from public health interventions.

(c) Geographical displacement, in which tightening controls in one country or geographical area inevitably produces an increase in drug production or supply in another country or geographical area. For example, as cocaine supply reduced in Peru and Bolivia in the second half of the 1990s, it increased in Colombia.[192]

(d) Substance displacement so that suppliers and users move on to other drugs with similar psychoactive effects when their current drug-of-choice is controlled. Most recently, for example, the UNODC has noted that while the markets for cannabis, cocaine and opiates appear to be shrinking, the market for amphetamine-type stimulants appears to be increasing and the problem caused by these stimulants is worsening.[193]

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190 Commission on Narcotic Drugs "Making Drug Control 'Fit for Purpose': Building on the UNGASS Decade" (7 May 2008) E/CN.7/2008/CRP.17 at 10.

191 United Nations Office of Drugs and Crime *World Drug Report 2009* (United Nations, New York, 2009) at 163 [*World Drug Report 2009*].

192 Commission on Narcotic Drugs, above n 190, at 11.

193 United Nations Office of Drugs and Crime *World Drug Report 2009*, above n 191, at 9.

(e) The way that we perceive and deal with drug users. As noted by the UNODC, "a system appears to have been created in which those who fall into the web of addiction find themselves excluded and marginalised from the social mainstream, tainted with a moral stigma, and often unable to find treatment even when they may be motivated to want it."[194]

4.19 It may sometimes be appropriate to bear these manifest costs of prohibition in order to deal effectively with new substances as they arise, but this should be based upon a proper analysis of the evidence; prohibition ought not simply to be the default response. We therefore now turn to a brief consideration of what the evidence tells us about the efficacy of prohibition.

The efficacy of the current approach

Prohibition as a means of controlling drug supply

4.20 In our Issues Paper, we reviewed some of the extensive literature on the efficacy of drug prohibition and the extent to which prohibition has succeeded in its stated aims.[195] The UNODC considers that global prohibition has at least led to drug use being contained. Around five per cent of the adult population worldwide (or between 140 – 250 million people) report using illegal drugs at least once in the past year. These proportions, which have remained relatively stable over recent years, are substantially smaller than for legal psychoactive substances such as tobacco and alcohol.[196]

4.21 In New Zealand, while drug use patterns have changed, the overall prevalence of illicit drug use is relatively stable and certainly much lower than the prevalence of legal drug use.

4.22 However, trends over recent years need to be considered in the context of over 40 years of global drug control. While some kind of plateau in levels of drug use may have been reached in recent years, the International Drug Policy Consortium argues that over the longer period there has been a "massive increase in the scale and diversity of international markets for illegal drugs, and increasing rates of drug use in almost every country".[197] Moreover, the current plateau may not last; the United Nations itself has said that the drug "problem" may get worse before it gets better.[198]

4.23 The scale of the global drugs market also remains immense. The wholesale international illegal drugs market was valued at US$94 billion in 2003 (compared to $17.4 billion for wine, $6.7 billion for beer, and less than $6 billion for coffee)

194 Commission on Narcotic Drugs, above n 190, at 10 – 11.

195 Law Commission *Controlling and Regulating Drugs* (NZLC IP16, 2010) at 114.

196 United Nations Office of Drugs and Crime *World Drug Report 2009*, above n 191, at 169. The World Health Organisation estimates that in 2000, there were 185 million users of illegal drugs worldwide, compared to 2 billion alcohol users and 1.3 billion tobacco smokers – see Marcus Roberts, David Bewley-Taylor and Mike Trace *Facing the Future: The Challenge for National Drug Policy* (Report 6, The Beckley Foundation Drug Policy Programme, Beckley (UK), 2005) at 5.

197 International Drug Policy Consortium *The 2006 World Drug Report: Winning the War on Drugs?* (International Drug Policy Consortium, London, 2006) at 2.

198 Commission on Narcotic Drugs, above n 190, at 10.

and the retail international illegal drugs market at $322 billion.[199] It is claimed that the illegal drugs market is the third most profitable market in the world, behind the markets in oil and arms.[200]

4.24 In New Zealand, the cannabis market was estimated to have a wholesale value in 2005 of between $74 million and $95 million, and a retail value of between $183 million and $235 million.[201] Some of the value of the illegal drugs market reflects the illegality of the substances involved and the risk in making them available. Nevertheless, figures such as these may be one reason why UNODC now considers the reduction or elimination of drug use to be an "aspirational goal akin to the elimination of war and poverty".[202]

4.25 Part of the reason for the apparent lack of efficacy of prohibition in doing any more than containing the problem is that drug supply is strongly influenced by the nature of the various drug markets themselves, including the ease with which the drug is produced and distributed and the extent to which supply and distribution is controlled by organised crime. For example, in surveys conducted between 2005 and 2007, 45 per cent of frequent drug users in New Zealand who had purchased cannabis in the last six months said that it took less than 20 minutes; 65 per cent of those who had purchased methamphetamine and 51 per cent of those who had purchased amphetamine were able to do so in one hour or less. In contrast, 43 per cent of those who had purchased ecstasy and 35 per cent of those who had purchased LSD said the purchase took days or weeks.[203] The latter drugs are clearly less available than the former and, by inference, more sensitive to law enforcement.

4.26 In the face of this, the strategies adopted by law enforcement agencies are generally likely to have only marginal impact. This is consistent with the fact that significant resources are currently deployed for relatively little return. In a report prepared for the New Zealand Police in 2008, economists Business and Economic Research (BERL) estimated that the cost of enforcing the law against illegal drugs amounted to a total of $303 million in 2005/06.[204] Enforcement activity targeting illegal stimulants was estimated to account for 48 per cent of that sum and 257,140 of the 598,000 policing hours dedicated to illicit drug enforcement. Activities targeting cannabis comprised another 38 per cent, or $116.2 million of the total budget, and accounted for 333,684 policing hours.[205]

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199 United Nations Office of Drugs and Crime *World Drug Report 2009*, above n 191, at 127–128.

200 Roberts, Bewley-Taylor and Trace, above n 196, at 1.

201 New Zealand National Drug Intelligence Bureau "New Cannabis": The Cornerstone of Illicit Drug Harm in New Zealand, 2007 Strategic Assessment (Wellington, November 2007) at 53.

202 United Nations Office of Drugs and Crime *World Drug Report 2009*, above n 191, at 163. For a critique of this comparison, see International Drug Policy Consortium, above n 197, at 10.

203 C Wilkins, R Giffiths and P Sweetsur *Recent Trends in Illegal Drug Markets in New Zealand 2006–2009: Findings from the 2006, 2007, 2008 and 2009 Illicit Drug Monitoring System* (Centre for Social and Health Outcomes Research and Evaluation, Massey University, Auckland 2010) at 24 [IDMS 2009]. At 34 a frequent drug user was defined as being someone who used methamphetamine or ecstasy at least monthly or who injected a drug intravenously at least monthly. The respondents to the survey are not a random sample of frequent drug users, but were instead recruited through promotional campaigns and "snowballing".

204 Adrian Slack and others *New Zealand Drug Harm Index* (prepared for the New Zealand Police, BERL, Wellington, 2008) at 62. This figure includes costs to the New Zealand Customs Service and the New Zealand Police, court costs and the cost of sentences imposed.

205 Ibid.

4.27 While the joint efforts of police and customs to interrupt and limit the domestic amphetamine market do appear to have succeeded in stemming its growth, analysis by the Department of Prime Minister and Cabinet Methamphetamine Working Group was less optimistic about the long term chances of enforcement measures eradicating this and other drugs:[206]

> Research on supply side interventions suggests that there are strong financial incentives for illegal drug manufacturers and suppliers to circumvent any barriers put up by governments. Removing meaningful quantities of an illegal drug tends to increase prices which in turn increase incentives for producers. The literature on this subject tends to suggest it is difficult for governments to sustain pressure on drug markets and fundamentally shape them.

4.28 The Working Group also concluded that strong law enforcement activity was likely to have the greatest chance of success when targeting "growing or immature markets", while treatment-focused responses were likely to have a greater effect on established or entrenched drug markets. As a recent review put it, "for most established markets, expanding enforcement beyond a [simple] base level is a very expensive way to purchase further increments in price", producing "diminishing returns".[207] Since the evidence suggests that New Zealand's methamphetamine market now appears to be maturing, with a stable or slightly declining user base and a smaller entrenched group of problem users,[208] increasingly rigorous enforcement is therefore likely to have only a marginal additional impact on the methamphetamine problem.

4.29 Overall, the evidence seems to point to a somewhat pessimistic conclusion about the efficacy of prohibition as a supply control measure. However, as noted in chapter 1, the limitations of prohibition should not be overstated. While several decades of prohibition may have coincided with a substantial growth in the volume of available illicit drugs which has only recently levelled out, there has at the same time been substantial social change, and there is simply no way of determining the extent to which the problem would have been worse without prohibition. At the least, it is reasonable to conclude that prohibition can be effective in discouraging nascent markets and reducing the supply of drugs which are not readily manufactured or produced locally.

Prohibition as a means of reducing demand

4.30 In our Issues Paper, we also considered the argument that prohibition can contribute to a reduction in the demand for drugs. We suggested a number of mechanisms by which this might occur. In the long term, prohibition may act as a tool to shape social attitudes and culture, maintaining and reinforcing the view that the use of particular drugs is wrong or harmful and should be avoided. More immediately, it may deter individuals from experimenting with drugs and influence the price and availability of drugs in the community.

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206 Department of the Prime Minister and Cabinet Methamphetamine Working Group *Research Synthesis – Review of Best Practice on Interventions to Reduce Methamphetamine Use and Associated Harm* (unpublished paper, Department of the Prime Minister and Cabinet Methamphetamine Working Group, Wellington, 2010) at [3.5].

207 Jonathan P Caulkins and Peter Reuter "How Drug Enforcement Affects Drug Prices" (2010) 39 Crime and Justice 213 at 259.

208 Department of the Prime Minister and Cabinet Methamphetamine Working Group, above n 206, at 5.

4.31 With respect to legal drugs like alcohol and tobacco, it is widely accepted that pricing policies, including the imposition of excise taxes, are among the most effective mechanisms for reducing consumption and therefore the aggregate levels of harm associated with the use of these two products. In New Zealand, the Government has recently adopted an aggressive tobacco taxation policy specifically targeted at reducing the prevalence of smoking in the community.[209]

4.32 Typically governments do not have the ability to directly influence the price of illegal drugs in this way, because these markets do not operate in the open economy. However, laws prohibiting the sale and supply of drugs in themselves might be expected to influence both price and availability. For example, drug enforcement activity which targets drug manufacture and supply chains can reduce the quantities of the drug in circulation, thereby reducing availability and, as with most scarce commodities, pushing up its market price. The risks of detection and prosecution inherent in drug manufacture and supply are also usually reflected in the price manufacturers and dealers will charge for various substances.

4.33 In its submission to this review, the New Zealand Police Association pointed to this country's experience with BZP as an example of the efficacy of prohibition as a tool for influencing price and availability. The Police Association argue that following the reclassification of BZP from a legal but restricted substance to an illegal Class C drug, its street price increased and availability dropped:[210]

> We believe the experience with BZP is illustrative of the demand reduction effects that flow from a legally prohibited status. When legal, BZP's arrival in popular awareness led to the explosive proliferation of corner shops dedicated to its supply, and the rapid normalisation of its usage. As soon as it was made illegal, there was a rapid contraction in availability, a reduction in use, and a massive rise in its street price.

4.34 It is undoubtedly correct that the criminalisation of BZP increased price and reduced availability. However, it is by no means clear whether the primary mechanism was supply control or demand reduction. It may well be that BZP became less attractive for suppliers (particularly those who wished to make a profit legally but did not wish to break the law) and that consumers adapted to the lack of supply and the increased price by turning to alternative substances. If these substances were more harmful, it is not axiomatic that the reduction in the prevalence of BZP would have resulted in a reduction in overall drug-related harm.

4.35 There are also a number of other reasons why prohibition is not always an effective tool for reducing the overall demand for drugs. First, just as prohibition can lead to perverse effects with respect to the choices drug users make, it can also lead to perverse effects with respect to those engaged in drug manufacture and supply. For example, successful enforcement operations which interrupt supply chains or reduce availability can create the sort of scarcity which often leads to higher prices and profits – thereby creating the very incentives which attract criminal organisations to drug manufacturing and supply in the first instance. Simultaneously, therefore, law enforcement can act to reduce demand and increase the incentive to supply.

209 In April 2010 the Government passed legislation increasing the excise tax on cigarettes by 10% in each of the next three years. At the same time the excise tax on loose tobacco was increased by 24%.

210 Submission of the New Zealand Police Association (submission dated 12 May 2010) at [56].

4.36 Secondly, prohibition's impact on consumer behaviour is also complex and will vary within different demographic groups and in relation to different drugs. Hence, while drug prevalence figures do support the view that a substance's illegal status deters significant segments of the population from becoming users, this is not universally true for all drugs in all settings. In New Zealand, for example, there is a high prevalence of cannabis use, despite its illegal status. In part this reflects the ease with which cannabis can be grown and the fact that it is typically priced within the same range as alcoholic products. It also reflects the difficulty of enforcing prohibition when drug use has become deeply entrenched within segments of the population, resulting in a degree of normalisation and destigmatisation: we estimate that only one per cent of all cannabis users in New Zealand in 2006 were prosecuted for their use.[211]

4.37 It is therefore not surprising that research suggests that fear of punishment or a drug's illegal status is not a major driver in a decision not to use, or to stop using, drugs.[212] This decision is instead driven by the impact of drug use on a user's family relationships, home and work life and physical health.[213] Nor does apprehension for cannabis use deter future use.[214] Many submitters also argued that the prohibition of cannabis lacked moral suasion given the widespread perception within the community that its use was no more and possibly less problematic than the use of alcohol and tobacco.

