Part 3
CONVENTION DRUGS

Chapter 6
Drug classification

INTRODUCTION

6.1 Drugs are classified as Class A, B or C for the purpose of fixing the penalty that applies to their illegal production, distribution, possession and use. Whether we retain this three-tiered system is one of the central issues for this review because it determines, at least in part, the offence and penalty structure for the regime.

6.2 In this chapter we examine the evolution of this system of classification. We then consider the criticisms that have been levelled at the similar system in the United Kingdom and their applicability to the New Zealand context. We examine also some specific issues that have arisen over the use of the classification system in New Zealand before reviewing options for reform and recommending changes.

NEW ZEALAND'S CLASSIFICATION SYSTEM

6.3 The ABC classification system has its origins in the 1973 report of the Blake-Palmer Committee.[299] The report noted that "there are significant differences in the potential for harm of the drugs used illegally and for the non-medical purposes *in their typical forms of illegal use*".[300] It recommended making a formal distinction between controlled drugs according to their potential for harm, especially between cannabis plant and the opiates, seeing this as having "important symbolic significance".[301] It also suggested that the failure of the law to draw such a distinction could be wrongly interpreted as indicating either that the "establishment" was outdated in its knowledge and attitude towards drugs or that the drugs involved were interchangeable.[302] The report also noted the different harms associated with the ways in which particular drugs are administered. Except where there are legitimate medical purposes, injecting a drug is generally more harmful than administering that same drug orally.[303]

299 A committee set up by the Board of Health in 1970 to inquire into drug abuse and drug dependency in New Zealand chaired by the Deputy Director of Health, Geoffrey Blake-Palmer.

300 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 42 [*Second Report*].

301 Ibid, at 48.

302 Ibid.

303 Ibid.

6.4 Accordingly the report recommended, among other things, that:[304]

- controlled drugs should be placed in several separate schedules (or parts of schedules) which broadly indicate their relative potential for harm and the degrees of control deemed necessary;
- consideration should be given to the suggestion that the illegal use or administration by injection of a drug prepared for oral use should be deemed to place it in a category of higher harmfulness carrying a higher maximum penalty; and
- provision should be made for periodic review, in light of the developing understanding of drugs and drug misuse, of both the classification of drugs and the penalties attaching to their illegal production, distribution, possession and use.

The Misuse of Drugs Act 1975

6.5 The Misuse of Drugs Act 1975 implemented many (but not all) of the report's recommendations. For example, the suggestion of different penalties for different forms of administration of a drug was not pursued. However, its recommendation for different classifications depending on the harmfulness of a drug was accepted, with the Act establishing a three-tier classification system. The system is modelled on the Misuse of Drugs Act 1971 (UK).

6.6 The Hansard debate on the Drugs (Prevention of Misuse) Bill (which later became the Misuse of Drugs Bill) contains no discussion of the different types of drug harm or how these are to be weighed in assigning individual drug classifications. Nor is it clear what process was used to put the different drugs into different schedules. There is nothing to suggest any rigorous scientific analysis was undertaken, although there is reference in the Hansard debate to experts and departmental officials giving evidence that satisfied members that substances were listed in the appropriate schedules based on knowledge of their effects at the time.[305]

Subsequent changes to the classification system

6.7 Since 1975 there have been a number of significant amendments to the classification system.

6.8 An amendment in 1998 added a fourth schedule to the Misuse of Drugs Act listing precursor substances. We return to the issues relating to precursor substances later in the chapter.

304 Ibid, at 100 for a full list of recommendations.

305 The role of officials and experts was discussed during the second reading debate; see (18 July 1975) 399 NZPD 3146.

6.9 An amendment in 2000 clarified that the classification of a drug is based on the risk of harm a drug poses to individuals or to society by its misuse. Accordingly:[306]

(a) drugs that pose a very high risk of harm are properly classified as Class A drugs; and

(b) drugs that pose a high risk of harm are properly classified as Class B drugs; and

(c) drugs that pose a moderate risk of harm are properly classified as Class C drugs.

6.10 In 2000 an amendment also altered the process for classifying drugs. In 1977, when the Act first came into force, the Executive had an unfettered power to classify substances as controlled drugs by Order in Council. New drugs could be readily added to the three schedules, and substances could be reclassified or removed. This power was curbed in 1992 so that an Order in Council could only change the name or description of any substance already classified as a Class A or B drug,[307] but could add, remove or alter the name of any Class C drug. Other amendments to drug classifications had to be made by Act of Parliament.

6.11 Fuller powers to classify drugs by Order in Council were restored in 2000,[308] subject to the requirement provided for in Parliament's Standing Orders that an Order in Council cannot be brought into force until it has been approved by a resolution of Parliament.

6.12 Another feature of the 2000 amendments was the establishment of the Expert Advisory Committee on Drugs (the EACD) to advise the Minister of Health on drug classifications. The Minister of Health cannot recommend to the Governor-General that an Order in Council be made under the process described above without consulting with and considering advice given by the EACD.[309] The amendment sets out a range of matters on which the EACD must advise and which the Minister must consider before making an Order in Council.

6.13 The classification system was amended again in 2005 with the introduction of the new restricted substances category. As we have already discussed above,[310] substances included in the restricted substances category are regulated rather than prohibited. Restricted substances can be added or removed by Order in Council subject to the affirmative resolution procedure.[311]

6.14 The 2005 amendment also introduced additional restrictions on the use of the Order in Council procedure for classifying drugs. These preclude the use of the procedure to decrease or remove the classification of a controlled drug. This means a controlled drug cannot be moved to a lower level of classification (for example from Class B to Class C) or changed to a restricted substance without recourse to the full legislative process.[312]

306 Misuse of Drugs Act 1975, s 3A.

307 Such an amendment could also only be made if it was necessary to render the name consistent with international scientific usage.

308 Misuse of Drugs Act 1975, s 4A.

309 Misuse of Drugs Act 1975, s 4B.

310 See paragraphs 5.25 to 5.30.

311 Misuse of Drugs Amendment Act 2005, s 34.

312 Misuse of Drugs Act 1975, s 4.

6.15 We return to the issues around the Order in Council process below.[313]

APPROACH IN OTHER JURISDICTIONS

6.16 Only in some jurisdictions are drugs classified for the purposes of determining maximum penalty levels. A range of different approaches are taken overseas.

United Kingdom

6.17 Like New Zealand, the United Kingdom has a three-tier classification system designed to control particular drugs according to their comparative harmfulness either to individuals or to society at large. There is no statutory definition of harm but the Misuse of Drugs Act 1971 (UK) establishes an Advisory Council on the Misuse of Drugs (ACMD) to keep the drug situation in the United Kingdom under review and to advise ministers on measures for preventing or dealing with drug misuse.

Canada

6.18 In Canada, the Controlled Drugs and Substances Act[314] classifies drugs for penalty purposes in four schedules. The maximum penalty for drug offences depends upon which schedule the drug appears in. There are also two classes of precursor substances. The Act does not specify the basis on which particular substances have been included in particular schedules. Canada does not have a statutory committee equivalent to the EACD in New Zealand or the ACMD in the United Kingdom.

Australia

6.19 In Australia, the National Drugs and Poisons Scheduling Committee established under the Therapeutic Goods Act 1989 (Cth) makes decisions at a federal level on the Standard for Uniform Scheduling of Drugs and Poisons (SUSDP). Decisions on the SUSDP do not in themselves have the force of law but are recommendations for incorporation into state and territory legislation. The SUSDP covers all medicines and controlled drugs. Neither New South Wales[315] nor Victoria[316] classifies drugs according to drug type. In each case, the maximum penalty depends on the conduct at issue (importing, manufacture, supply or possession etc), with drug type being a matter for sentencing discretion.

313 See paragraphs 6.61–6.71.

314 Controlled Drugs and Substances Act SC 1996, c 19.

315 Drug Misuse and Trafficking Act 1985 (NSW).

316 Drugs, Poisons and Controlled Substances Act 1981 (Vic).

Europe

6.20 According to the Police Foundation Inquiry report (discussed more fully below),[317] in most European jurisdictions drugs are not classified for penalty purposes.[318] It is left to the courts to decide the impact of drug type on penalty. While many European countries do have a classification system, this is generally for purposes connected with medical prescription. The exceptions are Italy and Portugal where a six-tier classification system is used, and the Netherlands which has a two-tier system. Under the two-tier system in the Netherlands, a distinction is drawn between drugs that have an unacceptable risk of harm (drugs like heroin, cocaine, LSD, amphetamine and cannabis oil) and hemp products (drugs like hashish and cannabis leaf).

CRITICISMS OF THE ABC CLASSIFICATION SYSTEM

6.21 There has been little discussion of or debate about the ABC classification system in New Zealand, although there has been criticism of the classification process.

Reviews of the ABC classification system in the United Kingdom

6.22 However, possible reform of the similar ABC classification system in the United Kingdom has been considered on a number of occasions over the last decade.

Police Foundation Inquiry report

6.23 In 1997 the Independent Inquiry into the Misuse of Drugs Act 1971 (the "Police Foundation Inquiry"), chaired by Viscountess Runciman, considered, amongst other matters, whether it remained appropriate to classify drugs using the three-tier ABC classification system based on comparative harm.[319] Noting that the United Kingdom was the only European country using such a system, the Inquiry considered whether to do away with classes of drug altogether and move to a "no class" approach or alternatively whether the number of classes should be reduced to two. The main advantage of the "no class" approach would be that attention would focus on the different forms of conduct at issue (for example, manufacture, supply, sale for profit, possession and use) irrespective of the drug involved, while the advantage of a two-tier approach was that it drew a clear division between seriously harmful and less harmful drugs.

6.24 While the logic of the two-tier system was attractive, the Inquiry doubted whether this accurately reflects the complexity of the situation. The Inquiry considered that there are drugs that occupy an intermediate position between less harmful drugs like cannabis and seriously harmful drugs like heroin, and it believed the classification system should reflect this.

6.25 Ultimately the Inquiry recommended no change to the three-tier system. However, it suggested there should be a much more systematic approach to the assessment of harm. The Inquiry argued that the major justification for controlling drugs lies in the harm that the use of drugs causes to users, people

317 See paragraphs 6.23–6.25.

318 The Police Foundation *Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971* (Police Foundation, London, 1999) at [6].

319 Ibid.

affected by users and the community at large. Having regard to the various harms involved, it suggested the following criteria for assessing the harmfulness of drugs for classification purposes:[320]

- their potential for dependency and addiction
- toxicity
- risk of overdose
- risk to life and health
- injectability
- association with crime
- association with problems for communities
- public health costs.

Nutt and Blakemore – matrix of harms

6.26 In the wake of the Police Foundation Inquiry, the ABC classification system was reviewed against a matrix of drug-related harm developed by Professors David Nutt, Colin Blakemore, William Salisbury and Leslie King.[321] The matrix uses nine criteria for determining the harmfulness of different substances grouped under three headings:

(a) *physical harms* which include (i) a substance's acute toxicity (ii) its chronic toxicity and (iii) its ability to be ingested by the more dangerous means of injection rather than swallowing;

(b) *likelihood of dependence* which includes (iv) the intensity of pleasure derived (v) psychological withdrawal symptoms and (vi) physical withdrawal symptoms;

(c) *social harms* which include (vii) the damage done to others by drug users' intoxication (viii) the likely health care costs of drug misuse and (ix) other social harms such as child neglect, acquisitive crime and the erosion of family relationships.

6.27 Two groups of experts were asked to score each substance for each of the nine parameters. The first group were consultant psychiatrists registered with the Royal College of Psychiatrists as specialists in addiction. The second were other scientists and experts in psychoactive drugs.[322] A four-point scale (0–3) was used with 0 being "no risk" and 3 "extreme risk". For each substance, the scores were combined as a "mean harm score" to provide an overall index of harm.

320 Ibid, at [38].

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

322 The first group completed the questionnaires independently. The second group used the Delphi method.

6.28 There was a significant correlation between the scores of the two groups of experts. The table below shows the mean scores for each drug that was ranked. Alcohol and tobacco have relatively high harm scores compared to a number of illegal drugs.

TABLE ONE

Matrix of harm: Nutt/Blakemore hierarchy of harms

	Physical Harm				Dependence				Social Harm			
	Mean	Acute	Chronic	Intravenous	Mean	Pleasure	Psychological dependence	Physical dependence	Mean	Intoxication	Social harm	Health care costs
Heroin	2.78	2.8	2.5	3.0	3.00	3.0	3.0	3.0	2.54	1.6	3.0	3.0
Cocaine	2.33	2.0	2.0	3.0	2.39	3.0	2.8	1.3	2.17	1.8	2.5	2.3
Barbiturates	2.23	2.3	1.9	2.5	2.01	2.0	2.2	1.8	2.00	2.4	1.9	1.7
Street methadone	1.86	2.5	1.7	1.4	2.08	1.8	2.3	2.3	1.87	1.6	1.9	2.0
Alcohol	1.40	1.9	2.4	NA	1.93	2.3	1.9	1.6	2.21	2.2	2.4	2.1
Ketamine	2.00	2.1	1.7	2.1	1.54	1.9	1.7	1.0	1.69	2.0	1.5	1.5
Benzodiazepines	1.63	1.5	1.7	1.8	1.83	1.7	2.1	1.8	1.65	2.0	1.5	1.5
Amphetamine	1.81	1.3	1.8	2.4	1.67	2.0	1.9	1.1	1.50	1.4	1.5	1.6
Tobacco	1.24	0.9	2.9	0	2.21	2.3	2.6	1.8	1.42	0.8	1.1	2.4
Buprenorphine	1.60	1.2	1.3	2.3	1.64	2.0	1.5	1.5	1.49	1.6	1.5	1.4
Cannabis	0.99	0.9	2.1	0	1.51	1.9	1.7	0.8	1.50	1.7	1.3	1.5
Solvents	1.28	2.1	1.7	0	1.01	1.7	1.2	0.1	1.52	1.9	1.5	1.2
4-MTA	1.44	2.2	2.1	0	1.30	1.0	1.7	0.8	1.06	1.2	1.0	1.0
LSD	1.13	1.7	1.4	0.3	1.23	2.2	1.1	0.3	1.32	1.6	1.3	1.1
Methylphenidate	1.32	1.2	1.3	1.6	1.25	1.4	1.3	1.0	0.97	1.1	0.8	1.1
Anabolic steroids	1.45	0.8	2.0	1.7	0.88	1.1	0.8	0.8	1.13	1.3	0.8	1.3
GHB	0.86	1.4	1.2	0	1.19	1.4	1.1	1.1	1.30	1.4	1.3	1.2
Ecstasy	1.05	1.6	1.6	0	1.13	1.5	1.2	0.7	1.09	1.2	1.0	1.1
Alkyl nitrites	0.93	1.6	0.9	0.3	0.87	1.6	0.7	0.3	0.97	0.8	0.7	1.4
Khat	0.50	0.3	1.2	0	1.04	1.6	1.2	0.3	0.85	0.7	1.1	0.8

Table: Mean independent group scores in each of the three categories of harm, for 20 substances, ranked by their overall score, and mean scores for each of the three subscales.[323]

323 Nutt and others, above n 321, at 1051.

6.29 The scores do not take into account the effect of prevalence. This reflects a deliberate decision on the part of the authors to focus on the intrinsic harm of a particular drug, independent of its rate of use.[324] "Social harm" refers to the effects at the individual level rather than the aggregated social costs for a drug, so that the assessment of social harm is different from those assessments under most other harm indices.

6.30 The authors of the study concluded that the results do not provide justification for the sharp A, B or C classifications in the Misuse of Drugs Act (UK).[325] They found a fairly poor correlation between a drug's class under that Act and its harm score. While recognising the convenience of the system for determining penalties, they considered that the sharply defined categories are essentially arbitrary unless there are obvious discontinuities in the full set of scores. However, if a three-tier system is to be retained, they suggested that drugs with harm scores equal to that of alcohol and above might be Class A, cannabis and below might be Class C and drugs in between might be Class B.[326]

6.31 Criticisms have been made of the Nutt and Blakemore matrix of harm. First, the matrix treats all harms as being of equal weight; the harm score for each drug is simply the mean of the total scores for the drug across all nine criteria. As a consequence, for example, acute physical harm including death has an equal weight to the harm of psychological dependence, or the social harm caused by intoxication. There is room for debate as to whether some types of harm should have greater weight than others when assessing the overall harmfulness of a drug.[327]

6.32 Secondly, the matrix has been criticised as too subjective. It relies, for example, on the subjective assessment of experts and therefore makes only indirect use of advances in knowledge of brain science, measurements of the clinical and social impact of drugs on individuals and populations, and the economic and social costs of drug misuse.[328]

6.33 More recently Professor Nutt and others have taken part in another exercise that involved scoring the same 20 substances against a broader range of 16 different health and social measures.[329] The evaluation criteria in this second exercise were divided into harms to users and harms to others, and clustered under physical, psychological, and social effects. In an attempt to address some of the criticisms of the earlier study, different weightings were applied to the different criteria. The

324 In a letter to the editor of The Lancet the authors explained: "Our method focused on the intrinsic harm of substances, independent of prevalence, because, to guide investment in policing and education, we need to be able to assess substances when their use is low, but with the potential to become widespread." David Nutt and others "Letter to the Editor" (2007) 369 The Lancet at 1857.

325 Nutt and others, above n 321, at 1051.

326 Ibid.

327 See letter to the editor from John Britten and others, who argue that the harm score for tobacco should be higher – "For tobacco, the score for chronic harm resulting from killing more than 100,000 people each year in the UK is more than offset by low scores for acute harm and intravenous use." John Britten and others "Letter to the Editor" (2007) 369 The Lancet 1857.

328 The Academy of Medical Sciences *Brain Science, Addiction and Drugs – An Academy of Medical Sciences working group report chaired by Professor Sir Gabriel Horn FRS FRCP* (The Academy of Medical Sciences, London, 2008).

329 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" (2010) 376 Lancet 1558.

broader range of criteria together with the weighting of criteria produced a different ranking, but Nutt and others argue that their overall results are broadly supportive of the earlier analysis against the original nine criteria.[330]

6.34 These two assessments illustrate that a purely objective assessment of drug harms is simply not possible. How different drug harms are weighted against each other is ultimately a matter of judgement.

Science and Technology Committee report

6.35 In 2006 the House of Commons Science and Technology Committee presented a detailed critique of the scientific anomalies within the three-tier classification system.[331] It concluded that the classification system was not "fit for purpose"[332] and should be abandoned.

6.36 The Committee proposed that the ranking of drugs based on harm should be "decoupled"[333] from penalties for drug offences because knowledge of drug harms was constantly evolving. This required constant revision of the classification system and the law could not keep up. Also, there was very little scientific knowledge of the harms associated with some drugs so there was insufficient evidence on which to base many classification decisions. The Committee suggested a more sophisticated and scientific scale of harm should be developed and continually revised in light of evolving scientific knowledge. The purpose of the scale would be to inform policy-making and education. The scale would also apply to alcohol and tobacco.

6.37 The Committee did not determine how penalties for drug offences should be set, other than noting that "a greater emphasis on the link between misuse of a drug and criminal activity" and "a cleaner distinction between possession and supply are possibilities".[334]

6.38 Other criticisms the Committee made of the ABC classification system are:

- there is no evidence that giving a drug a higher classification acts as a deterrent;
- there has been little evaluation of the impact of changes to drug classifications;
- there is uncertainty about the definition of harm which creates confusion about classification decisions;
- the boundaries between the classes are arbitrary;
- the rigid nature of the system makes it difficult to move substances between classes as new evidence emerges;
- the difficulties surrounding classification suggest that the time and effort involved in making classification decisions are unwarranted;
- there is no systematic approach to determining when reviews of classification are necessary.

330 Ibid, at 1561.

331 Science and Technology Committee "Drug Classification: Making a Hash of it?" HC (2005–2006) 1031.

332 Ibid, at 3.

333 Ibid.

334 Ibid, at 46.

6.39 The United Kingdom Government rejected the Committee's overall finding that the classification system is not "fit for purpose". It argued in support that the three-tier system allows meaningful distinctions to be made between drugs and "its familiarity and brand recognition amongst stakeholders and the public is not to be dismissed".[335]

RSA Commission report

6.40 The 2007 report of the Royal Society for the Encouragement of Arts, Manufacture and Commerce (RSA) Commission on Illegal Drugs, Communities and Public Policy (an independent Commission established by the RSA) also recommended abandoning the ABC classification system.[336] The report made similar criticisms to those made in the Science and Technology Committee's report. The RSA Commission was particularly concerned about the way the system was used by the Government to convey messages about drug use. It suggested that it failed to transmit the desired message in a coherent way. The RSA Commission also considered that the "opacity" of the classification system and the "oversimplifications built into its workings" reduced its value as a sentencing tool and undermined it as a prevention strategy, since prevention depends on the accuracy and plausibility of official information about drugs.[337]

6.41 The RSA Commission proposed an entirely new legal framework for the control of harmful substances. This would be in four parts:

(a) A new Misuse of Substances Act that would be drafted in broad and general terms, expressing the state's intention of controlling substances and defining in general terms the activities that would constitute offences such as cultivation, manufacture and supply of controlled substances. It would also make clear the circumstances in which the supply and use of controlled drugs would not constitute offences.

(b) A schedule setting out a graduated list or gradient of all specific offences in descending order of seriousness and the range of penalties to be attached to each offence.

(c) An index comprising a list of substances set out in descending order of harmfulness, which could be generated by a matrix mapping of the various types and degrees of harm associated with the substances in question.

(d) A table or regulatory map setting out the method and degree of regulation of each substance.

6.42 A key feature of the proposal is that neither the statute, nor the schedule to it, would name any individual substance, determine its criminality or allocate penalties to its supply or possession. The schedule would rank offences but not substances. Individual substances would be listed in an index and be ranked in

335 Secretary of State for the Home Department "Government Reply to the Fifth Report From the House of Commons Science and Technology Committee Session 2005–06 HC 1031: Drug Classification: Making a Hash of It?" (Cm 6941, 2006) at 3.

336 The RSA Commission on Illegal Drugs, Communities and Public Policy *Drugs – Facing Facts* (RSA, London, 2007).

337 Ibid, at 287.

order of their harmfulness on the basis of scientific and sociological evidence. The gravity of any offence and therefore the penalties attached would be determined by reference to the index.

6.43 However, the index would not form an integral part of the new Act itself. Instead the index, which would need to be well publicised, would have a "quasi legal" status and would be taken into account by courts when dealing with offences under the Act.[338] Both the index and the table would be regularly updated to include new substances and to reflect changes in the evidence relating to the relative harmfulness of substances that are already included. This would affect consequential changes in the penalties attached to offences involving the substances in the index. The RSA Commission noted that there may not currently be sufficient research capacity to achieve this. However, if necessary, it suggested a research capacity should be created to allow for regular (perhaps five yearly) reviews.[339]

Academy of Medical Sciences report

6.44 The Academy of Medical Sciences (AMS) as part of a broader health report considered the drugs classification system.[340]

6.45 The AMS commissioned a national programme of public engagement to ensure that its final recommendations were informed by both scientific evidence and public concerns and aspirations. It reported that participants in the public engagement considered the United Kingdom's drug classification to be "confused, inconsistent and arbitrary".[341] The AMS suggested, therefore, that the classification system needed to be revised to reflect more accurately the harms associated with each drug.

6.46 The report also called for the development of new quantitative indices of all harms attributable to legal and illegal drugs. These could be used by the ACMD, along with other evidence, to inform its advice on the harmfulness of individual substances and decisions on whether and how drugs should be classified. The new indices would also inform decisions as to whether the three-tier classification system itself is too fine or too coarse to "capture" the different levels of harm.[342]

338 Ibid, at 319.

339 The report records that Professor Nutt had suggested five yearly reviews in an evidence session with the Science and Technology Committee as part of its follow up on its report; see ibid, at 320.

340 The Academy of Medical Sciences (AMS) was invited by the United Kingdom Government to consider, in consultation with experts, the societal, health, safety and environmental issues raised by the Government's Foresight Report *Drugs Futures 2025*? (Office of Science and Technology, London, 2005) and to make recommendations for public policy and research needs. It convened a working group chaired by Sir Gabriel Horn to undertake the task. Chapter 5 of the working group's report considered the issue of harm and regulation, including the drugs classification system; see The Academy of Medical Sciences, above n 328.

341 Ibid, at 74.

342 Ibid, at 73.

6.47 For completeness, we note that although the report stopped short of calling for the legalisation of the possession and use of drugs, it recommended that in striking a balance between individual freedom and the harms of substance misuse, account needed to be taken of the long-term harm of criminalising the possession of drugs for personal consumption.

Applicability of criticisms to New Zealand's ABC classification system

6.48 The New Zealand classification system is more developed than its counterpart in the United Kingdom. It prescribes the basis for making drug classifications; it is more explicit about the classification process; and it sets out the factors that are to be taken into account in drug classification decisions.

6.49 Despite these differences, many of the broader criticisms of the classification system in the United Kingdom are relevant to New Zealand. Moreover, there has been no systematic review of the individual drug classification decisions made before the 2000 amendments, and it is generally accepted that some of the current classifications are anomalous in light of the available scientific evidence.[343]

Effectiveness of classification

6.50 The first criticism is that there is no evidence that the classification system itself or changes in individual drug classifications have a deterrent effect. The Science and Technology Committee report found there was no evidence that giving a drug a higher classification acts as a deterrent.[344] The report noted also that there has been little evaluation of the impact of changes to drug classifications.[345]

6.51 Deterrence is, however, only one of the purposes of sentencing. It is not the only or even the predominant purpose. Sentencing should reflect the seriousness of the offence and the culpability of the offender. The more harmful the drug, the more serious the offence and the greater the culpability of the offender. It is undoubtedly desirable that the effects of drug classifications, and changes to them, are evaluated, but the absence of information about their deterrent effect does not necessarily provide a reason for abandoning the current system.

Defining harm and inadequate evidence

6.52 The second criticism is that there is uncertainty about the definition of harm which creates confusion for classification decisions. Closely related to this are concerns that there is an insufficient evidence base for many classification decisions and that the boundaries between drug classes are arbitrary. In part, this argument rests on confusion about the purpose for which the definition of harm is used. We discussed in chapter 2[346] the difficulties that surround the measurement of drug harm and expressed some scepticism about the value of

343 For example, the assessment of LSD on the criteria outlined in the Misuse of Drugs Act 1975 indicates that LSD is inappropriately classified as a Class A drug; see Expert Advisory Committee on Drugs "Minutes of the Committee's Meeting 6 August 2009" (August 2009) at 5.

344 Science and Technology Committee, above n 331, at 1031.

345 Ibid.

346 See paragraphs 2.63–2.70.

attempts to describe and quantify the costs of all drug use. But these difficulties do not necessarily mean it is wrong to group drugs into broad harm categories for the purpose of fixing maximum penalties for drug offences.

6.53 Inevitably with any classification system there will be issues about where the boundaries between each category should be drawn. But the same is true in drawing the boundaries for any criminal offence. We acknowledge that the evidence base for drug harm is less developed for some drugs than for others. Nevertheless, there does appear to be broad consensus amongst scientists on the relative harms of most controlled drugs. For example, as noted in paragraph 6.28 above, there was a significant correlation between the scores of the two groups of experts that independently assessed drug harms for the Nutt and Blakemore matrix.

Decisions vulnerable to pressure and not based on scientific evidence

6.54 The third criticism is that the classification system is vulnerable to political and media pressure, resulting in decisions that are not based upon scientific evidence. This has undoubtedly been the experience in the United Kingdom, where recommendations of the ACMD about the classification of cannabis and ecstasy have been ignored by the United Kingdom Government. More recently, the Chair of the ACMD was sacked in 2009 because of his public comments about anomalous drug classifications.

6.55 In New Zealand, the recommendations of the EACD have never been ignored,[347] although there have been occasions, such as the recommendation relating to the classification of BZP, when the EACD itself has not been unanimous in its recommendations. However, the Government has on occasion made its views of a particular drug known before the EACD has examined the evidence, which has made it difficult for the EACD (which includes government officials in its membership) to take an alternative position.

6.56 We acknowledge the potential for drug classification decisions to be vulnerable to political and media pressure. However, even the most scientific scale of harms necessarily involves some element of value judgement. On that basis, arguably, it is appropriate for classification decisions to depend to some extent on political judgements. What is important is that those judgements are informed as far as possible by the evidence. In any event, public and media concern about particular drugs will almost inevitably feature in decisions about the penalties for drug offences no matter how they are set. The involvement of an expert advisory committee in the classification process at least ensures that evidence relating to drug harms is considered.

347 Although it should be noted that the Expert Advisory Committee on Drugs has never recommended a downward reclassification of any drug.

Failure to systematically review and update classifications

6.57 The fourth criticism of the current classification system is the lack of any systematic approach to reviewing drug classifications to take account of developments in scientific knowledge. If a tiered classification system is retained, this issue should be addressed by the inclusion of a statutory requirement that puts in place a system for regular review of classification decisions.

Acknowledging nuances in drug use behaviour

6.58 A final criticism is that the classification system acknowledges none of the nuances in drug-taking behaviour in terms of risk and harmfulness. The Blake-Palmer Committee was concerned about this issue even before the current Act was passed. The practical reality is that the harmfulness of a drug to an individual user depends on a range of factors, including the frequency of use, the mode of administration and individual personal factors.

6.59 However, while it is true that the harmfulness of use is contextual, this does not mean that an assessment cannot be made of the relative harmfulness of different drugs. It is the average harm arising from the use of a drug that is important, not its variability in the individual case.

Issues that have arisen in New Zealand

6.60 In addition to the broader criticisms and issues discussed above, three more specific issues have emerged in New Zealand. These concern the use of Orders in Council in the classification process, the utilisation of classification for regulatory purposes, and the classification of precursor substances.

Use of Orders in Council in classification process

6.61 As has already been noted, drug classification decisions can, in some situations, be made by Order in Council subject to an affirmative resolution procedure.

6.62 The affirmative resolution procedure works in the following way. Once an Order in Council is made, the Minister must lodge a notice of motion in the House that the order be approved. The notice of motion stands referred to the Health Select Committee which must report to the House on the motion within 28 days of its being lodged. The notice of motion can only be moved if the Health Committee has reported back on the motion or 28 days has passed. The approval must be obtained within a year of the notification of the making of an Order in Council in the *Gazette*. The House can only approve or reject an Order in Council; it cannot amend or substitute it.[348]

6.63 At the time it was introduced, it was argued that the power to classify drugs by Order in Council was necessary "to provide for the expeditious classification of controlled drugs" as a response to the "expansion of the illicit drug market in New Zealand".[349] It was seen as too time consuming to amend the schedules by an amendment to the Misuse of Drugs Act, since that limited New Zealand's

348 See Misuse of Drugs Act 1975, s 4A.

349 Hon Annette King (Minister of Health) (7 November 2000) 588 NZPD 6374.

ability to respond quickly to the creation of new synthetic or designer drugs.[350] The affirmative resolution procedure was intended to provide a check on Executive power.

6.64 The Order in Council/affirmative resolution procedure has been criticised by the Regulations Review Committee and the New Zealand Law Society amongst others. A particular concern is that a drug's classification determines whether an offence is committed and if so the maximum penalty, including life imprisonment in the case of a Class A drug. Decisions of this kind, which bear on individual liberty, should be subject to the full parliamentary process.[351]

6.65 The problem is compounded by the 2005 amendments that restrict the truncated procedure to upward but not downward classifications. It seems anomalous that a truncated Parliamentary process is available to create new offences and increase penalties but not remove or reduce them. George Tanner QC, then Chief Parliamentary Counsel, in a 2004 submission to the Regulations Review Committee, described the problem as follows:[352]

> The orthodox way of making laws is by Parliament enacting statutes and the Executive making regulations under the authority of statutes enacted by Parliament. This has served New Zealand well. The affirmative resolution procedure is an unfortunate hybrid that has none of the advantages of the traditional means of legislating. The process is part parliamentary and part executive. The clear distinction between the traditional law-making processes is blurred. The affirmative resolution procedure is muddled law-making.

6.66 There are a number of other difficulties with the procedure. It restricts the scope of public participation (because of truncated select committee consideration) and Parliamentary scrutiny and therefore "degrades the ordinary parliamentary law-making process".[353] In addition, Orders in Council are delegated legislative instruments and are therefore vulnerable to challenge on the ground of *ultra vires*.[354] Such a challenge might be brought if the procedural requirements imposed by the Act have not been adhered to, or if an order purports to do something that falls beyond the scope of the delegated legislative power.

6.67 Since the provisions came into force, the majority of Orders in Council have been to change the classification of existing drugs rather than classify new drugs. The relatively small numbers of Orders in Council dealing with new drugs suggest that the problem the procedure was established to fix may have been overstated. Moreover, the procedure is not necessarily any more expeditious than urgent legislation. For example, the Misuse of Drugs (Classification of Ephedrine and Pseudoephedrine) Order 2003 took over ten months to bring into force. Recently, an Order in Council classifying ketamine as a controlled drug lapsed and did not come into force because it was not approved by the House within a year of its being notified in the *Gazette*. Moreover, as we discussed in chapter 5,[355] the

350 Hon Georgina Te Heuheu (Associate Minister of Health) (5 October 1999) 580 NZPD 19707.

351 George Tanner "Submission by Chief Parliamentary Counsel to Regulations Review Committee – Inquiry into Affirmative Resolution Procedure".