4.38 Thirdly, as some submitters suggested, applying strong legal controls to low risk substances such as cannabis and BZP risks undermining the efficacy of prohibition as a means of deterring people from using higher risk drugs where there is a strong potential for harm.

4.39 Finally, enforcement of prohibition may be highly effective in reducing the demand for drugs among experimental and recreational users, but has very limited effectiveness in reducing demand by dependent users, who are typically a minority in number but consume the majority of drugs. Effective deterrence is dependent upon drug users making rational decisions about whether to use drugs, by weighing up the costs and benefits of doing so.[215] The illegality of drug use, and the fear of the legal consequences that flow from that illegality, should

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211 The vast majority of recorded drug offending in New Zealand involves cannabis. For example, of the 12,542 drug convictions recorded in 2008, 76% (9,504) related to cannabis and 37% of these (4,596) related to cannabis use. See Law Commission *Controlling and Regulating Drugs*, above n 195, at 117.

212 David Ryder, Noni Walker and Alison Salmon *Drug Use and Drug-Related Harm* (2nd ed, IP Communications, Melbourne, 2006) at 124; Robin Room and others *The Global Cannabis Commission Report – Cannabis Policy: Moving Beyond Stalemate* (The Beckley Foundation Global Cannabis Commission, Beckley (UK), September 2008) at 148; Dave Bewley-Taylor, Mike Trace and Alex Stevens *Incarceration of Drug Offenders: Costs and Impacts* (Briefing Paper 7, The Beckley Foundation Drug Policy Programme, 2005) at 6.

213 Bewley-Taylor, Trace and Stevens, above n 212, at 6.

214 Simon Lenton and others *Infringement versus Conviction: The Social Impact of a Minor Cannabis Offence under a Civil Penalties System and Strict Prohibition in two Australian States* (Monograph Number 36, National Drug Strategy Australia, 1998) at 25.

215 There is some controversy about the view that regulation is justified because the effects of drug intoxication or addiction impair users' ability to make rational decisions that are in their best interests. While some commentators accept that the effects of intoxication or addiction can impair a user's judgment in this way, others are less convinced. See Robert J MacCoun and Peter Reuter *Drug War Heresies: Learning from Other Vices, Times and Places* (Cambridge University Press, New York, 2001) at 64 and Douglas N Husak "Recreational Drugs and Paternalism" (1989) 8 Law and Philosophy 353 at 377–378.

mean that the costs to the user of engaging in drug use outweigh the perceived benefits to be derived from it. But when drug use is driven by addiction, the user simply does not engage in this type of rational calculation of the costs and benefits of use. Price matters little; indeed, an increase in price may simply fuel an increase in acquisitive crime to provide the money to pay for it.

4.40 In summary, while prohibition does reduce demand for some drugs from some user groups, it appears to be less significant than other non-legal factors in driving decisions about drug use. Moreover, its effectiveness is arguably extremely limited when a particular drug is widely available or when use is driven by addiction.

Criminalisation of people who use drugs

4.41 Alongside these questions about the efficacy of prohibition lie ethical concerns about the criminalisation of people whose drug use may be resulting in no serious harm to others (moderate cannabis users, for example) or whose drug use may be associated with underlying mental health or other social problems or be driven by drug addiction.

4.42 As discussed in chapter 2 of this report, surveys of frequent drug users in New Zealand have found high proportions reporting that they used drugs to cope with depression and physical or emotional pain and because they felt they were addicted.[216]

4.43 The Department of Prime Minister and Cabinet's Methamphetamine Working Group noted that the illegal status of drugs like methamphetamine can in fact exacerbate the harms associated with its use for some groups in society:[217]

> The illegal nature of possession and use is a barrier for those requiring treatment. In addition, time in prison often brings worse health outcomes for individuals and their criminal convictions impact on their financial position, personal and family relationships, and employment and travel prospects.

4.44 In its submission to this review, the New Zealand Nurses Organisation expressed similar concerns about the manner in which the criminal justice system can further victimise those whose drug offending arises from underlying problems such as childhood sexual abuse and family dysfunction:[218]

> [O]ften the children whom society has already failed to protect and who have been severely traumatised are not only not offered rehabilitative care, but are also excluded from regular health system checks and therefore even more at risk of developing negative social behaviours. Drug misuse and addiction in this context is a consequence of mental ill-health and it is entirely inappropriate to criminalise the victim, though we are aware that judgmental attitudes can affect clinical decisions.

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216 For example, a 2008 report drawing on the experiences of frequent drug users in New Zealand found 55 % of injecting users and 41 % of methamphetamine users had suffered from a mental illness. 50 % of the injecting users and 30 % of the frequent methamphetamine users had been imprisoned at some point; see IDMS 2009, above n 203, at 159.

217 Department of the Prime Minister and Cabinet Methamphetamine Working Group, above n 206, at 38.

218 Submission of the New Zealand Nurses Organisation (submission dated 30 April 2010) at 6 [11].

4.45 The New Zealand Police also acknowledged the futility of incarcerating repeat offenders whose criminal offending is associated with addiction:[219]

> People are frequently processed through the criminal justice system without having the underlying issues of their drug and alcohol addiction addressed.

4.46 Alongside this potential for the criminal justice system to victimise individuals whose offending arises from some pre- or co-existing disorder, there is also the potential for drug laws to exacerbate the harms and inequalities experienced by subpopulations, especially the young and ethnic minorities.

4.47 This can be a particular risk when prohibition is unevenly enforced within different communities and where the police are able to exercise wide discretionary powers with respect to how they respond to offences involving personal drug use. For example, a study of cannabis arrest and conviction patterns amongst the Christchurch Health and Development Study birth cohort discussed in chapter 2 concluded that ethnicity may be a risk factor for arrest. It found that, while overall prosecution and conviction rates were low for cannabis users (despite a high prevalence of cannabis use in the group), certain characteristics made some individuals more vulnerable to arrest than others.[220] Specifically, researchers found that even when ethnic and gender differences in cannabis use and other factors were taken into account:

- Māori had rates of arrest and conviction that were over three times higher than those of non-Māori;
- males had rates of conviction that were nearly ten times higher than for females;
- rates of arrest and conviction were also elevated amongst those with a history of previous arrest for non-cannabis related offences.

4.48 While there may be a legitimate explanation for elevated cannabis arrest rates among those who have been involved in other criminal offending, it is difficult to find an explanation for the disproportionately high rates among Māori (and males) that does not involve the possibility of some sort of bias or stereotyping.

4.49 One submitter suggested that the arbitrary and at times discriminatory nature of the enforcement of law with respect to cannabis was an almost inevitable consequence, given the high prevalence of use and the very large police resource that would be required to enforce the law consistently:[221]

> ... without such a state of affairs [doubling of policing] the prohibition laws must inevitably be enforced only in a casual and highly unfair way. Nearly all users, as long as they are discreet, may avoid the law without any difficulty. Only an unlucky few – the young, the poor, Māori – suffer. This brings the law into entirely justified disrepute.

4.50 This discussion illustrates how the criminalisation of drug users can produce a cascading effect that is potentially both disproportionate to the harm associated with the drug use itself and also highly prejudicial for other life outcomes. It also

219 Submission of the New Zealand Police (submission dated 18 June 2010) at 8.

220 D Fergusson, NR Swain-Campbell and LJ Horwood "Arrests and Convictions for Cannabis Related Offences in a New Zealand Birth Cohort" (2003) 70 Drug and Alcohol Dependence 53 at 60–61.

221 Submitter 183 (submission dated 27 April 2010).

raises questions about the efficiency of expending scarce resources on the detection, prosecution and punishment of drug users while doing nothing to treat the underlying health and addiction issues which are associated with a high proportion of frequent drug users.

4.51 Many of these issues were highlighted 30 years ago by the Blake-Palmer Committee which argued that, whether the aim was to protect the individual or society from the harm caused by drug use, "there are kinder and more effective methods than reliance on the criminal law alone to deal with the misuse of drugs".[222] The Committee therefore suggested that educational, therapeutic, social and supportive measures were needed to a much greater extent than had previously been the case. It recommended improving the treatment options and support for those dependent on drugs and argued for high quality community education about the risks of drug abuse and dependency.[223]

4.52 The Committee's recommendations proposing an increased emphasis on prevention and treatment were not matters that necessarily needed legislation. These proposals did not consequently feature in the new Act. Neither did the suggestions for the diversion of young offenders and other drug users away from the criminal justice system.

OUR CONCLUSIONS

4.53 The terms of reference for this review asked us to consider whether, in principle, the legislative regime for the control of drugs should reflect the principles of harm minimisation underpinning the *National Drug Policy*. In our view, the statute not only should, in principle, support the goals of harm reduction, but New Zealand's international obligations and its own domestic drug policy require such an approach.

4.54 In recent years UNODC has stressed the need for signatory countries to achieve a balance between strategies aimed at eliminating drugs and those aimed at reducing demand through prevention and treatment. UNODC's Executive Director, Antonio Maria Costa, has suggested that in many countries there is an imbalance between supply control measures and measures aimed at reducing demand and treating drug dependency.

4.55 As discussed in the preceding chapter, the 1961 and 1971 conventions create a positive requirement on signatory nations to "take all practicable measures for the prevention of the abuse of drugs and for the early identification, treatment, education after-care, rehabilitation and social integration" of drug users.[224] The manner in which the criminal law responds to drug users has profound implications for our ability to meet these obligations.

222 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report* (NZ Board of Health Report Series, No 18, Wellington, 1973) at 49.

223 Ibid, at 89.

224 United Nations Office on Drugs and Crime "Reducing the Adverse Health and Social Consequences of Drug Abuse: A Comprehensive Approach" (22 January 2008) at 1.

4.56 Similarly, the *National Drug Policy* itself is clear about the obligations and accountabilities of all branches of government – including the criminal justice sector – for realising its overarching goal of preventing and reducing "the health, social, and economic harms that are linked to tobacco, alcohol, illegal and other drug use".[225]

4.57 From this it follows that the legislative regimes for controlling both convention and non-convention drugs must positively advance this goal and the suite of supply control, demand reduction and problem limitation strategies which support it.

4.58 We recommend that, in order to further emphasise prevention and treatment and to ensure a coordinated legislative approach to all drug policy, the new legislative framework should be administered solely by the Minister of Health. Currently parts of the Act are administered by the Ministry of Justice and other parts by the Ministry of Health.

Convention drugs

4.59 Our analysis suggests that while the Misuse of Drugs Act has a vital role to play in reducing the supply of illicit drugs in the community and signalling the risks associated with their use, it does not adequately support the overarching goal of the *National Drug Policy*. Specifically, the law fails to recognise and respond appropriately to the health and addiction issues which frequently underpin the use of illicit drugs, and therefore does little to support demand reduction.

4.60 The law may deter some sections of the population from experimenting with drugs – axiomatically reducing the potential for harm. But for those who are already using and whose use is associated with addiction or other mental health problems, the criminal law's response can in some circumstances *exacerbate* rather than reduce drug-related harms. As we have seen in the preceding discussion, this is particularly true for some of the priority populations identified in the *National Drug Policy* as being at heightened risk of experiencing harmful impacts as a result of drug use – the young, Māori and Pacific peoples.

4.61 Crucially too, the illegal status of drugs and the risk of criminal prosecution can create an obstacle to drug users accessing appropriate education and treatment – both of which are critical components of the *National Drug Policy's* strategies. Furthermore, because the current Act does not provide statutory recognition for therapeutic options within the framework of the criminal law, it makes it very difficult to achieve the level of cross-sectoral collaboration mandated by the *National Drug Policy*.

4.62 It is also arguable that resources currently spent on the prosecution and punishment of individual drug users could be more effectively used to strengthen the enforcement efforts against organised criminal networks involved in drug manufacturing and trafficking.

225 For the purposes of the National Drug Policy "other drugs" refers to medicines that are diverted from their legitimate purposes, restricted substances listed in the Misuse of Drugs Act and products (e.g. volatile substances) that are manufactured and marketed for domestic or industrial purposes but are capable of being used to achieve psychoactive effect.

4.63 Submissions to this review revealed broad agreement with these conclusions and the underlying premise that the successful management of drugs is *both* a criminal justice *and* a public health policy problem. Submitters agreed that a flexible interface is required between the criminal law and other government policies designed to target health and social harms.

4.64 In its submission to this review, the Centre for Social and Health Outcomes Research and Evaluation (SHORE) argued strongly for the retention of prohibition for drugs that are currently illegal on the grounds that it served to reduce their availability and increased their street price, thereby reducing consumption over time, but argued against the criminalisation of drug users:[226]

> [W]e do not believe drug *users* as a rule should receive prison sentences or criminal convictions for drug use only. Rather they should be assessed by drug treatment and health professionals and the appropriate treatment or education intervention be undertaken. If drug and mental health treatment is not considered necessary, educational courses, fines, community work or donations to charities may be considered. The control regime must be flexible enough to respond to individual circumstances of drug use in a constructive way.