352 Ibid, at 12.

353 Ibid, at 12.

354 *Ultra vires* is a Latin phrase that literally means "beyond the powers".

355 See paragraphs 5.16 – 5.24.

regime under the Hazardous Substances and New Organisms Act 1996 applies to any new psychoactive substance. To that extent the justification for the Order in Council process[356] rests on a misunderstanding of the current law.

6.68 In our view, the Order in Council procedure is not justified and brings with it an unacceptable risk of challenge. Because decisions to classify substances create serious offences they should require full parliamentary scrutiny. Further, the new drugs regime we recommend in chapter 5 reduces the need to respond quickly and have substances prohibited and classified. If that regime is adopted it would be unlawful to manufacture or import any new synthetic or designer drug until it was approved by the regulator.

6.69 The Order in Council procedure has, however, an important strength; the process requires the Minister to take into account advice on certain matters (essentially relating to the harmfulness of the drug that is being classified) before promoting an Order in Council. This ensures that drug classification decisions are informed by expert opinion. Given the controversial and polarising nature of drug issues and emotional reactions to them, we believe that drug classification decisions need to be informed by expert evidence if good outcomes are to be achieved.

6.70 Therefore, if the executive's power to prohibit and classify by Order in Council is removed, as we recommend, the Minister should be required to present a report to the House, containing advice from the EACD, at the time legislation is introduced, or as soon as reasonably practicable thereafter in the case of a Member's Bill. The report would spell out the nature and extent of the harm associated with the substance being classified and, assuming a tiered system is retained, which tier of harm the substance falls into. This would ensure Parliament's decisions and public debate are fully informed by independent expert advice. Later in the chapter we propose changes to the criteria against which the EACD should report[357] and also changes to the membership of the EACD.[358]

6.71 If the Order in Council process is retained, notwithstanding our recommendation to the contrary, it should also allow downward classifications and the removal of substances. It is anomalous that currently the process can be used to create new offences (by adding substances to the schedules) and increase penalties (by reclassifying upwards), but primary legislation is required to reduce penalties (reclassifying downwards) or abolish offences (remove substances from the regime).

Sub-classifications within drug classes for ancillary purposes

6.72 Class B and C drugs are currently divided into sub-classifications. Class B drugs are divided into the sub-classifications B1, B2, and B3 and listed in Parts 1 to 3 of Schedule 2. Class C drugs are divided into seven sub-categories and are listed in Parts 1 to 7 of that Schedule 3.[359] When substances are classified or reclassified

356 The justification being that New Zealand needs to be able to respond quickly to the creation of new synthetic or designer drugs because they are not otherwise regulated until they are classified.

357 See paragraphs 6.104 – 6.120.

358 See paragraphs 6.129 – 6.141.

359 Parts 1 to 3 of sch 2 and Parts 1 to 6 of sch 3 were included in the Act when it was passed, while Part 7 of sch 3 was added by s 10 of the Misuse of Drugs Amendment Act (No 2) 1987.

they are placed within a particular part of the schedules. In practice, the EACD determines and recommends a particular sub-classification, although there is no statutory basis for the allocation of substances to different parts of the schedules.

6.73 There are relatively few statutory references to these sub-classifications. The most important one is in section 18(2) and (3) of the Act which extends warrantless search powers to drugs listed in Schedule 1, Part 1 of Schedule 2 and Part 1 of Schedule 3. The main purpose of the sub-classifications would seem to be to regulate matters such as prescribing, storage and record-keeping by persons authorised to deal in controlled drugs. These matters are currently largely dealt with in regulations. For example, Class C6 drugs (drugs listed in Part 6 of Schedule 3) can lawfully be sold over the counter without prescription. Supplies of Class C2 drugs can be held by approved managers or hospitals. Class C5 drugs (drugs listed in Part 5 of Schedule 3) are exempted from certain custody requirements. However, none of this is apparent on the face of the statute and the significance of the various sub-classifications is difficult to determine without a very close and careful reading of the regulations. In other words, the law is simply not accessible.

6.74 Moreover, there are significant risks in using the same classification system for law enforcement and regulatory purposes. The fact that particular categories of drugs might need a particular subset of regulatory controls does not necessarily mean that the same law enforcement powers should be available to detect misuse of those drugs. The considerations that apply to the application of law enforcement powers are quite different from those that apply to matters such as prescribing, storage and record-keeping. It is therefore problematic to use sub-classifications for these two quite separate purposes.

6.75 In our view, the regulatory controls on drugs and the law enforcement powers that apply to them need to be dealt with separately. If a tiered classification system is retained, it should only be used for the purposes of determining penalty and the ancillary purpose of applying law enforcement powers. It should not be sub-divided further and utilised for regulatory purposes. We address the need for greater transparency in how exemptions from prohibition are regulated in chapter 10.

Classification of precursor substances

6.76 A more recent issue to emerge concerns decisions around the classification of precursor substances. Some precursor substances are currently scheduled as controlled drugs as well as precursor substances. Lysergic acid, a precursor for LSD, is scheduled as a Class A drug as well as a precursor substance. Pseudoephedrine and ephedrine, precursors for methamphetamine, are currently scheduled as Class C drugs and also as precursor substances. An amendment bill before the House will, once enacted, increase the classification for pseudoephedrine and ephedrine to Class B2. Classifying substances as both precursors and controlled drugs and scheduling substances that are actually precursors as controlled drugs creates some difficulties.

Problems with dual classifications

6.77 Lysergic acid, pseudoephedrine and ephedrine were all already listed in Schedule 4 as precursors before they were classified as controlled drugs.[360] We have been unable to ascertain the reason or impetus for classifying lysergic acid as a Class A drug as well as a precursor, but pseudoephedrine and ephedrine were also classified as Class C drugs in 2003 in response to increasing concern about the use of methamphetamine.

6.78 Broadly, classification of a substance as a controlled drug rather than a precursor should enable greater controls to be placed on these substances. In relation to pseudoephedrine and ephedrine, however, the position is less clear. Usually, for example, controlled drugs cannot be purchased over-the-counter,[361] whereas many precursor substances can be.[362] However, there is a statutory exemption for some preparations of pseudoephedrine that enables it to be sold over-the-counter by pharmacists, and to be bought by any person.[363] An amendment to the Misuse of Drugs Act in 2005 also extended search and seizure powers without warrant to pseudoephedrine and ephedrine.[364] As a consequence, there are broader powers to search for these two Class C controlled drugs than many Class B drugs and on most other Class C drugs.[365]

6.79 It is unclear why, after classification as controlled drugs, lysergic acid, pseudoephedrine and ephedrine remained listed as precursors in Schedule 4. The dual classification of substances in this way is problematic, because a person undertaking the same activity in relation to the same substance may be subject to vastly different penalties depending on what charge is laid. For example, importation of a Class A drug into New Zealand carries a maximum penalty of life imprisonment, importation of a Class B drug carries a maximum penalty of fourteen years imprisonment and importation of a Class C drug eight years imprisonment. Importation of a precursor substance knowing that it will be used to produce or manufacture a controlled drug carries a maximum penalty of seven years imprisonment.

6.80 To avoid this problem, it would be preferable to schedule substances as either precursor substances or as controlled drugs, but not as both. Further, if a substance is a precursor used to manufacture a controlled drug, but is not itself a harmful psychoactive substance, it is not appropriate to classify it as though it is the controlled drug it is used to produce. Precursors like pseudoephedrine and ephedrine are one step removed from the harmfulness of the drug they are

360 Ephedrine and pseudoephedrine were made Class C drugs via the Misuse of Drugs (Classification of Ephedrine and Pseudoephedrine) Order 2003. Lysergic acid was made a Class A drug via the Misuse of Drugs Amendment Act 1996.

361 It is an offence to procure a controlled drug – see Misuse of Drugs Act 1975, s 7(1)(a).

362 Subject to any other regulatory restrictions that might apply. For example, piperidine is subject to controls in the Medicines Act 1981, and can only be purchased on prescription.

363 Misuse of Drugs Regulations 1977, reg 20(2). Reclassification of pseudoephedrine as a Class B2 drug would require it to be available only on prescription.

364 Misuse of Drugs Amendment Act 2005. See Misuse of Drugs Act 1975, s 18(3).

365 Note that these powers do not apply to Class B2 drugs – we assume that this will be addressed as part of the reclassification of pseudoephedrine and ephedrine to Class B2 drugs.

utilised to manufacture, so that the harm they cause is indirect and contingent on the use to which they are put. Dealing in them should therefore be treated differently from dealing in the harmful drug itself.

6.81 We recommend that precursors be separately scheduled as A, B or C precursors depending on the classification of the most harmful drugs they are potentially used to produce. We make recommendations on the structure of precursor offences in chapter 9. In chapter 11 we also discuss proposals for the application of search and seizure powers to precursor substances.

OPTIONS FOR REFORM

6.82 In the Issues Paper we considered four options for reforming the classification system.

Option 1: A single maximum penalty for all drugs

6.83 Under option 1, the ABC classification would be dispensed with entirely. Substances would still need to be classified as controlled drugs but would not be broken into classes as now. The same maximum penalty would apply to a drug offence irrespective of the particular drug involved. There are alternative ways of dividing offences involving different forms of conduct (that is, manufacturing, importing or exporting, or large-scale supply).

6.84 The actual sentence to be imposed in any individual case would be left to the discretion of the sentencing judge. There could, however, be some statutory guidance about the factors that are to be taken into account, including matters such as the harmfulness of the particular drug involved. The higher courts might also issue some sentencing guidance.

6.85 The main advantage of option 1 is that it would avoid most of the difficulties with classifying drugs, including some of the problems of assessing their relative harms, gaps in scientific knowledge and the need for a review of classifications from time to time to take account of developing knowledge. However, it would leave a very broad range of conduct to the discretion of the sentencing judge. For example, if the current life sentence was to be retained as the maximum penalty for dealing in methamphetamine (currently a Class A drug), it would mean that this penalty would be available for dealing in drugs such as BZP and cannabis (currently Class C drugs). There would be no systematic way of informing the judiciary about the different harms associated with different drugs. This would present significant difficulties. Parliament should give greater guidance than this as to the maximum penalties that should apply to drug offences that involve widely varying degrees of harm.

6.86 A variant on option 1 would be a system such as that proposed in the RSA report under which the substances would not be named in the statute but incorporated by reference to their scale on a "quasi-legal" scientifically-based index of drug harms. However, we consider there is a fundamental difficulty with this approach because it would provide none of the certainty that is required when defining serious criminal offences. It is essential that the public know, and understand, the boundaries of criminal offences and the penalties that apply. This means that, if dealing with particular substances is to attract substantial criminal penalties, both the nature of the substances and the nature of the dealings that are prohibited should be specified in primary legislation.

6.87 There was very little support for option 1 among submitters or organisations consulted during our consultation process. Only a small handful of submitters favoured it. One submitter argued that there is little difference in reality if someone is addicted to alcohol, cannabis or methamphetamine because the devastation caused is much the same.[366] We are not persuaded by this argument. Even if the experience of a dependent person is similar irrespective of the drug involved, the likelihood of becoming dependent differs. Dependence is also only one factor to consider when measuring the harmfulness of drugs. The Nutt and Blakemore matrix illustrates, for example, the significant differences between drugs in the relative risks of dependence and the types and magnitude of physical and social harms associated with them.[367]

6.88 Two other submitters argued that it was appropriate for judges when sentencing to have the type of broad discretion this option allows. With greater discretion judges would be open to considering submissions from counsel on the specific facts of a case.[368] We accept that judges must exercise discretion when sentencing, but do not think a single classification provides sufficient guidance as to the penalties that should be considered for drug offences involving widely varying degrees of harm.

Option 2: A two-tier classification system

6.89 Under option 2, there would be two classes of prohibited drugs: one for seriously harmful drugs and one for moderately harmful drugs.

6.90 The main advantage of a two-tier system is that it might provide clearer and more easily understood categories than a three-tier system and the lines may also be more easily drawn. However, arguably it is too simple a system to deal with the wide range of harms posed by different drugs. That was certainly the view of both the Blake-Palmer Committee and the Police Foundation Inquiry. It may also create misconceptions that there are "hard drugs" and "soft drugs" and that the latter are not harmful, although to some extent this occurs anyway under a three-tier classification, with Class C drugs being perceived as "soft drugs".

6.91 There was only limited support from submitters for this option. Those who supported it argued that it provided a clearer and more easily understood distinction between low and high risk drugs.[369] Market separation between low and high risk drugs was considered desirable and submitters argued that a two class approach would help achieve this. A few other submitters who proposed a separation of markets also argued for the legalisation of the drugs in the lower risk or "soft" category and therefore were effectively supporting option 1.[370]

366 Submission of Pauline Gardiner former director of WellTrust (submission received 5 April 2010) at 1.

367 Nutt and others, above n 321, at 1047.

368 Submitter 229 (submission dated 26 April 2010) at 2 and Submitter 341 (submission dated 20 April 2010).

369 Submission of Young Labour, New Zealand Labour Party (submission dated 1 April 2010) at 3 and Submitter 264 (submission dated 21 April 2010).

370 Submitter 116 (submission dated 14 April 2010) and Submitter 258 (submission dated 28 April 2010).

6.92 The National Addiction Centre submitted that the ranking of drugs by their level of harm is imprecise, partly due to only partial data being available, but mainly because harm is a multifaceted concept that cannot be readily reduced to a single index. On that basis they suggested just two tiers (moderate and high) for illegal drugs and another tier for legal regulated drugs (low).[371]

6.93 Like others, we are attracted to the simplicity and logic of a two-tier approach because it draws a clear and meaningful distinction between seriously harmful and less harmful drugs. However, as the National Addiction Centre has pointed out,[372] ranking drugs by their level of harm is a very imprecise science. We think that this makes it more difficult to separate drugs into two classes. Feedback from others during consultation suggests that there are a number of drugs, currently included in Class B, that occupy something of an intermediate position between less harmful drugs like cannabis in Class C and highly harmful drugs like methamphetamine in Class A. If we reduced the scale to two classes, many of the substances currently in Class B may be pushed into Class A.

6.94 The result would be that life imprisonment would be the maximum penalty for offending involving a broader range of drugs than is currently the case. We think this would be undesirable and a two-tier system is simply too blunt an instrument for differentiating between drugs. A three-tier system, because it provides an intermediate option, produces a more accurate demarcation of harm than two classes notwithstanding the imprecision around the measurement of harm.[373]

Option 3: Retain a three-tiered classification

6.95 Option 3 involves retaining the status quo in terms of the number of classes of drugs, although changes should be made to the current placement of substances within the scale and the criteria against which harm is assessed. As we have already noted, the main advantage of option 3 is that it provides for a more accurate discrimination between the different levels of harm posed by different drugs than a two-tier system. Three tiers also give a clearer signal about the level of penalty Parliament intends for certain types of offending involving particular drug types.

6.96 Against that, some of the current difficulties with classifying drugs remain, although the problem of classifications not being keep up-to-date could be addressed by including a requirement for the regular review of classification decisions to ensure that classification reflect the developing scientific knowledge and relevant changes in the drug landscape.

371 Submission of The National Addiction Centre (submission dated 6 May 2010) at 2.

372 Ibid.

373 This was also the view expressed by most members of the Expert Advisory Committee on Drugs during a consultation discussion with representatives of the Commission on 14 April 2010.

6.97 Most submitters and organisations we consulted favoured the retention of a three-tier ABC classification because of its ability to better differentiate between the levels of harm caused by different drugs.[374] One or two also made the point that it is now well understood.[375]

6.98 If the three-tier system is retained many submitters stressed the importance of undertaking a full scale review to assess the appropriate drug classification of current drugs before including them in new legislation. It is clear that some of the current classifications are inconsistent with what is now known about drug harms. For example, if the Nutt and Blakemore scheme for assessing harm is accepted the current classifications of LSD, GHB (fantasy) and ecstasy, which are all assessed as less harmful than alcohol, tobacco and cannabis, do not reflect the relative harm associated with these substances. Following a full scale review of classifications, some submitters also thought that there should be continual and regular monitoring and evaluation of the effects of classification decisions and of any changes that are made to them.[376] We agree.

Option 4: A more nuanced classification system based on a scientifically based drug harm matrix

6.99 Under option 4, further tiers would be added to the classification system, with maximum penalties being based on the score a drug type receives on a scientifically based drug harm matrix. This multi-tiered classification system would, like the current three-tiered scheme, be included in legislation.

6.100 The main argument for this option is its focus on evidence-based classification. In this respect, it could assist in promoting a better public understanding of drug harms. A few submitters favoured this more nuanced, multi-tiered approach to classification.[377]

6.101 However, this option has real difficulties. As we have already noted, ranking drugs by their level of harm is a very imprecise science. The problems surrounding the accurate measurement of drug harms discussed earlier are

374 For example, Submission of the Clendon/Manurewa CAYAD Reference Group (submission dated 30 April 2010) at 4; Submission of the National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at 5; Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 10; Submission of the Health Action Trust (submission dated 29 April 2010) at 5; Submission of the National Council of Women (submission dated 29 April 2010) at 1; Submission of CAYAD Otautahi (submission dated 30 April 2010) at 6; Submitter 330 (submission dated 29 April 2010) at 4; Submission of the Ministry of Health (submission dated 30 April 2010) at 8; Submission of the Pharmaceutical Society of New Zealand (submission dated 30 April 2010) at 1; Submission of the National Community Action Youth and Drug Advisory Group (NCAG) (submission dated 30 April 2010); Submission of the Alcohol Drug Association New Zealand (ADANZ) (submission dated April 2010) at 10; Submission of the New Zealand Law Society (submission dated 17 May 2010) at 5; Submission of the Auckland District Law Society (submission dated 21 May 2010) at 3; Submission of the New Zealand Police (submission dated 18 June 2010) at 2.

375 Submission of the New Zealand Law Society (submission dated 17 May 2010) at 5; Submission of the Auckland District Law Society (submission dated 21 May 2010) at 3.

376 For example, Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 10; Submission of the National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at 5; Submitter 330 (submission dated 29 April 2010).

377 Submitter 115 (submission received 14 April 2010); Submission of the New Zealand Nurses Organisation (submission received 24 April 2010) at 8; Submitter 298 (submission received 29 April 2010); Submission of the Alliance Party (submission received 4 May 2010).

simply exacerbated under this option. The more tiers in the system, the harder it becomes to categorise drugs into the appropriate harm category. In addition, a multi-tier system has the potential to distort the sentencing process because it would create a large number of offences with little between them in terms of culpability.

NEW CLASSIFICATION SYSTEM

6.102 We have concluded that an ABC classification system should be retained. Three classes provide for a more accurate discrimination between the different levels of harm posed by different drugs than two classes. It also avoids the difficulty, which arises under a multi-tiered system, of attempting to make very precise nuanced decisions with incomplete and imprecise evidence and information. A three-tier division provides adequate guidance to the courts over the level of penalty for different types of offending involving particular drug types.

6.103 However, we recommend that a full scale review be undertaken to determine the appropriate classification of all drugs currently scheduled. We think this is necessary to address existing inconsistences. There should also be a requirement for the regular review of classification decisions to ensure that drug classifications continue to reflect the developing scientific knowledge and relevant changes in the drug landscape. New legislation replacing the Misuse of Drugs Act should provide for this.

Criteria for determining classification

6.104 Classification criteria should be stipulated in statute.

6.105 The Misuse of Drugs Act currently lists a number of factors that are to be taken into account when making classification decisions. Section 4B of the Act requires the EACD to advise the Minister on, and the Minister to take into account, a number of matters when making drug classification decisions. These factors currently provide the basis for the assessment of drug harm:

(a) the likelihood or evidence of drug abuse, including such matters as the prevalence of the drug, levels of consumption, drug seizure trends, and the potential appeal to vulnerable populations; and
(b) the specific effects of the drug, including pharmacological, psychoactive, and toxicological effects; and
(c) the risks, if any, to public health; and
(d) the therapeutic value of the drug, if any; and
(e) the potential for use of the drug to cause death; and
(f) the ability of the drug to create physical or psychological dependence; and
(g) the international classification and experience of the drug in other jurisdictions; and
(h) any other matters the Minister considers relevant.

6.106 There are problems with the use of these factors as criteria for assessing drug harm for the purposes of determining penalties for offending.

6.107 Most fundamentally, the classification system is currently used to decide whether or not particular substances should be prohibited and, if so, the class into which each substance falls. This in turn determines the maximum penalty that applies to a substance's misuse. The same set of factors is therefore taken into account

in deciding whether or not a drug should be prohibited and in deciding maximum penalties for drug offences. But these are different decisions which depend upon quite different considerations.

6.108 The effect of having a single list of factors for both decisions is that it contains a number of factors that have no relevance to penalties for drug offences. For example, the therapeutic value of a substance (included in the current list) is relevant to the way a substance is regulated but is not relevant when determining the appropriate penalty levels for misuse.

6.109 In our view, the criteria that determine a drug's classification for penalty purposes need to differ somewhat from the factors that determine whether it is regulated or prohibited.

Criteria for classification

6.110 We have set out in chapter 5 our proposed criteria for determining whether a substance should be regulated or prohibited.[378] If the regulatory authority applying those criteria determined that a substance could not be effectively regulated and should be prohibited, the substance would be considered for classification as a Class A, B or C drug for the purposes of determining maximum penalties for offending relating to it.

6.111 The most important consideration for determining maximum penalties for drug offences, which is the real purpose of classification, is how much harm is caused to others by any particular substance. There was strong support from submitters for classification to be based on an assessment of risk of harm. The more harmful a substance is, the more culpable it is to deal with it and the higher the maximum penalty should be. It is therefore necessary to consider how to assess the nature and severity of drug harm.

Harm to others

6.112 We have already set out the different proposals for defining drug harm that are made in the various United Kingdom reports that consider drug classification. Although there are some differences between the proposals, most agree that the factors described under the headings "physical harms", "likelihood of dependence" and "social harms" used in the Nutt and Blakemore scheme[379] should be taken into account. Although "physical harm" and the "likelihood of dependence" focus on measuring the harm experienced by drug users, drug use does not occur in isolation. It occurs within a wider social context and there are flow-on effects for others. The relative measures under these headings for different substances therefore provide something of a proxy for the relative level of harm these substances cause to others as well.

378 See paragraph 5.54.

379 See paragraph 6.26.

Prevalence as a factor

6.113 More controversial is whether the prevalence of use of a particular drug should have any bearing on penalty. Section 4B(2)(a) of the Misuse of Drugs Act currently treats prevalence as a relevant factor. It requires consideration of "the likelihood or evidence of drug abuse, levels of consumption, drug seizure trends and the potential appeal to vulnerable populations". It is sometimes argued that prevalence should be taken into account in fixing maximum penalties because of the importance of deterring harmful conduct where it is prevalent.

6.114 Submitters were mixed on the issue of prevalence. Some expressed the view that it was relevant in measuring harm, although they acknowledged that accurately estimating the prevalence of illegal drugs is also very difficult.[380]

6.115 Our view is that prevalence in itself is not generally a relevant consideration for fixing maximum penalties, because it does not bear on an individual offender's culpability. In other words, an offender should be responsible only for the harm he or she causes, not for harm that is done by others. If maximum penalties act as a deterrent, there is no logical reason for wanting to deter dealing in or the use of very harmful drugs that have a low prevalence any less than the dealing in or use of very harmful drugs that have a high prevalence.

6.116 However, prevalence may be relevant where there is a loss of public amenity value due to the concentration of drug use in a specific area which causes public insecurity or fear when using public places in that area. This has, for example, occurred in a few large cities overseas when large numbers of intravenous drug users have been concentrated in city suburbs and drug use occurs in the streets or public alleys.[381] In New Zealand, there have also been shades of this type of problem with the congregation of highly intoxicated people in the inner city at times. In such circumstances there is arguably an increase in the level of social harm that arises due to the concentration of the problem in one area. We think that this should be reflected in the classification criteria and therefore propose that social harm should cover a loss of amenity value caused by drug use.

Overseas experience

6.117 Another factor currently included as relevant to the assessment of harm, under section 4B(2)(g), is "the international classification and experience of the drug in other jurisdictions". The experience of the drug in other jurisdictions is clearly relevant. However, we are not convinced that considering overseas drug classifications is useful, since countries use different classification systems that are not always evidence-based. Instead, there should be a requirement to consider assessments of drug harms undertaken both in New Zealand and in other jurisdictions.

380 For example Submission of the Alcohol Drug Association New Zealand (ADANZ) (submission dated April 2010) at 11; Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 11; Submission of the National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at 7.

381 This issue has led to the establishment of drug consumption rooms in Sydney, Vancouver and Zurich for example.

Other factors

6.118 Section 4B(2)(h) identifies as a factor "any other matters the Minister considers relevant". In our view, a broad open-ended factor of this kind is undesirable, because it leaves uncertainty about the matters that should be considered when assessing harm. It also detracts from the principle that decisions about drug classifications should as far as possible be evidence-based.

Conclusion – proposed criteria

6.119 In conclusion, classification decisions should reflect only the relative harmfulness of each drug. We recommend the following factors be incorporated in statutory 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).

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

Assessment undertaken by an expert committee

6.121 The next issue to consider is how harm is to be assessed. The Nutt and Blakemore scheme suggests that this should be done through the scoring of harm by experts from different disciplines. The AMS report, while acknowledging this process as a step forward, suggests that its reliance on the subjective assessment of experts means it makes only indirect use of advances in neuroscience, measurements of the clinical and social impact of drugs on individuals and populations and the economic and social costs of drug misuse. Implicit in this is the suggestion that objective criteria should replace subjective assessment.

6.122 However, in our view, a purely objective assessment of drug harms is simply not possible. How different types of drug harm are to be weighed against each other depends to an extent on values. We are not convinced, for example, that equal weight should be given to the different types of drug harms (that is, physical

harms, likelihood of dependence and social harms) as the Nutt and Blakemore scheme contemplates.[382] The judgements are more nuanced than that. There are also significant gaps in the evidence.

6.123 Notwithstanding these difficulties, we recommend that expert advice on drug harms should inform decisions about drug classification for the purposes of setting penalties for drug offences. Without this input, it is doubtful whether good policy outcomes can ever be achieved because of the controversial and emotive nature of drug issues.

6.124 Section 5 of the Misuse of Drugs Act authorises the Minister of Health to establish advisory and technical committees. As we have noted, legislative amendments in 2000 required the Minister to establish the EACD to advise the Minister on drug classification matters. Section 5AA(2) provides:

> (2) The functions of the Committee are –
>
> (a) to carry out medical and scientific evaluations of controlled drugs, and any other narcotic or psychotropic substances, preparations, mixtures, or articles; and
>
> (b) to make recommendations to the Minister about –
>
> (i) whether and how controlled drugs or other substances, preparations, mixtures, or articles should be classified; and
>
> (ii) the amount, level, or quantity at and over which any substance, preparation, mixture, or article that is a controlled drug (or is proposed to be classified as a controlled drug), and that is to be specified or described in clause 1 of Schedule 5, is to be presumed to be for supply; and
>
> (iii) the level at and over which controlled drugs to which clause 2 of Schedule 5 applies are presumed to be for supply; and
>
> (c) to increase public awareness of the Committee's work, by (for instance) the timely release of papers, reports, and recommendations.

6.125 In our view, there is a need for a statutory committee of experts to advise the Government on the nature and severity of drug harms to inform decisions about how drugs should be classified for the purposes of setting penalties for drug offences. There was considerable support among submitters for the retention of an expert advisory committee, with many submitters stressing the importance of ensuring that public debate about and decisions on drug classifications are informed by the available evidence.[383]

6.126 We recommend that a statutory committee of experts 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 their appropriate classification. The committee should consider assessments of the drug harm undertaken in both New Zealand and other jurisdictions.

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382 In a more recent article Professor Nutt and others have put forward a multicriteria decision analysis modelling a range of drug harms in the United Kingdom. Under this more nuanced approach they have developed some options for weighting the criteria; see Nutt, King and Phillips, above n 329, at 1558.

383 For example Submission of the Alcohol Drug Association New Zealand (ADANZ) (submission dated April 2010) at 12; Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 12; and Submission of the National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at 8.

6.127 We also recommend that 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.

6.128 We recommend also that the Minister be required to consider the committee's recommendations and to present a report containing the committee's advice and recommendations to the House at the time legislation proposing new drug classifications or changes to existing classifications is introduced. Ultimately it will be for Parliament to determine a drug's classification. However, our recommendation would ensure that Parliament has the benefit of expert advice and that public debate on any classification decision Parliament makes is informed by the best available evidence.

Composition of the expert committee

6.129 Section 5AA of the Misuse of Drugs Act prescribes the membership of the EACD. It requires:

(a) up to five people who between them have appropriate expertise in pharmacology, toxicology, drug and alcohol treatment, psychology, and community medicine;

(b) up to three people employed by the Public Service who between them have appropriate expertise in public health, the appropriateness and safety of pharmaceuticals and their availability to the public, and border control; and

(c) one Police employee, one employee of the Ministry of Justice with expertise in the justice system, and one person representing the views of consumers of drug treatment services.

6.130 Four issues arise over the composition of the expert committee:

- whether it should be independent;
- whether it should retain consumer representation;
- whether its current composition has the necessary expertise to advise government on drug regulation and classification; and
- its size.

Independence of the committee

6.131 There are arguments both for and against government representation on the committee. Government representation will ensure that the interests of government are factored into the committee's recommendations. Arguably, this is important for two reasons. First, the recommendations may have an impact on government expenditure. For example, recommendations about any given regulatory approach will inevitably involve costs, and recommendations about penalty levels may affect the prison population. The involvement of government officials may help to ensure that the recommendations are affordable and achievable. Secondly, as we have already indicated, to an extent the assessment of harms involves value judgements. Arguably, these judgements are more appropriately made by government than by experts.

6.132 However, there are, in our view, stronger arguments against government representation. Most importantly, the committee's recommendations may be perceived as lacking independence and may therefore lack credibility.

The involvement of government officials, or indeed anyone in a representative capacity, may also be seen as detracting from the principle that drug policy should be evidence-based.

6.133 On balance, we consider that an independent committee is the better option. The chair of the committee should not be a government official and the committee should have statutory independence. In any event, it is important that the evidence on which the committee recommendations are based, in particular the evidence relating to drug harms, should be made available both to Ministers and to the public so that there is transparency about the basis on which recommendations are made.

6.134 Most submitters on the point supported this view. One suggested that because drug issues become so political it is necessary to have an independent body to present evidence to the public and to make statements which politicians would regard as political suicide, if these are required.[384]

6.135 The New Zealand Customs Service supported an expert committee that was primarily independent, but argued that this did not preclude government agencies being represented. Customs said that officials should still be present on the committee because this limits the possibility of conflicting advice between the expert committee and government agencies as happened in the United Kingdom. Customs argued that resolving conflicting viewpoints within an expert committee, to achieve a consensus approach, is a more effective and efficient approach and can speed up the decision-making process.[385]

6.136 We are not persuaded by Customs' argument. We certainly agree that government agencies must advise their Ministers on the implication of any proposals to classify substances or change existing classifications for health services, the criminal justice sector and other enforcement agencies. However, government agencies do not need to be represented on the expert committee in order to provide their advice to Ministers.[386] We think the decision-making process will be more transparent if there is an independent assessment of the harm likely to be caused by a particular substance which is made available to Ministers together with any advice from officials about the implications of those proposals.

Representation of consumers of drug treatment services

6.137 The Committee currently includes one person representing the views of consumers of drug treatment services. It can be argued that this type of consumer representation is not necessary on a committee providing expert advice on the nature and severity of drug harm.

6.138 Some submitters considered that consumer representation is still important to ensure that decisions on drug policy remain fully informed by all stakeholders. They argued that while consumers may lack the specific technical expertise of other committee members, they may be in a better position to provide insight on

384 Submitter 135 (submission dated 21 April 2010) at 2.

385 Submission of the New Zealand Customs Service (submission dated 29 April 2010) at 7.

386 This position is also taken in the Submission of the Ministry of Health (dated April 2010) at 9.

areas where evidence is currently lacking, such as impacts on communities, drug trends and availability, by having extensive networks into consumer and known drug using networks or services.[387]

6.139 While we accept the point that there is value in having a person with knowledge of the nature and context of, and reasons for, drug use we are not persuaded that the inclusion of a person in a representative capacity is appropriate on this type of committee. Committee members should contribute their own personal expertise and perspective. We therefore recommend that the current provision for a representative be replaced by a requirement for a person with experience and knowledge of the nature and context of, and reasons for, drug use.

Committee expertise

6.140 We consider that expertise in pharmacology, toxicology, drug and alcohol and drug treatment and community medicine is important and should remain. We recommend, however, that 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 be added to that list.

Committee size

6.141 The optimal size for a committee of this type would be about eight or nine people. This should be sufficient to cover the needed areas of expertise without becoming unduly large and cumbersome. We therefore recommend a committee of up to nine people.

RECOMMENDATIONS > Continued next page

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.

387 For example, Submission of the National Committee for Addiction Treatment (NCAT) (submission dated 23 April 2010) at 8.

RECOMMENDATIONS

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
Dealing

INTRODUCTION

7.1 The Misuse of Drugs Act 1975 provides offences for dealing in controlled drugs. These offences cover sale and supply, possession for sale or supply, import, export, manufacture, production and cultivation. As currently drafted, these offences are potentially problematic because of the broad range of activities that they cover. The structure of the supply offences and how they are drafted is also complex and difficult to understand. In addition, the offence of possession for supply and its presumption of supply, which reverses the onus of proof, is controversial. This chapter considers the structure of the dealing offences in detail.

7.2 As we concluded in chapter 1, our starting point is that all dealing in psychoactive substances that are prohibited in accordance with our international obligations should continue to be illegal. Psychoactive substances that are not covered by the conventions should be prohibited where the harm they cause is so significant that there is practically no safe way to regulate their use, or where the costs of a lesser form of regulation exceed its benefits.

7.3 However, this does not mean that all dealing in prohibited drugs is equally serious. The current legislation reflects this point of view; for example, supplying Class A drugs (whether or not the supply involves a sale) carries the highest maximum penalty available in New Zealand (life imprisonment) while supplying Class C drugs to an adult without selling them carries a relatively low maximum penalty (up to three months imprisonment and/or a $500 fine). These distinctions in seriousness are based on drug class and, in relation to Class C drugs, whether the drug is supplied to an adult or a young person and whether money changes hands.

7.4 The only real question then is whether these distinctions are the right ones and, if so, whether they are made in the most appropriate way. In particular, most would agree that the most culpable dealing activity and, consequently, the activity for which the most severe penalty is required, is large-scale commercial dealing. Much of the discussion in this chapter centres around whether it is possible to make a distinction between this type of dealing and dealing on a lesser scale.

DEALING IN CONTROLLED DRUGS

Current offences and maximum penalties

7.5 The core dealing offences are in section 6 of the Misuse of Drugs Act. Section 6 provides that no person shall:

(a) import into or export from New Zealand any controlled drug, other than a controlled drug specified or described in Part 6 of Schedule 3; or

(b) produce or manufacture any controlled drug; or

(c) supply or administer, or offer to supply or administer, any Class A controlled drug or Class B controlled drug to any other person, or otherwise deal in any such controlled drug; or

(d) supply or administer, or offer to supply or administer, any Class C controlled drug to a person under 18 years of age; or

(e) sell, or offer to sell, any Class C controlled drug to a person of or over 18 years of age; or

(f) have any controlled drug in his possession for any of the purposes set out in paragraphs (c), (d), or (e).

7.6 Under section 7(1)(b), it is also an offence to "supply or administer, or offer to supply or administer, any Class C controlled drug to any other person, or otherwise deal in any such controlled drug".

7.7 The maximum penalties for each of these offences differ. Dealing in a Class A drug carries a maximum penalty of life imprisonment.[388] A presumption in favour of imprisonment also applies.[389] Dealing in a Class B drug carries a maximum penalty of 14 years imprisonment.[390] If a person is convicted of an offence in relation to a Class A or B drug and a sentence of imprisonment is imposed, the court must consider whether to also impose a fine.

7.8 Dealing in a Class C drug carries a maximum penalty of 8 years imprisonment,[391] except if the offence is one of supply to a person of or over 18 years of age.[392] The latter offence carries a maximum penalty of three months imprisonment and/or a $500 fine. A presumption against imprisonment in relation to that offence also applies.[393]

Supply

Current offences

7.9 As set out above, there are a number of separate offences with different maximum penalties covering the supply (defined in the Act as either distributing, giving or selling)[394] of prohibited drugs. These offences are:

- supplying or offering to supply any Class A controlled drug or Class B controlled drug to any other person;[395]
- supplying or offering to supply any Class C controlled drug to a person under 18 years of age;[396]

388 Misuse of Drugs Act 1975, s 6(2).

389 See Misuse of Drugs Act 1975, s 6(4). The presumption applies to supply of a Class A drug, or import, export, manufacture or production of a Class A drug with the intention to supply.

390 Misuse of Drugs Act 1975, s 6(2).

391 Misuse of Drugs Act 1975, ss 6(1)(d) and (e).

392 Misuse of Drugs Act 1975, s 7(1)(b).

393 Misuse of Drugs Act 1975, s 7(2)(b).

394 Misuse of Drugs Act 1975, s 2.

395 Misuse of Drugs Act 1975, s 6(1)(c).

396 Misuse of Drugs Act 1975, s 6(1)(d).

- selling or offering to sell any Class C controlled drug to a person of or over 18 years of age;[397]
- supplying or offering to supply any Class C controlled drug to any other person.[398]

7.10 The Act takes a particularly complex approach to supply. A distinction is made between "supply" (a supply without an exchange of money or other consideration) and "sale" (a supply with an exchange of money or other consideration) according to the class of the drug involved. One offence covers both activities in relation to Class A and Class B drugs. For Class C drugs, separate offences apply (with different maximum penalties) depending on whether or not the drug was sold. However, the Act's definition of "supply" includes "sale", meaning that "sale" is a subset of the broader activity of "supply". This approach is confusing and difficult to understand.

Proposed offences

7.11 We consider that there is significant potential to simplify the approach to the supply offences, particularly in relation to Class C drugs. In particular, we do not think it is necessary (or appropriate) to have separate offences with differing maximum penalties depending on whether or not the supply of a Class C drug involved a sale or was to a young person. Instead, we think the approach taken to supply of a Class A or B drug should apply. That is, there should be one offence covering any supply of a Class C drug, with a maximum penalty that enables all factors relevant to the particular instance of an offence to be taken into account. Our reasons for recommending this approach are as follows.

Removing the distinction between supply and sale

7.12 The distinction between sale and supply of Class C drugs reflects a view that, for those drugs, the culpability of an offender is always greatest when supply is coupled with a profit or a profit motive. We agree that whether a dealer makes a profit (and the extent of that profit) aggravates culpability and should be reflected in the sentence an offender receives. This is consistent with our view that the most severe legislative and enforcement response should be reserved for commercial dealers.

7.13 However, we do not consider profit to be so important that it should be a core element of the offence, while other equally relevant factors (such as the quantity of drugs) are not. For example, the fact that a large-scale dealer makes a large profit will substantially aggravate an offence and require a sentence at the upper end of the spectrum. But so too should the fact that a commercial dealer supplies a significant quantity of drugs to a vulnerable young person for free for the purposes of developing a future market. It does not seem right for the law to provide, as a starting point, that the dealer in the latter situation is less culpable than the former.

397 Misuse of Drugs Act 1975, s 6(1)(e).

398 Misuse of Drugs Act 1975, s 7(1)(b).

7.14 Removing this distinction for Class C drugs would also be consistent with the approach taken to Class A and B drugs. For those drugs, the law views supply and sale as involving the same level of criminality. It is difficult to see why this principle does not also apply to Class C drugs. It may reflect Parliament's intention in 1975 to treat Class C drugs differently, particularly cannabis, in circumstances of social supply. We think there are more appropriate ways to make this distinction. And, as we discuss later, even when it comes to social supply, we are not convinced that there should be a distinction in this regard between Classes A, B and C.

7.15 Finally, our proposed approach takes care of any difficulties posed by the reverse onus of proof which applies when a person is charged with selling a Class C drug to a person of or over the age of 18 years. Currently, if the prosecution proves that the defendant supplied the drugs, the defendant is also presumed to have sold the drugs unless he or she can prove otherwise.[399] Reverse onuses of proof like these are problematic, as we discuss below in relation to the offence of possession for supply.

7.16 Submitters largely supported removing the distinction between supply and sale. For example, the New Zealand Customs Service noted that it can be time-consuming and difficult to prove that an offender acted with a profit motive.[400] An individual submitter noted that:[401]

> Distinguishing sale from supply according to the class of drug in question is not logical. More importantly, when it comes to assessing how blameworthy an individual is (known in legal jargon as their 'culpability'), other factors such as the quantity of drugs being supplied are more relevant than whether or not the drugs were sold for profit.

No distinction in the offences according to scale

7.17 Submitters broadly supported our view expressed in the Issues Paper that the scale of the dealing is a much better reflection of culpability than whether it can be proved that money changed hands.[402] A focus on scale enables factors other than a profit motive to be taken into account more easily, particularly the amount of drugs involved in the transaction and the overall size of the offender's dealing operation.

7.18 The only possible approach to reflecting the scale of the offending in the offences themselves is to establish offences according to the quantity of the drug involved. This is the approach taken by many Australian jurisdictions.[403]

7.19 However, quantity often presents an incomplete picture of the seriousness of the offending. Other relevant factors include the value of drugs involved, any evidence of supply (such as tick lists, payment records, cash reserves and asset accumulation) and the offender's role (unexplained income, the identity of the

399 Misuse of Drugs Act 1975, s 6(5).

400 Submission of the New Zealand Customs Service (submission received 29 April 2010) at 8.

401 Submitter 282 (submission dated 29 April 2010).

402 Law Commission *Controlling and Regulating Drugs* (NZLC IP16, 2010) at [10.8]–[10.9] [*Controlling and Regulating Drugs*].

403 See, for example, the Australian Federal Criminal Code 1995 (Cth), Division 300; Criminal Code (ACT), ch 6; Drug Misuse and Trafficking 1985 (NSW), s 23.

customers and how the sale was initiated). A similar point has been made by New Zealand's Court of Appeal which, when providing sentencing guidance for methamphetamine manufacture, noted that the ability to assess the full extent of a methamphetamine manufacturing operation depends "on chance, the evidence of manufacture on hand at the time of police intervention, volumes of precursor materials located and the availability of extrinsic evidence (for example, in the form of electronic intercepts)".[404]

7.20 Moreover, an offence structure that focuses solely on scale risks the possibility that offenders may tailor their offending to fit within a lesser offence. For example, a dealer might keep only a small amount of drugs at his or her premises, and an importer might bring small but frequent quantities into the country.

7.21 We therefore favour an approach that enables the scale of the dealing to be reflected in the sentence an offender receives, rather than being an element of the offence. This reflects the current approach taken to scale in New Zealand. Submitters agreed with this approach.

Removing the distinction between supply to adults and supply to young people

7.22 As noted above, the Act makes a distinction between the supply of Class C drugs to adults and the supply of Class C drugs to young people. It is currently necessary to single out supply of Class C drugs to young people, given that the supply of Class C drugs to adults without profit is treated as a much less serious offence than other supply offences. Our recommendation to remove the distinction in the offences between sale and supply raises a question about whether the distinction between supply to adults and supply to young people should be retained.

7.23 Most submitters agreed with our view expressed in the Issues Paper that whether or not supply was to an adult or a young person should not be reflected in a separate offence but should instead be treated as an aggravating factor in sentencing.[405] For example, CAYAD Otautahi, a community-based organisation that works with young people to reduce alcohol- and drug-related harm, submitted that:[406]

> Our particular interest is in protecting youth from drug harms. The evidence that many drugs, including those in Class C have greater and more long lasting harms for young consumers adds strength to our desire to see supply to those under 18yrs of age considered at sentencing as an aggravating factor. We advocate for judicial discretion as opposed to the creation of a specific offence.

7.24 One submitter that disagreed with our proposal was the New Zealand Law Society. It argued that supply to a person under 18 years requires a more serious response given the evidence about the social harm that such supply causes. It also argued that the same approach should be taken to supply to people with an intellectual or psychological disability who are over 18.[407]

404 *R v Fatu* [2006] 2 NZLR 72 at [37].

405 Law Commission *Controlling and Regulating Drugs*, above n 402, at [10.48]–[10.52].

406 Submission of the CAYAD Otautahi (submission dated 30 April 2010) at 8.

407 Submission of the New Zealand Law Society (submission dated 17 May 2010) at 9.

7.25 The only reason to maintain a separate offence would be to provide for a separate, higher maximum penalty for supply to young people to recognise the community's view that supply to young people should be punished more severely than supply to adults. In this respect, a higher maximum penalty could be justified on the basis of evidence (as discussed in chapter 2) which indicates that drug use is more harmful to young people than to adults, and in light of young people's particular vulnerability.

7.26 However, we do not consider that a separate offence is justified or appropriate. As the Law Commission has argued in other contexts, victim-specific offences:[408]

- may lead to inconsistent charging practice (because the victim-specific offence will inevitably overlap with the generally applicable offence, which is likely to lead to varying police practice about which offence is charged when);
- create an arbitrary disparity because these offences single out some aggravating factors as more important than others;
- risk ad hoc specific offences being randomly inserted in the statute book every time an issue about a particular group of victims arises that causes political or public concern.

7.27 Nor do we believe such an offence is necessary. There is no similar offence covering the supply of Class A and B drugs to young people. We are not aware of any concern that the lack of an offence is hampering efforts to protect young people from suppliers of Class A and B drugs. Nor are we aware of any concern that the lack of a higher maximum penalty in these situations is resulting in the courts treating those who supply Class A and B drugs to young people too leniently.

7.28 In this respect, we see no reason why supply of Class C drugs to young people should be treated differently from supply of Class A and B drugs. Given the harm posed by Class A and B drugs, it is even more important to restrict the access of young people to them. However, if a separate aggravated offence for such activity were to be created, there would be a practical difficulty in setting the maximum penalty for it. This is because supply of Class A drugs is punishable by a maximum penalty of life imprisonment, and supply of Class B drugs is punishable by a maximum penalty of 14 years imprisonment.

7.29 We consider that the most appropriate approach is to have a broad supply offence with a maximum penalty that is set at a sufficiently high level to cater for cases where the supply is to a child or young person. This fact can then be treated as an aggravating factor at sentencing.[409]

7.30 This is not to say that specific protection of young people in this area may not be required. In particular, the New Zealand Customs Service has proposed that there should be new offences targeting dealers who co-opt young people into supply (for example, by acting as receivers for imported drugs). A similar approach is taken in the Australian Federal Criminal Code.[410] We discuss the

408 Law Commission *Review of Part 8 of the Crimes Act 1961: Crimes Against the Person* (NZLC R111, 2009) at [3.3]–[3.5] [*Review of Part 8*].

409 See Sentencing Act 2002, s 9(1)(g), which requires the sentencing judge to take into account that the victim was particularly vulnerable due to his or her age.

410 Criminal Code (Cth), s 309.

need for offences like these later in the chapter. We also consider that supply to young people should be excluded from our later recommendation for a presumption against imprisonment in cases of social dealing.

Import, export, produce, manufacture

Current offences

7.31 Under section 6 of the Misuse of Drugs Act, it is an offence to:

- import into or export from New Zealand any controlled drug, other than a drug included in Class C6;[411] or
- produce or manufacture any controlled drug.

Proposed offences

7.32 We propose no substantive change to these offences. In particular, as with supply, we do not think the offences themselves should be distinguished according to the scale of the dealing in question or whether the dealing was to a young person or an adult. Both matters should be dealt with at sentencing.

7.33 There is a question about whether import, export, production and manufacture should be dealt with more severely than other dealing activities, either because they make drugs available to the community that would otherwise not be, or due to the particular harms involved in the manufacturing process. However, even if such a distinction is appropriate, we do not think that separate offences are required. It is instead an issue that is relevant to the offences' maximum penalties and the approach to sentencing.

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

7.34 As noted above, the maximum penalties for the dealing offences currently depend on the class of drug in question. We think this is appropriate and recommend that the approach be continued. Under our proposed approach to drug classification, the placement of a drug in a particular class would reflect the harm that drug causes. It is appropriate that the maximum penalties attached to providing a drug to others are relative to that harm.

7.35 We queried in the Issues Paper whether there should be higher maximum penalties for some dealing activities than for others.[412] For example, the manufacture of methamphetamine, cannabis oil or home bake all require the use of dangerous and toxic chemicals and therefore create additional risk for the community. This may indicate that a higher maximum penalty for manufacture or production is justified.

7.36 There was some limited support for this approach in submissions. For example, the New Zealand Law Society argued that:[413]

411 See Misuse of Drugs Act 1975, sch 3. These drugs can lawfully be sold over-the-counter without prescription.

412 Law Commission *Controlling and Regulating Drugs*, above n 402, at [10.102]–[10.105].

413 Submission of the New Zealand Law Society (submission dated 17 May 2010) at 10.

> … importing and manufacturing is always viewed as more serious because it brings the drug into existence for subsequent distribution to the community. This "creation" of the drug should be treated more seriously than the subsequent distribution of the drug.

7.37 In contrast, the New Zealand Police Association's submission suggested that each dealing activity spanned the full range of culpability:[414]

> As a general comment, we would tend to see importation of marketable quantities as generally relatively more culpable than other dealing, since such offending almost always requires considerable and determined planning and organisation. It is invariably motivated by an intent to supply or develop a local market for a pure profit motive. Local manufacture of prohibited drugs often requires similarly calculated and organised criminal activity, but might also in some cases be somewhat more opportunistic and spontaneous with more mixed motivations. Supply offending may cover the full range of degrees of culpability. As a further comment, we would note that manufacture of methamphetamine is not the only extremely hazardous manufacturing process. We are informed anecdotally by our overseas counterparts that a large proportion of deaths and injuries associated with drug manufacture overseas are a result of fires and explosions during the manufacture of cannabis oil.

7.38 On balance, we are inclined to accept the Police Association's view. With regard to manufacture, in particular, we do not regard this harm as such a significantly aggravating factor that an enhanced maximum penalty is required. While harm may arise through the manufacturing process, this is no more significant for sentencing purposes than many other aggravating factors (for example, supply to children). The main drug with which additional harm from the manufacturing process is commonly associated (methamphetamine) already carries a maximum penalty of life imprisonment and no enhancement to its maximum penalty would be possible.

7.39 On this basis, we do not consider any change is required to the maximum penalties for dealing in a Class A drug (life imprisonment) or dealing in a Class B drug (14 years imprisonment). However, our support for these maximum penalties is based on our proposals to put in place a more robust classification system. If drugs are properly classified, these penalties are appropriate for drugs that fall into those classes. They are also in line with maximum penalties in comparable jurisdictions where, for example, penalties for the most serious dealing offences range from 20 years to life imprisonment.[415]

7.40 However, we do consider that a change is required in the maximum penalty for dealing in a Class C drug. This is primarily as a result of our recommendation that there be a single supply offence that covers both sale and supply of Class C drugs and supply to adults or young people.

414 Submission of the New Zealand Police Association (submission dated 12 May 2010) at 16.

415 See Law Commission *Controlling and Regulating Drugs*, above n 402, at [10.37].

7.41 Submitters who commented on the maximum penalty for supply of Class C drugs had mixed views. Some submitters, particularly those who supported the legalisation of drugs, argued for a lower penalty. For example:[416]

> … it probably has little impact on the decision to deal, and is downright immoral in light of the fact that such a dealer is supplying a safer drug (in the case of cannabis) than alcohol. The maximum should be 6 months, as an extended sentence will only further reduce their chances of ever being able to get a legitimate job, and they will be more likely to re-enter the dealing market, only now with an increased network of contacts thanks to their prison time…

7.42 Others considered a tougher approach was required:[417]

> Throw away the key … We are constantly hearing sentencing decisions that leaves one astounded by the lack of logic. Regardless of family commitments and situations, the law should be enforced to the letter of the law.

7.43 Maximum penalties should be set to reflect the worst instance of an offence (for this offence, presumably large-scale commercial supply to children and young people). In the context of the Law Commission's current review of maximum penalties, it has developed a systematic methodology (as yet unpublished) for determining the relative seriousness of different offences. Based on that methodology, the offence of dealing in Class C drugs under section 6 is regarded as having an equivalent seriousness ranking to 22 other offences, of which 13 have current maxima of either five years or seven years imprisonment. Class C drug dealing is the only offence in the statute book with a maximum penalty of eight years imprisonment, thus making it out of step with the framework of maximum penalties. We therefore recommend that the maximum penalty for the new combined offence be a term of imprisonment not exceeding seven years.

7.44 A reduction in the maximum penalty by one year will not necessarily result in a significant change to actual sentence levels. For example, in 2004 to 2006 (the years for which statistics are available to us), 90 per cent of sentences for this offence were at or below two and a half years imprisonment and the highest sentence was six years two months.

7.45 The proposed maximum penalty represents a significant increase from the current maximum penalty for the offence of supplying or offering to supply a Class C drug to a person of or over 18 years of age. As noted above, that offence is treated as involving the same level of culpability as a possession offence and carries a relatively low maximum penalty (three months imprisonment and/or a $500 fine). Under our proposed approach, that same activity will now be subject to a seven year maximum. Again, however, we do not consider that this change will have a significant impact on sentence levels. Most supply of a Class C drug to an adult will continue to be seen as involving low culpability and will therefore be sentenced near the bottom of the range. As discussed later, a statutory presumption against imprisonment in cases of social dealing will also apply.

416 Submitter 298 (submission received 29 April 2010) at 11.

417 Submitter 302 (submission dated 30 April 2010).

Presumption in favour of imprisonment: dealing in Class A drugs

7.46 As noted above, there is currently a presumption in favour of imprisonment in relation to supply of Class A drugs.[418]

7.47 Presumptions for and against imprisonment are a form of statutory guidance about the type of sentence that should be imposed. They enable Parliament to set a sentencing policy for a particular offence or offence type. This policy may be intended to supplement or override sentencing policy that has been developed by sentencing and appellate judges in individual sentencing decisions.

7.48 In this respect, the effect of the statutory presumption for Class A supply seems clear. For the three years from 2004 to 2006, 97 per cent of cases where supply of a Class A drug was the lead offence resulted in imprisonment being imposed.

7.49 However, the seriousness with which Class A supply is viewed (particularly when methamphetamine is involved) may have led to this result without the need for a statutory presumption. Some evidence for this view can be found in imprisonment rates for other offences where statutory presumptions do not exist – over the same period, for example, 100 per cent of cases where attempted murder was the lead offence, and 89 per cent of cases where aggravated burglary was the lead offence, resulted in imprisonment.

7.50 Statutory presumptions are rare. Apart from those in the Misuse of Drugs Act, the only statutory presumptions that exist are for murder and sexual violation.[419] The immediate question therefore is whether, across all offences in the statute book, drugs offences are so exceptional that a statutory presumption for or against imprisonment is justified. We do not think that they are. However, removal of the presumptions might signal a change in approach to sentencing drugs that is not intended. In addition, other than the blunt instrument of the maximum penalty, statutory presumptions are the only mechanism available to Parliament to provide sentencing guidance. In the absence of any other more effective mechanism, we support their retention in the drugs context for that reason.

7.51 We therefore recommend that the current statutory presumption of imprisonment for dealing in Class A drugs should be retained, subject to our recommendation below in relation to social dealing. Assuming that drugs are appropriately classified, commercial dealing in a Class A drug is the most serious of all the dealing behaviours. Imprisonment in all but the most exceptional cases is therefore appropriate.

418 Where an offence relating to Class A drugs is committed under paragraph (c) (supply) or (f) (possession for supply), or against (a) (importation and exportation) or (b) (production or manufacturing) in circumstances suggesting intention to supply the drugs under paragraph (c), there is a presumption in favour of imprisonment: Misuse of Drugs Act 1975, s 6(4).

419 Sentencing Act 2002, s 102; Crimes Act 1961, s 128B.

Current offence

7.52 Under section 6(1)(f) of the Misuse of Drugs Act, it is an offence to possess a controlled drug for the purposes of sale or supply.

Presumption of supply

7.53 As discussed in the Issues Paper, the key legal issue arising in relation to this offence is how to prove that the defendant possessed drugs for the purpose of sale or supply, rather than for his or her own use.[420] This is currently addressed by the presumption contained in section 6(6) which provides:

> For the purposes of subsection (1)(f), a person is presumed until the contrary is proved to be in possession of a controlled drug for any of the purposes in subsection (1)(c), (d), or (e) if he or she is in possession of the controlled drug in an amount, level, or quantity at or over which the controlled drug is presumed to be for supply (see section 2(1A)).

7.54 This presumption reverses the onus of proof so that, to avoid a conviction, a defendant who possesses a specified quantity of the drug in question must prove on the balance of probabilities that he or she did not possess the drug for the purposes of supply. Quantities for each drug are set based on advice from the Expert Advisory Committee on Drugs about the nature of the drug and how it is used, the presumption level for that drug in other jurisdictions and any other relevant factors.[421]

7.55 The Misuse of Drugs Act was influenced by the United Nations Single Convention on Narcotic Drugs 1961. In the Commentary to this Convention, the United Nations General Assembly endorsed the use of presumptions of supply:[422]

> If Governments choose not to punish possession for personal consumption or to impose only minor penalties on it, their legislation could very usefully provide for a legal presumption that any quantity exceeding a specified small amount is intended for distribution. It could also be stipulated that this presumption becomes irrebuttable if the amount in the possession of the offender is in excess of certain limits.

7.56 However, in *R v Hansen*, a majority of the Supreme Court held that the presumption in section 6(6) 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.[423]

7.57 Section 25(c) affirms the right of those charged with an offence to be presumed innocent until proven guilty according to law. This long-standing principle of criminal law requires the State to prove a defendant's guilt beyond reasonable doubt. In general, any provision which requires a defendant to disprove on the

420 Law Commission *Controlling and Regulating Drugs*, above n 402, at [10.55]–[10.63].

421 Misuse of Drugs Act 1975, s 4B(4).

422 United Nations *Commentary on the Single Convention on Narcotic Drugs 1961* (United Nations) art 4, at [21].

423 *R v Hansen* [2007] 3 NZLR 1 per Tipping, Anderson and McGrath JJ. Elias CJ did not think that s 5 should be considered and Blanchard J considered that the limitation was justified under s 5.

balance of probabilities the existence of a presumed fact, particularly where that fact is an important element of the offence, is inconsistent with the right to be presumed innocent.

7.58 Given the Supreme Court's conclusion in relation to the presumption in section 6(6), the Issues Paper discussed in detail a number of options for addressing the problems of proof that the presumption seeks to remedy, while respecting the fundamental protection conferred by section 25(c). We suggested that there were four potential options:[424]

(a) retain the presumption, but in a form that can be justified under section 5 of the Bill of Rights Act;
(b) remove the presumption;
(c) establish an evidential onus;
(d) repeal the offence of possession for supply in favour of one or more possession offences (our preferred option).

Should the presumption be retained?

7.59 It would be possible to retain the presumption but make some changes to it so that it is more likely to be justified under section 5 of the Bill of Rights Act. In particular, the current presumption levels could be reviewed to make sure that they are not out of date and more accurately reflect the quantities that are unlikely to be possessed for personal use, and the legislation could prescribe a robust process for regular review of those levels. This option was supported by the New Zealand Law Society, the Auckland District Law Society, and the New Zealand Police Association.

7.60 The New Zealand Law Society considered that removal of the presumption was unnecessary. It argued that:[425]

> … the presumption has operated for many years within New Zealand's jurisdiction and does not appear to have led to a large number of "wrongful convictions". In fact, claims of personal use above the presumptive amounts are often run as a defence and often succeed.

7.61 The Auckland District Law Society considered that the current regime was flexible and realistic.[426] The New Zealand Police Association argued that Parliament was under no obligation to change the law as a result of the Supreme Court's decision and that the current approach should be retained:[427]

> In a case where the presumption is triggered, the fact that the accused was in possession of a substantial quantity of illegal drugs [are] not in question. The presumptive levels are, in our opinion, set at levels whereby it is not credible to presume the drugs were for personal use, and represent quantities sufficient to cause significant social harm, beyond harm to the accused, if distributed. It is our view that these facts justify the reversed onus…At a practical level, the current presumption has clear secondary benefits to investigators, in that an accused may be motivated by

424 Law Commission *Controlling and Regulating Drugs*, above n 402, at [10.64]–[10.95].

425 Submission of the New Zealand Law Society (submission dated 17 May 2010) at 9.

426 Submission of the Auckland District Law Society Inc (submission dated 21 May 2010) at 5.

427 Submission of the New Zealand Police Association (submission dated 12 May 2010) at 17.

exposure to the higher penalties to make a statement or give information that they would otherwise not be inclined to give. This can be extremely helpful in investigating the other individuals and groups involved in supply chains of illicit drugs.

7.62 Other submitters saw it differently:

> One of the worst aspects of the current law is the presumption of supply for possession over a specified amount. In the case of cannabis it is 28 grams. For some this would be a year's supply, while for others it would be a week's supply. This is a flagrant injustice which violates the principle of innocent until proven guilty, and penalises those who have the forethought to stock up in advance to provide for their personal requirements.[428]

> New Zealand's Bill of Rights Act affirms the fundamental 'innocent until proven guilty', therefore all presumption[s] in relation to drug offences are in breach of the Bill of Rights Act. In all cases, if a person is charged with a crime (be it drug related or not) the onus should be on the prosecution to provide evidence of the truth of the charge. This issue is one of the main concerns I have with the current Misuse of Drugs Act, as it implies that people who use or supply drugs somehow have less rights than others, and this is very dangerous territory to be treading in the justice system of a democracy.[429]

7.63 Two main arguments can be made for retaining a presumption. First, the presumption requires the defendant to give evidence about his or her own usage, something that he or she is uniquely placed to prove. We consider that this argument, in particular, has dubious validity. The defendant may sometimes be the only person able to provide evidence on the point, but this will not invariably be so. There will often be surrounding circumstances from which the intent to supply can be readily inferred, so that it can be easily proved by the prosecution. These will include the quantity of the drug having regard to the type of drug involved, the packaging of the drugs (if any), unexplained funds and assets held by the defendant, assorted paraphernalia that might indicate commercial activities involving drugs, comings and goings from the defendant's premises and telephone records.

7.64 In this respect, possession for supply is no different from an offence such as burglary, which requires proof of entry with intent to commit a crime. That intent will sometimes be peculiarly within the knowledge of the defendant, but much more often will be obvious from his or her other conduct. The argument that a reverse burden is justified because the defendant is uniquely placed to prove an element of the offence only has force where inferences can rarely be drawn from surrounding circumstances. (In this respect, the New Zealand Police submission notes that current practice is to prosecute for this offence if factors such as profit-making are evident.[430] This factor is not peculiarly within the defendant's knowledge.)

428 Submitter 104 (submission received 9 April 2010).

429 Submitter 305 (submission dated 30 April 2010).

430 Submission of the New Zealand Police (submission dated 18 June 2010) at 3.

7.65 Secondly, if there was no presumption, it would sometimes be difficult for the prosecution to prove that the defendant in fact possessed the drug for the purposes of supply. There might be nothing more than the possession of a suspiciously large quantity of the drug from which to determine the defendant's purpose. In those cases, the prosecution would potentially have to call expert evidence about the ordinary patterns of use of the particular drug in order to demonstrate to the judge or jury that the defendant possessed more of the drug than would usually be possessed by a high user of the drug. This would be time-consuming and expensive. In other words, it is the practicalities of proof that justify the reversal of the onus of proof.

7.66 Although we acknowledge that these difficulties of proof sometimes exist, we do not think that they are sufficient to justify the retention of the presumption. This is particularly so in light of the difficulties that the presumption is causing under the Bill of Rights Act. Even a reformed approach to setting presumption levels when new substances are classified is unlikely to address any of the concerns that the Supreme Court expressed.[431] In short, we think that there are better ways to achieve the same objective.

Other options

7.67 Three other options were discussed in the Issues Paper. First, the offence of possession for supply could be retained but without the presumption. The prosecution would be required to prove a defendant intended to supply the drugs in his or her possession. We think that this option would increase the cost and time of prosecutions, and may lead to inconsistent charging practice (because individual police officers would have to determine whether a quantity was sufficient to charge as possession for supply or not). We do not recommend it.

7.68 Secondly, the legal onus could be replaced with an evidential onus. This would mean that, in the absence of any evidence to the contrary, it would be presumed that the drugs were intended to be supplied. However, if the defendant raised sufficient evidence that he or she possessed the drugs for personal use, the prosecution would have to disprove that contention (and the offence) beyond a reasonable doubt. This option was supported by the Police, although no reason for its view was given.[432]

7.69 In our view, this option does not address the difficulties of proof in a possession for supply case. In particular, unless the quantities of drug involved are very substantial, the defendant will almost always claim that he or she possessed the drugs for his or her own use, meaning that the prosecution will be required to prove the purpose of possession in almost every case. Therefore, in a practical sense, there is very little difference between an evidential presumption and no presumption.

431 See *Report of the Attorney–General under the New Zealand Bill of Rights Act 1990 on the Misuse of Drugs Amendment Bill* (23 April 2010).

432 Submission of the New Zealand Police (submission dated 18 June 2010) at 3.

Our preferred option: an aggravated possession offence

7.70 The third option, which was our preferred approach in the Issues Paper and was supported by most submitters who commented on this issue, is to repeal the offence of possession for supply and replace it with an "aggravated" possession offence. 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.

7.71 This option is clearly compliant with the Bill of Rights Act. It also avoids the necessity of having to call expert witnesses to prove that the amount was above levels ordinarily possessed for personal use. Instead, this issue would shift to the sentencing stage. 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, which would need to be proved by the defendant on the balance of probabilities under section 24(2)(d) of the Sentencing Act 2002. In other words, the question of supply would shift from the trial stage to the sentencing stage, but with the onus and standard of proof remaining the same as that applying under the current presumption.

7.72 There is a risk with this option that those dealing in drugs will simply modify their behaviour by moving and possessing drugs in smaller quantities in order to avoid conviction for the more serious offence. However, this is equally true of the current situation where transactions can be structured to avoid attracting the presumption of supply.

7.73 If this approach was taken it would be necessary to determine the quantity of drugs which comprised "aggravated" possession. These quantities would need to be set at a level that is likely to be inconsistent with personal use. We recommend that the expert advisory committee recommended in chapter 6 be required to advise government on the quantity of drugs that would comprise "aggravated" possession (and, by default, "simple" possession).

Maximum penalties

7.74 Maximum penalties for the new aggravated possession offence will be required. We propose that, as with all dealing offences, a class-by-class approach to the maximum penalties is taken.