4.65 Submissions from the New Zealand Police and the Ministry of Health also revealed a broad consensus over the need for a wider menu of enforcement options in relation to personal drug use offences. The Ministry of Health explicitly supported the closer alignment of the criminal law with the *National Drug Policy* and in particular the adoption of a new approach which should "seek to mitigate the potential harms associated with prohibition and reduce the inequitable enforcement of current laws on users".[227]

4.66 The Police supported greater use of the Police Adult Diversion Scheme together with increased access to drug assessment and treatment in circumstances where "drug abuse and dependence have been identified".[228] They specifically acknowledged that improved access to drug and alcohol treatment services was likely to contribute to a reduction in crime:[229]

> Police considers that by reducing the demand for illicit drugs through effective treatment, a positive impact can be made on the volume of crime such as burglary and other types of property theft.

4.67 In a similar vein, the University of Otago's National Addiction Centre highlighted the complex bi-directional associations between drug use and criminal offending and stressed the important role law enforcement can play in breaking these criminal cycles:[230]

> Drug misuse can therefore be a driver of crime while at the same time engagement in the criminal justice system can be an important therapeutic window, providing the opportunity for insight into the consequences of drug use and a decision to make changes in one's life.

226 Submission of SHORE and Whariki Research Centre, School of Public Health, Massey University (submission dated 29 April 2010).

227 Submission of the Ministry of Health (submission dated 30 April 2010) at 14.

228 Submission of the New Zealand Police (submission dated 18 June 2010) at 4.

229 Submission of the New Zealand Police (submission dated 18 June 2010) at 8.

230 Submission of the National Addiction Centre (submission dated 6 May 2010) at 2.

4.68 This concept of the criminal justice system providing a "therapeutic window" underpins many of the alternative approaches to personal drug use adopted by other countries outlined in our Issues Paper. It is a concept we believe is consistent with the international conventions and one which will better align the criminal law with the harm reduction goal of the *National Drug Policy*.

Non-convention drugs

4.69 Submissions also revealed strong consensus on the broad principles proposed for the regulation of new substances which are not covered by the Misuse of Drugs Act or the international drug conventions which underpin it.

4.70 While there were varying opinions about the best approach, most submissions agreed that the regime should be driven by an evidence-based assessment of the potential harms likely to arise from the use of any new substance and that the strength of regulation should be proportionate to that assessment.

4.71 The Police agreed with our proposal that any scheme for new drugs should "generally be regulated with restrictions, rather than prohibition, but with prohibition available as a last resort where regulation had proved ineffective".[231] They also agreed that any psychoactive substance falling within the ambit of the new regime should require an approval from the regulatory body before it could be manufactured or imported.

4.72 The National Addiction Centre drew our attention to the medical profession's experience with BZP before it was classified as a prohibited substance and suggested this added weight to the argument for regulating rather than prohibiting drugs where possible. The Centre suggested that the large number of emergency department admissions for BZP-related problems in the years before it was prohibited may have been a consequence of its legal status and the fact that, before the drug was reclassified, users who had suffered ill-effects were not afraid to seek medical help and advice.

4.73 Submitters also emphasised the need for any new regulatory regime to be strongly focused on protecting public health and in particular the health of young people and other vulnerable groups. Many drew parallels with the over-commercialisation of the current legal drugs, alcohol and tobacco, and cautioned that commercial interests could seize the opportunity provided by regulation (as opposed to prohibition) to promote the use of "legal highs". In its submission SHORE argued for a system of regulation which included legal prohibition of sales to young people (under 20) and bans on advertising and marketing of all such substances.

4.74 Finally, as discussed earlier, there is the potential for consumers to respond to changes in the legal status, price and availability of different drugs by substituting between drugs. Therefore, it will be important to actively monitor the impact of different regulatory approaches on the prevalence of different drugs in the community and the impact on overall levels of drug-related harm.

231 Submission of the New Zealand Police (submission dated 18 June 2010) at 1.

Our objectives

4.75 The rest of this report is divided into two parts. Part 2 deals with our proposed regulatory scheme for the control of new psychoactive substances, while Part 3 addresses the management of convention drugs under the criminal law and the interface between this law and various other statutes including the Medicines Act.

4.76 However, before turning to this detailed discussion we need to set out the key objectives we wish to achieve as a result of our proposed reforms.

4.77 Most fundamentally, we believe that the objectives of any new drugs legislation should be closely aligned with the objectives of the *National Drug Policy*. The current Act seems poorly aligned with the policy platform of harm minimisation that is at the core of that Policy. The Act is a criminal justice statute. Its focus is on controlling the supply of drugs by eliminating their illegal importation, production and supply. The use of drugs, even by those who are dependent on them, is largely treated as a matter solely of criminal policy rather than health policy. It should, however, be the concern of both.

4.78 Accordingly, the objectives of our recommended legislative framework include ensuring that:

- drug laws actively contribute to demand reduction by providing opportunities for drug treatment and other therapeutic and non-punitive responses to harmful drug use associated with addiction and other mental health issues;
- the harms associated with the criminalisation of drug users are mitigated wherever possible by introducing a wider menu of legal responses to personal drug use offences;
- personal drug offending which does not result in harm to others is met with a consistent, proportionate and just response;
- criminal justice resources are effectively targeted;
- any changes to the sanctions and penalties relating to the use of convention drugs are effective in reducing harm and do not have the perverse effect of increasing drug prevalence; and
- the new regime for the management of non-convention drugs protects public health and prevents the manufacture and sale of un-trialled substances.

RECOMMENDATION

R1 The Misuse of Drugs Act 1975 should be repealed and replaced by a new Act, which should be administered by the Ministry of Health.

Part 2
NEW DRUGS

Chapter 5

New psychoactive substances

INTRODUCTION

5.1 As discussed in chapter 1, a major impetus for our review was the emergence of a rapidly evolving market in new synthetic psychoactive substances. Party pills containing benzylpiperazine (BZP) became popular during the early 2000s.[232] When they first appeared BZP-based party pills were promoted and marketed as a "legal" alternative to prohibited drugs. They were manufactured and sold without restriction for about five years until the restricted substances regime was enacted.[233]

5.2 As restrictions tightened on BZP in 2008,[234] another wave of party pills emerged. Manufacturers substituted 1,3 dimethylamylamine (DMAA) and other synthetic compounds for BZP. These produced similar effects but fell outside regulation.[235] Similarly, pills and products containing the synthetic cathinone methylone, which was claimed to be a non-neurotoxic replacement for ecstasy, become available in 2005. These were sold without restriction for several months until chemical analysis determined that methylone was actually an analogue of the controlled drug methcathinone[236] and therefore automatically classified and prohibited as a Class C drug.

232 Most of the first generation of party pills contained BZP also contained trifluromethylpenylpiperazine (TFMPP) which is similar in effect to ecstasy. A report prepared for the Ministry of Health estimated that approximately 20 million doses of party pills containing BZP and TFMPP were sold in New Zealand between 2002 and 2006; see Beasley and others *The Benzylpiperazine (BZP)/Trifluromethylphenylpiperazine (TFMPP) and Alcohol Safety Study* (Medical Research Institute of New Zealand, Wellington, 2006) at 3.

233 The Expert Advisory Committee on Drugs recommended that provision be made within the Misuse of Drugs Act 1975 for the control of substances which had a low risk of harm but needed some degree of control. The Committee proposed that age restrictions and other restrictions on sales should be applied to such psychoactive substances. See Expert Advisory Committee on Drugs *Advice to the Minister on Benzylpiperazine (BZP)* (2004).

234 BZP was a restricted substance until it was re-classified in 2008 as a Class C drug and prohibited under the Misuse of Drugs Act 1975. Although it had not been a restricted substance, TFMPP was also classified as a Class C drug in 2008; see the Misuse of Drugs (Classification of BZP) Amendment Act 2008.

235 Expert Advisory Committee on Drugs "Minutes of the Committee's Meeting 6 August 2009" (August 2009) at 2–3.

236 Associate Minister of Health and Chair of the Ministerial Committee on Drug Policy Hon Jim Anderton said he received advice from the Chair of Expert Advisory Committee on Drugs, Dr Ashley Bloomfield, that the substance methylone is an analogue of a Class B controlled drug and therefore is captured by the analogue provisions of the Misuse of Drugs Act, which makes it an illegal substance. See New Zealand Government "Experts' advice on EASE" (press release, 5 April 2006).

5.3 More recently products containing synthetic cannabinomimetic substances have become commercially available. Synthetic cannabinomimetic substances are cannabinoid agonists so when herbal material that has been laced with them is smoked or vapourised, it produces an effect that mimics the high associated with cannabis.[237]

5.4 This brief overview illustrates how the range of new psychoactive substances available for sale across the counter and through the internet has changed and increased in recent years. There is good reason to think that the development of new psychoactive substances will continue.

5.5 New psychoactive substances now pose a major challenge to the way we currently regulate drugs. In this chapter we identify problems with our current regulatory regime which does not adequately control the manufacture, distribution and supply of these substances. We recommend a major overhaul of regulation in this area and the adoption of a new regime.

REGULATORY ISSUES WITH NEW PSYCHOACTIVE SUBSTANCES

5.6 The main problems we have identified with the application of the current regulatory schemes are canvassed below.[238]

Controlled drug analogues

5.7 First, some of new psychoactive substances fall within the ambit of the controlled drug analogue provisions in the Misuse of Drugs Act 1975.

5.8 As discussed in chapter 3, "controlled drug analogue" is defined as a substance that has a structure substantially similar to that of any substance scheduled as a controlled drug.[239] The Act was amended in 1996 so that the definition of a Class C drug included all controlled drug analogues.[240] This amendment was made to address the problem of new synthetic drugs being developed by subtle chemical changes to substances scheduled as controlled drugs as a way of circumventing the prohibition imposed by the Act.

5.9 The analogue provisions have proved reasonably effective, but only catch some of the new substances. If a new synthetic substance is structurally similar to a parent controlled drug it is caught by the analogue provisions, but if it has different and distinct chemistry from any scheduled drug it is not. Whether a new substance is an analogue depends entirely on its chemical similarity to another classified substance and nothing else. Whether it is harmful or harmless

237 Expert Advisory Committee on Drugs "Minutes of the Committee's Meeting 29 July 2010" (July 2010) at 2–3.

238 For a detailed discussion of the different regulatory schemes under which psychoactive substances are currently regulated see ch 5 of Law Commission *Controlling and Regulating Drugs* (NZLC IP16, 2010) [*Controlling and Regulating Drugs*].

239 Analogues that are themselves listed in the schedules of controlled drugs are excluded from the definition of analogue and analogues that are classified medicines under the Medicines Act 1981 are also excluded from the definition of controlled drug analogue.

240 Misuse of Drugs Amendment Act 1996.

is simply irrelevant. In practice determining whether a substance is or is not an analogue requires expert chemical analysis that involves making fine distinctions between one chemical structure and another.

5.10 A number of chemical assessments by the Institute of Environmental Science and Research Limited (ESR) over recent years illustrate the problems with this approach. In March 2009, the Ministry of Health arranged for the forensic testing by ESR of a number of herbal products infused with synthetic cannabinomimetic substances. The active ingredient incorporated into a number of the products was found to be a synthetic cannabinomimetic substance called CP 47,497. Forensic assessment determined that CP 47,497 is structurally similar to the controlled drug tetrahydrocannabinol (THC) and is therefore an analogue of THC. This meant that CP 47,497 is a Class C controlled drug so that it is a criminal offence to supply or use it. Products containing CP 47,497 were removed from the New Zealand market as a result.[241]

5.11 However, immediately following the removal of CP 47,497 new products emerged containing other uncontrolled cannabinomimetic substances. Testing of these revealed the synthetic cannabinomimetic substances JWH-018 and JWH-073.[242] Forensic assessment determined that these JWH compounds are not sufficiently similar in chemical structure to THC to be analogues, so that these substances are not prohibited as Class C controlled drugs.[243] The experience overseas also shows that as one synthetic cannabinomimetic substance is regulated, manufacturers move to replace it with an unregulated one. Fine distinctions in chemistry of this type mean that products containing known analogues are withdrawn from the market, and products that produce similar effects, but do not contain analogues, simply take their place.[244]

5.12 Although we recognise the reasons for adopting a simple and straightforward definition of a drug analogue, it is unsatisfactory to have the choice of regulatory approach for substances determined by such artefactual distinctions in chemical structure. The focus on chemical structure does not take into account the extent to which analogue substances have the same or a similar impact on receptors as their parent drug. The analogue may, for example, only loosely bind to receptors in the brain and have, as a result, quite a different impact and pose a different risk of harm. Analogues will not necessarily behave in the same way or have a

241 Expert Advisory Committee on Drugs "Minutes of the Committee's Meeting 7 May 2009" (May 2009) at 3–4.

242 Expert Advisory Committee on Drugs "Minutes of the Committee's Meeting 6 August 2009" (August 2009) at 5–6.

243 Expert Advisory Committee on Drugs "Minutes of the Committee's Meeting 29 July 2010" (July 2010) at 2–3.

244 Expert Advisory Committee on Drugs "Minutes of the Committee's Meeting 6 August 2009" (August 2009) at 5–6.

similar harm profile to their parent drug.[245] According to the experts, they may be more or less potent or harmful, and often their potency or risk of harm is unknown.[246]

5.13 We have discussed this issue with members of the Expert Advisory Committee on Drugs (EACD). The majority of the Committee recognise that the application of the analogue provisions to new drugs produces significant anomalies and distortions. They consider that the case of cathinone derivatives illustrates this well. While some of these derivatives may be harmful, there is no evidence that many of the other derivatives are any more harmful than caffeine, but because they have a substantially similar chemical structure to methcathinone, which is a Class B drug, all of them are analogues and are prohibited as Class C drugs. Legislative change would be needed to remove the default Class C classification from those that do not pose a sufficient risk of harm to warrant this classification.[247]

5.14 An additional problem with the analogue provisions is the uncertainty around the degree of similarity a substance must have to another to be considered an analogue. The test in the provision is "a structure substantially similar to that of any controlled drug". When the chemical structure of a new substance is almost identical to a controlled drug it will clearly meet the test, and when its structure differs significantly it will not. But there is some difficulty applying the provisions when substances fall between these two extremes. Is a substance with a structure that is 65 per cent the same as a controlled drug, for example, substantially similar or not? Assessments, particularly in this middle ground, involve very fine grained distinctions at the molecular level and inevitably an element of judgement and interpretation.

5.15 These difficulties illustrate the significant limitations on the extent to which drug analogue provisions can be utilised to manage the emergence of new psychoactive substances. Matching the chemical structures of new substances to those that are already prohibited is not an effective way of determining which substances should be regulated or prohibited.

245 It cannot, for example, be assumed that the risks associated with the use of synthetic cannabinomimetic substances will be necessarily comparable to those of THC; see the Expert Advisory Committee on Drugs "Minutes of the Committee's Meeting 29 July 2010" (July 2010) at 2.

246 The Commission discussed the relative potency of analogues and parent drugs with Keith Bedford, General Manager Forensic and Jill Vinter from Environmental Science and Research Limited (ESR) at a consultation meeting on 14 April 2010.

247 Expert Advisory Committee on Drugs "Minutes of the Committee's Meeting 29 July 2010" (July 2010) at 4.

Applying the Hazardous Substances and New Organisms Act 1996

5.16 The Hazardous Substances and New Organisms Act 1996 (HSNO) technically applies to almost all new psychoactive substances which are not caught by the definition of controlled drug analogue, because they come within the definition of "hazardous".

5.17 Hazardous substances cannot be imported into New Zealand or manufactured here unless they come within an approval issued by the Environmental Risk Management Authority (ERMA) under the Act.[248] Although HSNO does not directly regulate retail sales of hazardous substances (except fireworks), it indirectly regulates retail sales because only hazardous substances that have been imported or manufactured in accordance with an approval can be distributed and sold in New Zealand. These approvals impose conditions on the way hazardous substances can be packaged, displayed, and handled right through the distribution chain.

5.18 The definition of "hazardous substance" in the Act is multi-faceted because hazards can take many forms. The aspect of the definition that is relevant to psychoactive substances is toxicity to human beings. A substance is toxic as defined in the Act if it is "capable of causing ill health in, or injury to, human beings".[249]

5.19 Most, if not all, psychoactive substances meet the minimum degree of toxicity required to make them hazardous substances, since they will have a significant adverse biological effect on health, at least if used to excess.[250]

5.20 We think that there is little doubt that HSNO does technically cover new psychoactive substances. The Ministry of Health is an enforcement agency under HSNO and the Act could be utilised to regulate the manufacture and import of new psychoactive substances intended for recreational use. However, in practice HSNO has never been applied or used in this way.

5.21 The main reason is that it was never contemplated that HSNO would cover these types of substances. Historically, HSNO has its origins in environmental protection. HSNO set up a structure to provide a coherent overall system for managing the risks chemical substances and new organisms posed to the environment and the health and safety of people in it.[251] As we discuss later in the chapter,[252] the assessment criteria in HSNO are consequently broad and require a balancing of all of the positive and adverse effects of approving or not

248 Hazardous Substances and New Organisms Act 1996, s 25(1).

249 "Toxic" is defined in section 2 of Hazardous Substances and New Organisms Act 1996.

250 Schedule 4 of the Hazardous Substances (Minimum Degrees of Hazard) Regulations 2001 prescribes the minimum degree of hazard for toxic substances. The relevant part of Schedule 4 requires as a minimum degree that: "data for the substance, indicates, in the opinion of an expert, evidence of a significant adverse biological effect or a significant toxic effect other than an effect referred to in any of paragraphs (a) to (r) on the function or morphology of an organ or on the biochemistry or haematology of an organism or human being as a result of exposure to the substance and in the case of a significant adverse biological effect the change is relevant to health".

251 Hon Simon Upton (Minister for the Environment) (8 November 1994) 544 NZPD 4603.

252 See paragraphs 5.37–5.39.

approving the substance. They are therefore not well tailored to assessing the more intangible benefits and risks associated with the deliberate ingestion of psychoactive substances.

5.22 A further reason why HSNO has not been utilised has been some ambiguity over whether it or another regulatory regime applies. Some substances fall at the margins of HSNO. Substances that are technically food or medicines, for example, are excluded from HSNO and are instead regulated under other regimes.[253] There has been uncertainty over which regime covers some substances containing psychoactive ingredients.

5.23 When psychoactive substances are incorporated into drinks and tablets and marketed as energy enhancers and health supplements it may not be clear which regime applies. These products are consumed orally; they contain psychoactive ingredients but also other ingredients, including nutrients commonly used in dietary supplements. At various stages substances have been consciously marketed in different ways to try and bring them within a specific regime. In 2005, for example, when BZP was being sold over the counter, pills containing BZP were packaged and labelled as "dietary supplements" to bring them within the group of foods regulated under the Dietary Supplements Regulations 1985. The perception was that this regime imposed less restriction than others. BZP was also incorporated, along with high doses of caffeine, into a brand of energy drink marketed in 2005. These products were later withdrawn after it became clear BZP was not a permitted additive, but the example illustrates the difficulties that have arisen over identifying the applicable regulatory regime.

5.24 HSNO is able to capture potentially harmful substances intended for consumption that are not caught by other regimes, however, in practice the overall regulatory framework for substances has not relied on it to do so. As a result substances that do not fit clearly within one of the regimes may go unregulated.

Restricted substances regime

5.25 The restricted substances regime introduced by the Misuse of Drugs Amendment Act 2005 was established to regulate psychoactive substance like party pills that are not so harmful that they need to be scheduled and prohibited as controlled drugs under the Misuse of Drugs Act. Substances that are assessed by the EACD as posing less than moderate risk of harm can be brought within the restricted substances regime by Order in Council.

5.26 When substances are scheduled as restricted substances they can be legally manufactured, imported, distributed, sold and used as recreational drugs provided the restrictions in the Misuse of Drugs Amendment Act and regulations made under it are complied with. Restricted substances cannot be sold or supplied to anyone under the age of 18 years. There are restrictions on the types of premises from which they can be sold and on how they can be packaged, labelled and displayed. Also importantly, restricted substances cannot be advertised except within the premises from which they are sold or on the internet.

253 Regulations 5 and 6 of the Hazardous Substances (Minimum Degrees of Hazard) Regulations 2001 have respectively excluded medicines and food from the definition of hazardous substance.

5.27 The regime contains broad regulation-making powers. Additional restrictions, including substance specific controls, can consequently be imposed by regulation.

5.28 When first enacted the restricted substances regime covered BZP, which is the only drug to ever have been covered by the regime, and then only briefly. The schedule of restricted substances has remained empty since BZP was reclassified as a Class C controlled drug.

5.29 This is, at least in part, due to a fundamental problem with the definitions used to determine the scope of the regime. The regime, as currently enacted, is ineffective. Substances that are controlled drugs, controlled drug analogues, medicines, foods, or hazardous substances cannot be scheduled and regulated as restricted substances; they are expressly excluded.[254] Because of the broad and inclusive definition of "hazardous substance" in section 2(1) of HSNO, any harmful psychoactive substance, unless subject to one of these express exclusions, is a hazardous substance and therefore excluded from the restricted substances regime. Accordingly, there appear to be no psychoactive substances that can be scheduled and brought within the regime.

5.30 A Misuse of Drugs Amendment Bill introduced on 22 April 2010 contains an amendment designed to address this particular problem. The Bill, when enacted, will remove the exclusion that prevents a hazardous substance from being scheduled as a restricted substance.

Conclusion

5.31 There is a fundamental problem with the current combination of regulatory regimes. There is no mechanism for effectively regulating new psychoactive substances before they reach the market. Some new substances, because of their chemical structure, are analogues and come within the controlled drugs regime, but most do not. New psychoactive substances can be manufactured, imported and sold without restriction until they are proven to be harmful and scheduled either as restricted substances or controlled drugs. There is in practice a significant time lapse between when new substances start to become available for use and when authorities have gathered sufficient evidence on patterns of use and their effects to determine whether they should be scheduled and regulated or prohibited. There is then a further time lapse while the scheduling process is undertaken. During this period, potentially harmful psychoactive substances are being marketed and sold without restriction.

5.32 The current approach to regulation of psychoactive substances needs a major overhaul. Stargate International described the current situation in their submission as an "unregulated market … dominated by profiteers with little concern for public welfare".[255] We agree. The lack of adequate regulation creates an unacceptable level of risk for the public. It makes it possible for potentially unsafe substances to be marketed and sold without restriction. It also allows

254 A number of other substances including alcohol and tobacco and herbal smoking products are also excluded for the definition; see Misuse of Drugs Amendment Act 2005, s 31(b) for the full list.

255 Submission of Stargate International (submission dated 30 April 2010) at 4.

relatively safe substances to be sold without precautionary labels or advice on safe levels of consumption. This increases the risk that even relatively safe substances will be used in unsafe ways.

A NEW REGULATORY APPROACH

5.33 We have concluded that there should be a new regulatory regime that requires psychoactive substances to be assessed and approved before they can be manufactured, imported or distributed within New Zealand. This effectively reverses the current approach under both the controlled drugs and restricted substances regime, where a psychoactive substance can be manufactured, imported and sold without restriction until it is proven to be harmful and is either regulated or prohibited.

5.34 Submitters were strongly in favour of a change that placed responsibility on those wishing to make and distribute these products to demonstrate their safety and obtain approval before releasing them. This is the model utilised in HSNO. The New Zealand Drug Foundation, for example, said that this type of regime would ensure that the risks associated with the recreational use of all psychoactive substances are assessed and appropriate controls are put in place before such substances become available for sale.[256]

Option of regulating under HSNO

5.35 We considered whether this could best be done by actively regulating new psychoactive substances under HSNO rather than establishing a separate regulatory framework for them. There are both advantages and disadvantages with this approach.

5.36 The advantages of regulating under HSNO are:

- the mechanisms are already in place for approving the import and manufacture of hazardous substances and appeals against approval decisions;
- there may be an insufficient number of new recreational psychoactive substances to justify the expense of a separate system;
- it avoids the need for a separate definition of new psychoactive substances and the attendant difficulties at the margins of determining which regime should regulate a particular substance; and
- one regime to cover all forms of hazard may result in more consistency over the level of hazard tolerated. Consistency of regulatory approach was essentially the rationale for the enactment of HSNO.[257]

5.37 However, there are disadvantages in using HSNO. Psychoactive substances have not historically been regulated under the predecessor statutes to HSNO. Consequently, the criteria in HSNO are not entirely appropriate for psychoactive substances. When considering an application for an approval for a hazardous substance under HSNO, ERMA must take the following into account:

- any controls that may be imposed on the substance;
- all effects of the substance during the lifecycle of that substance; and
- the likely effect of the substance being unavailable.

256 Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 7.

257 Hon Simon Upton (Minister for the Environment) (8 November 1994) 544 NZPD 4603.

5.38 If the positive effects of the substance being available outweigh the adverse effects, the application can be approved, but otherwise it must be declined. An application can also be declined if the applicant fails to provide sufficient information for the assessment.

5.39 The positive effects of a psychoactive substance that is for recreational use are much less tangible than for substances typically evaluated under the criteria. Without more specific guidance it may be difficult for a regulator to weigh the intangible recreational benefits people may enjoy against a substance's more tangible adverse effects. The matters the regulator is required to consider do not expressly include the likely consequences of any proposed regulatory model or the possible displacement effects that may result from the way other substances are regulated. This strongly indicates that criteria tailored specifically for assessing psychoactive substances are preferable.

5.40 Also, the large number of substances that fall to be regulated under HSNO creates a risk that this small group of new substances may not receive as much attention as they would under a separate regime. If there is to be a regime to regulate all new psychoactive substances, it is important that there be careful monitoring and evaluation of its effectiveness. This is more likely to occur under a separate regime.

A new separate regime

5.41 On balance, we have reached the view that a new regime with its own criteria and approval process is preferable to regulation through HSNO. It should bring together the most relevant aspects of both the HSNO and restricted substances models. It would replace the restricted substances regime and the controlled drug analogue provisions in the Misuse of Drugs Act.

5.42 The proposed new regime should abut, ideally without any gaps, against all the other relevant regulatory regimes. To avoid the problems that have arisen with the restricted substances regime, psychoactive substances that are to be covered by the new regime need to be specifically excluded from HSNO.