7.75 Currently, the maximum penalties for the possession for supply offence are the same as for the supply offence itself. The fact that supply has not actually taken place may then become relevant at sentencing.[433] We do not support this approach for the aggravated possession offence. The offence cannot be equated to a completed supply offence. It is, at best, an attempted supply.

433 See discussion in *R v Conway* CA275/04, 23 March 2005 at [16]:

> It would be unrealistic to have separate sentencing bands or sentencing ranges for possession for supply cases. The fact a supply might not in fact have occurred at the time of apprehension would simply be a factor to be taken into account when fixing the appropriate starting point. In some cases, the fact that supply had not actually occurred may be a factor in favour of lowering the starting point. Sometimes, however, depending on circumstances, it may have no effect on starting point.

7.76 Under the general criminal law, the maximum penalty for an attempt is 10 years if the completed offence is punishable by life imprisonment, and in other cases is half the maximum penalty for the completed offence.[434] Application of this rule indicates the following maximum penalties for the aggravated possession offence:

(a) aggravated possession of a Class A drug = 10 years imprisonment;
(b) aggravated possession of a Class B drug = 7 years imprisonment;
(c) aggravated possession of a Class C drug = 3 years imprisonment.

7.77 We think these penalties appropriate in light of the conduct to which they will apply. As discussed above, maximum penalties should be set with reference to the worst instance of an offence. For these offences, this will be possession of a large amount of drugs where the actual supply of a drug has not (yet) taken place. The proposed penalties are also in line with other penalties in the Act. For example, they are less than those provided for conspiracy to deal in a controlled drug[435] and the same as those that apply to the use of premises or a vehicle to commit an offence against the Act.[436]

CULTIVATION

Current offence and maximum penalty

7.78 Section 9 of the Act prohibits the cultivation of any prohibited plant, except pursuant to a licence made under the Act or otherwise permitted by the Act's regulations.[437] Anyone who contravenes section 9 (regardless of the class of drug involved) is liable to a maximum penalty of seven years imprisonment.[438]

Proposed offence

7.79 We propose no substantive changes to this offence.

Maximum penalty

7.80 The maximum penalty for this offence in other jurisdictions is consistently much higher than in New Zealand. For example, in a number of jurisdictions, if very large quantities of plant are cultivated commercially, the penalty is a term of imprisonment of life,[439] 25 years[440] or 20 years.[441] Some jurisdictions include cultivation within the manufacturing or producing offence, which brings with it a high maximum penalty. For example, in Queensland, the penalty is 20 years

434 Crimes Act 1961, s 311(1).

435 Misuse of Drugs Act 1975, s 6(2A). The maximum penalty for conspiracy to deal in a Class A drug is 14 years imprisonment, in a Class B drug 10 years imprisonment and in a Class C drug 7 years imprisonment.

436 Misuse of Drugs Act 1975, s 11(2).

437 An example is the Misuse of Drugs (Industrial Hemp) Regulations 2006.

438 Misuse of Drugs Act 1975, s 9(2).

439 See Criminal Code (Cth), Division 300 and the Criminal Code (ACT), s 616 (with intention to sell); Controlled Substances Act 1984 (SA), s 33B (with intent to sell or belief that another person intends to sell); Drugs, Poisons and Controlled Substances Act 1981 (Vic), s 72.

440 Misuse of Drugs Act (NT), s 7(2).

441 Drugs Misuse and Trafficking Act 1985 (NSW), s 33(3).

for producing cannabis in excess of a specified amount.[442] Tasmania has a maximum penalty of 21 years imprisonment for cultivation, which applies regardless of the drug or the amount.[443]

7.81 The reason for the low penalty in New Zealand probably reflects the fact that the majority of cultivation in New Zealand is likely to be cannabis. However, this does not explain the inconsistency with Australia where this is also likely to be the case. Canada and the United Kingdom, which both have high maximum penalties in respect of cultivation, specify different penalties for cannabis outside the normal classification system. These are seven years in Canada[444] and 14 years on indictment and 12 months on summary conviction in the United Kingdom.[445]

7.82 There was no strong call in submissions for a higher maximum penalty for this offence. In addition, as determined by the methodology used for the Law Commission's review of maximum penalties, the cultivation offence is regarded as having an equivalent serious ranking to 25 other offences, of which all but one have current maxima of seven years or less.

7.83 Retaining a seven year maximum penalty will mean that the maximum penalty for this offence is the same as for supply of a Class C drug. We think this is appropriate, given the likelihood that cannabis will remain the predominant plant cultivated in New Zealand. In this respect, it is also consistent with the approach taken to production/manufacture and supply of a Class A or B drug (when that drug is not a prohibited plant). For those drugs, the maximum penalties for production/manufacture and supply are the same.

SOCIAL DEALING

7.84 We proposed in the Issues Paper that a distinction should be made between dealing (whether supply, import, export, production, manufacture or cultivation) on a commercial scale and dealing on a "social" scale.[446] By "social dealing", we were referring to dealing of a small quantity, to friends or acquaintances and without what in ordinary usage would be regarded as a profit (or only a very small one).

7.85 The current offence of supply of a Class C drug to an adult is effectively a social supply offence. It treats supply of Class C drugs without profit as involving the same criminality as a possession or use offence. A review of the Parliamentary debates at the time the Misuse of Drugs Act was passed suggests that the offence was primarily aimed at the giving or sharing of marijuana cigarettes between adults.[447]

442 Drugs Misuse Act 1986 (Qld), s 8(d). The specified amount is 500gm or, if the aggregate weight of plants is less than 500gm, 100 plants. See also Controlled Drugs and Substances Act SC 1996 c 19 (Canada), s 7 where the penalty is life for sch I or II drugs, although cannabis is excluded from this, the maximum penalty for cannabis being 7 years and see Misuse of Drugs Act 1971 (UK) where the penalty for production of Class A drugs is life.

443 Misuse of Drugs Act 2001 (Tas), s 7 but an intention to sell or a belief that another person intends to sell is required. See also Misuse of Drugs Act 1981 (WA) where the penalty for cultivation with an intention to sell is 25 years.

444 Controlled Drugs and Substances Act SC 1996 c 19 (Canada), s 7.

445 Misuse of Drugs Act 1971 (UK), s 6(2) and sch 4.

446 Law Commission *Controlling and Regulating Drugs*, above n 402, at [10.21]–[10.32] and [10.107]–[10.109].

447 In these debates, one MP, Dr Wall, referred to this type of behaviour as "a social 'shout'" (18 July 1975) 399 NZPD 3148.

7.86 However, the offence is currently limited in scope. It only applies to supply of Class C drugs and focuses solely on whether money has changed hands. We do not immediately see why the offence should be limited to Class C drugs or why it should only apply to supply rather than any other dealing activity. The offence also fails to have regard to equally important factors such as the amount of drugs involved. We think a new, broader approach is required.

7.87 Some submitters disagreed with this view. They argued that any dealing caused harm and required a severe response regardless of whether or not it took place in a social or commercial context. For example:

> Social dealing should not be treated differently to other forms of dealing. Dealing is dealing, full stop.[448]

> Whether the accused are supplying drugs for enormous profit or whether they are simply supplying their friends with drugs, we feel that the accused are putting others in danger. Just because the accused may have only supplied their friends with drugs, does not take away from the fact that they are still supplying illegal and harmful substances to others. All drugs have effects on the human body, with each individual drug impacting the body in a different way…For example if someone supplies drugs socially to their friends for no profit and that friend becomes addicted to that drug, surely then the person who supplied the drugs should be held responsible as much as a person who sells for profit and in doing so creates an environment for potential drug addiction.[449]

> It would also be difficult to justify on a harm minimisation basis a more lenient approach to, for example, the social sharing of intravenously administered heroin between 10 users, than to the commercial supply of a bullet of cannabis to one user. In our view it is preferable to allow for the evaluation of all the facts, and application of appropriate discretion, if warranted, at the various junctures throughout the criminal justice process, from charging to sentencing.[450]

7.88 However, most submitters supported a distinction being made between commercial and social dealing, either because they considered there to be a clear difference in the harm caused by the two forms of dealing or because they saw the circumstances in which social dealing occurred as being quite different from a commercial dealing situation. For example:

> We believe that social supply of drugs should be dealt with more like the personal possession of drugs and deserves less harsh penalties. This reflects our view that the state should be focusing its efforts to curb the supply of illicit drugs by targeting large scale commercial dealers.[451]

> Social supply should not be treated as similar to supply for profit, as under the current system people who participate in social supply are often reducing harm by helping their friends to avoid interaction with organised criminals.[452]

448 Submission of Fight against P/Sensible Sentencing (submission dated 16 March 2010) at 11.

449 Submitter 193 (submission dated 15 April 2010).

450 Submission of the New Zealand Police Association (submission dated 12 May 2010) at 15.

451 Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 14.

452 Submitter 305 (submission dated 30 April 2010).

> Yes. Social dealing should be treated differently due to many reasons. The nature of social dealing differs greatly from other forms. For example dealing amongst friends often results in a limited number of people exposed to the drugs as opposed to a large amount being distributed to more people.[453]
>
> In most cases this scenario involves either a person giving away single dosage unit amounts of surplus drugs, or a group of people banding together to purchase a quantity of drugs which none of them would be able to afford individually, with the only distinguishing feature of the "dealer" being that they are the member of the group who happens to collect the drugs from the actual dealer, and the only time period during which they are deemed to be dealing being limited to the time it takes to get home and divide the drugs up. Where all parties are adults, such scenarios should be clearly distinguished from selling for profit and should not be subject to penalties beyond those for simple possession, but on the other hand any kind of distribution of drugs to minors under 18 years old should be subject to punishment regardless of whether a profit motive is involved.[454]

7.89 We remain of the view that social dealing is less culpable than commercial dealing, and that this distinction should be reflected in the law if possible. The absence of any significant commerciality makes the criminality of social dealing more analogous to possession. In addition, the circumstances of the offending tend to justify a more lenient sentencing response, with less reliance on imprisonment and greater use of all other options, including diversion into treatment.

7.90 However, even amongst those who agreed that the response to commercial and social dealing should in principle be different, there was doubt expressed about whether a distinction could be made in practice. We suggested in the Issues Paper that the following circumstances would indicate social supply:[455]

(a) supply in small quantities;
(b) an offender who was also using the drugs;
(c) supply to friends or acquaintances;
(d) offending that is not motivated by profit.

7.91 All of these indicators were questioned by submitters. Some submitters queried our reliance on amount, on the basis that the amount dealt did not indicate much about the dealing context. One submitter queried the relevance of whether or not an offender was using the drugs.[456] Some submitters pointed out that most dealers supply to someone they know or that "when you're a dealer, everyone's an acquaintance".[457] This is supported by New Zealand research, which indicates

453 Submitter 444 (submission dated 20 April 2010) at 1.
454 Submitter 348 (submission received 30 April 2010) at 2.
455 Law Commission *Controlling and Regulating Drugs*, above n 402, at [10.31].
456 Submission of the Health Action Trust (submission received 29 April 2010) at 13.
457 Consultation meeting with Southern CAYAD, Christchurch, 17 March 2010.

that many users obtain drugs from friends, social acquaintances or family members/partners.[458] Others queried the applicability of factor (d) when a dealer was dealing drugs to fund his or her own habit.

7.92 We acknowledge these concerns. At the least, they support our view that it is not workable to have a separate offence of social dealing. Establishing an offence requires that there is a precise statutory definition of the behaviour being targeted. This is simply not possible for social dealing.

7.93 If there were to be an offence of social dealing, the only possible option would be to define the offence with reference to the amount of drugs dealt. However, as we have noted above, quantity provides a very incomplete picture of the offending. Although social dealing should always involve small amounts of the drug in question, a number of other factors like those identified above are also relevant. A broad assessment of the circumstances is required. This indicates that a sentencing-based approach is the only real option. Submitters also favoured this approach.

Presumption against imprisonment: social dealing

7.94 A presumption against imprisonment, rather than a separate offence, would overcome some of the difficulties of defining "social dealing". For the purposes of a presumption, "social dealing" would not need to be precisely defined. Nor would it affect the liability of an offender for the dealing he or she engaged in. It would simply provide a signal to the judge, when he or she was satisfied that the dealing occurred in a "social dealing" context, that options other than imprisonment should be used. This includes sentences that enable or require a dealer to address his or her own using behaviour.

7.95 We therefore recommend that there should be a statutory presumption against imprisonment in cases of social dealing. The presumption 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.

7.96 Given the acknowledged harm to young people of drug use, the presumption should not apply to cases where the dealing was to someone under the age of 18 years. However, in all other cases, it should apply regardless of the class of drug involved. This is because the availability of a more rehabilitative approach to sentencing should not depend on the drug being dealt. The presumption should also apply to all dealing offences, whether import, export, production, manufacture or cultivation. It should also apply to the proposed offence of aggravated possession.

458 A 2009 study found that, in the last six months, 69% of frequent methamphetamine users purchased methamphetamine from a friend, 58% purchased methamphetamine from a social acquaintance and 8% purchased methamphetamine from a partner or family member. 69% purchased methamphetamine from a dealer and 42% purchased it from a gang member or associate. In relation to ecstasy, 83% of frequent ecstasy users purchased ecstasy from a friend, 58% from a social acquaintance, and 8% from a partner or family member. 39% purchased ecstasy from a dealer and 5% purchased it from a gang member or associate. C Wilkins, R Griffiths 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 51 and 79 respectively.

7.97 The key issue is how to ensure that the presumption applies to the intended conduct. As noted above, our proposed indicators of social dealing (supply in small quantities; an offender who was also using the drugs; supply to friends or acquaintances; offending that is not motivated by profit) were all questioned by submitters. Consequently, we think that some revision of these criteria is required. In particular, we agree with submitters that supply to friends or acquaintances characterises most dealing situations so that its relevance in this context is limited. While the remaining three criteria are broadly indicative of the behaviour we are targeting, it is arguably the fact that the dealing is not motivated by profit which is the most indicative of a social dealing situation. The other two factors are of secondary importance.

7.98 We therefore recommend that 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 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 will retain overall sentencing discretion to determine the most appropriate sentence in light of the offence and offender being sentenced.

ADMINISTERING Current offences and maximum penalties

7.99 It is an offence under the Act to administer, or offer to administer, a drug to another person. The structure of the administering offences is similar to that for the supply offences – that is, there are separate offences (with different maximum penalties) prohibiting:

(a) administering or offering to administer any Class A controlled drug or Class B controlled drug to any other person;[459]

(b) administering or offering to administer any Class C controlled drug to a person under 18 years of age;[460]

(c) administering or offering to administer any Class C controlled drug to any other person.[461]

7.100 The maximum penalties for administering are the same as those for the core dealing activities. That is, administering a Class A drug carries a maximum penalty of life imprisonment, administering a Class B drug carries a maximum penalty of 14 years imprisonment, administering a Class C drug to a person under 18 years carries a maximum penalty of 8 years imprisonment, and administering a Class C drug to a person over 18 years carries a maximum penalty of three months imprisonment and/or a $500 fine.

Proposed offence

7.101 "Administering" is not defined in the Act. In the United Kingdom, where there is an offence of supply but not of administration, the Court of Appeal held that a defendant who injected another person (Fowler) with Fowler's own heroin

459 Misuse of Drugs Act 1975, s 6(1)(c).

460 Misuse of Drugs Act 1975, s 6(1)(d).

461 Misuse of Drugs Act 1975, s 7(1)(b).

could not be convicted of supply.[462] New Zealand commentaries have suggested that this case offers an example of when a charge of administering rather than supply is appropriate.[463]

7.102 Where the person administering the drug also supplies it, he or she can (and should) be charged with supply. However, there needs to be a separate offence to cover the administration of a drug provided by the person to whom it is administered, since this risks harm to that person. In the absence of such an offence, the generic offences of injury by an unlawful act and culpable homicide would not be available, if injury or death materialised.

7.103 We recommend, as proposed in the Issues Paper, that administering (or offering to administer) a controlled drug should be a separate offence with its own maximum penalty.[464] Such an offence is qualitatively different from supply or other dealing offences and should not be lumped together with them.

7.104 Only nine submitters commented on this proposal. The two submitters who did not agree with it[465] did not provide a reason for their view.

Maximum penalties

7.105 Administering a drug is a form of endangerment and this should be reflected in the penalty level. The Law Commission's report on Part 8 of the Crimes Act recommended a maximum penalty of two years imprisonment for endangerment offences where injury or death does not result.[466] We suggested in the Issues Paper that this would be an appropriate maximum penalty for administering drugs, whatever their class.

7.106 We continue to take this view. There was some concern in submissions that this penalty would not be sufficient given the potential consequences for the recipient including injury or death. However, where injury or death did result, other offences with higher maximum penalties would be available. This includes, for example, the offence of manslaughter which has a maximum penalty of life imprisonment.

NEW OFFENCES

7.107 The New Zealand Customs Service has proposed that consideration be given to establishing new offences to cover conduct that does not appear to be covered by the existing legislation. These offences are:[467]

(a) preparing a drug for supply (for example, packaging of the drugs after obtaining possession);
(b) transporting or smuggling of drugs;
(c) guarding or concealing drugs;
(d) inciting people under the age of 18 to act as a receiver for imported drugs.

462 *R v Harris* [1968] 2 All ER 49.

463 Don Mathias *Brookers Misuse of Drugs* (online looseleaf ed, Brookers) at [406]; Bruce Robertson (ed) *Adams on Criminal Law* (online looseleaf ed, Brookers) at [MD6.17].

464 Law Commission *Controlling and Regulating Drugs*, above n 402, at [10.114]–[10.116].

465 Submission of the Murupara Community Board (submission received 29 April 2010) at 7; Submission of the New Zealand Police (submission dated 18 June 2010) at 4.

466 Law Commission *Review of Part 8*, above n 408.

467 Submission of the New Zealand Customs Service (submission received 29 April 2010) at [10].

7.108 Some Australian jurisdictions have incorporated (a), (b) and (c), or variations of them, in their definition of "traffic" or "supply".[468] For example, the Australian Commonwealth Criminal Code defines "traffic" as including:[469]

- preparing the substance for supply with the intention of selling any of it or believing that another person intends to sell any of it;
- transporting the substance with the intention of selling any of it or believing that another person intends to sell any of it;
- guarding or concealing the substance with the intention of selling any of it or assisting another person to sell any of it.

7.109 We do not think new offences covering (a), (b) and (c) are required. In all instances, it would be open to authorities to charge an individual with the offence of possession (whether simple or aggravated). The fact that the conduct was undertaken for the purposes of supply would then be treated as an aggravating factor at sentencing. If that conduct was for the purpose of providing assistance to another (for example, the actual dealer), the person could be charged as a party to the dealing and would be subject to the maximum penalty for the dealing offence.

7.110 We are also not convinced that a specific incitement offence, as proposed in (d), is necessary. In New Zealand, it is an offence to incite, counsel or procure any person to commit an offence.[470] Anyone who does so is liable to the maximum penalty of the offence incited, counselled or procured. We are unclear how often the incitement offence is used in the drugs context. A new and more specific offence may encourage prosecutors to lay charges in this situation more often. However, the only real reason to establish a new offence would be if it was considered that the maximum penalties for the dealing offences in this context were insufficient. We do not believe that to be the case. Nor have we seen any evidence to suggest that the existing incitement offence is problematic in a dealing context.

RECOMMENDATIONS > Continued next page

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.

468 See Criminal Code (ACT), s 602; Criminal Code (Cth), s 302.1; Drug Misuse and Trafficking Act, s 3 (NSW); Misuse of Drugs Act (NT), s 3; Drugs Misuse Act 1986, s 4 (Qld).

469 Criminal Code (Cth), s 302.1. See also Criminal Code (ACT), s 602; Drugs, Poisons and Controlled Substances Act 1981 (Vic), s 4; Drug Misuse and Trafficking Act 1985 (NSW), s 3.

470 Crimes Act 1961, s 66(1)(d).

RECOMMENDATIONS

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 was 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

Personal possession and use

INTRODUCTION

8.1 In New Zealand, there is some limited distinction in law and in practice between the approach taken to drug possession, use and related offences, particularly in relation to Class C drugs, and other drug offences such as commercial production and supply.[471] Many jurisdictions, including all Australian states and territories, the United Kingdom and various European states have gone further.

8.2 The approach that should be taken to personal possession and use[472] offences in relation to already prohibited drugs was the subject of more submissions than any other topic covered by our Issues Paper. Many submitters, particularly cannabis users or those involved in the cannabis law reform lobby, argued strongly for a complete overhaul of our drugs laws and supported the legalisation or decriminalisation of drugs (primarily cannabis) for personal use. For the reasons discussed in chapter 1, we are not recommending reform of that magnitude.

8.3 However, it is clear that for many submitters, the approach that New Zealand takes to the personal possession and use of prohibited drugs is the source of much disquiet and dissatisfaction. This is not limited to those in the cannabis reform lobby but extends to health-based organisations working with those dependent on drugs, community-based organisations working to support and assist individuals and their families affected by drug use, and advocacy groups who otherwise support a strong prohibitionist approach.

8.4 We believe that there is considerable scope in New Zealand to put in place a new approach to the personal possession and use of prohibited drugs that is fair, just and equitably enforced and that provides a proportionate response to the harm those offences cause.

471 This includes a statutory presumption against imprisonment in relation to possession or use of a Class C drug (see section 7(2)(b) of the Misuse of Drugs Act 1975) and the availability of the Police Adult Diversion Scheme.

472 We are generally using the term "personal possession and use" to refer to the offences of possession and use under s 7 of the Misuse of Drugs Act 1975 and the offence of possession of utensils under s 13 of the Misuse of Drugs Act 1975.

8.5 This chapter considers what offences are required in relation to the personal possession and use of prohibited drugs and makes recommendations for a new approach to those offences when they are dealt with by the police or the courts.

OFFENCES

Possession and use

Current offences

8.6 Under section 7 of the Misuse of Drugs Act 1975, it is an offence to procure, possess, consume, smoke or otherwise use a drug unless that occurs under a statutory exemption or pursuant to a licence.[473] This offence carries a maximum penalty of six months imprisonment and/or a $1,000 fine in relation to a Class A drug, and a maximum penalty of three months imprisonment and/or a $500 fine in relation to a Class B or C drug.[474] There is a statutory presumption against the use of imprisonment in relation to possession or use of a Class C drug.[475]

Proposed offences: "simple" and "aggravated" possession

8.7 In chapter 7, we recommended that the current possession for supply offence be repealed and replaced with an offence of aggravated possession. As a result, there will be two possession offences: "simple" possession and "aggravated" possession. The offences will be defined by reference to quantity, with the quantities for the "aggravated" possession offence set on a drug-by-drug basis at a level that is likely to be inconsistent with personal use. The proposed expert advisory committee would be required to advise government on the quantity of drugs that would satisfy the aggravated possession offence.

Abolish the offence of drug use?

8.8 We questioned in the Issues Paper whether it was necessary to retain an offence of drug use.[476] In Canada, the United Kingdom, Queensland and the Northern Territory, drug use itself is not a criminal offence. Individuals who police detect using drugs are instead charged with the offence of possession. In addition, although our international conventions require that drug use be limited to medical or scientific purposes, they do not require that drug use for other purposes is itself a criminal offence.

473 Misuse of Drugs Act 1975, s 7(1)(a).

474 Misuse of Drugs Act 1975, s 7(2)(b).

475 Misuse of Drugs Act 1975, s 7(2)(b) provides that a judge should not impose a custodial sentence unless he or she considers one should be imposed by reason of the offender's previous convictions or any exceptional circumstances relating to the offence or the offender.

476 Law Commission *Controlling and Regulating Drugs* (NZLC IP16, 2010) at [11.5]–[11.10] [*Controlling and Regulating Drugs*].

8.9 There were mixed views on this issue in submissions. Many submitters agreed with our tentative view that it was sufficient to rely on the offence of possession and that the use offence should be abolished.[477] In this respect, statistics indicate that, in relation to offences recorded by the police in 2009, 95 per cent of cannabis possession and use offences, and 99 per cent of non-cannabis possession and use offences, related to possession.[478]

8.10 However, the use offence has not itself caused any difficulty. Its retention would therefore not cause any harm. The high proportion of people convicted of drug possession rather than drug use is likely to reflect the difficulties of proving use and may indicate little about the need for an offence. In addition, as argued by some submitters,[479] removing the offence may provide a signal that drug use itself is acceptable. That is undesirable. Some may also see it as odd not to criminalise the activity that the legislation aims to prevent and discourage.

8.11 We do not think a separate criminal offence for drug use is necessary from a strictly legal point of view. It is difficult to conceive of any realistic scenario where a person could be using drugs but not possessing them.[480] Whether the offence remains in place therefore depends solely on the symbolic role its existence is perceived to play. From that perspective, we acknowledge that arguments can be made for the offence's retention. As its retention rests primarily on symbolic and political concerns, we make no recommendation about its abolition or retention.

8.12 If the offence is abolished, we do not consider there to be any need to make specific provision for "aggravated" forms of use – for example, use that occurs on a public street. There are other criminal offences that cover much the same ground. For example, drug use in public may fall within the ambit of section 4 of the Summary Offences Act 1981, which makes it an offence punishable by a maximum penalty of $1,000 to behave in an offensive manner in or within view of any public place.

477 For example, Submission of the Ministry of Health (submission dated 30 April 2010) at 13; Submission of the Clendon-Manurewa CAYAD Reference Group (submission dated 30 April 2010) at 5; Submission of the National Committee for Addiction Treatment (submission dated 23 April 2010) at 12; Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 17; Submission of the New Zealand Nurses Organisation (submission dated February 2010) at 9; Submission of the Auckland City CAYAD Reference Group (submission dated 30 April 2010) at 6; Submission of the Alcohol and Drug Association of New Zealand (submission dated 30 April 2010) at 17; Submission of the New Zealand Law Society (submission dated 17 May 2010) at 11; Submission of the Auckland District Law Society Inc (submission dated 21 May 2010) at 6.

478 Possession includes procurement. However, we assume most if not all "possession" offences relate to possession itself. Statistics New Zealand Table Builder <www.statistics.govt.nz>. Note that an individual caught using drugs could not be charged with separate offences of possession and use.

479 For example, Submitter 189 (submission dated 26 April 2010) at 3; Submitter 200 (submission dated 26 April 2010) at 3; Submitter 248 (submission received 28 April 2010) at 2; Submitter 235 (submission dated 21 April 2010) at 2; Submission of the New Zealand Police Association (submission dated 12 May 2010) at 20.

480 The most likely scenario is where a person is injecting drugs into another where the legal elements of possession may not be satisfied in the case of the person who is being injected.

Possession of utensils

Current offence

8.13 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) for the purpose of committing an offence against the Act.[481] The maximum penalty is 12 months imprisonment and/or a fine not exceeding $500.[482]

8.14 Despite the wording of the offence, we are not aware of any recent cases of individuals being charged with the possession of utensils for the purpose of committing any offence against the Act other than the possession or use of drugs. In particular, there are now more serious offences in the Act that cover the possession of utensils for dealing purposes.

8.15 Section 13 also prohibits the possession of a needle or syringe for the purpose of committing an offence against the Act, when that needle or syringe has been obtained outside the authorisations contained in the Health (Needle and Syringes) Regulations 1998 or has been obtained from someone other than a pharmacist, pharmacy employee, approved medical practitioner or authorised representative.[483] The maximum penalty is also 12 months imprisonment and/or a fine not exceeding $500.[484]

8.16 The 1998 Regulations and related provisions support New Zealand's Needle and Syringe Exchange Programme, which has been in place since 1988. The Programme was a response to concern over the risk of the HIV virus spreading among intravenous drug users. Under the Programme, people can buy clean needles and syringes from specified exchange outlets and can also, for free, exchange used injecting equipment for new on a one-for-one basis. Similar approaches are adopted in overseas jurisdictions.[485]

8.17 Needle exchange programmes both in New Zealand and overseas have had demonstrated success in reducing the prevalence and/or incidence of HIV infection in injecting drug users. [486] A reduction in the reuse or sharing of injecting equipment also reduces the risk of other blood-borne illnesses such as hepatitis. Needle exchange is now well established across the country, although there are some access difficulties for people living in more remote areas.

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481 Misuse of Drugs Act 1975, s 13(1)(a).

482 Misuse of Drugs Act 1975, s 13(3).

483 Misuse of Drugs Act 1975, s 13(1)(aa).

484 Misuse of Drugs Act 1975, s 13(3).

485 Needle and syringe exchange programmes are available within a number of countries across Europe, Oceania (the term is used in United Nations publications to cover Australia, New Zealand, Pacific and Melanesian state), parts of North America and, more latterly, within developing countries. See Neil Hunt, Mike Trace and Dave Bewley-Taylor *Reducing Drug-Related Harms to Health: An Overview of the Global Evidence* (Report 4, The Beckley Foundation Drug Policy Programme, Beckley (UK), 2004) at 1.

486 Cited by ibid, at 5. For New Zealand research, see Campbell Atkins *New Zealand's Needle and Syringe Exchange Programme Review* (Centre for Harm Reduction, Wellington, 2002) at 5. That review found that New Zealand had one of the lowest rates of HIV infection in intravenous drug users (0.9%) among more developed nations. Provisional figures from Needle Exchange New Zealand that were provided by the Ministry of Health indicate that this figure was reduced to 0.3% in 2009.

Abolition of the offence

8.18 Our Issues Paper proposed that the offence in section 13 be removed.[487] This was essentially on the basis that the offence served no useful purpose and may itself be causing harm.

8.19 Submitters were divided on this issue. The views of organisations tended to depend on whether the organisation was health-based or had a law enforcement/legal background. Broadly, health-based organisations and organisations like the New Zealand Drug Foundation and Alcohol Drug Association New Zealand favoured the abolition of the offence, while legally-based and law enforcement organisations did not.

8.20 From a health perspective, a prohibition on the use of utensils is arguably counter-productive to the overall goal of the *National Drug Policy* (and this review) to reduce drug-related harm. As noted by one submitter:[488]

> … The laws relating to utensils (other than syringes and needles) are some of the most farcical aspects of the Misuse of Drugs Act and should be removed. That cannabis 'heads' wrapped in a cigarette paper should be less of a crime than cannabis leaf in a wooden pipe demonstrates how ill conceived and uninformed the Misuse of Drugs Act is. Cannabis implements like pipes, bongs and vaporisers can have beneficial effects and can make the use less harmful to the user. Criminalising their possession and use is draconian and calls into question the claim that such a policy is designed to decrease harm.

8.21 The role of utensils in reducing harm was also noted by the New Zealand Nurses Organisation:[489]

> The possession of utensils for the purpose of using drugs should also be removed, as there is an abundance of evidence that it can lead to riskier ways of taking drugs (for example, swallowing, injecting, smoking unfiltered) and can also act as a deterrent to use of needle-exchange facilities for injecting users, with attendant public health issues.

8.22 Submitters who did not support the abolition of the offence considered that the prohibition of utensils was consistent with, or supported, overall efforts to reduce drug use in the community. For example:[490]

> The reason provided in 1999 and 2003 that cannabis and methamphetamine utensils were prohibited was to remove a perceived legal anomaly. Possession and use of cannabis and methamphetamine was prohibited, but there was no prohibition on the visibility and availability of utensils associated with the use of these controlled drugs. Ministers felt that there was a conflicting message to young people about the safety and appropriateness of drug taking. Unless this reason has changed, Customs considers that for the sake of consistency the prohibition should be maintained.

487 Law Commission *Controlling and Regulating Drugs*, above n 476, at [11.11]–[11.15].

488 Submission of the Drugs Rights Project (submission dated at 14 May 2010) at 24.

489 Submission of the New Zealand Nurses Organisation (submission dated February 2010) at 9.

490 Submission of the New Zealand Customs Service (submission received 29 April 2010) at 13.

8.23 Similarly, the New Zealand Police Association argued:[491]

> The offence of possession of utensils should remain, as such possession (with or without the presence of drugs) is very strongly connected with actual drug use, given the offence also requires that the purpose of possession be established. A clear analogy can be drawn with the possession of burglary tools or conversion instruments. At a practical level, this is a useful charge for investigators, which we do not believe is used in a way disproportionate to the overall circumstances.

8.24 Another submitter argued that apprehension for this offence provides a further opportunity to identify and address problematic drug use.[492]

8.25 We are not aware of any evidence that existence of the offence itself deters drug use. If an individual has gone to the trouble of obtaining a prohibited drug, it is difficult to believe that he or she will be deterred from using that drug because a required utensil is illegal. Dealers may themselves supply utensils. 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. It also compromises any argument that could be made about the symbolic message against drug use that the utensils offence sends.

8.26 Nor do we consider it is appropriate to retain the offence on the basis that the police find it "useful" for investigative purposes or as an indirect way to address problematic drug use. An activity should only be criminalised if that activity is harmful in itself or clearly leads to harm. This cannot be said of the utensils offence. In addition, the utensils offence increases the potential for the arbitrary and discriminatory exercise of police discretion, an issue about which submitters expressed significant concern.