5.43 We think it is necessary to exclude food, medicines, controlled drugs, alcohol, tobacco and non-psychoactive herbal smoking products from the coverage of the proposed new regime. The definition of "herbal smoking product" in section 2 of the Smoke-free Environments Act 1990 should also be reviewed and, if necessary, amended to ensure that herbal smoking products containing psychoactive chemicals, additives or substances (such as synthetic cannabinomimetic substances like JWH compounds) are regulated under the new regime proposed here.

Scope of the regime

5.44 It is necessary to define "psychoactive substance". While in most cases it will be clear whether a substance is covered by the regime, there are some substances that are closer to the margins. We want to ensure that the legislation clearly identifies all psychoactive substances that are included and also those that are excluded.

Primary purpose of inducing a psychoactive response

5.45 We recommend that the coverage be restricted to psychoactive substances that are manufactured for the primary purpose of being administered, ingested, inhaled or injected in order to induce a psychoactive response. This is the position under the restricted substances regime. Otherwise the regime would capture substances like paint, glue and other solvents which, though capable of being inhaled for recreational purposes, are primarily used for other purposes.

5.46 Products that contain psychoactive substances, but are primarily for other purposes, should continue to be regulated under HSNO for their dominant use. We think that ERMA should, when issuing approvals under HSNO, give consideration to the potential for products containing psychoactive substances to be misused for their psychoactive effects. ERMA can, when assessing such products under HSNO, impose appropriate controls and restrictions that reflect this risk.

5.47 Sometimes substances intended for consumption as recreational highs may be disguised as having some other dominant purpose. In the past, for example, some psychoactive substances were disguised and sold as compact disc cleaners. Some of the synthetic cannabinomimetic substance products are currently marketed and sold as "herbal incense", although they are essentially intended for consumption.

5.48 However, we do not think that this poses a significant problem. It is simply a question of fact whether a product is being presented as having one purpose but being used for another. Products containing synthetic cannabinomimetic substance and sold as "herbal incense" are unlikely to escape the coverage of the new regime. There is really no conceivable reason why synthetic cannabinomimetic substances would be incorporated into herbal incense unless it was intended to be inhaled for a psychoactive response. In any event, if some products do fall outside the new regime, because they have other primary legitimate uses, they will come within HSNO and therefore be subject to regulation under that legislation.

Issues of scope – Stargate International proposal

5.49 Stargate International proposed in its submission that a much broader new regulatory regime should be enacted.[258] Its proposed regime would not only cover new psychoactive substances but also all other substances that are intended to be administered to humans for a non-therapeutic purpose and that produce a specific pharmacological action or effect in the body. As well as new psychoactive substances, Stargate proposed that the regime should also include non-psychoactive "lifestyle" drugs such as aphrodisiacs, some cosmetics, and the wide and growing range of substances used in athletics and bodybuilding to increase bulk and endurance. Substances covered by the medicines regime would be expressly excluded, so that the broader proposed regime would effectively complement the medicines regime by covering all other substances that are intended for ingestion and have a pharmacological effect.

258 Submission of Stargate International (submission dated 30 April 2010) at 2.

5.50 We see considerable advantages in the approach Stargate have proposed. It would reduce the issues around overlapping regimes and would also support a broader more consistent regulatory approach across all lifestyle products. It is, however, beyond our terms of reference to give appropriate consideration to this option. We would need to do further consultation and research before we could recommend a broader regime of this kind. However, based on the consideration we have been able to give this option, we think that it should be examined further. We recommend that the Government consider the question of whether our proposed regime for psychoactive substances should, at a future date, be expanded into a broader regime to include a wider range of non-therapeutic lifestyle and recreational substances intended for human consumption.

Consultation between regulatory bodies

5.51 Since we are dealing with the regulation of new substances there will inevitably continue to be some difficulties over the coverage of the proposed new regime. Even with a carefully crafted definition, factual assessments will need to be made as to whether some products close to the margins come within the proposed regime or the food, alcohol, or medicines regimes.

5.52 We have considered options for a requirement for regular consultation between the relevant regulatory bodies with the aim of ensuring that potentially harmful products do not fall between regulatory regimes. In our Issues Paper, we proposed that a panel comprising representatives of the various regulatory bodies could be established to make determinations about which regulatory regime applies to a product where there is genuine doubt. Any person intending to import or manufacture a substance which fell at the margins of the various regimes could then seek a determination from the panel about which regime applied.[259] This would protect importers/manufacturers from possible prosecution for failing to obtain the appropriate approvals.

5.53 There was very little support for this proposal from submitters. In its submission, the Ministry of Health agreed that coordination between the different regulatory bodies was important but submitted that adequate coordination mechanisms already exist.[260] The Ministry, and indeed other submitters, considered that a further mechanism is unnecessary. We accept the Ministry's advice. We therefore recommend that the regulator for the new regime be required to facilitate regular consultation between the relevant regulatory bodies utilising existing mechanisms.

Criteria for approval

5.54 In our Issues Paper, we proposed the following criteria for deciding whether a psychoactive substance should be issued an approval under the proposed new regime:

(i) the nature of the harm caused by the substance and any benefits associated with its use;

259 See Law Commission *Controlling and Regulating Drugs*, above n 238, at 165.

260 Submission of the Ministry of Health (submission dated April 2010) at 7.

(ii) whether that harm can be effectively managed by the imposition of regulatory controls (including considering any research into the impact of different regulatory controls on minimising harm generally and also specifically (if available) for that substance);

(iii) the likely consequences of any proposed regulation or prohibition of the substance (including the cost of different regulatory options); and

(iv) any possible displacement effects that might occur because of the way other substances are regulated. (While this could be considered under the previous criterion it is important enough to be expressly included.)

5.55 In assessing issues of effectiveness under the second criterion, it would be important for the regulator to consider the prevalence of use of a substance. If a substance is widely available and widely used, some types of regulatory restriction or prohibition might be less effective than they might be with a less prevalent substance.

5.56 Under the third criterion, the relevant consequences of various regulatory options for the substance would need to be assessed by the regulator. This would involve identifying the consequences, measuring the magnitude of those consequences and, to the extent it is possible, quantifying them to facilitate comparison with the consequences of prohibition.

5.57 The fourth criterion expressly requires consideration of the risk that full prohibition of a substance might encourage the use of more harmful substances. It also takes into account the possibility that the use of more harmful prohibited drugs may be discouraged by the availability of less harmful alternatives.

5.58 There are significant gaps in the available evidence concerning the effectiveness of different regulatory approaches. We pointed out some of the challenges in measuring drug harms in chapter 2.[261] Even if more robust evidence was available, there are significant elements of judgement involved. Many drug harms are intangible and cannot readily be quantified in monetary terms. What value is attached to these harms is inherently subjective. There are also subjective trade-offs to be made between the priority and weight to be given to the various harms suffered by different persons and groups.

The approval process

5.59 Anyone wishing to manufacture, import or distribute a new psychoactive substance would be required to apply to the regulator for an approval. As part of the application process, they would be required to provide the regulator with all available information about the composition of the substance and its known health effects. This would need to include accurate information on the composition and strength of a substance, and all available information on its effects (including any adverse effects) on the human body when used.

261 See paragraphs 2.63–2.70.

5.60 The regulator would apply the criteria (specified in paragraph 5.54 above) and determine whether to:

- issue an approval on appropriate conditions; or
- decline the application for an approval; or
- decline the application for an approval and refer the substance for classification as a prohibited drug. (We discuss the regime and process for prohibiting drugs in the next chapter.)

5.61 If an approval is issued, the approved substance would be able to be legally manufactured, imported and supplied subject to the regulatory controls imposed by the regime. We recommend that all manufacturers and importers of approved substances should be required to report to the regulator any new information they acquire on the adverse effects of the substances they deal in.

Where an approval is declined

5.62 If a substance is assessed and not approved, because it appears from the available evidence (such as, for example, the experience with it in other jurisdictions) that it has such significant adverse effects that these cannot be adequately managed with conditions, the regulator should refer the substance to the body responsible for classifying prohibited drugs so that the substance can be considered for inclusion in the prohibited drugs regime. We think that there needs to be a clear link between a decision not to approve, and the process for bringing an unapproved substance within the prohibited drugs regime. Imposing a requirement on the regulator to make a referral where legalisation with restrictions is not appropriate achieves this.

5.63 However, there may be some situations where it would not necessarily be appropriate to refer a substance for classification as a prohibited drug. An application for an approval might be appropriately declined by the regulator because there is insufficient information on which to adequately assess the risks associated with the substance. In such circumstances it might be premature to refer the substance for a decision on whether it should be prohibited.

5.64 In all cases where a new substance is not approved, but the substance is not classified as a prohibited drug, it would be illegal to manufacture, import or distribute it, but not illegal to possess or use it. Once an unapproved substance is classified as a prohibited drug, possession and use of it would also be unlawful.

Different strengths and combinations of psychoactive ingredients require separate approval

5.65 We propose that each distinct combination of psychoactive ingredients should be considered a separate substance and should therefore require an approval, but once one manufacturer or importer has obtained an approval for a substance others will be free to also utilise it. This is the approach taken in HSNO. If, for example, an approval is obtained for a party pill containing 75 milligrams of DMAA, then anyone later wishing to import and distribute other brands of party pills that contain DMAA at the same strength would be able to do so under that approval, provided they comply with all the conditions imposed on the approval.

5.66 However, if another manufacturer wants to manufacture and distribute party pills containing 100 milligrams of DMAA, or 75 milligrams of DMAA combined with other active ingredients, then he or she would need to obtain a separate approval because that would be considered a different substance. Where the combination or strength of the active ingredients is different, its effects on the body are also different. The requirements for obtaining approvals should reflect this.

Transitional arrangements will be needed

5.67 Transitional arrangements will be needed to deal with products that are legally on the market at the time the new regime comes into force. We think that a period of about 12 months would be needed to allow the manufacturers and importers of these products to apply for and obtain an approval.

Reassessment permitted where significant change has occurred

5.68 The regime is to deal with new substances. As has been noted, the longer term health effects of many of these substances will simply not be known. The regime needs therefore to include a mechanism allowing the regulator to undertake a reassessment of an approved substance. Reassessments are provided for under HSNO to deal with significant new changes that affect safety.[262] We propose a similar approach here, although the grounds on which a reassessment should be available differ from those specified in HSNO. Any person should be able to apply to the regulator requesting a reassessment, and the regulator should grant an application for a reassessment in the following situations:

- where significant new information relating to the effects of the substance becomes available; or
- other substances with similar benefits, but less adverse effects, have become available and these could be approved in substitution.

5.69 The regulator should also be able to initiate a reassessment where satisfied that one of these grounds applies.

Who should be the regulator?

5.70 The options we have considered are:

- the Minister of Health;
- the Director-General of Health;
- ERMA; or
- a new independent regulator.

5.71 We suggested in our Issues Paper that the function of issuing approvals might be given to either the Director-General of Health or the Minister of Health. However, as we noted, both of these options are problematic because of the tendency for decision-making around drugs to become highly politicised. The regulator needs to be able to make its decisions on the basis of all the evidence and information available about the potential effects of the substance and the ability to effectively manage risks around its use through regulatory controls. Most submissions on this issue stressed the importance of decisions being made

262 Hazardous Substances and New Organisms Act 1996, s 63.

objectively on the basis of evidence. Some submitters thought it would be difficult, given the emotive and politicised nature of public debate around drugs, for a Minister to exercise this regulatory function in that way.[263] There was more support among submitters for the Director-General undertaking the function.[264]

5.72 Having reviewed the arguments, we are not persuaded that either the Minister or the Director-General would be an appropriate regulator. We consider that the most important consideration is the need for the regulatory function to be independently exercised and to be seen to be so exercised because it concerns decisions on individual applications. We do not believe it is appropriate for a Minister to apply criteria and determine individual applications in the way the regime requires. There needs to be an independent regulator and the regulator must, like ERMA, be an entity with statutory independence.

5.73 We were concerned, however, that there might be insufficient work under the regime to justify the cost of a separate regulator, so considered whether ERMA might be given the function of considering applications and issuing approvals under the regime. On balance, we do not think this is viable because, while there are some parallels between the approval processes, the nature of the expertise needed to determine applications differs considerably from that utilised when assessing applications under HSNO. As presently constituted ERMA does not have the specific expertise required to deal with this group of substances.

5.74 We think that a separate regulatory authority is needed. It could comprise a small committee with the appropriate expertise to review and evaluate the evidence and make determinations based on what is known of the risks, costs and benefits, and to determine applications for approvals for psychoactive substances. The proposed authority would not need to have its own administrative or corporate structure. Indeed, given the scale of its task, separate administrative and research support is probably unnecessary. We think the option of having the Ministry of Health provide the necessary support for the proposed authority should therefore be explored.

NATURE OF REGULATORY CONTROLS

5.75 A model of legalisation with regulatory restrictions should be the starting point for regulating new psychoactive substances not covered by the conventions. The restrictions that are imposed should normally be the minimum necessary to address the risk of harm posed by the substance. The restrictions obviously must not cause more harm than they alleviate. Full prohibition should be a last resort option when lesser regulatory restrictions have proved ineffective.

263 For example, Submission of the Auckland District Law Society (submission dated 21 May 2010) at 3; Submission of the New Zealand District Law Society (submission dated 17 May 2010) at 4; Submission of the Alliance Party (submission dated 4 May 2010) at 1; Submission of Dr J Elisabeth Wells, Research Associate Professor, Department of Public Health and General Practice, University of Otago (submission dated 21 April 2010) at 2.