8.27 It is true that, all else being equal, a person who possesses utensils but no drugs is arguably no less culpable than a person who possesses both utensils and drugs. The only practical difference between the two may be one of timing as to when the drugs are consumed. However, in reality, most users found with utensils will also have drugs in their possession or will be committing other offences at the same time. This is borne out by statistics provided to us by the Ministry of Justice, which indicate that the vast majority of prosecutions for the utensils offence are accompanied by other charges.[493]

8.28 It was also argued to us that it was counterintuitive to abolish the utensils offence given that consuming drugs by way of a needle or syringe was the most harmful way in which drugs could be used. We agree that intravenous drug use is a particularly harmful way to use drugs and that efforts should be made to encourage safer forms of use. However, the introduction of New Zealand's Needle and Syringe Exchange Programme in 1988 means that the debate in

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

492 Submission of Pauline Gardiner, former executive officer of WellTrust (submission received 5 May 2010) at 3.

493 In 2008, the utensils offence was charged on its own in 16% of cases, with a possession/use offence in 52% of cases, with another drugs offence in 7% of cases and with other non-drug offences in 25% of cases.

New Zealand on this issue has moved on substantially. The main focus in this area is on ways to ensure that needles and syringes, when they are used, are clean, not shared and used as safely as possible.

8.29 In this respect, agencies involved in New Zealand's Needle and Syringe Exchange Programme universally supported the abolition of the offence on the basis that it compromised the Programme's effectiveness. They argued that the threat of arrest and prosecution made intravenous drug users reluctant to risk being caught carrying injection equipment, with the consequence that they were less likely to return used equipment to a needle exchange and were more likely to dispose of it in an unsafe way. They claimed that, despite provisions in the Misuse of Drugs Act that aim to exclude needles and syringes that had been obtained from an authorised outlet from the ambit of the offence, the prosecution of intravenous drug users for needle and syringe possession is evident "despite official police comment saying otherwise". This directly impacts on needle exchange outlets because their workers have to take time out from the Programme to attend court. Some drug users plead guilty to the charge "because it is 'easier' to do so".[494]

8.30 The Ministry of Health was also concerned about the impact of the offence on the successful implementation of the Needle Exchange Programme. This included that equipment, other than needles and syringes, which were provided by a Programme to make injecting safer (for example, wheel filters and butterflies that reduce blood clots and vein damage) were prohibited. The Ministry also expressed concern that someone who obtains a clean needle from a partner or a friend is in breach of the Act.[495]

8.31 In summary, therefore, we consider that the arguments made from a harm perspective for the abolition of the offence outweigh any arguments that can be made for its retention from a law enforcement perspective. In particular, to the extent that the offence deters safer drug use, we think it causes harm rather than prevents it. We are particularly concerned about its potential impact on the Needle and Syringe Exchange Programme.

8.32 We therefore recommend that it no longer be an offence to possess utensils for the purpose of using drugs. It is important to note that this recommendation relates only to the possession of utensils and not their supply. The supply of utensils is a separate issue that is addressed in chapter 9.

8.33 One risk with removing the offence is the removal of an incentive on intravenous drug users to obtain needles and syringes from authorised needle exchange outlets. Accessing needles and syringes via an authorised needle exchange outlet protects intravenous drug users from prosecution (because it must be proved that the individual did not obtain the utensils from an authorised outlet for the

494 Submission of the Rodger Wright Centre (submission dated April 2010) at 5. Similar views were expressed by: Submission of the National Committee for Addiction Treatment (submission dated 23 April 2010) at 14; Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 22; Submission on behalf of Hamilton Needle Exchange (submission dated 29 April 2010); Submission of Needle Exchange Timaru (submission received 30 April 2010); Submission of Needle Exchange New Plymouth (submission dated 30 April 2010); Submission of the Alcohol Drug Association New Zealand (submission dated April 2010) at 17.

495 Submission of the Ministry of Health (dated 30 April 2010) at 18.

user to be convicted for their possession). As discussed above, some users apparently consider this protection to be more illusory than real. Nevertheless, some users may consider there to be less reason to obtain needles and syringes from an authorised outlet if they can legally possess needles and syringes obtained elsewhere, even if from less reputable sources.

8.34 We think that there are sufficient incentives for users to continue using authorised needle exchanges even with the removal of this incentive. This includes the low cost of needles and syringes, the ability to exchange, for no charge, used needles and syringes for clean ones on a one-for-one basis, and the broader assistance and support that outlets can provide to users.

8.35 We consider the recommendation to abolish the offence to be a measured response to the difficulties the offence poses, as highlighted in submissions. However, we are aware that the recommendation will be controversial. If it is not accepted, we recommend that other measures be considered to address some of the concerns that have been outlined above.

8.36 In particular, there is a need to clarify 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"). Enabling people to do so is consistent with the overall objectives of the Needle and Syringe Exchange Programme. A person who distributes needles and syringes in this way does not commit an offence under section 13 of the Act.[496] However, he or she does commit an offence under regulation 12 of the Health (Needles and Syringes) Regulations 1998. (The latter is a much less serious offence with a maximum penalty of a fine of $500.) We discuss elsewhere in this Report our concerns about the inclusion of substantive offences in secondary legislation. However, for the purposes of this discussion, it is sufficient to emphasise the undesirability of having two offence provisions that are in direct conflict with each other. It also puts authorised outlets and "secondary distributors" in a difficult position.

8.37 Consideration should also be given to the possibility of exempting from the offence other utensils and equipment that is harm reducing. This includes, for example, vapourisers for using cannabis or wheel filters and butterflies for use with needles and syringes.

8.38 Finally, we see no reason why the maximum penalty for possessing a utensil to use a Class B or C drug should be greater than that for possessing or using the drug itself. It may reflect the wider scope that the offence had when it was first introduced. Whatever the reason for it, it is an anomaly that requires attention.

496 See s 13(1)(aa)(ii) of the Misuse of Drugs Act 1975, under which an offence in this respect is only committed if a person possesses a needle or syringe that another person (an "acquirer") obtained on his or her behalf from a supplier who the acquirer could not have reasonably believed was a pharmacist, pharmacy employee, approved medical practitioner, or an authorised representative.

Needle exchange in prisons

8.39 During consultation on our Issues Paper, an issue was raised with us about the lack of needle and syringe exchange programmes in prison.[497] As in the general community, there are clear health benefits from prisoners who use drugs intravenously being able to access clean needles and syringes. However, the prison environment creates some particular challenges for how a needle exchange programme might operate. There is some difficulty in a prison being seen to facilitate illicit drug use by making appropriate utensils available. In addition, it would not be appropriate for a prisoner to be able to retain needles or syringes given the risk that these utensils would then be used as weapons.

8.40 We understand that Needle Exchange New Zealand has been investigating the possibility of undertaking a needs analysis to determine the extent to which prisoners use drugs intravenously. That research would provide valuable information to determine the extent to which an exchange programme in prison is required. Further consideration could then be given to whether it is possible to overcome the obstacles that we have identified here.

PROPOSED APPROACH TO PERSONAL POSSESSION AND USE OFFENCES

Current approach by the police and the courts

8.41 Responding to the possession and use of drugs occupies a significant amount of police and court time and attention. Personal possession and use offences comprised 69 per cent of the approximately 25,000 drug offences recorded by the Police in 2009.[498] In that year, 2,167 people were prosecuted and 1,454 people were convicted for a possession or use offence under section 7 of the Act where that was the most serious charge. This accounted for 32 per cent of all people prosecuted and 30 per cent of all people convicted for drug offences in 2009.[499]

8.42 In many cases, police detection of these offences is likely to be incidental to the detection of other offences. This was emphasised to us by the New Zealand Police Association whose members reported anecdotally that possession offences are almost always detected as a result of police contact with an offender for other reasons.[500]

8.43 Police often take a low-level and diversionary response when a personal possession or use offence is detected, particularly when it is the only offence for which a person has come to police attention. Most drug users are not the subject of any enforcement action in relation to their use. For example, in relation to the most widely used illegal drug in New Zealand, cannabis, we estimate that less than one per cent of all users in New Zealand in 2008 were prosecuted for

497 In recent years clean needle and syringe programmes have been developed within prisons in a few European jurisdictions.

498 25,020 drug offences were recorded, 17,205 of which related to personal use offences (drug possession or use, or possession of utensils). Statistics New Zealand Table Builder < www.statistics.govt.nz > .

499 Statistics New Zealand Table Builder < www.statistics.govt.nz > . We did not have statistics available to us on the number of people prosecuted and convicted for the possession of utensils.

500 Submission of the New Zealand Police Association (submission dated 12 May 2010) at 18.

their cannabis use.[501] New Zealand research has also found that most cannabis users are not prosecuted or convicted for cannabis-related offences.[502] This low-level (or lack of) response has also mitigated some of the costs and harms that would otherwise have been caused by drug prohibition.

8.44 The proportion of minor drugs offences for which formal action is taken is likely to reduce further as a result of a new Pre-charge Warning Scheme that was implemented in September 2010. A pre-charge warning is available to anyone over the age of 17 years who is apprehended by the police for an offence with a maximum penalty of six months imprisonment or less. Possession of methamphetamine and offences that arise out of a family violence incident are excluded from the Scheme. The aim of the Scheme is to provide an appropriate low-level response to offences where some police intervention is required but where a prosecution is not in the public interest. An evaluation of a pilot scheme operating across the Auckland region found that about 10 per cent of all charges were resolved by way of a warning between November 2009 and May 2010.[503] In six per cent of cases, the warning related to the procurement or possession of cannabis.[504]

8.45 In addition to the new Pre-charge Warning Scheme, the Police Adult Diversion Scheme provides another opportunity to divert low-level drug offenders from the system. Broadly, the Scheme is targeted to first offenders when the offence is minor or a conviction would be out of all proportion to the offence's seriousness. The Scheme is generally not available for Class A and B drug offences,[505] but may be available for minor instances of Class C drug offending such as possession or use of a Class C drug, as well as cultivation of cannabis and possession of needles or other utensils.[506]

8.46 The Scheme requires that a prosecution commence and an acknowledgement of guilt be made before an offender can be considered for diversion. An offender must sign a diversion agreement which will also set out the conditions of diversion, such as participation in alcohol or drug counselling. If the offender successfully completes

501 The 2007/08 New Zealand Alcohol and Drug Use Survey found that 14.6 % of respondents aged between 16 and 64, equating to 385,000 people, used cannabis in the last 12 months. 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. In 2008, 1,782 people were prosecuted for possessing or using cannabis. Statistics New Zealand Table Builder < www.statistics.govt.nz > . In Australia, it has been estimated that fewer than one in 50 cannabis users are arrested in any one year – see Wayne Hall "A Cautious Case for Cannabis Depenalization" in Mitchell Earleywine *Pot Politics: Marijuana and the Cost of Prohibition* (Oxford University Press, New York, 2007) 91 at 102. New Zealand Police apprehension statistics indicate that approximately 3 % of users were apprehended for a possession or use offence over that same period. Statistics New Zealand Table Builder < www.statistics.govt.nz > . However, unlike prosecuted cases, apprehensions statistics are not organised according to the most serious offence and more than one apprehension will be recorded for one incident if more than one offence has been committed. Some over-counting is therefore likely.

502 DM 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.

503 A total of 3,137 charges were resolved by a pre-charge warning between November 2009 to May 2010 across the Auckland region. For the same period, 31,647 charges were resolved by prosecution after arrest. J O'Reilly *New Zealand Police Pre-Charge Warnings Alternative Resolutions Evaluation Report* (New Zealand Police, Wellington, 2010) at 10.

504 Ibid, at 23.

505 However, it may be available in some circumstances for possession of small amount of cannabis oil, which is a Class B drug.

506 Police Diversion Policy < http://www.police.govt.nz > .

diversion (by fulfilling the diversion conditions), the charge will be withdrawn. If not, the prosecution of the offender continues. As with pre-charge warnings, there is no statutory basis for the Diversion Scheme, and its implementation is a matter of police discretion with the assistance of police guidelines.

8.47 If a prosecution does proceed to the point of conviction, personal possession and use offences that are not accompanied by other offending are likely to receive a relatively low-level response by the courts. A fine is the most common sentence imposed.[507] Diversionary options are also available such as a discharge without conviction or an order to come up for sentence if called upon.

8.48 The criminal justice system also provides an opportunity for the diversion of drug offenders into treatment or other rehabilitative options. For example, a court may adjourn proceedings to enable an offender who has pleaded or been found guilty to undertake a rehabilitative programme prior to sentencing.[508] The offender's participation in that programme may then be taken into account in an offender's sentence.

Concerns with the current approach

8.49 Despite the apparently low-level response that the criminal justice system currently provides to people charged with personal possession and use offences, we are not convinced that it is the best approach. Nor were most submitters. This is for the following reasons.

8.50 Interaction with the criminal justice system inevitably imposes costs on society and creates harms to the individual concerned. These costs and harms are clearly justified when the offence is serious or causes harm to others. For example, as we noted in chapter 4, we consider that the use of the criminal law backed by strong sanctions is entirely appropriate to reduce the supply of drugs in the community and penalise those who profit from their manufacture and sale. But we are less convinced that the criminal law and criminal sanctions are effective tools to respond to people whose drug use may be resulting in no serious harm to others or whose drug use may be associated with underlying health and other problems, including mental health disorders and drug dependence.

8.51 One response to this argument, made by submitters in the law enforcement area, is that the exercise of police discretion minimises the costs and harms that prohibition might otherwise cause; that is, it ensures that the response in practice to minor drug offences is proportionate and appropriate. However, the existence of this discretion can be a double-edged sword. Other submitters argued that the amount of discretion which currently exists simply provides an opportunity for

507 57% of people convicted in 2009 for a possession or use offence under s 7 of the Act received a monetary penalty, 29% received a community-based sentence, 12% received a conviction and discharge or an order to come up for sentence if called upon, and 2% received a custodial sentence. These proportions are broadly equivalent to previous years.

508 Sentencing Act 2002, s 25.

unfairness, discrimination and uncertainty. In this respect, it seems counter-intuitive to rely on the exercise of police discretion to mitigate the harshness of the prohibition regime when that discretion is seen by many as part of the problem.[509]

8.52 We also have some reservations about an approach where the enforcement policy to personal possession and use offences is essentially regarded as an operational decision about the exercise of police discretion that is made behind closed doors. It is clear from submissions to this review that the approach that should be taken to the enforcement of these offences is controversial and involves difficult questions of public policy. It is appropriate, therefore, for the public via democratically-elected representatives to have input into that approach. For example, despite the overall decrease in police apprehensions for personal possession and use offences over the last decade, there has been a consistent increase in police apprehensions for these offences since 2005.[510] In our view, it is unsatisfactory that the basis for this apparent change in approach by the police remains unarticulated and untested.

8.53 We acknowledge that the implementation of the Pre-charge Warning Scheme changes the landscape in some important respects. In particular, the availability of warnings for minor drug offences should ensure that many more low-level drug offenders are diverted from the formal criminal justice system in the future. More broadly, we welcome the introduction of the Scheme as an apparently effective way of reducing the burden of low-level offending on the police and the courts. However, we do not think that its introduction is so significant that there is no longer a need to do anything additional that specifically targets drug offences and offenders.

8.54 Nor does the Scheme do much to address the concerns we raise above in paragraphs 8.51 to 8.52. In particular, the nature and scope of the Scheme has not been the subject of any public or political input. In this respect, it seems anomalous that possession of methamphetamine has been excluded from its ambit, while other Class A drugs have not. But most fundamentally, the Scheme still relies on the appropriate exercise of police discretion, guided by some open-ended criteria.[511] The evaluation of the pilot scheme raised some concerns about the consistency of decision-making in this regard.[512] In light of the concerns expressed by submitters, we consider that less reliance on the exercise of police discretion in this area is warranted.

8.55 Some submitters pointed to experience with approaches in overseas jurisdictions, which demonstrates that there are viable alternatives to New Zealand's current approach. All Australian states and territories, the United Kingdom and many European countries have adopted less punitive approaches to personal possession

509 These concerns were alluded to in the Ministry of Health's submission, which advocated for a "systematic and proportionate response to the harms associated with the use of drugs" which sought to "mitigate the potential harms associated with prohibition and reduce the inequitable enforcement of current drug laws on users". Submission of the Ministry of Health (submission dated 30 April 2010) at 18. Similar concerns were expressed by other individual submitters, sometimes with reference to their own drug use.

510 Apprehensions for personal possession and use offences decreased from 18,145 in 2000 to 13,937 in 2005 but have consistently risen in more recent years. There were 17,830 apprehensions for personal possession and use offences in 2009. Statistics New Zealand Table Builder < www.statistics.govt.nz > .

511 The criteria were supplied to us by the New Zealand Police in February 2011.

512 J O'Reilly, above n 503, at 23.

and use offences. These approaches, which were reviewed in detail in the Issues Paper,[513] include infringement notice systems, formal cautioning schemes and other diversionary approaches. These options tend to provide a less expensive response to low-level offending, with greater opportunities for diversion into treatment where that is required.

8.56 A key concern expressed by enforcement authorities is the impact that taking a less punitive approach to personal possession and use offences may have on levels of use, either due to the impact of the particular approach itself or due to the perceived softening or relaxation of attitudes towards drug use. Coupled with this latter concern is a concern that this perception will undermine the overall enforcement approach that is taken to prohibited drugs.

8.57 There is no evidence from the experience in other jurisdictions that these concerns will be borne out if a less punitive approach is taken in New Zealand. Most studies of overseas approaches have concluded that changes in use levels are independent of the regulatory approach in place.[514] In addition, these types of approaches tend to be implemented as part of an overall and deliberate strategy to achieve a greater legal and practical distinction between drug users and suppliers, and to redirect law enforcement resources towards the latter. They appear to have been successful in this regard.

8.58 There is also little, if any, evidence to suggest that enforcement action of any sort deters an individual from continuing to use drugs. As discussed in chapter 4, factors other than the certainty and severity of punishment, such as the impact of drug use on a user's family relationships, home and work life, appear to have a greater influence on whether an individual uses, or continues to use, drugs.[515]

8.59 People also obey the law because they believe it is morally appropriate to do so, either on the basis that they agree with the content of the law itself or that, even if they do not, they agree that the law was legitimately made.[516] Social and cultural attitudes towards the activity and law in question are therefore crucial. In this respect, we note that, at least in relation to cannabis, the most recent surveys suggest almost 147,000 New Zealanders ignore the prohibition against using cannabis each week[517] and 385,000 New Zealanders ignore the prohibition each year.[518] This itself brings the law into disrepute.

8.60 The approach taken by the overseas jurisdictions, all of whom are signatories to the 1961, 1971 and 1998 international conventions, also indicates that it is possible to take a less punitive approach and still meet the obligations those conventions impose. In chapter 1, we noted that ensuring that our recommendations are consistent with the conventions is not only a requirement of our terms of reference

513 Law Commission *Controlling and Regulating Drugs*, above n 476, at ch 7.

514 Ibid, at [11.25].

515 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.

516 Andrew von Hirsch and others *Criminal Deterrence and Sentence Severity: An Analysis of Recent Research* (Hart Publishing, University of Cambridge Institute of Criminology, 1999) at 3.

517 Ministry of Health, above n 501, at 47.

518 Ibid, at 43.

but also an absolute and overriding principle in itself. Those obligations in relation to personal possession and use activities were discussed in detail in the Issues Paper[519] and reviewed briefly in chapter 1. While they require that the possession and use of convention drugs for other than medical or scientific purposes must continue to be restricted and unlawful, there are a number of permissible responses under the conventions when offences established for that purpose are detected. These responses range from the application of a non-prosecution policy to the use of non-custodial sentences if a prosecution is taken.

8.61 It appears that the United Nations is itself moving towards a less punitive approach in relation to personal possession and use offences. In 2009, the United Nations Office on Drugs and Crime (UNODC) stated that drug possession cases are a "non-priority" and that arrest is only appropriate in a small proportion of those cases. UNODC also stated that "the law must allow for non-custodial alternatives when a police officer stumbles upon small amounts of drugs", with imprisonment in these cases rarely being beneficial.[520] In addition:

> … law enforcement should shift its focus from drug users to drug traffickers. Drug addiction is a health condition: people who take drugs need medical help, not criminal retribution. Attention must be devoted to heavy users. They consume the most drugs, cause the greatest harm to themselves and society – and generate the most income to drug mafias.[521]

8.62 This approach is also reflected in the Government's Methamphetamine Action Plan, released in October 2009. The Action Plan notes that "sending users to prison rather than diverting users to [alcohol and other drug treatment] can make the problem worse"[522] and includes proposals to divert users from the criminal justice system at an early stage.[523]

8.63 In conclusion, we maintain our view expressed in the Issues Paper[524] that a less punitive enforcement approach to personal possession and use offences, which is established on a transparent and official basis, is appropriate. Such an approach would:

- provide a more proportionate response to the harm that drug use causes;
- enable law enforcement resources and activity to focus on more harmful drug-related offending like commercial dealing;
- address or mitigate some of the harms and costs that inevitably result from drug prohibition;
- provide greater opportunities in the criminal justice system to divert drug users into drug education, assessment and treatment;
- be in line with the approach taken in all Australian states and territories, the United Kingdom and many European countries.

519 Law Commission *Controlling and Regulating Drugs*, above n 474, at ch 10.

520 United Nations Office of Drugs and Crime *World Drug Report 2009* (United Nations, New York, 2009) at 167.

521 Ibid, at 2.

522 Department of Prime Minister and Cabinet *Tackling Methamphetamine: An Action Plan* (Policy Advisory Group, October 2009) at 2.

523 Ibid, at 43–44.

524 See Law Commission *Controlling and Regulating Drugs*, above n 476, at [11.19]–[11.28].

Options proposed in the Issues Paper

8.64 The Issues Paper identified three options that we thought should be considered as possible responses to a personal possession and use offence.[525] These options were:

(a) A formal cautioning scheme for all drugs. This option, which was based on similar schemes in Australia, would provide a graduated response to individuals who were apprehended for personal possession and use offences. An individual would be able to receive up to two cautions before being required to attend a brief intervention session and be assessed to identify whether he or she was in need of specialist drug treatment. A user who came to police attention for a fourth time, or who did not consent to the caution notice being issued, would be prosecuted.

(b) An infringement offence scheme for less harmful drugs. This option, which was also based on similar schemes in Australia, would enable the police to issue an infringement notice to an individual apprehended for a personal possession and use offence. Individuals issued with a notice would be required to pay a fine and could, in some cases, be required to attend a drug education session. As with most other infringement offence schemes, prosecution and conviction for a personal possession and use offence would not be possible.

(c) A "menu of options", which would enable the approach taken when an offence is detected to be tailored to the individual circumstances of the offence and offender. Options available to the police would range from the issuing of a caution or infringement notice, to referral to drug assessment with a view to treatment, to prosecution.

8.65 Views amongst submitters on these options varied. Most submitters who expressed a preference supported a cautioning scheme (option (a)) or the "menu of options" (option (c)). More submitters favoured the former over the latter.

8.66 Support for options (a) and (c) centred primarily on the opportunity these options provided to divert a user into education, assessment and treatment. For example:

> … Offending arises in association with drug use due to a variety of factors – the disinhibiting effects of drugs, the need to meet the cost of an expensive drug habit and drug offences being the three primary mechanisms. 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 in to the consequences of drug use and a decision to make changes in one's life. Such changes are far more likely with appropriate initial intervention and the opportunity to follow through on the decision to change by engaging in a comprehensive treatment process.[526]
>
> The Ministry [of Health] does not have a preferred option but considers there to be some potentially constructive concepts in all three of the approaches. The option with greatest alignment to a health-centric approach would be option 1 as this appears to provide the best means for identifying and applying the most effective

525 Ibid, at [11.35]–[11.65].

526 Submission of the National Addiction Centre (submission dated 6 May 2010) at 2.

> approach to the needs of a user. A cautioning scheme is an early opportunity to provide information on the legal and health consequences of drug use and to identify any treatment requirements, before a user becomes involved in the criminal justice system. This option would also provide a back-up mechanism for a user to 'progress' to a mandatory brief intervention and possible prosecution in the event of a third apprehension or non-acknowledgement of a caution...[527]

8.67 Both options also enable the response to be tailored to the circumstances of the offence and the individual user. Many submitters agreed that a drug-specific approach was required, with the most intensive responses reserved for those using drugs which caused the most harm. For higher risk drugs like methamphetamine, some submitters supported an approach which enabled the user to be referred directly for treatment on the first occasion his or her use came to the attention of the police:[528]

> A different cautioning scheme than that proposed would be needed to deal with use of more harmful drugs and it would need to be considered whether any cautionary system at all was appropriate (eg for use of methamphetamine or opioids). We believe that enforcement provides an excellent opportunity to ensure drug users are referred for evaluation and assessment of their drug use and its harm to self and others. Therefore, along with a first caution, users of class A and B drugs should be required to undertake mandatory drug assessment and treatment if needed. That is, assessment of their drug use should be a priority with the aim of addressing drug use and underlying problems.

8.68 While many submitters expressed some support for an infringement notice system as part of a "menu of options" available to the police, there was little support for the implementation of an infringement notice system on its own. Those submitters aligned with the cannabis law reform group, NORML, argued that:[529]

> … Infringement notice systems can turn into revenue-gathering devices and be used to harass people. Drug laws already punish disproportionately the young, the poor and Maori; this tendency would increase under an infringement notice system.

8.69 Others commented on the problems encountered in similar schemes in Australia, with particular reference to the potential for users to accumulate large amounts of unpaid fines. The Australian schemes tend to have an initial compliance rate before enforcement action is taken of around 50 per cent. In New Zealand, it has been estimated that only 39 per cent of infringement fees by value are paid to the prosecuting authority without enforcement action being taken.[530]

8.70 We are also concerned about the impact of an infringement notice system on net-widening – that is, there is a strong risk that infringement notices would be issued to people who previously would have had no action taken against them for their drug use. The low-level response that an infringement notice aims to

527 Submission of the Ministry of Health (submission dated 30 April 2010) at 18.

528 Submission of the Centre for Social Health Outcomes and Research (SHORE) (submission dated 29 April 2010) at 2.

529 Submission of NORML (submission dated 14 May 2010) at 7. The same point was made by 3145 NORML form submissions.

530 Ministry of Justice and New Zealand Law Commission *Review of the Infringement System: Options for Reform* (Wellington, 2004) at 39.

provide may not make this particularly problematic. However, if experience with other infringement systems is borne out, enforcement action to recover the unpaid fine would be taken against the majority of people who were issued with a notice. This would increase the level of contact between a user and the criminal justice system, and increase the cost of the system to the State, beyond what may be proportionate to the original offence.

8.71 Whatever approach is taken, submitters who commented on the issue agreed that the approach needs to be provided in legislation. Doing so was necessary to provide certainty and transparency for the police, the wider public and drug users.

Other options proposed by submitters

8.72 The approaches to personal possession and use offences taken in the Netherlands and Portugal were raised by many submitters as viable options for New Zealand. These were discussed in detail in our Issues Paper.[531] We have reconsidered the applicability of both approaches to New Zealand but have discounted them for the reasons outlined below.

The Netherlands

8.73 Cannabis remains a prohibited drug in the Netherlands. However, since 1976, there has been a formal policy of not prosecuting offences that involve a small amount of cannabis (5 grams or less) for personal possession and use.[532] Instead, personal possession and use of cannabis is "actively tolerated"[533] in the home and in licensed coffee shops, where small amounts of cannabis can also be purchased.[534] Coffee shops are officially sanctioned and regulated, with national guidelines about how they are to be run and where they are to be located. Official action, including prosecution, will only be taken against individuals (and coffee shops) who do not comply with the guidelines.

8.74 The Netherlands also applies a similar approach to the possession of small quantities of other drugs for personal use. Anyone found in possession of less than half a gram of a drug included in List 1 of the Opium Act 1976 will generally not be prosecuted. Instead, the police will confiscate the drugs and consult a care or support agency about the individual user.[535]

531 See Law Commission *Controlling and Regulating Drugs*, above n 476, at [7.60]–[7.82] and [7.83]–[7.91].

532 Chris Wilkins *A Framework for Assessing Alternative Drug Control Regimes* (Centre for Social and Health Outcomes Research and Evaluation, Massey University, Auckland, August 2008) at 29.

533 Room and others, above n 515, at 113.

534 Ibid.

535 List 1 includes, for example, heroin, cocaine, methamphetamine, morphine, opium. See European Legal Database on Drugs "Netherlands Country Report" < www.emcdda.europa.eu > .

8.75 Research indicates that the approach taken to cannabis in the Netherlands has not, in itself, led to an increase in rates of cannabis use among adults,[536] although there remains a question about its impact on rates of use among young people.[537] The approach does appear to have been particularly successful in separating the market for, and users of, cannabis from those of other substances.[538]

8.76 We have a number of reservations about the Netherlands' approach. Contrary to the understanding of many submitters, the possession and use of drugs remain illegal. That law is simply not enforced. It is essentially overridden by a formal non-arrest or non-prosecution policy. The requirements of police independence mean that the content of the policy could not be provided in legislation but would instead be a matter for the police. If the policy simply formalised the current approach that police already take to minor or inconsequential offences, it may have little real impact in practice.

8.77 There is also a risk of creating confusion in the public's mind about what the law actually requires. This is because the law as applied in practice differs markedly and officially from what the law says. Clear guidelines that are made widely available are one way to manage that risk, as is making any changes to practice widely known. Even then, however, application of the guidelines is likely to differ case-by-case due to the exercise of police discretion and changing police priorities.

8.78 This approach is also likely to attract concern from other jurisdictions on the basis that it undermines the global effort against drugs. In recent years, the Netherlands has been coming under increasing pressure, including from the European Union, United States and UNODC, to move towards a more restrictive approach.[539] It has been argued that the Netherlands' approach undermines the domestic drug policies of other jurisdictions, stimulates cross-border tourism, and undermines international efforts in the "war against drugs".[540] This pressure

536 Room and others, above n 515, at 143.

537 Ibid, at 114:

> On balance we would say that the case is still open about whether de facto legalisation led to more use by youth and an earlier age of onset; it cannot be ruled out that increases in youth prevalence may have been associated with increasing de facto legalisation, and subsequent decreases with tightening up of this policy…The Dutch experience raises the question about whether going beyond depenalisation to de facto legalisation may increase rates of use among the young, who are most vulnerable to the adverse effects of cannabis. Some will disagree with this analysis, but we believe at this stage a cautious conclusion is warranted, pending further research.

538 Ibid, at 143. A study shows 87% of the Amsterdam sample bought cannabis from coffee shops, compared to 95% of the San Franciscan sample who bought cannabis from friends who knew a dealer, or from "known dealers".

539 Most recently, in December 2010, the European Court of Justice has upheld a regulation issued by the Municipal Council of Maastricht that prohibited any coffee shop owners from allowing entry to people who do not reside in the Netherlands. See Court of Justice of the European Union "The Prohibition on the Admission of Non-residents to Netherlands' 'Coffee-shops' Complies with European Union Law" Press Release No 121/10 < www.curia.europa.eu > .

540 Room and others, above n 515, at 114.

has led to the Netherlands progressively tightening its approach.[541] As a result, the number of coffee shops has decreased from approximately 1,500 in the mid-1990s to just over 700 in 2004.[542]

Portugal

8.79 In Portugal, an individual who is apprehended for the purchase, possession or consumption of a drug for personal use is referred to administrative authorities for consideration of his or her education and treatment needs (with the drugs usually confiscated). These administrative authorities, Commissions for Dissuasion of Drug Addiction, are locally-based panels (supported by technical experts) which decide how users who come to police attention should be dealt with.

8.80 Users must appear in front of a Commission within 72 hours of a police citation being issued. The Commission then has a variety of options available to it, ranging from the imposition of a warning or a fine to more intensive and restrictive measures such as reporting requirements, or a prohibition on being in a certain place, associating with certain people or working in a particular occupation or profession.[543] The Commission can suspend the imposition of sanctions on the condition that the user seeks treatment.

8.81 Most cases dealt with by the Commissions involve cannabis.[544] Since 2001, there has been a decrease in the use of provisional sanctions with treatment and an increase in punitive sanctions such as warnings, bans on being in certain places and requirements to report to a Commission.[545] This has been attributed to the lack of appropriate treatment options for people who are dependent on drugs other than heroin.[546]

541 See ibid, at 114 and Dirk Korf "An Open Front Door: The Coffee Shop Phenomenon in the Netherlands" in Sharon Rodner Sznitman, Borje Olsson and Robin Room *A Cannabis Reader: Global Issues and Local Experiences* (European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2008) 137. This includes reducing the number of coffee shops, increasing the minimum age of purchase from 16 to 18, increasing enforcement of cannabis use outside the tolerated bounds, and restricting the proximity of coffee shops to schools.

542 Korf, above n 541, at 142.

543 The full range of sanctions are: fines; warnings; banning the consumer from working in a particular profession or occupation, particularly where the consumer or a third party may be at risk; banning the consumer from being in certain places; prohibiting the consumer from associating with certain people; forbidding the consumer from travelling abroad without permission; reporting requirements; prohibiting the consumer from being granted with or renewing a firearms license for defence, hunting, precision shooting, or recreation; seizure of objects belonging to the consumer which represent a risk to him or her or to the community or which encourage the committing of a crime or other offence; privation from the right to manage the subsidy or benefit attributed on a personal basis by public bodies or services, which shall be managed by the organisation managing the proceedings or monitoring the treatment process, when agreed to by the consumer.

544 64% in 2008. The proportion of cases involving cannabis has increased since 2001 (from 53% in 2001 to 70% in 2006) and the proportion of cases involving heroin has decreased (from 33% in 2001 to 14% in 2006). Caitlin Hughes and Alex Stevens "What Can We Learn from the Portuguese Decriminalisation of Illicit Drugs?" (2010) 50 British Journal of Criminology 999 at 105 ["Portuguese Decriminalisation"].

545 Ibid. Provisional sanctions with treatment reduced from 31% of sanctions in 2002 to 18% of sanctions in 2008. The use of punitive sanctions increased from 3% in 2002 to 15% in 2008.

546 Ibid.

8.82 The approach taken in Portugal appears to have been particularly effective in reducing drug-related harm, especially in relation to heroin use which was a matter of particular public concern prior to the reforms.[547] The number of users seeking treatment for drug abuse and addiction has also increased. This includes a 147 per cent increase in the number of people in substitution treatment between 1999 and 2003.[548] There has also been an increase in the nature and number of drug treatment programmes, and drug-related deaths[549] and disease[550] have declined.

8.83 The impact on the criminal justice system in Portugal has also been significant. In 2000, 7,592 individuals in Portugal were charged in relation to drug use. These individuals are now referred to the Commissions, and only appear before the criminal courts if there is evidence of drug trafficking or any other criminal offence. There is little evidence of net-widening.[551]

8.84 While drug use appears to have increased overall in Portugal since 2001, there is evidence of a similar increase in neighbouring countries, Spain and Italy.[552] In addition, the increase is not the same across all age groups and all drugs. For example, drug use has decreased amongst those aged 15–19, but increased amongst those aged 20–24.[553] While there has been an increase in cannabis use, particularly amongst young people aged 16–18,[554] there has been a decrease in heroin use in that same age bracket.

8.85 The approach taken in Portugal appears to have been successful in achieving its objectives.[555] We support many aspects of the Portuguese approach, particularly in regard to its aim to divert users away from the criminal justice system and make treatment available to those who require it. However, we do not think the use of Commission-like bodies is appropriate for New Zealand. This is for the following reasons.

547 The United Nations reports a stable or declining trend in opiate use in Western Europe, and an increasing trend in Eastern Europe. United Nations Office of Drugs and Crime, above n 520, at 54.

548 From 6,040 people in 1999 to 14,877 people in 2003. Caitlin Hughes and Alex Stevens *The Effects of Decriminalisation of Drug Use in Portugal* (Briefing Paper 14, the Beckley Foundation Drug Policy Programme, 2007) at 2 [*Effects of Decriminalisation in Portugal*].

549 There was a 59% reduction in drug-related deaths between 1999 and 2003. This reduction was solely attributable to a reduction in heroin-related deaths (which reduced from 350 in 1999 to 98 in 2003). Deaths related to other drugs increased over the same period (from 19 to 54). Ibid, at 3.

550 There has also been a reduction in drug-related disease. Between 1999 and 2003, a 17% reduction in notification of new, drug-related cases of HIV was reported (Room and others, above n 515, at 3). Since 2000, a mild reduction in the rates of new hepatitis B and C infections was also reported (Glenn Greenwald *Drug Decriminalisation in Portugal: Lessons for Creating Fair and Successful Drug Policies* (Cato Institute, Washington, 2009) at 16).

551 Before and after the reforms, the number of people detected for use/possession offences has remained at approximately 6,000 per year. Hughes and Stevens "Portuguese Decriminalisation", above n 544, at 109.

552 Hughes and Stevens *Effects of Decriminalisation in Portugal*, above n 548, at 5.

553 Greenwald, above n 550, at 14.

554 Lifetime prevalence of cannabis use among students aged 16–18 increased from 9.4% in 1999 to 15.1% in 2003. Hughes and Stevens *Effects of Decriminalisation in Portugal*, above n 548, at 3.

555 Hughes and Stevens *Effects of Decriminalisation in Portugal*, above n 548; Greenwald, above n 550; Hughes and Stevens "Portuguese Decriminalisation", above n 544.

8.86 First, the Commissions require significant resources to establish and maintain. The Commissions have been described by some as "excessive in design", "very resource intensive" and "too bureaucratic in operation".[556] We think there are other less resource-intensive ways to ensure that users who come into contact with the criminal justice system are referred to assessment and treatment where that is required.

8.87 We also have reservations about the role the Commissions play in imposing what are essentially criminal sanctions. We do not think it is appropriate for a community-based panel to impose the type of punitive sanctions that are available to the Commissions without court oversight to ensure that the sanctions are imposed transparently and consistently across the country. This concern is exacerbated if, as appears to have occurred in Portugal, punitive sanctions are imposed on users because appropriate treatment options are not available.

8.88 Aspects of the Portuguese system also appear to lack required due process. In particular, there appears to be little, if any, ability for a user apprehended by police to challenge whether or not an offence was actually committed.

Our preferred option: A mandatory cautioning scheme

8.89 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. The key objectives of the scheme would be to remove minor offences from the criminal justice system and provide greater opportunities for those in need of treatment to access it.

Key components

8.90 The key components of this scheme are as follows:

(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 possessing a Class A drug for the first time 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.

556 Hughes and Stevens *Effects of Decriminalisation in Portugal*, above n 548, at 6.

(ii) A user apprehended for possessing a Class B drug 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 possessing a Class C drug 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.

8.91 The primary advantage of this option is that it provides a formal opportunity, at the earliest stages of the criminal justice process, to consider the drug treatment needs of those apprehended for a personal possession and use offence. Because not all of those apprehended will be in need of drug treatment, access to low-level treatment interventions is limited to particular users. These users are those who come to police attention for a personal possession and use offence at all for a Class A drug, more than once for a Class B drug, or more than twice for a Class C drug.

8.92 The different approach to users of different drug classes responds to the views of many submitters that a "one size fits all" approach is not appropriate given the vastly different harms that different drugs pose. If drugs are appropriately classified, the drugs in Class A will be those that are the most addictive and that otherwise cause the most serious harm to users. It is appropriate that the response to users of these drugs is escalated, and access to low-level treatment interventions is increased, beyond what would be available to people who use less addictive and less harmful drugs. The response to Class B and C drugs similarly reflects the level of harm that those drugs pose.

8.93 We accept that an approach based on drug class has limitations. For example, further work will be required to determine the approach that should be taken to multi-drug users who come to police attention at different times for drugs in different classes. But more fundamentally, whether or not a user might benefit from a brief intervention session will not always be determined by the class of drug he or she is using. A user of a Class A drug might not require immediate intervention while some users of Class C drugs might. For this reason, it has been suggested to us that a better approach might be to provide a brief intervention with screening to every person who is apprehended for a personal possession or use offence with a referral to treatment if necessary.

8.94 While acknowledging these concerns, we have decided an approach organised according to drug class is the best approach for two reasons. First, classification of a drug in a particular class does indicate the risk of harm that the drug, all else being equal, poses to a user. Assuming drugs are appropriately classified, it is

therefore appropriate to extrapolate from drug class to the likely needs of a user for further intervention. In that sense, the approach essentially reflects a pragmatic decision about where the resource of the brief intervention that is attached to the cautioning scheme is best directed. (There is nothing to prevent brief interventions being made available for those who fall outside the caution scheme, whether or not they are in the criminal justice system.) Providing brief interventions to all offenders who are apprehended for a personal possession or use offence risks "over-intervention" (in the sense that many who receive one will be unlikely to require any further assistance). It also focuses on only one of the scheme's objectives (providing greater opportunities for those in need of drug treatment to access it).

8.95 Secondly, we see an approach based on drug class as the only real way to limit the amount of discretion available to police to decide whether or not a caution should be issued. For the reasons discussed earlier, we consider that objective eligibility criteria, which depend less on the assessment of individual police officers, are required.

8.96 In this respect, the concerns expressed by submitters about the exercise of police discretion have led us towards a more prescriptive scheme than that envisaged in the Issues Paper. For example, we propose that a caution be issued regardless of a user's criminal history or whether he or she is being charged with other offences. This is contrary to the features of similar Australian regimes, which tend to restrict cautions to first offenders. However, we consider that eligibility for a caution must be clear and transparent. Including these users in the scheme is also consistent with the scheme's objectives.

8.97 We envisage that a brief intervention delivered as part of a cautioning scheme would include a preliminary screening as well as a discussion with the user about the risks around his or her drug use and whether he or she would benefit from assessment and treatment. The brief intervention would therefore focus on discussing and identifying a person's need for referral to a specialist treatment service, rather than providing treatment itself.

8.98 As was discussed in the Commission's report *Alcohol in Our Lives: Curbing the Harm*,[557] there is good evidence that brief interventions can be highly cost-effective for treating less severe alcohol-use problems.[558] They can change patterns of alcohol consumption and reduce alcohol-related problems, but are under-utilised in New Zealand.[559] There is less evidence about the effectiveness of these types of brief interventions in respect of other drug use. However, it is important not to artificially separate alcohol from other drug use. Many people with drug problems also have alcohol problems and require similar interventions for both.

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557 Law Commission *Alcohol in Our Lives: Curbing the Harm* (NZLC R114, 2010) at 426.

558 T Babor and others *Alcohol: No Ordinary Commodity* (Oxford University Press, New York, 2003).

559 See, for example: J Sheridan and others "Screening and Brief Interventions for Alcohol: Attitudes, Knowledge and Experience of Community Pharmacists in Auckland, New Zealand" (2008) 27 Drug and Alcohol Review 380; J Hosking and others "Screening and Intervention for Alcohol Problems among Patients Admitted Following Unintentional Injury: a Missed Opportunity?" (2007) 120 New Zealand Medical Journal 2417; J Pulford and others "Alcohol Assessment: the Practice, Knowledge and Attitudes of Staff Working in the General Medical Wards of a Large Metropolitan Hospital" (2007) 120 New Zealand Medical Journal 2608; JP McMenamin "Detecting Young Adults with Alcohol Use Disorder in General Practice" (1997) 110 New Zealand Medical Journal 127.

8.99 Brief interventions should be provided by community-based organisations who work in the alcohol and drug sector rather than the police, given the potential for further offending in the nature of other drug use to be disclosed. As we note in chapter 12, community alcohol and drug treatment services are already stretched. A number of issues around access to and funding of treatment services will therefore need to be addressed before the cautioning scheme can be implemented.

8.100 The requirement that a caution notice can only be issued when a user acknowledges responsibility for an offence and consents to the caution being issued is both a necessary safeguard and required as a practical matter. The need for consent may make the user more likely to comply with the caution requirements. In addition, when a user is being referred to a brief intervention session with a view to possible treatment, it is appropriate that he or she has a choice about whether or not to participate. (We recognise that consent in this context may not be truly voluntary, because if consent is withheld prosecution is likely to follow.)

8.101 We anticipate some criticism that there is no requirement to participate in any treatment that a brief intervention identifies as being required. While such a requirement might be desirable from a treatment perspective, we do not support it being a mandatory caution condition. The offences that fall within the cautioning scheme will be minor offences. In accordance with standard and accepted criminal justice principles, care therefore needs to be taken that the response the cautioning scheme provides is not wholly disproportionate to the seriousness of the offence. As a related point, given the low-level offences the scheme will be dealing with, we consider it inappropriate in these circumstances to compel people to attend treatment.

Legal status of the offences under a cautioning scheme

8.102 There was a significant amount of confusion amongst submitters about the implications of a cautioning scheme (or any of the other options proposed in the Issues Paper) for the legal status of personal possession and use offences. The implementation of a cautioning scheme will not change the legal status of these offences. They will remain criminal offences that are subject to criminal penalties.

8.103 Nor does the cautioning scheme preclude the prospect of convictions for minor drug offences; while convictions for these offences should reduce under the scheme, they would still be possible whenever a prosecution was commenced. Under our proposal, a prosecution would remain possible in at least the following situations:

(a) if a user had exhausted all of his or her caution options; or
(b) if a user disputed the offence, in which case the police would be required to prove the offence against the user in the normal way; or
(c) if the user did not attend the brief intervention session as required.

8.104 The possibility of prosecution also means that a caution should only be considered when a prosecution for the offence would otherwise commence (that is, the police consider that there is sufficient evidence to support a charge). This may also limit the extent of net-widening that may otherwise occur.

Offences included within a cautioning system

8.105 A caution notice should be able to be issued in respect of any "simple" possession offence. As discussed above, the possession offences will be defined by reference to quantity, with the quantities for the "aggravated" possession offence set on a drug-by-drug basis at a level that is likely to be inconsistent with personal use. While some people charged with the simple possession offence may actually have possessed the drug for dealing purposes, we do not think it appropriate to try and limit the applicability of the cautioning regime any further. The availability of cautions whenever a person is charged with a simple possession offence is the simpler and more transparent approach.

8.106 The offences of drug use and the possession of utensils should also come within the cautioning scheme if they remain criminal offences. In chapter 10, we also recommend that the cautioning scheme apply to a "restricted person" who commits the offence of procuring or attempting to procure a prescription or supply of a controlled drug, knowing he or she is a restricted person, in contravention of a restriction notice.[560] That offence is akin to a personal possession or use offence.

8.107 The more difficult question is whether a cautioning scheme should be available in respect of any other offences when they are committed in the context of personal use – particularly dealing offences like aggravated possession, cultivation of a prohibited plant or importing or exporting drugs.

Aggravated possession

8.108 Most people charged with aggravated possession will possess the drugs for the purpose of dealing. However, it may be appropriate to provide some limited discretion to enable a caution notice to be issued when a person charged with aggravated possession is clearly committing the offence in a personal context. Whether this discretion is necessary or appropriate will partly depend on the approach the expert advisory committee takes to setting the quantities of each drug to which the offence applies (in particular, whether the quantities are set at a sufficiently high level that a dealing context will be apparent in almost all cases where aggravated possession is charged).

Cultivation of a prohibited plant

8.109 Cultivation of a prohibited plant is an offence under section 9 of the Misuse of Drugs Act with a maximum penalty of seven years imprisonment. We have already discussed this offence in chapter 7 in the context of dealing and proposed that, at a minimum, a presumption against imprisonment should apply where cultivation occurs in the context of social dealing.

8.110 All Australian infringement offence regimes include limited cannabis cultivation for personal use within them. The number of plants able to be cultivated is no more than two, and is usually limited to plants that are not hydroponically

560 See ch 10 at paragraph 10.88.

grown on the basis that naturally-growing plants are less potent and less likely to be grown by commercial suppliers. Those Australian jurisdictions that have a cautioning scheme for cannabis tend not to include cultivation within it.

8.111 The primary reason for including cultivation within any new regime is to weaken the criminal black market in cannabis supply. Even though many cannabis users receive their supply through social networks, often for no or little charge,[561] that supply still represents the end of a criminal supply chain. Enabling users to "grow their own" therefore weakens the cannabis black market. Submitters who supported including limited cultivation within the scope of a cautioning regime primarily did so for this reason.[562]

8.112 However, including cultivation within the proposed cautioning scheme regime does cause some difficulties. In particular, the number of plants may not provide a reliable indication of the amount of cannabis that may actually be possessed and used. There is a vast difference in the amount of cannabis that may be extracted from a seedling by comparison with a fully matured plant.

8.113 There is also some risk that the "allowable" number of plants will be grown for supply rather than personal use, or that commercial dealers will co-opt a number of growers and then sell the resulting combined amount on the black market. There was concern that this was occurring in the early stages of South Australia's Cannabis Expiation Notice Scheme,[563] and that is one reason why the maximum number of cultivated plants subject to the Scheme has progressively reduced from ten to one since the Scheme started.[564] Western Australia's now repealed infringement system addressed this issue in a different way, by requiring that the cannabis plants be located at the offender's principal place of residence, with no other cannabis plants cultivated at that residence by any other person.[565] A 2007 statutory review recommended that cannabis cultivation be removed from the Western Australian scheme.[566] Cultivation is not included in Western Australia's new regime.[567]

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561 Chris Wilkins and others "Estimating the Dollar Value of the Illicit Market for Cannabis in New Zealand" (2005) 24 Drug and Alcohol Review 227 at 229. In comparison to South Australia, for example, where the dealer was the main supplier of cannabis – see 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 29.

562 Submitter 50 (submission dated 10 March 2010); Submitter 55 (submission dated 13 March 2010); Submission of the Health Action Trust (submission dated April 2010) at 10; Submitter 327 (submission dated 30 April 2010) at 2.

563 A Sutton and E McMillian "Criminal Justice Perspectives on South Australia's Cannabis Expiation Notice Procedures" (2000) 19 Drug and Alcohol Review 281.

564 The original ten plant limit was reduced to three plants in 1999, one plant in 2000, and then one non-hydroponic plant in 2001. Room and others, above n 515, at 111.

565 Cannabis Control Act 2003 (WA), s 7.

566 Drug and Alcohol Office *Statutory Review: Cannabis Control Act 2003 Executive Summary Report to the Minister of Health* (Drug and Alcohol Office, Perth, 2007) at 6. 94% of notices were issued in relation to possession of utensils or possession of cannabis. The Western Australian Police were of the view that the inclusion of cultivation of non-hydroponic plants contributed to the scheme being unnecessarily complex.

567 That regime replaces the infringement offence system. Individuals in possession of cannabis utensils or under 10gms of cannabis (not being a cannabis plant under cultivation, cannabis resin or any other cannabis derivative) may either be prosecuted or required to participate in a "cannabis intervention session" which aims to educate people about the adverse health and social consequences of cannabis use; the laws relating to cannabis possession, use and cultivation; and effective strategies to address cannabis using behaviour. See the Cannabis Law Reform Act 2010.

8.114 There seems a stronger argument for including cultivation in an infringement offence regime than in a cautioning scheme. A cautioning scheme has a greater focus on identifying and addressing problematic use, whereas the focus of an infringement offence system is on keeping users out of the criminal justice system. To achieve the latter, it makes sense that users can cultivate a small supply of their own cannabis without being subject to criminal prosecution. The same argument does not apply to a cautioning scheme, because the possibility of prosecution remains. However, for the reasons stated above, we do not consider that an infringement offence regime for minor drug offences is appropriate for New Zealand.

8.115 On balance, therefore, we consider that cultivation of a prohibited plant should continue to be dealt with via prosecution. As discussed in paragraph 8.120, a presumption against imprisonment should apply when the purpose of cultivation was to produce drugs for the offender's own use.

Import, export, production, manufacture

8.116 In theory, the import, export, production or manufacture of drugs can be committed in a personal use context. However, we maintain our view expressed in the Issues Paper that these activities should not be included in the proposed cautioning scheme.[568]

8.117 For convention drugs, there appears to be little, if any, scope to take such an approach. Regardless of convention requirements, however, there is a risk that the amounts imported or exported would be tailored to comply with the amounts included within any new regime. In addition, taking a less restrictive approach to activities like import and export may compromise the integrity of our borders and international efforts towards drug control. The potential harms inherent in the manufacturing process also mean a less restrictive approach to those activities is not appropriate.

PROPOSED APPROACH FOR THE COURTS TO PERSONAL POSSESSION AND USE OFFENCES

8.118 As discussed in paragraph 8.103, prosecution for a personal possession and use offence will remain possible even if a cautioning regime is implemented.

8.119 Currently, it is possible for a less severe approach to be taken to these offences when they are prosecuted than to other drug offences. This includes the possibility of Police Adult Diversion, and the prospect of sentencing being adjourned to enable an offender to undertake a treatment programme prior to sentencing.[569] There is also a statutory presumption against imprisonment in relation to sentencing for the possession or use of a Class C drug. The question is whether anything further is required.

Presumption against imprisonment

8.120 In chapter 7, we discussed the issue of statutory presumptions for and against imprisonment. Although statutory presumptions are rare, we noted that they are the only mechanism available to Parliament to provide sentencing guidance, apart from the blunt instrument of an offence's maximum penalty. We recommended

568 See Law Commission *Controlling and Regulating Drugs*, above n 476, at [11.81]–[11.83].

569 Sentencing Act 2002, s 25.

that a statutory presumption against imprisonment should apply in cases of social dealing. This would be primarily indicated by whether or not the offending was motivated by profit, with the quantity of drugs and whether or not the offender was using the drugs identified as relevant considerations.

8.121 We recommend that a presumption against imprisonment should also apply whenever the circumstances indicate that the offence was committed in a personal use context. This includes where the offender has been convicted of a dealing offence (cultivation, import, export, production or manufacture of drugs) but where that activity was carried out to generate drugs solely for the offender's own use. The presumption should also apply to the proposed aggravated possession offence. It is inconsistent to have the presumption 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 could ever be met by the use of imprisonment for personal use offending (although imprisonment would remain available in exceptional cases).

Police Adult Diversion Scheme

8.122 There is a question about the applicability of the existing Police Adult Diversion Scheme if a cautioning scheme is implemented. In particular, there seems little to be gained in requiring a drug user who has exhausted all of his or her caution options to then be diverted from the court on the condition that he or she complete some unrelated conditions (such as making a donation to a charity) or that he or she be required to participate in drug assessment or treatment. The only point in offering diversion in these cases is if it was thought that the threat of imminent prosecution would give the offender additional motivation to attend treatment that had earlier been recommended as part of a brief intervention. However, we think that the continued applicability of the Scheme in these cases is more likely to cause confusion.

8.123 We 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. 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. This includes possession of Class A and B drugs.

Court-based assessment and treatment

8.124 Many submitters argued that greater use should be made of the court system to provide the defendant with assessment and treatment where alcohol or drug abuse and dependence are identified. We agree. Options for how this might be achieved are discussed in chapter 12.

PROPOSED APPROACH TO PERSONAL POSSESSION AND USE OFFENCES COMMITTED BY YOUTH

8.125 If a new approach is taken to personal possession and use offences committed by adults, there is a question about whether that approach should also be adopted in relation to the same offences committed by children and young people.

8.126 Available evidence indicates that the greatest drug-related harm, at least for cannabis and possibly for other drugs, is when use begins in adolescence and is frequent during young adulthood.[570] The latest New Zealand research suggests that drug use before the age of 15 increases the risk of a range of negative outcomes, including involvement in crime and early pregnancy.[571] The law in relation to personal possession and use should reflect this evidence and, to the extent possible, protect young people from the harm of drug use.

8.127 However, for many youth, experimentation with drug use is a natural part of growing up. Rates of cannabis use are reasonably high amongst young people. The Christchurch and Dunedin longitudinal studies found that, at age 18, approximately 45 per cent of young people in their studies had at least tried cannabis.[572] By age 21, approximately nine per cent of these users were cannabis dependent.[573]

8.128 As with any offending committed by children and young people, personal possession and use offences are dealt with in the youth justice system. That system already provides specific and tailored responses to offending by children and young people. These responses range from diversion via Police Youth Aid through to prosecution in the Youth Court, where a range of sanctions, from a discharge to residential sanctions, are available.[574] If an offence is proved, the Youth Court can also transfer a young person to the District Court for sentencing.[575]

8.129 In 2009, there were 1,768 police apprehensions in New Zealand of children and young people aged 16 and under for illegal drug offences.[576] The majority of apprehensions were for possession and use offences (68 per cent), involved cannabis (94 per cent) and were committed by 14–16 year olds (85 per cent). Most apprehensions resulted in a warning or caution (45 per cent) or referral to Police Youth Aid (38 per cent). Only a small proportion resulted in prosecution (12 per cent).[577] The vast majority of personal possession and use offences committed by children and young people are therefore dealt with outside any formal court process.

570 See, for example, paragraphs 2.37 and 2.85–2.90 of ch 2.

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

572 David M Fergusson and L John Horwood "Cannabis Use and Dependence in a New Zealand Birth Cohort" (2000) 113 New Zealand Medical Journal 156 at 156; and Richie 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 at 545.

573 Fergusson and Horwood, ibid, at 157; Poulton and others, ibid.

574 Children, Young Persons, and Their Families Act 1989, s 283.

575 Children, Young Persons, and Their Families Act 1989, s 283(o).

576 The number of apprehensions does not equate to the number of individuals. An "apprehension" means that a person has been dealt with by the Police in some manner (e.g. a warning, prosecution, referral to youth justice family group conference etc) to resolve an offence.

577 Statistics New Zealand Table Builder < www.statistics.govt.nz > .

8.130 Many submitters supported an approach that applied the cautioning scheme, or a variant of it, to personal possession and use offences committed by young people. The following submission, made by the New Zealand Drug Foundation, National Committee for Addiction Treatment and the Alcohol and Drug Association of New Zealand broadly reflects that view:[578]

> We believe that an enhanced response to personal use offences committed by youth is necessary. Youth who use drugs are more vulnerable to drug-related harms than adults. They are also more likely to engage in risky behaviours when older and to develop drug-related problems. Furthermore, drug-dependent youth are less likely than adults to seek treatment. As such, we believe it is important that any intervention for young people apprehended with drugs aims to direct them into education and assessment.
>
> While there is already significant scope within the youth justice system in New Zealand to identify and deal with drug treatment or other rehabilitative needs, we believe that inadequate numbers of youth are receiving the interventions they need. For example, in 2008, 42% of youth apprehensions by police for illegal drug offences resulted in a warning or caution only. Many of these youth could benefit from an intervention that couples a caution or warning with at least one mandatory educational session. This session would aim to increase their knowledge and understanding of the harms associated with drug use, and should be flexible enough to provide or refer those who need it for further assessment and counselling. Support and involvement with families during this process is also important. Failure to attend could result in the young person being referred back to the youth court.
>
> The implementation of such a scheme within the youth justice system would ensure consistency and certainty when dealing with youth drug personal use offences, and would maximise the opportunities to provide education and assessment to a group that are particularly vulnerable to the harms from the misuse of drugs.

8.131 The proposed cautioning scheme for adults has parallels with the youth justice system, including its link to drug treatment in appropriate cases and its escalation towards prosecution if offending is persistent. The key difference is that the response provided through the cautioning scheme, including the progression through the cautioning levels, would be subject to legislative guidance and be more prescriptive, whereas the approach taken in individual cases in the youth justice system is a matter for police discretion.

8.132 On balance, however, 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. The cautioning scheme does not lend itself easily to that kind of approach.

8.133 This is not to say that there is not more that should be done for youth offenders who are using illegal drugs. However, any proposed measures need to be developed with the objectives and imperatives of the youth justice system in mind, rather than developed as an adjunct to it.

578 Submission of the New Zealand Drug Foundation (submission dated 29 April 2010) at 22; Submission of the National Committee for Addiction Treatment (submission dated 23 April 2010) at 18; Submission of the Alcohol and Drug Association of New Zealand (submission dated April 2010) at 17.

RECOMMENDATIONS

> Continued next page

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.

RECOMMENDATIONS

(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.

(i) 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.

(j) 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.

(k) 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.

(l) 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

Other offences and penalties and procedural provisions

INTRODUCTION

9.1 This chapter considers those offences in the Misuse of Drugs Act 1975 that are not covered in other chapters, particularly chapter 7 (dealing) and chapter 8 (personal possession and use). It also makes recommendations about provisions in the Act that relate to matters of criminal and other procedure including, for example, the defences available to a defendant charged with a drug offence and matters of forfeiture.

PRECURSOR SUBSTANCES

9.2 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"). New offences were consequently included in the Misuse of Drugs Act in 1998, with further controls imposed in 2005.

9.3 Under the Act, it is an offence to:

(a) 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[579] (maximum penalty of seven years imprisonment);[580]

(b) import or export any precursor substance knowing that it will be used to produce or manufacture any controlled drug[581] (maximum penalty of seven years imprisonment);[582]

579 Misuse of Drugs Act 1975, s 12A(1)(b).

580 Misuse of Drugs Act 1975, s 12A(3)(a). A lesser penalty applies upon summary conviction (s 12A(4)(a)). The Criminal Procedure (Reform and Modernisation) Bill 2010 (243–1) proposes to remove those maximum penalties that apply upon summary conviction.

581 Misuse of Drugs Act 1975, s 12AB(1).

582 Misuse of Drugs Act 1975, s 12AB(2).

(c) 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[583] (maximum penalty of five years imprisonment);[584]

(d) import or export any precursor substance without a reasonable excuse[585] (maximum penalty of 12 months imprisonment and/or a $1000 fine).[586]

9.4 Precursor substances are defined by their inclusion in Schedule 4 of the Act.[587]

9.5 The above offences have been framed in a way which recognises that most precursor substances also have legitimate industrial or medical uses. These uses often constitute a precursor's primary purpose. For example, acetone is scheduled as a precursor substance but is also used as an industrial chemical. Piperidine, another precursor substance, is also a prescription medicine. As a consequence, controls over these substances cannot be so restrictive that their legitimate use is unduly limited. This is why it is not an offence to possess or deal with a precursor substance, unless it is accompanied by an intention of producing, manufacturing or cultivating a controlled drug.[588]

9.6 As discussed in chapter 6, our main concern in this area is the overlap in regulation that occurs when a substance is classified as a controlled drug and scheduled as a precursor substance. We recommended in that chapter that precursor substances should be classified as either a controlled drug or a precursor substance, but not both. Essentially, a substance should only be classified as a controlled drug if it is a psychoactive substance, not if it is being used to manufacture or produce such a substance. We also recommended 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.

9.7 If this approach is taken, the maximum penalties for the precursor offences should differ depending on a substance's scheduling as an A, B or C substance 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

583 Misuse of Drugs Act 1975, s 12A(2)(b).

584 Misuse of Drugs Act 1975, s 12A(3)(b). A lesser penalty applies upon summary conviction (s 12A(4)); see above n 580.

585 Misuse of Drugs Act 1975, s 12AC(1). 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 (s 12AC(2)). The prosecution must negate beyond a reasonable doubt any reasonable excuse raised by the defendant (s 12AC(3) and (4)).

586 Misuse of Drugs Act 1975, s 12AC(5).

587 Schedule 4 is divided into three parts. The first two parts correspond to the Tables in the 1998 Convention. The Convention imposes additional pre-export notification obligations in respect of substances listed in Table 1/Part 1 (see art 12(10)). Part 3 of sch 4 is limited to ephedrine and pseudoephedrine, and was created in 2005 so that enforcement powers enabling warrantless search powers under s 18(2) of the Misuse of Drugs Act could apply.

588 It also accounts for the overlap in the regulation of precursor substances that exists between the Misuse of Drugs Act, the Hazardous Substances and New Organisms Act 1996 and the Medicines Act 1981.

attempt offences.[589] For example, supplying a precursor substance that is used to manufacture methamphetamine should carry a maximum penalty of 10 years imprisonment which is nominally half the maximum penalty for dealing in a Class A drug (life imprisonment). Possessing a precursor substance with the intention that it be used to manufacture methamphetamine should carry a maximum penalty of 5 years imprisonment, which is half the proposed maximum penalty for the new aggravated possession offence in relation to Class A drugs (10 years imprisonment).

OFFENCES COMMITTED FOR THE PURPOSE OF COMMITTING OTHER DRUG OFFENCES

9.8 The Misuse of Drugs Act contains a number of offences in relation to activities that are undertaken for the purpose of committing another, usually more serious, drug offence.

Pipes and utensils

Possession of pipes and utensils

9.9 It is an offence under section 13 to possess a pipe or other utensil for the purpose of committing an offence against the Act.[590] Regardless of the class of drug involved, this offence carries a maximum penalty of 12 months imprisonment and/or a $500 fine.[591]

9.10 As currently drafted, the offence has a wide ambit and extends to the possession of utensils for any purpose. In chapter 8, we recommended that it no longer be an offence to possess utensils for the purpose of *using* drugs.

9.11 Since 1998, the possession of equipment (including utensils) to produce, manufacture or cultivate drugs has been covered by a separate offence (see paragraph 9.17(c)). We are not aware of any recent cases of individuals being charged under section 13 with the possession of utensils for the purpose of committing any dealing offence against the Act (for example, sale or supply).[592] Therefore, if the recommendation to abolish the offence as it relates to using drugs is accepted, there is no need to retain a residual offence in respect of the possession of utensils for any other purpose.

Import and supply of pipes and utensils

9.12 Section 22(1A) of the Act provides a statutory power which enables the Minister of Health to prohibit, by notice in the *Gazette*, the import or supply of pipes and utensils (other than needles or syringes) that may be used to administer a controlled drug or to prepare a controlled drug to be administered. Contravention of this notice is an offence carrying a maximum penalty of three months

589 Under s 72 of the Crimes Act 1961, the maximum penalty for an attempt is 10 years if the completed offence is punishable by life imprisonment, and in other cases is half the maximum penalty for the completed offence.

590 Misuse of Drugs Act 1975, s 13(1). However, it is not an offence if the needle or syringe is obtained under the Health (Needles and Syringes) Regulations 1998 or obtained from a pharmacist, pharmacy employee, approved medical practitioner or authorised representative – see Misuse of Drugs Act, s 13(1)(aa).

591 Misuse of Drugs Act 1975, s 13(3).

592 The only case we could find is *R v Tunui* (1992) 8 CRNZ 294 (HC), where the defendant was charged with possession of utensils for the purpose of homebaking morphine. That case pre-dates the inclusion of the offence in the Misuse of Drugs Act discussed in paragraph 9.17(c).

imprisonment and/or a $1,000 fine for an individual, or a $5,000 fine for a body corporate. There is a current notice prohibiting the import or supply of utensils for using cannabis or methamphetamine.[593]

9.13 The Misuse of Drugs Amendment Bill, which was reported back from the Health Committee on 29 November 2010, extends this statutory power to enable the Minister to prohibit the offering of utensils for sale and the possession of utensils for the purpose of supply or sale. The prohibition will also be able to apply to any "identifiable component of a pipe or other utensil", in addition to pipes and utensils that are intact or assembled.[594]

9.14 Our proposed abolition of the offence relating to the possession of utensils is not intended to signal that these utensils are desirable items but rather to recognise that the relevant offence serves no useful purpose and may itself be causing harm. We therefore consider that, at the least, 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.