264 For example, Submission of the Auckland District Law Society (submission dated 21 May 2010) at 3; Submission of the Alliance Party (submission dated 4 May 2010) at 1; Submission of Dr J Elisabeth Wells, Research Associate Professor, Department of Public Health and General Practice, University of Otago (submission dated 21 April 2010) at 2.

5.76 As a general rule the level or degree of regulation should increase with the level of risk, with restrictions imposed reflecting the purpose for which things are used and the nature of the risks they pose. This is the approach taken to the regulation of medicines, food, hazardous substances and a few recreational drugs (notably alcohol and tobacco).

5.77 In all regulatory schemes the decision to prohibit goods, services or activities altogether is the last resort and is generally only justified if it can be shown to be the only effective way to prevent the harm. This occurs where the harm is so significant that there is virtually no way to safely undertake the activity or use the goods, or where the less restrictive alternative regulatory option is not an efficient model because the costs of regulating exceed the benefits of not prohibiting.

Generic restrictions in statute

5.78 While there are some significant differences between psychoactive substances which might require different controls, such as those relating to the appropriate dosage that can safely be consumed, some more generic regulatory requirements should be applied to all recreational psychoactive substances, if they are approved.

5.79 We recommend an approach that combines a number of generic statutory controls in primary legislation with more tailored substance-specific conditions that can be imposed, as appropriate, as conditions of an approval by the regulator.

Age restrictions

5.80 Age restrictions should apply to the sale and supply of all recreational psychoactive substances.

5.81 The Misuse of Drugs Amendment Act currently prohibits the sale or supply of a restricted substance to, or by, a person under 18. This restriction is consistent with current age restrictions on the sale of alcohol under the Sale of Liquor Act 1989 and tobacco under the Smoke-free Environments Act. These all set a minimum age at which psychoactive substances can be purchased by young people or supplied to them.

5.82 Age restrictions of this type are used across the world to limit the access young people have to legally available psychoactive substances. In the case of alcohol a legal purchase age is recognised internationally as being a highly effective and inexpensive supply control mechanism.[265] In our view it is likely to have a similar effect for other psychoactive substances.

5.83 Alcohol and other psychoactive drugs have the potential to affect neurological development in adolescents. Age restrictions might therefore be justified from a perspective of harm reduction, because there is evidence that such substances

265 T Babor and others *Alcohol: No Ordinary Commodity* (Oxford University Press, New York, 2003) at 127.

do pose a greater risk of harm to young people.[266] In chapter 2 we noted,[267] for example, the increasing evidence of a causal relationship between cannabis use in early teens and some mental health disorders, and the greater impact of cannabis on the perceptions, short-term memory, attention, and motor skills of young people.

5.84 Whether new psychoactive substances regulated under the proposed regime will affect young people and their development more adversely than other people is difficult to assess. This is partly because we do not at present know what those substances will be. Based on experience with other psychoactive substances, it is reasonable to assume that some might, while others might not. But even if new psychoactive substances that are developed in the future do not affect young people more adversely than other people, it can be assumed that they will have the potential to cause a range of physical and psychological harms, particularly if used repeatedly or excessively.[268] Again we think this is a reasonable assumption to make based on experience to date with the new synthetic drugs that have emerged over recent decades, including "party pills".

5.85 Given the risk of harm, there is a strong argument, as discussed in chapter 1,[269] for the State to take a paternalistic approach and impose age restrictions aimed at preventing access to these potentially harmful substances until young people are sufficiently mature to assess the risks for themselves.

5.86 The difficulty comes with determining the appropriate age threshold. In the case of alcohol and tobacco this has been contentious. The legal purchase age for alcohol has been under discussion for a number of years. While there may be some important differences between the risks of harm associated with alcohol and those associated with the psychoactive substances regulated under the proposed regime, there are similar considerations around a young person's maturity to make decisions on substance use, for example, in relation to likely addiction, impact on schooling and social development. There are also similar issues around the impact of age restrictions on the access of those younger than the set age. There is therefore good reason for applying the same age limit that applies to alcohol to new psychoactive substances.

266 See the discussion on this point and the harm alcohol causes youth in Law Commission *Alcohol in Our Lives: Curbing the Harm* (NZLC R114, 2010) at 251 [*Alcohol in Our Lives: Curbing the Harm*]; and Law Commission *Alcohol in Our Lives: an Issues Paper on the Reform of New Zealand's Liquor Laws* (NZLC IP15, 2009) at 47.

267 See paragraphs 2.95–2.106.

268 In one study undertaken on the use by young people of legally available party pills containing BZP, a range of negative emotional or psychological effects were identified as occurring during the 'comedown' period. These included feeling depressed or down, tense and edgy, angry or annoyed, socially withdrawn, or anxious or paranoid. Other negative impacts relating to the 'comedown' period included lack of sleep/inability to sleep, loss of appetite, lethargy, headache, nausea, aching and tense body, impaired work or study performance (including absences) and dehydration. See Janie Sheridan and Rachael Butler *Legal Party Pills and their Use by Young People in New Zealand: A Qualitative Study Final Report of Findings* (University of Auckland, Auckland, 2007) at vii.

269 See paragraph 1.60.

5.87 There was almost universal support from submitters in favour of age restrictions, with many proposing a minimum age of purchase of 20 years.[270] In *Alcohol in Our Lives: Curbing the Harm,* the Law Commission recommended that the purchase age for alcohol be increased from 18 to 20 years without exceptions.[271] In November 2010 the Government introduced the Alcohol Reform Bill which, when passed, will reform the sale and supply of alcohol. The legal purchase age for alcohol is being reconsidered under the provisions of that bill. The policy proposal put forward in the bill is to increase the age at which alcohol can be purchased from an off-licence from 18 to 20 years. If that change is made, we recommend that the age at which new psychoactive substances can be purchased should also be 20 years. Otherwise the age threshold for purchase should be set at 18 years.

Advertising/promotional restrictions

5.88 The restricted substances regime prohibits the advertising of restricted substances in the mainstream media – television, radio, newspaper or other periodical such as a magazine. Regulations can also be made specifying other media in which advertising is prohibited. There is also a prohibition on other promotions of restricted substances such as the distribution or supply of a restricted substance free-of-charge or the offering of incentives such as promotional gifts to encourage purchase. Regulations made under the Act provide that advertising for a restricted substance may appear only on premises where a restricted substance is sold or supplied. Such advertising must be confined to the inside of the premises and must not be easily visible or audible from outside the premises. However, the regulation expressly excludes advertising on the internet from these restrictions.

5.89 Even broader advertising restrictions apply to the advertising of tobacco products in New Zealand. Section 22 of the Smoke-free Environments Act prohibits the publication of, or the making of arrangements to publish, any tobacco product advertisement. The term "tobacco product advertisement" is broadly defined in section 2 of the Act. It means "any words, whether written, printed or spoken including on film, video recording or other medium, broadcast or telecast and any pictorial representation or device used to encourage the use or notify the availability or promote the sale of any tobacco product or promote smoking behaviour" and includes:

(a) any trade circular, any label and any advertisement in any trade journal; and

(b) any depiction in a film, video recording, telecast or other visual medium, of a tobacco product or tobacco product trade mark where in return for that depiction any money is paid or any valuable thing is given whether to the maker or producer of that film, video recording, telecast or visual medium or to any other person; and

270 For example, Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 7; Submission of Health Action Trust (submission dated April 2010) at 3; Submission of Taranaki District Health Board (submission dated 27 April 2010) at 1; Submission of Community Action on Youth and Drugs (CAYAD) Otautahi (submission dated 30 April 2010) at 6; Community Action on Youth and Drugs (CAYAD) Te Tai Tokerau Region (submission dated 29 April 2010) at 3; Community Action on Youth and Drugs (CAYAD) Auckland City CAYAD Reference Group (submission dated 30 April 2010) at 7.

271 Law Commission *Alcohol in Our Lives: Curbing the Harm*, above n 266, at 266.

(c) the use in any advertisement or promotion to the public of a tobacco product manufacturer's name where that name or any part of that name is used or is included in a tobacco product trade mark.

5.90 This definition would appear to include advertising on the internet.

5.91 In contrast, far less restriction is placed on the advertising and promotion of alcohol. The regulation of alcohol advertising has become progressively more liberal over the past 30 years.[272] The model for alcohol is currently one of industry self-regulation. Advertisements for alcohol that comply with the Code of Practice for Advertising Liquor can be run in all mainstream media. The Code requires that all advertising of alcohol must adhere to certain principles. There are also guidelines issued to help advertisers interpret and apply the principles in the Code. In 2009, a separate Alcohol Promotions Code was established to cover promotion.

5.92 The Advertising Standards Authority (ASA) oversees the Code. Complaints can be made to the ASA about any advertisement in any media that any person considers breaches the Code. The ASA funds a separate self-regulatory body called the Advertising Standards Complaints Board that adjudicates on complaints received about advertisements that may breach a code of advertising practice. Where a complaint is upheld, advertisers are expected to voluntarily withdraw the advertisement.

5.93 In addition, section 154A of the Sale of Liquor Act deals with some forms of promotion. It is an offence for a licensee or manager of licensed premises to do anything in the promotion of the business (or in any event or activity held on the premises) that is intended or likely to encourage people on the licensed premises to consume alcohol excessively.

5.94 The different models for tobacco and alcohol represent the two ends of the spectrum of approaches that might be taken to regulating the advertising and promoting of other recreational psychoactive substances.

5.95 The experience with alcohol advertising convinced the Commission that self-regulation is not an effective regulatory model for alcohol-related advertising and sponsorship. In *Alcohol in Our Lives: Curbing the Harm*, the Commission recommended moving in stages towards much more stringent controls on alcohol advertising and promotion.[273]

5.96 If new recreational psychoactive substances are to be legal and regulated rather than prohibited, we believe it will be important to prevent the kind of commercialisation that surrounds alcohol. One way of preventing commercialisation is by imposing and enforcing broad restrictions on advertising and promotion.

5.97 We recommend that advertising of substances approved under the regime be prohibited except at the point of sale, either within premises where they are sold or supplied, or on internet sites from which they are sold or supplied. We think that only advertising material that communicates objective product information,

272 For a discussion of the history of alcohol advertising see ch 19 in Law Commission *Alcohol in Our Lives: Curbing the Harm*, above n 266.

273 Ibid, at 350–362.

including the characteristics of the substance, the manner of its production and its price should be permitted at point of sale. This restriction should apply to advertising on websites selling these products also. The promotion of new psychoactive substances, including sponsorship, should be prohibited in all media.

Consistency with the New Zealand Bill of Rights Act 1990

5.98 The proposed restrictions on advertising raise issues of consistency with the right to freedom of expression in section 14 of the New Zealand Bill of Rights Act 1990. Section 14 protects the right to freedom to seek, receive and impart opinions of any kind and in any form. The right has been interpreted to extend to all forms of communication which attempt to express an idea or meaning, including commercial speech such as advertising.[274]

5.99 However, courts in other jurisdictions have generally been willing to limit commercial expression more readily than other forms of speech. For example, in *Markt Intern and Beerman v Germany*,[275] the European Court of Human Rights held that member states have a wider margin of appreciation when it comes to imposing limitations on freedom of expression that impinge on commercial expression than they do with other forms like artistic or academic expression.

5.100 Some commentators argue that freedom of expression arguments should not apply, or should apply only very weakly, to "lifestyle" advertising – advertisements that promote a favourable image associated with the product but which provide no information about it.[276] On this view the best argument in favour of free speech coverage of advertising derives from the interests of consumers in product information, and the disinclination to exclude from coverage communications which convey a meaning.[277] Neither argument applies to lifestyle advertising.

5.101 Nevertheless, in both the United States and Canada the courts have struck down blanket bans on advertising. In the United States, the Supreme Court struck down a blanket ban on advertising the price of prescription drugs.[278] In Canada, the Supreme Court held that a blanket advertising ban on cigarette advertising infringed the Canadian Charter of Rights and Freedoms because it did not limit the right to freedom of expression as little as reasonably possible in the circumstances. The Court accepted that a more targeted tobacco advertising ban could be justified.[279] These cases concerned advertising products that were already legal.

274 *Irwin Toy Ltd v Attorney-General* (Quebec) [1989] 1 SCR 927 (SCC).

275 *Markt Intern and Beerman v Germany* (1989) 12 EHRR 61 (ECHR).

276 Eric Barendt *Freedom of Speech* (2nd ed, Oxford University Press, Oxford, 2005), at 395 and 416; R Moon "Lifestyle Advertising and Classical Freedom of Expression Doctrine" (1991) 36 McGill Law Journal 76.

277 Barendt, above n 276, at 416.

278 *Virginia State Board of Pharmacy v Virginia Citizens Consumer Council Inc* 425 US 748 (1976).

279 *RJR McDonald Ltd v Canada* [1995] 3 SCR 199.

5.102 Where a bill is prima facie inconsistent with a right or freedom, it may still be found to be consistent with the Bill of Rights Act if the inconsistency is considered to be a reasonable limit which is justified under section 5 of that Act. The test is two-fold:

- Does the provision serve an important and significant objective?
- Is there a rational and proportionate connection between that objective and the provision?[280]

5.103 In our view, the restrictions we have proposed satisfy the first limb of the test, as they serve an important and significant objective. This is consistent with the approach taken by the Attorney-General in recent years in the context of alcohol advertising. When considering the Liquor Advertising (Television and Radio) Bill 2009, which sought to limit the exposure of people of all ages to broadcast liquor advertising, the Attorney-General concluded that the reduction of harm caused by high levels of alcohol consumption was a significant objective.[281] This same argument can be made in respect of other drugs.