9.15 However, we have some reservations about the scale of the changes included in the Amendment Bill. We are concerned that the broad nature of the changes, particularly the extension to components of pipes and utensils, is likely to make the new provisions difficult to enforce in practical terms and lead to inconsistent and selective enforcement. For the reasons discussed in chapter 8, we do not believe that controls on utensils do much, in themselves, to reduce drug use or to reduce the harm arising from drug use.

9.16 The extent of these changes also reinforces our view, expressed in the Issues Paper,[595] that prohibitions of these sorts should be contained in primary legislation and not via a regulation-making power and *Gazette* notice. As a matter of principle, it is inappropriate to establish substantive offences in secondary legislation. As discussed later in chapter 10, section 22 is essentially a reserve power that is intended to deal with unanticipated and urgent safety issues. We do not consider that the controls over utensils fall into this category.

Other offences

9.17 It is an offence to:

(a) Knowingly permit any premises, vessel, aircraft, hovercraft, motor vehicle or other conveyance to be used for the purpose of committing an offence under the Act.[596] The maximum penalty, which depends on the class of drug in relation to which the offence was committed, is 10 years for a Class A drug, seven years for a Class B drug and three years in any other case.[597]

(b) Supply, produce or manufacture any equipment or material that is capable

593 Misuse of Drugs (Prohibition of Cannabis Utensils and Methamphetamine Utensils) Notice 2003.

594 Misuse of Drugs Amendment Bill 2010 (126–2), cl 4.

595 Law Commission *Controlling and Regulating Drugs* (NZLC IP16, 2010) at [12.24] [*Controlling and Regulating Drugs*].

596 Misuse of Drugs Act 1975, s 12(1).

597 Misuse of Drugs Act 1975, s 12(2). Lesser penalties apply upon summary conviction (s 12(3)); see above n 580.

of being used in, or for, the production or manufacture of any controlled drug or cultivation of a prohibited plant, knowing that the equipment or material is to be used for that purpose.[598] The maximum penalty is seven years imprisonment.[599]

(c) Possess any equipment or material that is capable of being used in, or for, the production or manufacture of any controlled drug or cultivation of a prohibited plant with the intention that the equipment or material be used for that purpose.[600] The maximum penalty is five years imprisonment.[601]

9.18 We recommend the retention of all three offences. Although a person who commits the offence in (a) could also be held liable as a party to the principal offence, a separate offence is more transparent and makes liability clear, including for juries who can find parties' liability difficult. We are not aware of the offence causing any difficulty.

9.19 We proposed in the Issues Paper that the maximum penalty for the offences in (b) and (c) should be revised so that they link more directly to the seriousness of the offence that may have otherwise been committed and to the class of drug involved.[602] We have reconsidered that approach. First, it may sometimes be difficult to prove the class of drug involved. Secondly, if maximum penalties did differ according to drug class, the maximum penalties of seven years and five years imprisonment seem appropriate for the worst class of case for these offences (large-scale offending involving Class A drugs). Given that those maximum penalties would therefore be retained for offences involving a Class A drug, there seems little to be gained in putting in place lesser maximum penalties for offences involving drugs in Class B and C. This can instead be dealt with at sentencing.

9.20 The New Zealand Customs Service has proposed that a new offence be established to prohibit the import or export of pill presses or other equipment such as glassware that is used to produce or manufacture controlled drugs.[603] We agree that an offence of this type would be useful, provided that it is drafted in such a way as to clearly exclude the import and export of this equipment for legitimate purposes. A potential model is provided by sections 12AB and 12AC of the Act, which establish offences relating to the import and export of precursor substances for unlawful use or without a reasonable excuse.

OFFENCES COMMITTED OUTSIDE NEW ZEALAND

9.21 The Misuse of Drugs Act includes offences in relation to activities undertaken in other jurisdictions that, if committed in New Zealand, would constitute an offence of:

(a) dealing (section 6);

(b) cultivation of a prohibited plant (section 9);

598 Misuse of Drugs Act 1975, s 12A(1)(a).

599 Misuse of Drugs Act 1975, s 12A(3)(a). A lesser penalty applies upon summary conviction (s 12A(4)(a)); see above n 580.

600 Misuse of Drugs Act 1975, s 12A(2)(a).

601 Misuse of Drugs Act 1975, s 12A(3)(b). A lesser penalty applies upon summary conviction (s 12A(4)(a)); see above n 580.

602 Law Commission *Controlling and Regulating Drugs*, above n 595, at [12.27].

603 Submission of New Zealand Customs Service (submission received 29 April 2010) at 15.

(c) supplying, producing or manufacturing equipment, material or substances used in the production or cultivation of controlled drugs (section 12A);
(d) knowingly importing or exporting a precursor substance for unlawful use (section 12AB);
(e) laundering the proceeds of drug offences (section 12B).

Offence committed while outside New Zealand

9.22 Under section 12C, it is an offence to do or omit to do any act outside New Zealand that would, if done or omitted in New Zealand, constitute one of the offences identified in paragraph 9.21. The maximum penalty for the offence is the same as it would be if the offence was committed in New Zealand.[604]

9.23 A person cannot be charged under section 12C unless he or she is a New Zealand citizen[605] and is present in New Zealand,[606] and the Attorney-General has given consent to a charge being laid.[607] Even if the Attorney-General's consent has not been obtained, a person who is alleged to have committed an offence against section 12C may be arrested, a warrant for his or her arrest may be issued and executed and he or she may be remanded in custody or on bail.[608] The Attorney-General may make such inquiries as he or she thinks fit when deciding whether or not to give consent.[609]

9.24 The relevant act or omission must be an offence under the law of the place where the act was done or omitted.[610] This reflects the international law principle of dual criminality which aims to provide additional protection for the individual concerned and to address differences in the development of criminal law and offences in different countries. There is an evidential onus on the defence to raise as an issue that the act or omission was not an offence where it was committed.[611] We discuss evidential onuses such as these later in the chapter.

9.25 This offence was introduced as part of New Zealand's obligations under the 1988 Convention. The requirement that the person be *present* in New Zealand gives effect to the "prosecute or extradite" rule in the 1988 Convention, which requires a party to prosecute an alleged offender found in its territory or extradite him or her to another party's jurisdiction for prosecution to occur. It is the same formulation as used in the Crimes of Torture Act 1989, which extends extra-territorial jurisdiction to acts of torture.

9.26 We discussed in the Issues Paper[612] whether the offence should instead take the same approach as the extra-territorial provisions in the Crimes Act, which extend jurisdiction to a person *ordinarily resident* in New Zealand.[613] Under that formulation, jurisdiction extends to people who are not in New Zealand at the

604 Misuse of Drugs Act 1975, s 12C(3).
605 Misuse of Drugs Act 1975, s 12C(2)(a).
606 Misuse of Drugs Act 1975, s 12C(2)(b).
607 Misuse of Drugs Act 1975, s 28A(1).
608 Misuse of Drugs Act 1975, s 28A(2).
609 Misuse of Drugs Act 1975, s 28A(3).
610 Misuse of Drugs Act 1975, s 12C(4).
611 Misuse of Drugs Act 1975, s 12C(5).
612 Law Commission *Controlling and Regulating Drugs*, above n 595, at [12.34]–[12.35].
613 See Crimes Act 1961, ss 7A and 105D.

time a charge is laid but who effectively make their home here.[614] However, we do not consider this change to be necessary. The 1988 Convention does not require that jurisdiction be asserted over people ordinarily resident in New Zealand. There is instead discretion for states to do so. In addition, the Crimes Act provision applies to a very limited range of offences. We consider the approach taken in section 12C to be more appropriate in the drugs context given the section's broad application.

Offence committed while in New Zealand

9.27 Under section 10, it is an offence, while in New Zealand, to aid, incite, counsel or procure an act or omission in another country if that act or omission:

(a) is an offence in that country corresponding to one of the offences identified in paragraph 9.21 above;[615] or

(b) would, if done or omitted in New Zealand, constitute one of the offences identified in paragraph 9.21,[616] and is an offence in the country where it occurred.[617]

9.28 It is difficult to see why both paragraphs are necessary. Any conduct that would be an offence under paragraph (b) would also be an offence under paragraph (a). We recommend that the drafting of the provision be simplified and clarified.

9.29 The maximum penalty if the act or omission constitutes an offence of dealing is 14 years imprisonment.[618] Otherwise, the maximum penalty is seven years imprisonment.[619]

9.30 We have some reservations about the maximum penalties for this offence, particularly in respect of their relativities with the same offence if committed in New Zealand. In particular, a person who aids, incites, counsels or procures an offence overseas that corresponds to or constitutes the offence of dealing in a Class C drug faces a maximum penalty that is six years higher than if the offence occurred in New Zealand.[620]

LAUNDERING PROCEEDS OF DRUG OFFENCES

9.31 Under section 12B, it is an offence to engage in a money laundering transaction or intend to do so in respect of property that is the proceeds of one of the following offences:

(a) dealing (section 6);

(b) cultivation of a prohibited plant (section 9);

614 Under s 4 of the Crimes Act 1961, people are "ordinarily resident" in New Zealand if their home is in New Zealand; they are residing in New Zealand with the intention of residing here indefinitely; or having resided in New Zealand with the intention of establishing their home here, or with the intention of residing in New Zealand indefinitely, they are outside New Zealand but intend to return to establish their home or reside in New Zealand indefinitely.

615 Misuse of Drugs Act 1975, s 10(1)(a).

616 Misuse of Drugs Act 1975, s 10(1)(b).

617 Misuse of Drugs Act 1975, s 10(4).

618 Misuse of Drugs Act 1975, s 10(2)(a). A lesser penalty applies upon summary conviction (s 10(3)); see above n 580.

619 Misuse of Drugs Act 1975, s 10(2)(b). A lesser penalty applies upon summary conviction (s 10(3)); see above n 580.

620 The maximum penalty for dealing in a Class C drug is eight years (Misuse of Drugs Act 1975, s 6(2)(c)).

(c) supplying, producing or manufacturing equipment, material or substances used in the production or cultivation of controlled drugs (section 12A);

(d) knowingly importing or exporting a precursor substance for unlawful use (section 12AB).

9.32 A maximum penalty of seven years imprisonment applies if the money laundering transaction was actually engaged in,[621] with a maximum penalty of five years imprisonment if property was possessed or obtained with the intention of money laundering.[622]

9.33 It is a defence if the act to which the charge relates was done, in good faith, for the purpose of or in connection with the enforcement or intended enforcement of the Misuse of Drugs Act, Criminal Proceeds (Recovery) Act 2009, Financial Transactions Reporting Act 1996 or Anti-Money Laundering and Countering Financing of Terrorism Act 2009.[623] If the alleged act resulting in criminal proceeds was committed outside New Zealand, it is to be presumed that the act was an offence where it was committed, unless the defendant puts the matter at issue.[624]

9.34 This offence was introduced in 1998 to meet New Zealand's obligations under the 1988 Convention. Although it overlaps with the generic money laundering offence in the Crimes Act,[625] we recommend a drug-specific offence be retained. A separate offence facilitates the application of special rules relating to extra-territoriality and extradition that were required by the 1988 Convention[626] and means that it can be readily included in the list of offences to which section 35A (relating to extradition) and sections 10 and 12C (relating to extra-territorial offences) of the Act apply.

MISCELLANEOUS OFFENCES

Theft of controlled drugs

9.35 Under section 11, it is an offence to:

(a) steal a controlled drug; or

(b) with intent to defraud by any false pretence, either directly or through the medium of any contract obtained by the false pretence:

(i) obtain possession of or title to a controlled drug; or

(ii) procure a controlled drug to be delivered to any person other than the offender or;

(c) receive a controlled drug obtained by any crime, or by any act, wherever committed that, if committed in New Zealand, would constitute a crime, knowing that the controlled drug had been dishonestly obtained or being reckless as to whether or not the controlled drug had been stolen or so obtained.

621 Misuse of Drugs Act 1975, s 12B(2).

622 Misuse of Drugs Act 1975, s 12B(3).

623 Misuse of Drugs Act 1975, s 12B(6).

624 Misuse of Drugs Act 1975, s 12B(8)

625 Crimes Act 1961, ss 243–245. The original money laundering offence was inserted by the Crimes Amendment Act 1995.

626 See Misuse of Drugs Act 1975, s 35A in relation to extradition, and Misuse of Drugs Act 1975, ss 10 and 12 in relation to extra-territoriality.

9.36 Offences under section 11 carry a maximum penalty of seven years imprisonment, which is the same maximum penalty as for the most serious theft, receiving and deception offences in the Crimes Act.[627]

9.37 The offence is not strictly necessary, given that the general dishonesty offences in the Crimes Act cover the same ground.[628] However, a separate offence provides additional transparency and enables a drug-specific approach to be taken to the offence's maximum penalty (maximum penalties for the offences in the Crimes Act are linked to the amount stolen or received).[629]

Possession of seed or fruit of prohibited plant

9.38 Under section 13(1)(b), it is an offence to possess the seed or fruit (not being a controlled drug) of any prohibited plant, except if authorised to do so under the Act[630] or as may be provided by regulations.[631] The maximum penalty is 12 months imprisonment and/or a fine not exceeding $500.[632]

9.39 It is a defence if the person charged proves that the prohibited plant to which the charge relates was of the species Papaver somniferum (opium poppy), and that it was not intended to be a source of any controlled drug or that it was not developed as a strain from which a controlled drug could be produced.[633] We discuss legal onuses such as these later in the chapter.

9.40 We are not aware of any charges being laid under this section in recent times. The most common seed that is likely to be possessed is cannabis seed, which is itself a Class C controlled drug. Its possession is therefore charged as an offence under section 7 of the Act. However, the offence remains necessary in order to ensure New Zealand complies with its international obligations.

False statements

9.41 Under section 15, it is an offence for any person to:

(a) make any declaration or statement which he or she knows to be false in any particular;

(b) utter, produce or make use of any statement or declaration which he or she knows to be false in any particular; or

(c) knowingly utter, produce or make use of any document that is not genuine;

for the purpose of obtaining a licence or for any other purpose under the Act. The maximum penalty is 12 months imprisonment and/or a fine of $1,000.

627 See Crimes Act 1961, ss 223 and 247.

628 See Crimes Act 1961, ss 219 (theft), 240 (obtaining by deception) and 246 (receiving).

629 See Crimes Act 1961, ss 223 (punishment of theft), 241 (obtaining by deception) and 247 (punishment of receiving).

630 Under a licence to cultivate prohibited plants issued under s 14 of the Misuse of Drugs Act 1975.

631 For example, Misuse of Drugs (Industrial Hemp) Regulations 2006.

632 Misuse of Drugs Act 1975, s 13(3).

633 Misuse of Drugs Act 1975, ss 9(4) and 13(2).

9.42 We recommend the retention of this offence. However, its scope should be limited to false statements that are made for the purpose of obtaining a licence. While it is appropriate that the licensing authority be able to prosecute a person who knowingly provides false information for that purpose, we do not think it is appropriate to have a broad offence that covers false statements made "for any other purpose under the Act". The circumstances in which it is an offence to make a false statement or use a document that is not genuine should be expressly stated.

Other offences?

Children found in clandestine drug laboratories

9.43 In chapter 2, we noted that exposure to the highly flammable, corrosive and explosive chemicals involved in methamphetamine manufacture is a particularly serious social harm associated with that drug. The New Zealand Police had earlier expressed concern to us that current criminal offences are insufficient to ensure the liability of those who have exposed others, particularly children, to the dangers associated with methamphetamine manufacture.

9.44 In 2007, the Law Commission recommended the revision of much of Part 8 of the Crimes Act, which deals with offences against the person.[634] This includes changes to the offence of wilful neglect (charged as cruelty to a child under section 195 of the Crimes Act), which is the offence that until now has been the most applicable in these situations. That offence applies to a person "who, having the custody, control, or charge of any child under the age of 16 years,…wilfully neglects the child in a manner likely to cause him unnecessary suffering, actual bodily harm, injury to health, or any mental disorder or disability."

9.45 The relevant recommendations from the Commission's review include:[635]

(a) A redrafted and broader section 195 of the Crimes Act. This includes the replacement of the "wilful" requirement (which requires that the alleged neglect be deliberate) with the lesser "gross negligence" standard (which requires that the alleged neglect was a major departure from the standard of care to be expected of a reasonable person). The offence would also be extended to apply to children under the age of 18 years, and the maximum penalty raised from five years to 10 years.

(b) An extension of the scope of statutory duties on parents and guardians, by introducing an additional duty to take reasonable steps to protect a child from injury. "Injury", which would be defined as meaning actual bodily harm, would include, for example, physical harm caused by exposure to methamphetamine and/or dangerous chemicals used in its manufacture.

(c) Revised endangerment offences, so that anyone who did any unlawful act or omitted to perform any statutory duty committed an offence punishable by up to two years imprisonment if, in the circumstances, that act or omission was likely to injure another. Where injury resulted, the maximum penalty would be up to three years imprisonment. The lesser "gross negligence" standard would also apply to these offences.

634 Law Commission *Review of Part 8 of the Crimes Act 1961: Crimes Against the Person* (NZLC R111, 2007).

635 Ibid, at chs 4 and 5.

9.46 The above recommendations, which have been accepted by the Government,[636] make substantial changes to the laws relating to child neglect and ill-treatment. They provide much greater scope for successful prosecutions to be brought against individuals who do not adequately protect children from the harm of drug manufacture. In the light of these recommendations, we do not consider that any additional offences are required.

9.47 We understand that there may be a separate issue relating to the steps that should be taken, and powers that are available, to address the needs of children who have been exposed to methamphetamine chemicals – for example, because their home is being used as a clan lab. Current powers that can be used by police officers and Child, Youth and Family workers are provided in the Children, Young Persons, and Their Families Act 1989. They include the ability to remove children from the premises[637] and for children to be medically examined.[638] We understand this to be primarily a practice issue, rather than an area where legislative amendment is required.

GENERAL MAXIMUM PENALTY

9.48 Under section 27, where a maximum penalty for a particular offence under the Act is not specified, the default penalty is imprisonment for up to three months and/or a fine of up to $500.[639] The offences to which this penalty applies tend to be in the nature of regulatory offences rather than core criminal offences – in particular:

(a) contravention of or failure to comply with any condition of a licence granted under the Act (section 14(6));
(b) obstruction of those exercising powers under the Act (section 16);
(c) refusing or neglecting to comply with a demand or requirement to produce records and inspect documents (section 19(4));
(d) publishing information about a drug dependent person obtained from a statement made by a medical officer of health under the Act, or commenting on that statement (section 20(5));
(e) publishing the name or particulars of a controlled drug in contravention of an order made by the court or the coroner (section 21(2));
(f) contravention of, or failure to comply with, a notice issued by the Minister of Health prohibiting dealing in or using specified controlled drugs (section 22(2));
(g) prescribing, supplying or administering a controlled drug to a person dependent on that drug, in contravention of the Act (section 24(1) and (1A));
(h) prescribing or supplying a controlled drug to a restricted person (section 25(2)(a));
(i) being a restricted person, procuring or attempting to procure a controlled drug (section 25(2)(b)).

636 See Simon Power, Minister of Justice "Govt to Strengthen Crimes Act to Protect Children" (Press Release, 18 December 2009) <www.beehive.govt.nz>.

637 Either by way of a court-ordered place of safety warrant under s 39 of the Children, Young Persons, and Their Families Act 1989 or, if the situation is more urgent, without warrant under s 42.

638 See Children, Young Persons, and Their Families Act 1989, s 53.

639 Misuse of Drugs Act 1975, s 27.

9.49 In other parts of this Report, we have recommended the repeal of the offences in section 20 (see (d) above), section 21 (see (e) above) and section 22 (see (f) above). The offence identified in (a) applies in a licensing context so is dealt with in chapter 10 along with other licensing matters.

9.50 Although there is no difficulty in principle with a general maximum penalty that applies to a number of offences, it is more transparent and accessible for a maximum penalty to appear alongside the offence to which it applies.

9.51 In addition, as a matter of principle, we do not consider that it is appropriate to provide maximum penalties that include both a term of imprisonment and a fine. There is no obvious relativity between a particular level of imprisonment and a fine of a particular amount. Where maximum penalties are stated in this way, there is no consistency across the statute book in the level of imprisonment and the amount of fine that are specified. Finally, whether or not a maximum fine is specifically provided as part of an offence's maximum penalty, a fine may be imposed for that offence in accordance with the provisions of the Sentencing Act 2002.[640] We recommend that maximum penalties for drugs offences that specify a maximum term of imprisonment should not specify a maximum fine.

9.52 We consider that a maximum penalty of three months imprisonment continues to be appropriate for the offences identified in (b), (c), (g), (h) and (i) above.

9.53 The offence in (b) may apply in respect of the criminal or regulatory powers that are conferred in the Act. In the criminal context, it is analogous to the offence of resisting a police, prison or traffic officer that is provided in the Summary Offences Act 1981.[641] It is appropriate that the maximum penalty for both offences is aligned. That offence carries a maximum penalty of three months imprisonment or a $2,000 fine.

9.54 The offence in (c) will primarily apply in a regulatory context – in particular, to enforce the compliance of health practitioners with statutory exemptions or the licensing regime discussed in chapter 10. It has some parallels with the offence we propose in chapter 5 relating to the failure of a manufacturer or an importer of an approved substance to file an annual return or report, or including false or misleading information in them. That offence has a proposed maximum penalty of three months imprisonment. It makes sense for the maximum penalties for both offences to be aligned.

9.55 Although committed in a different context, the offences in (g), (h) and (i) are analogous to personal possession and use offences. In respect of the offences in (h) and (i), which relate to the restricted persons regime, a maximum penalty of three months imprisonment is the same as that provided for the equivalent offence in the Medicines Act 1981 which covers drug seekers targeting prescription medicine.[642]

640 Sentencing Act 2002, s 39(1).

641 Summary Offences Act 1981, s 23.

642 Medicines Act 1981, ss 49 and 78.

LIMITATION PERIODS

9.56 Under section 28, most charges in relation to alleged offences committed under the Misuse of Drugs Act or its regulations must be laid within four years of their commission.[643] An exception is made for dealing,[644] cultivation of a prohibited plant,[645] or aiding offences against the corresponding law of another country.[646] There is no time limit on when charges in relation to these offences can be laid.

9.57 Limitation periods reflect a number of considerations. The prosecuting authority must have sufficient time to investigate an offence and decide on appropriate charges, to ensure that people are held to account for their criminal activity and do not escape liability simply because of the passage of time. However, long limitation periods may themselves impede justice, by creating a risk of undue delay and by making witnesses' memories less reliable. When the offence is minor, defendants may also suffer disproportionate stress and pressure from the possibility of a prosecution hanging over their head for an extended period of time.

9.58 We see no reason why the limitation periods in drugs cases should differ from the limitation periods that apply more generally in criminal cases.[647] The Criminal Procedure (Reform and Modernisation) Bill, which was introduced into Parliament in November 2010, reforms the current general limitation periods so that, broadly:

(a) a 12-month limitation period will apply to offences with a maximum penalty that does not exceed six months imprisonment or a $20,000 fine;

(b) a five-year limitation period will apply to offences with a maximum penalty of between six months imprisonment and three years imprisonment;

(c) there will be no limitation period for offences with a maximum penalty of more than three years imprisonment.[648]

9.59 If these limitation periods are applied to the current offences in the Misuse of Drugs Act, the limitation periods for most offences would either remain unlimited or slightly increase from four years to five years. However, the limitation periods for possession and use offences under section 7 would decrease from four years to 12 months, as would the limitation periods for many regulatory offences. We do not consider any of this to be problematic. In particular, we do not think there should be any restriction on when charges for the most serious offences should be laid. And, as noted in the Issues Paper, we do not consider that a four-year limitation period is necessary, appropriate or proportionate to the seriousness of personal use offences.[649]

643 Misuse of Drugs Act 1975, s 28(2).

644 Misuse of Drugs Act 1975, s 6.

645 Misuse of Drugs Act 1975, s 9.

646 Misuse of Drugs Act 1975, s 10.

647 Currently, in respect of criminal charges more generally, charges that are laid in the summary jurisdiction must be laid within six months of the offence being committed. In indictable matters, there is a limitation period of 10 years for offences carrying a maximum penalty of up to three years imprisonment and/or a $2,000 fine, and no limitation period for offences with a greater maximum penalty.

648 Criminal Procedure (Reform and Modernisation) Bill 2010 (243–1), cl 22.

649 Law Commission *Controlling and Regulating Drugs*, above n 595, at [12.65]–[12.71].

9.60 If, contrary to our recommendations in chapter 8, the possession of utensils offence remains in place and its maximum penalty is not aligned to the possession and use offences, we recommend that its limitation period is aligned to that for those offences. Given the close connection between these offences, it is anomalous for the limitation periods to differ.

LIABILITY FOR THE ACTS OF ANOTHER

Liability of a principal for the acts of an agent

9.61 Under section 17(1), a principal is liable for an offence committed by any person acting as his or her agent at the time of the offence, as if the principal had personally committed the offence, if the offence was committed with the principal's consent or connivance or was attributable to his or her neglect.[650] This is in addition to the liability of the agent for that same offence. Section 17(1) also explicitly applies in an employment context; liability for an act committed by a person who is subject to the supervision or instructions of another will fall on the latter, instead of or in addition to the former.

9.62 There is no separate maximum penalty that applies in these situations. Where section 17(1) applies, the principal is liable for the same maximum penalty as the agent, with each person's respective culpability reflected in his or her sentence.

9.63 Section 17(1) is contrary to the general approach of the criminal law to parties' liability. Under section 66 of the Crimes Act, a person is only liable as a party to an offence if he or she:

- does or omits an act for the purpose of aiding any person to commit the offence;
- abets any person in the commission of the offence; or
- incites, counsels or procures any person to commit the offence.[651]

9.64 In contrast to section 17(1), therefore, section 66 does not extend parties' liability to a person whose negligence enables an offence to occur. However, section 17(1) is replicated in a number of other statutes, all of which apply in a regulatory context.[652] This is because it is in the regulatory context, rather than in the criminal context, that principals are likely to have relationships with agents that affect their fulfilment of specific statutory obligations.

9.65 A particular concern arises with the Misuse of Drugs Act because section 17(1) applies to offences with substantial terms of imprisonment, including life imprisonment. This makes the Act different from other statutes in which this type of liability arises. It reflects the breadth of the Act, which deals with both serious criminal conduct as well as conduct in a regulatory context. A similar provision exists in the Medicines Act.[653]

650 Misuse of Drugs Act 1975, s 17(1).

651 Crimes Act 1961, s 66(1).

652 See, for example: Crown Minerals Act 1991, s 102; Lawyers and Conveyancers Act 2006, s 264; Agricultural Compounds and Veterinary Medicines Act 1997, s 58; United Nations Convention on the Law of the Sea Act 1996, s 10; Maritime Transport Act 1994, s 410; Land Transport Act 1998, s 79; Health Act 1956, s 69ZZS; Hazardous Substances and New Organisms Act 1996, s 115; Food Act 1981, s 29; Building Act 2004, s 386; Climate Change Response Act 2002, s 141; Wine Act 2003, s 109; Animal Products Act 1999, s 144; Weights and Measures Act 1987, s 31; Medicines Act 1981, s 79; Petroleum Demand Restraint Act 1981, s 24; Arms Act 1983, s 67.

653 Medicines Act 1981, s 79.

9.66 Some concerns have been raised by submitters about the scope of section 17(1). In particular, the New Zealand Law Society argued that the provision was "contrary to good principle" because it appeared to impose an "open-ended and broad liability to prevent another's offending".[654]

9.67 On balance, we think that section 17(1) should be retained. Our understanding of the provision is that it does not apply to every situation where there is a principal and an agent, but is limited to situations where the agent is acting for the principal in the commission of the offence. For example, a pharmacist would not be liable if an employee stole morphine and sold it after-hours to friends, because the employee was not acting as the pharmacist's agent at the time of the offence. However, a pharmacist would (and, in our view, should) be liable if an employee sold morphine over-the-counter without a prescription, so that an offence was committed due to the pharmacist's failure to ensure proper procedures were followed. We consider that the current wording of section 17(1) is sufficient to reflect this distinction. If there is any ambiguity, the provision should be redrafted to put the matter beyond doubt.

9.68 In addition, we do not think that principals should always be liable to the same maximum penalty as their agents. This is particularly the case if the principal is liable on the basis of negligence. To take the above example, it seems difficult to justify making a negligent pharmacist liable to life imprisonment if the drug the agent sold over-the-counter without a prescription was a Class A drug. We prefer an approach where the applicable maximum penalty is half the maximum penalty that applies to the agent.

Liability of company directors

9.69 Under section 17(2), if a body corporate is convicted of an offence against the Act, a director or other person involved in the management of that company will be guilty of a like offence if it is proved that the offence was committed with his or her consent or connivance or that it was attributable to his or her neglect. In a similar way to section 17(1), a director or other person involved in the company will be liable for the maximum penalty that applies to the offence with which he or she has been charged.

9.70 The liability of directors and others involved in the company is also a well-established principle of criminal law. This type of liability aims to pierce the corporate veil, and ensure that those individuals who bear some responsibility for the company's offending are individually held accountable for their actions.

9.71 As with section 17(1), we think that there should be a lower maximum penalty when section 17(2) applies due to negligence, rather than consent or connivance. Otherwise, we propose that this provision be retained, subject to any redrafting as for section 17(1).

654 Submission of the New Zealand Law Society (submission dated 17 May 2010) at 18.

MATTERS OF PROOF, ONUSES AND DEFENCES

Matters of proof

9.72 The Misuse of Drugs Act contains explicit provisions to simplify and streamline the process for proving particular matters in court once a charge has been laid.

Cannabis preparations

9.73 Cannabis preparations, for example, cannabis resin or oil, are Class B drugs. The Act defines a cannabis preparation as a preparation containing any tetrahydrocannabinols (THC) produced by subjecting cannabis plant material to any kind of processing.[655]

9.74 Under section 29B, the prosecution must prove the presence of THC when an offence of dealing, possessing or using a cannabis preparation is alleged.[656] The required processing is then deemed to have occurred unless the preparation is in a form that is clearly recognisable as plant material.[657] If there is a dispute between the prosecution and defence, the fact-finder (whether judge or jury) must determine it by simply looking at the material.[658]

9.75 Section 29B was inserted into the Act in 1982, along with an amended definition of a cannabis preparation. This was in response to difficulties encountered in court cases in distinguishing between cannabis resin and cannabis plant.[659] It provides a straight-forward and clear process for proving that the substance the alleged offender was dealing, possessing or using was a Class B cannabis preparation and not a Class C cannabis plant.

Evidence of analysis

9.76 The Act includes provisions that avoid the need for evidence to be called from scientific analysts in every case to prove the chain of custody and that a substance, preparation, mixture or article was the particular controlled drug or precursor substance alleged. A certificate to that effect is instead admissible in evidence.[660]

9.77 Section 31 includes detailed requirements about the circumstances in which a certificate may be given, and the information that must be included within it. These requirements are strict, and the courts will hold the certificate to be inadmissible if they are not complied with.

9.78 For the certificate to be admissible in evidence, the prosecution must serve the certificate on the defence at least seven clear days before the hearing at which the certificate is to be used. If the defence requires that the analyst be called as a witness, for example, because it wishes to challenge the analysis or question the analyst about related matters, it must provide written notice of this

655 Misuse of Drugs Act 1975, sch 2, part 1.

656 Misuse of Drugs Act 1975, s 29B(a).

657 Misuse of Drugs Act 1975, s 29B(b).

658 To be determined "by means of a visual inspection unaided by any microscope or magnifying glass (other than spectacles ordinarily worn) or by any other device" (Misuse of Drugs Act 1975, s 29B(d)).

659 See *Tarlton v Police* (1986) 2 CRNZ 283 (HC) at 284 and *R v Gillan* [2005] DCR 319 at 326.

660 Misuse of Drugs Act 1975, s 31(2).

requirement to the prosecution at least three clear days before the hearing.[661] The court may also direct, on its own initiative or on application by the defence, that the analyst be called as a witness.[662]

9.79 The New Zealand Law Society has suggested that consideration be given to aligning these requirements with the disclosure regime provided in the Criminal Disclosure Act 2008.[663] We do not think this is necessary. Disclosure of the certificate already falls within the 2008 Act's regime.[664] The requirements in section 31 provide a "back-stop" to this regime to ensure that the defence is provided with an adequate opportunity to respond to the certificate when it is relied on by the prosecution.

9.80 Although we think section 31 could be drafted more clearly, we are not aware of any difficulties with how it operates in practice. It reflects a pragmatic approach to proving the results of scientific analysis in court, with necessary safeguards for the defendant to ensure it is only used in appropriate cases.

Evidential onuses on the defendant

The effect of evidential onuses

9.81 The general principle in criminal matters is that the prosecution must prove the elements of the offence with which the defendant is charged, and rebut any defences, beyond a reasonable doubt. This is in accordance with the overarching right, reflected in section 25(c) of the New Zealand Bill of Rights Act 1990, to be presumed innocent until proven guilty.

9.82 Evidential onuses on the defendant require the defence to point to evidence that a particular issue or defence applies in a particular case. Once raised by the defence, the prosecution must rebut or disprove that issue or defence beyond a reasonable doubt. If the issue or defence is not raised, it is presumed not to apply and the prosecution has no onus in respect of it.