5.104 In terms of the second limb of the test, we acknowledge that there is less certainty, but believe that on balance the proposed restrictions can be justified. Research suggests there is a need to prevent commercialisation of new psychoactive substances to ensure they do not become as prevalent as alcohol and tobacco and to minimise the harm they might otherwise cause. The experience with alcohol and tobacco demonstrates that there is sufficient connection between the level of exposure to advertising and the level and patterns of consumption to satisfy the "rationality" requirement in the second limb.[282]

5.105 While the proposed ban is broad, it is not a blanket ban. The restrictions we propose do not completely ban the advertising of new psychoactive substances, and would not prevent suppliers from communicating product information at the point of sale to allow people to make informed product choices. Based on the experience with alcohol and tobacco, we think that this breadth of restriction is necessary for it to be effective. If advertising restrictions of this kind are not imposed, it may be necessary to prohibit the manufacture or import of these substances altogether which would entail a greater restriction on individual freedom. Finally, the proposed restrictions are to apply to new products, so those who choose to enter the market will do so knowing of the restrictions that are imposed.

5.106 In our view the restrictions we have proposed constitute a reasonable limit which is justified under section 5 of the Bill of Rights Act.

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280 *Ministry of Transport v Noort* [1992] 3 NZLR 260 (CA); *R v Hansen* [2007] 3 NZLR 1 (SC).

281 *Report of the Attorney-General Under the New Zealand Bill of Rights Act 1990 on the Liquor Advertising (Television and Radio) Bill*, presented to the House of Representatives pursuant to section 7 of the New Zealand Bill of Rights Act 1990 and Standing Order 261 of the Standing Orders of the House of Representatives (2 July 2009).

282 In the case of alcohol, this was the conclusion reached by the Attorney-General when considering the Liquor Advertising (Television and Radio) Bill; see *Report of the Attorney-General Under the New Zealand Bill of Rights Act 1990 on the Liquor Advertising (Television and Radio) Bill*, above n 281, at 12.

Places of sale restrictions

5.107 The restricted substances regime provides for regulations to be made limiting places from which restricted substances can be sold or supplied. The Misuse of Drugs (Restricted Substances) Regulations 2008 currently prohibit the sale or supply of restricted substances from:

(a) places where alcohol is sold;
(b) petrol stations;
(c) non-fixed premises such as vehicles, tents and mobile street cars;
(d) places where children gather (schools, recreational facilities and sports facilities).

5.108 By way of contrast, the Sale of Liquor Act requires premises at which alcohol is sold to be licensed.

5.109 We doubt that there would be a sufficient number of new recreational psychoactive substances to warrant the introduction of a full licensing system like that applying to alcohol. However, we recommend that the restrictions currently in the Misuse of Drugs (Restricted Substances) Regulations should be included in legislation setting minimum requirements applying to the sale of all recreational psychoactive substances.

5.110 It is desirable to keep the sale of alcohol and other psychoactive substances separate, since the combination of alcohol and some other psychoactive substances is more harmful than either substance individually. The harms associated with all new psychoactive substances may not necessarily be increased by alcohol, but there is evidence that when some drugs (for example, BZP, ecstasy, fantasy) are combined with alcohol the toxicological effects are much harder to predict.

5.111 Similarly, driving while under the influence of alcohol or other drugs is inherently undesirable. For this reason, the Sale of Liquor Act prohibits the sale of alcohol at petrol stations.[283] The same principle should apply to other legally available psychoactive substances. Their sale should be separated from activities related to driving. Pharmacies should also be added to the list of places prohibited from selling or supplying psychoactive substances. The substances we are concerned with are not therapeutic products and there should be no room for misunderstanding about that. Submitters were supportive of these restrictions being imposed.[284]

5.112 As well as these statutory restrictions, we recommend that the regulatory body should have the power to impose additional restrictions on the place of sale, if appropriate, having regard to the nature of the substance.

283 Section 36(3)(a) of the Sale of Liquor Act 1989 prohibits an off-licence from being granted to sell alcohol from any service station or other premises in which the principal business is the sale of petrol or other automotive fuels.

284 For example, Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 7.

Promotional gifts and free-of-charge supply

5.113 We also recommend that incentives to encourage purchase such as promotional gifts or free-of-charge supply by retailers should be prohibited.

Restrictions on who can supply recreational psychoactive substances

5.114 The restricted substances regime imposes no restrictions on who can sell or supply restricted substances other than a restriction on sale or supply by persons under 18. However, the court can prohibit a person from selling or manufacturing a restricted substance if that person is convicted of an offence relating to a restricted substance within two years of being sentenced on another such offence. When imposing the sentence for the second (or subsequent) offence, the court may make an order to this effect.[285]

5.115 We do not think that two convictions should be needed to trigger this power because there may be cases where there is such a blatant disregard for the regulatory requirements that immediate action is appropriate. We therefore recommend that the court should be able to make an order on conviction for a first offence.

5.116 There also needs to be further protections in respect of people convicted of offences. In a market where some recreational psychoactive substances are legal and others are not, it is important that the legal market is kept separate from the black market. On that basis, we recommend that there should be a prohibition on the manufacture and sale of legal substances by any person who has been convicted within the previous five years of a dealing offence under the Misuse of Drugs Act (or its replacement legislation) or an offence under the Crimes Act 1961 with a maximum penalty of seven years or more.

5.117 Some further restrictions are also required. The New Zealand Drug Foundation submitted that the age restriction should be broader and should apply to importing and manufacturing as well as to selling and supplying psychoactive substances. They also proposed that the age restriction should be set at 20 and not 18 if the legal purchase age is increased to 20.[286] We agree with both of these proposals and recommend accordingly.

Packaging and labelling requirements

5.118 The Misuse of Drugs (Restricted Substances) Regulations require that restricted substances are stored in child-proof and tamper-proof containers that have a label with the phone number and address of the National Poisons Centre. Both requirements are obviously useful safety precautions. They also make it abundantly clear to potential purchasers or users that the substances are potentially harmful and, as such, send a useful health message. They should therefore be included in the new regime.

5.119 In addition, packaging should be accurately labelled with a full list of ingredients and their respective quantities.

285 Misuse of Drugs Amendment Act 2005, s 54.

286 Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 8.

Conditions of approval

5.120 As well as the generic restrictions recommended above, more tailored specific conditions are required. Therefore, legislation should also specify a range of matters where the regulator has power to impose additional tailored conditions as part of an approval.

5.121 We recommend that additional conditions should relate to any or all of the following:

(a) additional place of sale restrictions;
(b) labelling restrictions and requirements;
(c) packaging restrictions and requirements;
(d) health warning requirements;
(e) signage requirements;
(f) quantity, dosage, form and serving requirements;
(g) storage and display restrictions;
(h) record-keeping requirements;
(i) any other requirements considered necessary or desirable to minimise the harm that might occur as a result of use of the substance.

5.122 We recommend that the legislation require any person selling or supplying a psychoactive substance, as well as the manufacturer or importer, to comply with any specific conditions relating to these matters that have been specified in the manufacturing or importing approval for a substance.

Manufacturing codes of practice

5.123 We proposed in our Issues Paper that the legislation should empower the regulator to issue codes of manufacturing practice. These codes would be binding on manufacturers and importers of psychoactive substances covered by the regime. It is important that there are codes governing the production, manufacture and preparation of substances intended for consumption. There need to be restrictions on levels of residual impurities permitted in products intended for consumption as well as adequate quality controls on the manufacturing and packaging process to ensure consistency and to minimise the risk of unacceptable levels of contaminants. Codes may also impose requirements for laboratory practice and cover the sampling and testing of substances. Submitters supported the imposition of such requirements.[287]

5.124 We recommend that the conditions of approval for a substance also stipulate the applicable code or parts of a code of manufacturing practice that must be complied with by the manufacturer.

287 For example, Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 7; Submission of Health Action Trust (submission dated April 2010) at 3; Submission of Alcohol Drug Association NZ (ADANZ) (submission dated 30 April 2010) at 9; Submission of Stargate International (submission dated 30 April 2010) at 9.

Powers to recall products

5.125 Under the restricted substances regime, the Minister of Health has power to recall a restricted substance if the Minister considers the substance is:

(a) unsound or unfit for human consumption;
(b) damaged, deteriorated or perished;
(c) contaminated with any poisonous, deleterious or injurious substance.

5.126 We consider a power of this kind is necessary and recommend that the regulator have the power to recall any product at any time.

PRICE CONTROL

5.127 We did not put forward proposals around price controls in the Issues Paper. However, a few submitters raised the option of utilising taxation to reduce the demand for psychoactive substances.[288] The Commission has since examined this option (together with other price control options) in relation to alcohol in the report *Alcohol in Our Lives: Curbing the Harm*.[289] Our conclusion in that context was that price is a critical factor in moderating demand for alcohol. Increased affordability of alcohol facilitates its excessive and harmful consumption, which is reflected in a rise in health and other social harms in recent years. Cheap products are favoured by heavy, harmful and young drinkers.[290]

5.128 In that report we recommended increases in the level of excise tax imposed on alcohol because there is good evidence from many countries to support the use of excise tax to address alcohol-related problems. To provide information for modelling the impacts of changes in excise tax levels and also to enable the government to investigate the option of a minimum price regime for alcohol, the Commission also recommended that retailers and producers should be required to provide sales and price data.[291]

5.129 The experience with alcohol highlights the potential risk that future demand for new psychoactive substances may be stimulated by price. We therefore think it would be prudent for government to investigate the option of using excise tax as a mechanism for regulating the retail price of new psychoactive substances in a similar way to alcohol and tobacco. To facilitate this, manufacturers and importers should be required to file annual returns and reports, similar to those required in respect of tobacco products under section 35 of the Smoke-free Environments Act, to provide data on the quantities of each approved product sold by the manufacturer or importer each year and the recommended retail price.

ENFORCEMENT

5.130 The proposed regime needs to make appropriate provision for enforcement. We discuss the specific enforcement provisions required for the regime here. Chapter 11 discusses enforcement in respect of prohibited drugs.

288 For example, Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 7; Submission of Health Action Trust (submission dated April 2010) at 3; Submission of Alcohol Drug Association NZ (ADANZ) (submission dated 30 April 2010) at 9; Submission of the New Zealand Customs Service (submission received 29 April 2010) at 7.

289 See chs 17 and 18 in Law Commission *Alcohol in Our Lives: Curbing the Harm*, above n 266.

290 Ibid, at 320–321.

291 Ibid, see recommendations 100–103, at 320.

Enforcement authorities

5.131 Responsibility for enforcing the proposed regime would fall to police, the New Zealand Customs Service and the Ministry of Health.

5.132 The Director-General of Health should have a power to appoint enforcement officers and to issue them with warrants of appointment for the regime. In practice, enforcement officers are likely to exercise similar responsibilities under other legislation administered by the Ministry. It would be over to the Director-General to ensure that officers are appropriately qualified and trained.

5.133 It is essential that the requirements of the regime are actively enforced. One of the main reasons for the EACD recommendation to reclassify BZP as a Class C controlled drug was the "absence of a significant administration and enforcement capacity such as exists for pharmaceuticals and for legal drugs, tobacco and alcohol."[292] In our view the administrative and enforcement capacity to regulate these substances should be made available.

5.134 There is certainly reason to believe that appropriately regulating these substances may be more effective at minimising drug-related harm than prohibiting them altogether and there is the opportunity to test this in a closely monitored and controlled environment. The restricted substances regime in New Zealand has been the subject of significant international interest for this reason. It would be unfortunate if the failure to provide adequate resources for administration and enforcement meant that this opportunity is wasted.

Power of entry for inspection

5.135 We propose that there be a power to enter premises (other than a private dwelling house) and to inspect documents and take samples of substances for the purposes of monitoring compliance with any approval to manufacture or import under the regime and with any of the statutory requirements or conditions attached to that approval. When enacted, Part 4 of the Search and Surveillance Bill would apply, with the exclusion of provisions relating to the detention of persons found on the premises.

5.136 Where entry to a private dwelling house is necessary, we propose that a warrant authorising entry to those premises should be required, as is common with regulatory inspection powers across the statute book.

Warrantless power of search

5.137 We also consider that a new power to search places, vehicles or people without a warrant is required in circumstances where there is reasonable cause to suspect a person is committing the offence of dealing in a substance that has not received regulatory approval. Untested and unapproved substances have the potential to cause significant harm to the public. It is appropriate to enable prompt and

292 Expert Advisory Committee on Drugs "Minutes of the Committee's Meeting 29 November 2006" (November 2006).

immediate enforcement action to prevent these substances being distributed. Providing a warrantless search power in this context is consistent with our overall approach to warrantless powers of search, as discussed in chapter 11.

Prohibited goods

5.138 Under HSNO,[293] where hazardous substances are imported without an approval, they become prohibited imports under section 54 of the Customs and Excise Act 1996 so that section 209 of that Act applies.[294] Consequently section 122 of HSNO enables customs officers to direct that hazardous substances imported in breach of HSNO remain on the ship or vessel by which they were brought to New Zealand or that they are removed from New Zealand at the importer's expense. In addition, prohibited imports are forfeited to the Crown[295] and can be seized.[296]

5.139 These provisions currently apply to psychoactive substances regulated under HSNO. They are useful provisions and we think that equivalent provisions covering psychoactive substances imported without an approval should be included in the proposed new regime.

Offences under the regime

5.140 The regulatory requirements need to be supported by offence provisions that apply where a person contravenes the controls in the regime.

Dealing in psychoactive substances that have not been approved

5.141 First, it should be an offence for any person to knowingly or recklessly manufacture, import, or supply any unapproved psychoactive substance.

Breaching the generic or specific conditions of an approval

5.142 Secondly, it should be an offence for any person to manufacture, import, or supply any psychoactive substance in breach of the generic or specific terms and conditions of an approval.

5.143 We propose that, in contrast to the first offence, this second offence would be a public welfare/regulatory offence. Liability would be strict and the prosecution would not need to prove that the defendant knowingly or recklessly breached the requirement. However, the defendant would have a defence if, on the balance of probabilities, he or she could prove a total absence of fault – that is, that he or she had exercised all due diligence.[297] The shift in the burden of proof can be justified in this type of regulatory context. People choose to participate in the regulatory regime by manufacturing, importing or supplying approved substances. We think that the need for a high standard of public health and

293 Hazardous Substances and New Organisms Act 1996, s 121.

294 Under section 209 of the Customs and Excise Act 1996 it is an offence to import a prohibited import.

295 Customs and Excise Act 1996, s 225.

296 Customs and Excise Act 1996, s 226.

297 *Civil Aviation Department v MacKenzie* [1983] NZLR 78 (CA).

safety justifies placing responsibility on the participants for ensuring that they are aware of, and take care to comply with, all the applicable regulatory requirements of the regime.

5.144 This offence will cover situations where a person sells or supplies an approved psychoactive substance to any person who is under the age of 18 (or 20 if the age of purchase was set at 20 to ensure consistency with alcohol).

Breaching information requirements

5.145 Earlier in the chapter,[298] we recommended that manufacturers and importers should be required to file annual returns and reports providing data on the quantities of each approved product sold by the manufacturer or importer each year and the recommended retail price. It should be an offence for a person to fail to do this, or to knowingly provide false or misleading information in an annual return and report.

5.146 It should also be an offence for any person to knowingly include false or misleading information when applying for an approval or for an applicant to omit from their application any adverse information concerning the substance, and for a manufacturer or importer to knowingly fail to report any significant new information of any adverse effects of any substance they deal in.

Obstruction of enforcement officer

5.147 Finally, it should be an offence for any person to wilfully obstruct an enforcement officer undertaking functions or exercising powers under the regime. This is a standard provision for regulatory regimes of this type.

Penalties

5.148 Offences under the restricted substances regime are punishable by fines not exceeding $5,000 in the case of an individual and $10,000 in the case of a body corporate. In addition, as we have already noted, the court may prohibit a person from selling or manufacturing a restricted substance if that person is convicted of an offence relating to a restricted substance within two years of being sentenced on another such offence. We think these penalties are inadequate for the regime proposed here.

5.149 In contrast, the penalties for contravention of the HSNO regime attract penalties of up to three months imprisonment and fines of up to $500,000. That regime covers a broad range of hazardous substances as well as new organisms, some of which can create significant environmental or public health risks. It might be argued that offending involving psychoactive substances under the proposed regime does not involve a similar degree of risk.

5.150 However, offending that involves manufacturing, importing and supplying unapproved substances has the potential to be of a very serious nature. There is the potential that untested and unapproved substances are very harmful. Dealing in unapproved substances creates significant unknown health risks on the public.

298 See paragraph 5.129.

In addition, some serious breaches of the conditions imposed on approvals (particularly those relating to the levels of contaminants present in such substances) also have the potential to impose significant unknown health risks on the public.

5.151 We therefore think that for offending of this type, which poses serious risks, the maximum penalties need to be similar to those in HSNO. Although most offending will not be of this kind, the penalty regime needs to accommodate the potential for those rare cases that pose these types of serious risk. Where people are actually harmed there may be other criminal charges of an appropriate nature that would also apply.

5.152 We therefore recommend for the offences of:

(a) knowingly or recklessly manufacturing, importing, or supplying any unapproved psychoactive substance – three months imprisonment for an individual and a fine not exceeding $500,000 for a body corporate;
(b) manufacturing, importing, or supplying any psychoactive substance in breach of the generic or specific terms and conditions of an approval – three months imprisonment for an individual and a fine not exceeding $500,000 for a body corporate;
(c) breaching information requirements – three months imprisonment for an individual and a fine not exceeding $125,000 for a body corporate; and
(d) obstruction – a fine not exceeding $5,000 for an individual and a fine not exceeding $10,000 for a body corporate.

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R2 There should be a new regime with its own criteria and approval process for regulating new psychoactive substances.

R3 The coverage of the new regime should be restricted to psychoactive substances that are manufactured for the primary purpose of being administered, ingested, inhaled, or injected in order to induce a psychoactive response.

R4 Products that contain psychoactive substances, but are primarily for other purposes, should continue to be regulated under HSNO for their dominant use and ERMA should, when issuing approvals under HSNO, give consideration to the potential for products containing psychoactive substances to be misused for their psychoactive effects.

R5 The Government should consider whether the new regime for psychoactive substances should, at a future date, be expanded to include a wider range of non-therapeutic lifestyle and recreational substances intended for human consumption.

R6 The regulator for the new regime should be required to facilitate regular consultation with the regulatory bodies under other related regimes, including HSNO, to address any issues that arise at the boundaries of the regime.

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R7 The new regime should require anyone who wishes to manufacture, import or distribute a new psychoactive substance to apply for an approval for the substance before doing so.

R8 The following criteria should be applied by the regulator when deciding whether a psychoactive substance should be issued an approval under the new regime:

(a) the nature of the harm caused by the substance and any benefits associated with its use;

(b) whether that harm can be effectively managed by the imposition of regulatory controls (including considering any research into the impact of different regulatory controls on minimising harm generally and also specifically (if available) for that substance);

(c) the likely consequences of any proposed regulation or prohibition of the substance (including the cost of different regulatory options); and

(d) any possible displacement effects that might occur because of the way other substances are regulated.

R9 The regulator should consider all applications and determine whether to:

(a) issue an approval on appropriate conditions; or

(b) decline the application for an approval; or

(c) decline the application for an approval and refer the substance for classification as a prohibited drug.

R10 If an approval is issued, the approved substance should be able to be legally manufactured, imported and supplied subject to the regulatory controls imposed by the regime.

R11 All manufacturers and importers of approved substances should be required to report to the regulator any new information they acquire on the adverse effects of the substances they deal in.

R12 If a substance is assessed and not approved, because it appears from the available evidence that it has such significant adverse effects that these cannot be adequately managed with conditions, the regulator should refer the substance to the body responsible for classifying prohibited drugs so that the substance can be considered for inclusion in the prohibited drugs regime.

R13 Where a new substance is not approved, but the substance is not classified as a prohibited drug, it should be illegal to manufacture, import or distribute it, but not illegal to possess or use it.

R14 Each distinct combination of psychoactive ingredients should be considered a separate substance and should require an approval.

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R15 Any person should be able to apply to the regulator requesting a reassessment of a substance, and the regulator should grant an application for a reassessment if:

(a) significant new information relating to the effects of the substance becomes available; or

(b) other substances with similar benefits, but less adverse effects, have become available and these could be approved in substitution.

R16 The regulator should be able to initiate a reassessment where satisfied that one of the grounds in R15 above applies.

R17 The regulator should be a separate regulatory authority with the appropriate expertise to determine applications for approvals.

R18 There should be a number of generic statutory conditions in primary legislation that apply to all approved substances.

R19 The regulator should have the power to impose additional more tailored substance-specific conditions as a condition of an approval.

R20 The age at which new psychoactive substances can be purchased should be the same age as that at which alcohol can be purchased from an off-licence.

R21 The advertising of substances approved under the regime should be prohibited except at the point of sale, either within premises where they are sold or supplied, or on internet sites from which they are sold or supplied.

R22 Point of sale advertising should be confined to material that communicates objective product information, including the characteristics of the substance, the manner of its production and its price. This restriction should also apply to advertising on websites selling these products.

R23 The promotion of new psychoactive substances, including sponsorship, should be prohibited in all media.

R24 Incentives to encourage people to purchase approved substances, such as promotional gifts or free-of-charge supply by retailers, should be prohibited.

R25 The sale or supply of approved substances should be prohibited from:

(a) places where alcohol is sold;

(b) petrol stations;

(c) pharmacies;

(d) non-fixed premises such as vehicles, tents and mobile street cars; and

(e) places where children gather (such as schools, recreational facilities and sports facilities).

R26 When a person is convicted of an offence relating to an approved substance, the sentencing court should have the power to prohibit that person from selling or manufacturing approved substances for a period of time.

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R27 Any person under the age of 18 should be prohibited from manufacturing, importing or selling approved substances under the regime. However, this age restriction should increase to 20 if the legal purchase age is increased to 20.

R28 Any person who has been convicted within the previous five years of a dealing offence under the Misuse of Drugs Act 1975 or an offence under the Crimes Act 1961 with a maximum penalty of seven years or more should also be prohibited from manufacturing or selling any approved substance under the regime.

R29 Approved substances should be packaged and stored in child-proof and tamper-proof containers.

R30 Approved substances should be accurately labelled with a full list of ingredients and the phone number and address of the National Poisons Centre should be included on all labels.

R31 The regulator should have the power to impose additional specific conditions as part of an approval relating to any or all of the following matters:

(a) additional place of sale restrictions;

(b) labelling restrictions and requirements;

(c) packaging restrictions and requirements;

(d) health warning requirements;

(e) signage requirements;

(f) quantity, dosage, form and serving requirements;

(g) storage and display restrictions;

(h) record-keeping requirements;

(i) any other requirements considered necessary or desirable to minimise the harm that might occur as a result of use of the substance.

R32 Any person selling or supplying a psychoactive substance, as well as the manufacturer or importer, should be required to comply with any specific conditions relating to the matters that have been specified in the manufacturing or importing approval for a substance.

R33 The regulator should have the power to issue binding codes of manufacturing practice governing the production, manufacture and preparation of substances, requirements for laboratory practice and for sampling and testing of substances.

R34 The conditions of approval for any approved substance should stipulate the applicable code or parts of a code of manufacturing practice that must be complied with by the manufacturer.

R35 The regulator should have the power to recall any approved substance at any time if it considers that the substance is:

(a) unsound or unfit for human consumption;

(b) damaged, deteriorated or perished;

(c) contaminated with any poisonous, deleterious or injurious substance.

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R36 The Government should investigate the option of using excise tax as a mechanism for regulating the retail price of new psychoactive substances in a similar way to alcohol and tobacco.

R37 Manufacturers and importers should be required to file annual returns and reports, similar to those required in respect of tobacco products under section 35 of the Smoke-free Environments Act 1990, to provide data on the quantities of each approved product sold by the manufacturer or importer each year and the recommended retail price.

R38 Responsibility for enforcing the proposed regime should fall to police, New Zealand Customs Service and the Ministry of Health.

R39 The Director-General of Health should have a power to appoint enforcement officers for the regime.

R40 There should be a power to enter premises (other than a private dwelling house) and to inspect documents and take samples of substances for the purposes of monitoring compliance with any approval issued under the regime and with any of the statutory requirements or conditions attached to that approval.

R41 A warrant should be required to authorise entry to a private dwelling house.

R42 When enacted, Part 4 of the Search and Surveillance Bill should apply to the exercise of the search powers provided for the new regulatory regime, with the exclusion of provisions relating to the detention of persons found on the premises.

R43 There should be a power to search places, vehicles or people without a warrant in circumstances where there is reasonable cause to suspect a person is committing the offence of dealing in a substance that has not received regulatory approval.

R44 Where any substance covered by the regime is imported without an approval, it should become a prohibited import under section 54 of the Customs and Excise Act 1996 and section 209 of that Act should apply.

R45 The following offences and maximum penalties should be established:

(a) knowingly or recklessly manufacturing, importing, or supplying any unapproved psychoactive substance – maximum penalty three months imprisonment for an individual and a fine not exceeding $500,000 for a body corporate;

(b) manufacturing, importing, or supplying any psychoactive substance in breach of the generic or specific terms and conditions of an approval – maximum penalty three months imprisonment for an individual and a fine not exceeding $500,000 for a body corporate;

(c) knowingly including false or misleading information in an application for an approval or omitting any adverse information concerning the substance from an application – maximum penalty three months imprisonment for an individual and a fine not exceeding $125,000 for a body corporate;

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(d) a manufacturer or importer knowingly failing to report any significant new information of any adverse effects of any substance they deal in – maximum penalty three months imprisonment for an individual and a fine not exceeding $125,000 for a body corporate;

(e) a manufacturer or importer failing to file an annual return and report or knowingly providing false or misleading information in an annual return and report – maximum penalty three months imprisonment for an individual and a fine not exceeding $125,000 for body corporate; and

(f) wilfully obstructing an enforcement officer undertaking functions or exercising powers under the regime – maximum penalty a fine not exceeding $5,000 for an individual and a fine not exceeding $10,000 for a body corporate.