9.83 Evidential onuses therefore avoid the need for the prosecution to prove a particular issue, or rebut a particular defence, in every case. However, unlike reverse legal onuses, they do not shift the burden of proof. They are therefore more likely to be consistent with the Bill of Rights Act.

9.84 Currently, a defendant has a clear evidential onus in relation to anything that might be categorised as a defence.[665] For example, in a case of assault, unless the defence points to evidence that the defendant used force in self-defence, the prosecution is not required to prove that the defendant did not use force for that purpose. However, in reality, something akin to an evidential onus often also applies to the core elements of the offence. To again take the example of assault,

661 Misuse of Drugs Act 1975, s 31(3).

662 Misuse of Drugs Act 1975, s 31(4).

663 Submission of the New Zealand Law Society (dated 17 May 2010) at 18.

664 See, in particular, the disclosure requirements in s 13(3) of the Criminal Disclosure Act 2008.

665 In the Misuse of Drugs Act 1975, this includes the defences in s 10 (that an act or omission was not an offence where it was done or omitted) and s 12B(6) (that drug proceeds were laundered in connection with enforcement of the Act).

if the defendant disputes that the force applied was intentional, he or she will need to point to some evidence which raises that as a reasonable possibility. Otherwise, the obvious inference will be drawn that the action was an intended one.

9.85 The question is, therefore, whether there is continued value in expressly stating that an evidential onus exists. A related question is whether specifying an evidential onus in relation to a particular element suggests it should be treated differently from another element that may, in practice, carry an evidential onus as well.

Explicit evidential onuses in the Misuse of Drugs Act

9.86 Under section 12AC(4), a defendant charged with an offence of importing or exporting a precursor substance without reasonable excuse has the onus of pointing to evidence that he or she had a reasonable excuse.[666] We do not think this onus needs to be explicitly stated. The defence will always have the onus of pointing to evidence which suggests that a reasonable excuse exists. It also risks confusion to explicitly identify the evidential onus in this provision and not in comparable provisions where the defendant may also avoid liability if he or she has a reasonable excuse. Section 12AC(4) is currently slated for repeal under the Criminal Procedure (Reform and Modernisation) Bill.[667]

9.87 The Act includes two evidential onuses which require the defendant to point to evidence that a relevant act was not an offence in the country where it occurred. Under section 12B(8), a defendant charged with an offence of laundering drug proceeds that resulted from acts done overseas must point to evidence that the act which is alleged to constitute the offence was not an offence in the country where it occurred.[668] The same applies under section 12C(5) to a defendant charged with committing a specified drug offence outside New Zealand.[669]

9.88 We think there is some value in continuing to explicitly state these evidential onuses. In one sense, it seems unreasonable to require the defendant to raise the issue of whether the conduct was an offence where it was done when that issue should be able to be easily proved by the prosecution. However, in most cases, the effect of the international drug conventions means that what is an offence in New Zealand will also be an offence elsewhere. It therefore seems unnecessary for the prosecution to be required to prove this in every case.

9.89 There is also an explicit evidential onus on a defendant in summary proceedings, who is charged with an offence for which possession of a controlled drug is an element of the offence, to point to evidence that the amount possessed was not of a usable quantity.[670] This was a response to a 1975 Court of Appeal decision that a drug could not be possessed if the amount held was not of a usable quantity

666 Misuse of Drugs Act 1975, s 12AC(4).

667 Criminal Procedure (Reform and Modernisation) Bill 2010 (243–1), sch 6.

668 Misuse of Drugs Act 1975, s 12B(8).

669 Misuse of Drugs Act 1975, s 12C(5).

670 Misuse of Drugs Act 1975, s 29A.

– that is, if it was "minute and useless residue".[671] The Court based its decision on the object of the then Narcotics Act 1965, which was to prevent the illicit use of drugs rather than to eliminate the existence of drugs as an end in itself.[672]

9.90 Section 29A provides that the prosecution is not required to prove that the amount of drug possessed by the defendant was of a usable quantity unless the defence raises the issue.[673] If the defence does so, the prosecution must prove that the amount possessed was usable beyond a reasonable doubt. Section 29A also includes procedural provisions to ensure that the prosecution has an opportunity to respond to the issue once raised.[674]

9.91 We recommend the repeal of section 29A. The "usable quantity" requirement is just one element of the legal concept of possession. It is anomalous for an evidential onus for this element to be covered in statute, when other elements like the need for the person to have control over the drug alleged to be possessed, are not covered. The legal position in relation to all of the elements are the same – that is, if the defendant disputes an element of possession, he or she will need to point to some evidence which raises that as a reasonable possibility. It is also anomalous for section 29A to apply only to summary proceedings and not indictable proceedings. Whether or not a drug was of a usable quantity is not an issue that is confined to summary cases. [675]

9.92 The procedural provisions in section 29A, which are essentially designed to prevent an "ambush attack" by the defence, are also superseded by a new proposal to require the defence to identify the issues in dispute in every case. This proposal, which has its roots in previous Law Commission projects,[676] is reflected in the Criminal Procedure (Reform and Modernisation) Bill.[677]

Legal onuses of proof on the defendant

9.93 In chapter 7, we discussed the onus of proof that is placed on the defendant in relation to the presumption of supply. In *R v Hansen*,[678] the Supreme Court found that the reverse onus in relation to the presumption of supply breached section 25(c) and was not a justified limitation on that right under section 5 of the Bill of Rights Act. This decision puts into question the other three reverse onuses of proof in the Misuse of Drugs Act.

671 *Police v Emirali* [1976] 2 NZLR 476 at 480.

672 Ibid.

673 Misuse of Drugs Act 1975, s 29A(1).

674 Misuse of Drugs Act 1975, s 29A(2).

675 See, for example, *R v Yorston* [2008] NZCA 285.

676 See, in particular, Law Commission *Criminal Pre-trial Processes: Justice Through Efficiency* (NZLC R89, 2005) and Ministry of Justice and Law Commission *Discussion Document: Identification of Issues in Dispute* (May 2009).

677 Criminal Procedure (Reform and Modernisation) Bill 2010 (243–1), cls 64–67.

678 *R v Hansen* [2007] 3 NZLR 1 (SC).

Acting under an exemption or pursuant to a licence

9.94 Under section 30, when it is proved that a person possessed a controlled drug or did anything with a controlled drug that would amount to an offence, the defence must prove that a statutory exemption applies, or that the drug was possessed or the act was done pursuant to a licence or as permitted by regulations.[679] Section 30 applies, for example, when an individual is charged with dealing,[680] possessing or using a controlled drug[681] or cultivating a prohibited plant.[682]

9.95 The argument for the legal onus falling on the defence in these cases is that a defendant who is acting under an exemption, licence or regulation should have no difficulty in proving that to be the case. The onus should therefore be easily discharged.[683] It is rather more difficult for the prosecution to prove that an exemption, licence or regulation does *not* apply (although, in relation to licences held on a register, it should not be a significant hurdle for the prosecution to prove that the defendant does not possess one).

9.96 However, an evidential onus is more consistent in this situation with other provisions in the Act. As discussed above, under section 12AC, there is an evidential onus on the defence to raise that a defendant has a reasonable excuse for importing or exporting a precursor substance so that an offence is not committed.[684] These excuses include that a medical practitioner, dentist, veterinarian or pharmacist is acting in accordance with a statutory exemption.[685] It is not clear why there should be a legal onus on the defendant in one situation and an evidential onus in the other. (As discussed in paragraph 9.86, we do not think there is a need to make explicit provision for the evidential onus in section 12AC.)

9.97 The New Zealand Law Society agreed that an evidential onus for the matters covered in section 30 was preferable to a legal onus. It suggested that this change should be "… combined with a requirement that notice be given of the evidence to be called on the issue sufficient to allow the prosecution to have a reasonable opportunity of calling evidence to the contrary if necessary".[686] The Criminal Procedure (Reform and Modernisation) Bill, which includes provisions to require the defence to identify the issues in dispute before the trial, goes some way towards the Law Society's proposal. However, a requirement on the defence to disclose evidence represents a major departure from the status quo. While we consider it could have significant benefits, we see no reason why it should be limited to this offence alone. It is therefore outside the scope of this review.

679 Note that we recommend that exemptions and permissions contained in regulations be moved into primary legislation – see ch 10.

680 Misuse of Drugs Act 1975, s 6.

681 Misuse of Drugs Act 1975, s 7.

682 Misuse of Drugs Act 1975, s 9.

683 *R v Hunt* [1987] 1 AC 352 (HL) at 374.

684 Misuse of Drugs Act 1975, s 12AC(1).

685 Misuse of Drugs Act 1975, s 12AC(2).

686 Submission of the New Zealand Law Society (submission dated 17 May 2010) at 20.

Controlled drug analogues

9.98 A controlled drug analogue is a substance with a chemical structure that is substantially similar to a controlled drug[687] and that may mimic the effect of a controlled drug. As discussed in chapter 5, controlled drug analogues are defined as Class C drugs, unless otherwise classified.[688]

9.99 Under section 29C, when the possession of a controlled drug analogue is alleged, it is a defence if the defendant proves that either:

(a) he or she did not possess it to use it in a manner intended to have a pharmacological effect or to supply or administer it to any other person;[689] or

(b) he or she possessed it to supply or administer it to any other person in accordance with any procedure approved by the Director-General of Health.[690]

9.100 Section 29C was inserted by the Misuse of Drugs Amendment Act (No 2) 1987, which extended the Act's coverage to controlled drug analogues.

9.101 In chapter 5, we recommended the repeal of the controlled drug analogue provisions in favour of a new approach that places the onus on manufacturers and suppliers of new substances to prove that they are safe. As a consequence, section 29C is no longer required and can be repealed.

Possession of Papaver somniferum for an innocent purpose

9.102 When charged with cultivation of a prohibited plant, or possession of a seed or fruit, the defendant has the onus of proving that the seed, fruit or plant was not of the species Papaver somniferum, and that it was not intended to be a source of any controlled drug or that it was not developed as a strain from which a controlled drug could be produced.[691]

9.103 We see no difficulty with a requirement that the defendant prove the purpose for which poppies were possessed. This is a matter that is peculiarly within the defendant's knowledge, and which he or she should be able to readily establish. However, we do not think the same can be said for the requirement that the defendant prove the nature of the substance possessed. This is a fundamental element of the charge, and should not be difficult for the prosecution to prove.

687 Misuse of Drugs Act 1975, s 2.

688 Misuse of Drugs Act 1975, s 2.

689 Misuse of Drugs Act 1975, s 29C(a).

690 Misuse of Drugs Act 1975, s 29C(b).

691 Misuse of Drugs Act 1975, s 9(4).

Mistake as to the nature of the controlled drug or precursor substance

9.104 Under section 29, where the prosecution must, and does, prove that a substance, preparation, mixture or article involved in an alleged offence was a particular controlled drug or precursor substance, the defendant cannot be acquitted on the basis that he or she did not know that the substance, preparation, mixture or article was that drug or substance. For example, if the prosecution proves that the defendant supplied a Class A drug (and therefore committed an offence under section 6(1)(c)), the defendant can still be convicted of that offence even though he or she thought the drug supplied was in Class C (which is a separate offence under section 7(1)(b)).[692]

9.105 Section 29 applies when the defendant is charged with an offence under any of sections 6 (dealing), 7 (possession and use), 12 (use of premises or vehicle, etc), 12A (equipment, material and substances used to produce or cultivate controlled drugs), 12AB (knowingly importing or exporting precursor substances for unlawful use) or 12AC (importing or exporting precursor substance without reasonable excuse). It reflects the fact that the criminality of these offences is the defendant's intention to engage in illegal conduct in relation to a controlled drug or precursor substance. That the defendant thought he or she was engaging in conduct with one illegal drug or substance when in fact it was with another is irrelevant to the defendant's liability for the offence. The defendant is "skating on thin ice" by intending to act illegally at all. (The fact that the defendant thought he or she was engaging in conduct with a drug of a different class may be taken into account in sentencing.)

9.106 The situation would be different if the defendant thought that the substance was entirely innocent – for example, that the plants being grown were tomato plants rather than cannabis plants.[693] In that case, the defendant would not think he or she was acting illegally and should therefore not be held criminally liable for his or her actions.

9.107 We recommend that section 29 be retained. However, as a drafting matter, the drafting of the section is quite complex and could be vastly simplified to make its meaning more clear. This includes an explicit statement of the requirement for the prosecution to prove that the defendant knew that the substance was a controlled drug or precursor.

692 For a case example, see *Marks v R* HC Auckland M67202, 5 November 2002 where the fact that the defendant thought he was producing morphine, when he in fact produced heroin, was irrelevant to a charge of producing heroin.

693 See, for example, *R v Strawbridge* [1970] NZLR 909 (CA) where the defendant was acquitted of a charge of cannabis cultivation in this situation. For further discussion see Don Mathias "Guilty Knowledge about Drugs" [1991] NZLJ 280.

Current legislative framework

9.108 The Misuse of Drugs Act includes a specific forfeiture regime upon conviction for offending against the Act. The core components of this regime are:

(a) For any offence, the offender must forfeit all articles in respect of which an offence was committed and which are in the offender's possession (for example, a pipe to smoke methamphetamine or the methamphetamine itself).[694]

(b) For dealing offences:

(i) a judge may order the forfeiture of money found in the offender's possession if satisfied that the money was related to the offending;[695]

(ii) a judge must order the forfeiture of a motor vehicle, aircraft, ship, boat or other vessel owned by the offender if satisfied that it was used to commit the offence, unless it would be unjust to do so in the circumstances of the case.[696]

9.109 When a dealing offence relates to import or export, the Customs and Excise Act 1996 also applies. That Act enables Customs to seize and forfeit prohibited goods (whether controlled drugs, precursor substances or utensils).[697] The goods are condemned and disposed of upon conviction.[698] If a conviction does not eventuate, a civil forfeiture regime applies.[699]

9.110 In addition to these two regimes, the Misuse of Drugs Amendment Act 1978 enables a court to indirectly forfeit dealing proceeds when sentencing a person convicted of a dealing offence. The court may impose a greater fine than it otherwise would have if:

(a) it is satisfied on the balance of probabilities that any money or assets owned by the offender were acquired by him [or her] directly or indirectly from the offence;[700] or

(b) on application by the Crown:

(i) it is satisfied beyond reasonable doubt that, before the commission of the offence being sentenced, the offender engaged in an activity that amounted to another drug dealing offence; and

(ii) it is satisfied on the balance of probabilities that any money or assets owned by the offender were acquired by him [or her] directly or indirectly from that offence.[701]

694 Misuse of Drugs Act 1975, s 32(1).

695 Misuse of Drugs Act 1975, s 32(3). This applies where the judge is satisfied that money found in a person's possession was received in the course of or consequent upon the commission of that offence, or was in the person's possession for the purpose of facilitating the commission of an offence against s 6.

696 Misuse of Drugs Act 1975, s 32(4).

697 Customs and Excise Act 1996, s 225. See s 54(1)(a) in relation to pipes and other utensils.

698 Customs and Excise Act 1996, s 236.

699 See Part 14 of the Customs and Excise Act 1996. Broadly, that regime requires the Chief Executive of the New Zealand Customs Service to review the seizure decision upon application and to direct the goods' disposal if that application is unsuccessful.

700 Misuse of Drugs Amendment Act 1978, s 38.

701 Misuse of Drugs Amendment Act 1978, s 39(1).

9.111 Proceeds from drug offending can also be recovered under the Criminal Proceeds (Recovery) 2009. That Act, which replaced the Proceeds of Crime Act 1991, enables the courts to impose:

(a) an assets forfeiture order to recover tainted property (for example, a house that has been bought with the proceeds of crime);[702]

(b) a profit forfeiture order to recover monetary benefits from an offence;[703]

(c) an instrument forfeiture order to recover property used to commit, or to facilitate the commission of, the offence (for example, vehicles).[704]

Orders to forfeit profit

9.112 The profit forfeiture regime provided in the Criminal Proceeds (Recovery) Act is much broader in scope than the profit forfeiture regime that is currently provided in the Misuse of Drugs Act and that was provided in the Proceeds of Crime Act.[705] This is in the following four ways:

(a) An order to forfeit profit can be made whether or not any criminal proceedings have been taken against the offender.[706]

(b) Profit forfeiture orders can be made in relation to a greater range of offending. This includes proceeds derived from offences punishable by a maximum penalty of five years or more, as well as any offence from which proceeds or benefits of a value of $30,000 or more was derived or acquired.[707] The Criminal Proceeds (Recovery) Act also enables profit forfeiture orders to be made against those who have not undertaken, or been directly involved in, the criminal activity from which the criminal proceeds were derived.[708] In the drugs context, this includes the mastermind or "Mr Big" character of a large-scale commercial dealing operation who lives off the proceeds of the offending but ensures that his or her links to the offending itself are well concealed.[709]

(c) The defendant now has the onus, on the balance of probabilities, to show that any proceeds or benefits that are identified in the application for the order were not derived from criminal activity.[710] This places a greater burden on the defendant than under the Proceeds of Crime Act[711] or the Misuse of Drugs Act.[712]

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702 This is defined in s 5 as property that has wholly or partly been acquired, or directly or indirectly derived, from significant criminal activity as defined in s 6.

703 Criminal Proceeds (Recovery) Act 2009, s 55.

704 Criminal Proceeds (Recovery) Act 2009, s 70; Sentencing Act 2002, s 142N.

705 The description in this paragraph of the features of profit forfeiture orders under the Criminal Proceeds (Recovery) Act 2009 equally applies to the forfeiture of assets under that Act.

706 Criminal Proceeds (Recovery) Act 2009, s 6(2).

707 Criminal Proceeds (Recovery) Act 2009, s 6(1).

708 Criminal Proceeds (Recovery) Act 2009, s 7.

709 Bruce Robertson (ed) *Adams on Criminal Law* (online looseleaf ed, Brookers) at [CP3.02] [*Adams on Criminal Law*].

710 Criminal Proceeds (Recovery) Act 2009, s 53(2).

711 See *Adams on Criminal Law*, above n 709, at [CP3.02]. The reverse onus under the 1991 Act applied only to the difference between the value of the defendant's property after the offence period and its value before the offence period.

712 The court must be satisfied on the balance of probabilities.

(d) The scope of the profit forfeiture order is significantly broader. It can be used to recover profits that have been unlawfully derived from criminal activity dating back seven years from the time an application for a restraining order[713] or a profit forfeiture order has been made.[714]

9.113 The broad scope of the Criminal Proceeds (Recovery) Act regime raises the question of whether it is necessary to retain a specific profit forfeiture regime in the Misuse of Drugs Act. Any forfeiture order that can be made under the Misuse of Drugs Act can also be made under the Criminal Proceeds (Recovery) Act.[715]

9.114 We recommend that, primarily for pragmatic and procedural reasons, a specific regime to forfeit drugs proceeds, akin to the regime in the Misuse of Drugs Act, should be retained. Under the Misuse of Drugs Act, forfeiture can be dealt with relatively simply at sentencing and remains a criminal matter. Forfeiture under the Criminal Proceeds (Recovery) Act requires a separate application and is a civil process. In this respect, the New Zealand Police noted in its submission that the forfeiture of smaller amounts of money may not reach a threshold that would justify taking action under the Criminal Proceeds (Recovery) Act.[716]

9.115 This specific profit forfeiture regime should extend to any dealing proceeds found in the possession of an offender who has been convicted of the new aggravated possession offence. Currently, forfeiture of dealing proceeds when an offender has been convicted of the possession for supply offence can sometimes be problematic, due to the way in which the relevant statutory provisions are drafted.[717] The new provisions should be drafted in such a way as to be clear that they extend to dealing proceeds regardless of the dealing offence charged.

9.116 We do not consider there is any need to retain the court's residual discretion in the Misuse of Drugs Amendment Act to indirectly forfeit dealing proceeds through the imposition of a greater fine. The Criminal Proceeds (Recovery) Act regime and the specific regime we propose for forfeiting drugs proceeds covers the ground. More fundamentally, we do not think it appropriate or justifiable to enable judges to impose fines in relation to offences for which a prosecution has not been taken and a conviction has not been obtained.

713 A restraining order prevents any dealing in the property other than as provided for in the order – see Criminal Proceeds (Recovery) Act 2009, s 24.

714 Criminal Proceeds (Recovery) Act 2009, s 53.

715 This assumes that the maximum penalty for dealing offences remains at five years or more. We are not proposing any changes in this respect – see ch 7.

716 Submission of the New Zealand Police (submission dated 18 June 2010) at 7.

717 See *R v Collis* [1990] 2 NZLR 287 (CA) and *Bishop v R* [2010] NZCA 66. The difficulty arises due to the wording of s 32(3), which requires the judge to be satisfied that money found in the offender's possession was received in the course of or consequent upon the commission of the convicted offence, or was in the person's possession for the purpose of facilitating that offence. This can be problematic when it has not been proved that any dealing has actually taken place (even if both parties accept that the offending was committed in a dealing context) and, in both *Collis* and *Bishop*, led the Court to conclude that forfeiture could not take place.

Orders to forfeit instruments of crime

9.117 Instrument forfeiture orders are provided for under new provisions in the Sentencing Act 2002.[718] Unlike Criminal Proceeds (Recovery) Act orders, instrument forfeiture orders can only be made in conjunction with criminal proceedings, following conviction for a qualifying offence.[719]

9.118 The Sentencing Act regime differs from the Misuse of Drugs Act regime in two key respects. First, it enables a sentencing judge to forfeit any instrument used to commit, or to facilitate the commission of, an offence that is punishable by a term of imprisonment of five years or more.[720] Under the Misuse of Drugs Act, the sentencing judge may order the forfeiture of any vehicle or conveyance used by the offender in the commission of a dealing offence. "Articles" in respect of which the offence was committed and which are in the offender's possession are also automatically forfeited upon conviction for any Misuse of Drugs Act offence.

9.119 Secondly, the Sentencing Act regime provides that instrument forfeiture orders, and any other instrument forfeiture that qualifies for the regime, must be taken into account in an offender's sentence.[721] Until now, forfeiture under the Misuse of Drugs Act has been additional to any sentence imposed for the offending.

Forfeiture of unlawful instruments

9.120 There is no doubt that, regardless of the seriousness of the offence, an ability to forfeit unlawful items (for example, controlled drugs) is required following conviction. We therefore recommend that a separate forfeiture regime be retained for this purpose.

9.121 Currently, the Misuse of Drugs Act regime requires the Minister of Health to direct whether forfeited articles should be sold, destroyed or otherwise disposed of.[722] At least in relation to unlawful articles, we do not think it necessary to involve the Minister at all. Unlawful articles should always be destroyed. In practice, some judges already order that destruction occur as part of making a forfeiture order.[723] We recommend that there is a statutory provision to the effect that, following conviction for any drug offence, the sentencing judge must order the forfeiture and destruction of unlawful items in respect of which an offence was committed.

718 See Sentencing Act 2002, ss 142A–142Q in particular.

719 The disposal or otherwise of seized items where conviction does not result is covered by Part 4, subpart 5 of the Search and Surveillance Bill 2010 (45–2).

720 Sentencing Act 2002, s 4. Includes an attempt to commit, conspiring to commit or being an accessory to an offence if the maximum term of imprisonment for that attempt, conspiracy or activity is five years or more.

721 Sentencing Act 2002, s 10B(1)(a). Even if forfeiture takes place under the Misuse of Drugs Act 1975, if the offence is punishable by a term of imprisonment of five years imprisonment or more, forfeiture must be taken into account in sentencing under s 10B(1)(b) of the Sentencing Act 2002.

722 Misuse of Drugs Act 1975, s 32(2).

723 See, for example, *R v Sawtell* HC Wellington CRI-2008-078-000910, 24 July 2009 and *R v Spear* HC Rotorua CRI-2007-063-003004, 13 November 2008. Other judges make an order only in relation to forfeiture – see, for example, *R v Tahana* HC Rotorua CRI-2007-63-1030, 21 November 2008.

9.122 Unlike the forfeiture of otherwise lawfully possessed instruments of crime, we do not consider that the forfeiture of unlawful items should be taken into account in an offender's sentence. The forfeiture of unlawful items does not act as an additional punishment on the offender, but is rather aimed at destroying illegally obtained and possessed property.

9.123 The New Zealand Customs Service has raised with us a concern about the requirement for enforcement agencies to retain the total quantity of seized items until a conviction is entered or a case is otherwise disposed of. This creates logistical difficulties, particularly when large amounts of controlled drugs or precursor substances are involved. We recommend that enforcement agencies be authorised by statute to retain a representative sample of the seized articles and dispose of the remainder. Any dispute that eventuates about the amount seized would need to be dealt with as a matter of evidence – for example, on the basis of statements from customs officers, or photographs or other supporting material of the amount seized.

Forfeiture of lawful instruments used for an unlawful purpose

9.124 The instrument forfeiture regime in the Sentencing Act encompass the current ability in the Misuse of Drugs Act to order the forfeiture of any vehicle or conveyance used by the offender in the commission of a dealing offence. This aspect of the Misuse of Drugs Act forfeiture regime can therefore be abolished.

9.125 However, the Sentencing Act regime is narrower in scope than the current Misuse of Drugs Act regime in some respects. This is due to the broad power, under the latter Act, to order the forfeiture of any "articles" in respect of which any drug offence was committed and which are in the offender's possession. Although the term "articles" is not defined, the relevant provision can be used to forfeit items like utensils, point bags, scales and other drug-related paraphernalia.[724]

9.126 If forfeiture of lawful instruments used for an unlawful purpose is left to the Sentencing Act regime, there will be some instances where forfeiture will not be possible where it may have been expected. In particular, the five-year maximum penalty threshold in the Sentencing Act means that it will not be possible to forfeit dealing paraphernalia when a person is convicted of the new offence of aggravated possession of a Class C drug. Nor will it be possible to forfeit premises or vehicles when a person is convicted of the current offence of knowingly permitting any premises, vessel or other conveyance to be used for the purpose of an offence in relation to a Class C drug.[725] Both offences will have maximum penalties of three years. We do not consider it necessary to establish a specific forfeiture regime in relation to these offences. Forfeiture in respect of the latter offence is unlikely now.[726] In any event, Parliament has decided that

724 See, for example, *R v Collins* HC Auckland CRI-2007-090-005304 & CRI-2008-404-000326, 3 March 2009 in which the judge ordered the forfeiture of recipes for manufacturing methamphetamine.

725 Misuse of Drugs Act 1975, s 12(2).

726 The courts have held that vehicles are not "articles" for the purposes of s 32(1) of the Act given the specific provisions enabling the forfeiture of vehicles for a dealing offence under s 32(4) – see *Mosen v Police* HC Hamilton AP57/92, 29 June 1992; *Attorney-General v May* (1985) 2 CRNZ 75 (HC). It is unlikely that the courts would ever order the forfeiture of premises under s 32(1) following conviction for this offence, as it would be substantially disproportionate to the seriousness of the offence.

instruments of crime should only be forfeited when the applicable offence is punishable by a maximum penalty of five years or more. We see no reason to make an exception to that rule for these offences.

IMMUNITY FROM LIABILITY

9.127 The Misuse of Drugs Act protects from civil and/or criminal liability those people carrying out functions conferred on them by the Act, unless they acted in bad faith or without reasonable care. This includes where they have acted without jurisdiction or on the basis of a mistake of law or fact.[727]

9.128 Police officers who are working undercover for the purposes of investigating a suspected offence against the Act, or of any person suspected of an offence, are also protected from prosecution for offences against the Act.[728] The protection extends to any other member of the police who is directing or assisting the officer in the investigation.[729] Prosecutions in these circumstances can only be taken with the Attorney-General's leave.[730]

9.129 Both types of protection are a necessary corollary to the Act's enforcement. They also have parallels in other Acts that include enforcement provisions.[731]

EXTRADITION

9.130 In accordance with New Zealand's international obligations, particularly the 1988 Convention, the Act includes provisions to facilitate the extradition of offenders from New Zealand for drug offences committed in other countries.[732] The provisions deal with:

(a) the offences under the Act that are treated as being included in existing extradition treaties between New Zealand and countries that are parties to the conventions;[733]

(b) a requirement that a court not order the surrender of a person to another country if the Attorney-General certifies that proceedings may be brought against the same person in New Zealand;[734]

(c) an evidential provision about how to establish that a foreign country is a party to the 1961, 1971 or 1988 Conventions.[735]

9.131 These provisions are necessary to give effect to our international obligations and to ensure that extradition in appropriate cases occurs in an expeditious manner. We see no difficulties with the provisions and propose no changes to them.

727 Misuse of Drugs Act 1975, s 34.

728 Misuse of Drugs Act 1975, s 34A(1). We note the technical issue that the provision on its face only applies to "acts" committed by an officer, and not more passive behaviour such as possession or permitting premises to be used to commit a Misuse of Drugs Act offence, and that it also does not cover attempts. *Adams on Criminal Law*, above n 709, at [MD34A.01], suggests both are covered as a matter of policy.

729 Ibid.

730 Misuse of Drugs Act 1975, s 34A(2).

731 See, for example, the Search and Surveillance Bill 2010 (45–2), cls 158–160, under which everyone is immune from civil or criminal liability who, broadly, executes a warrant or an order under the Bill in good faith; and the Fisheries Act 1996, s 220, which confers civil and criminal liability on fishery officers in the same terms as the Misuse of Drugs Act 1975. Other examples include: Films, Videos, and Publications Classification Act 1993, s 199; the Human Assisted Reproductive Technology Act 2004, s 74; and the Major Events Management Act 2007, s 47.

732 Misuse of Drugs Act 1975, ss 35, 35A, 35C and 35D.

733 Misuse of Drugs Act 1975, ss 35 and 35A.

734 Misuse of Drugs Act 1975, s 35C.

735 Misuse of Drugs Act 1975, s 35D.

Reports to an offender's professional body

9.132 Under section 33, when a medical practitioner, pharmacist, dentist, midwife, designated prescriber or veterinarian is convicted of an offence against the Act or its regulations, the court must cause the particulars of the conviction to be sent to that person's professional body.

9.133 In respect of all of the professions listed above except veterinarians, a similar obligation is imposed on court registrars under section 67 of the Health Practitioners Competence Assurance Act 2003. However, that obligation is framed more broadly and only imposes an obligation on registrars when they know that a person convicted is a health practitioner. In contrast, the Misuse of Drugs Act requirement is imposed on the court itself and is expressed in mandatory terms.

9.134 We assume the approach in the Health Practitioners Competence Assurance Act was taken due to the difficulties, in practice, in enforcing the type of approach taken by the Misuse of Drugs Act provision. In reality, there is no sanction that could be imposed on the court if it failed to ensure that a conviction was notified to the offender's professional body. For that reason, although a stricter approach to notifying convictions under the Misuse of Drugs Act may be appropriate given how critical professional integrity is to the overall scheme of the Act, we think the Health Practitioners Competence Assurance Act's approach is, on balance, preferable. It may also make little difference in reality to the practice of notifying convictions. We therefore recommend that section 33 be repealed.

9.135 There is no similar requirement in the Veterinarians Act 2005, although a conviction for any offence punishable by more than three months imprisonment may be a reason for disqualification from registration.[736] An amendment to the Veterinarians Act to include such a requirement seems required.

Suppression of name of controlled drug

9.136 Under section 21, in proceedings before a court or coroner in which a controlled drug is referred to, the court or coroner may order that the name of that drug not be published in relation to those proceedings for up to five years.[737] It is an offence to do so, punishable by a maximum penalty of three months imprisonment and/or a $500 fine.[738] The suppression order does not apply to scientists or relevant professionals (for example, lawyers or doctors), to those studying to become scientists or relevant professionals, to scientific or other publications intended for circulation amongst relevant professions, or to any publication published by or on behalf of the Crown.[739]

9.137 We assume that the rationale of this provision, which dates back to the Narcotics Act, was concern that publication of the name of a controlled drug would encourage others to use or deal with it and, by doing so, cause harm to themselves or others. However, we are not aware of an order being made under this provision in recent times. It is also in conflict with modern social attitudes and principles. This includes, for example, the view that, wherever possible, it is preferable to make information

736 Veterinarians Act 2005, s 9.

737 Misuse of Drugs Act 1975, s 21(1).

738 Misuse of Drugs Act 1975, s 21(2).

739 Misuse of Drugs Act 1975, s 21(1).

available to enable individuals to make their own assessment about what is in their best interests. In a different but related context, the Law Commission has also emphasised the principle of open justice, which dictates that there should be no restriction on the publication of information about a court case except in very special circumstances or for compelling reasons.[740] We do not consider that the suppression of the names of drugs meets this test. We recommend the provision's repeal.

RECOMMENDATIONS

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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.

740 Law Commission *Suppressing Names and Evidence* (NZLC R109, 2009) at 7.

RECOMMENDATIONS

> Continued next page

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.

RECOMMENDATIONS

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

Exemptions from prohibition

INTRODUCTION

10.1 Many prohibited drugs have important medical uses. Opioids such as morphine and codeine are used primarily for pain relief. Methadone is used in treatment for drug addiction and many other drugs are used in other areas of medicine as tranquillisers, sedatives, stimulants and antipsychotics. Legislation prohibiting the dealing in and use of drugs must therefore contain exemptions that authorise the production, distribution and supply of some prohibited drugs for use in medical treatment.

10.2 Exemptions are also needed to authorise the use of prohibited drugs in medical and other research and drug studies. There are a few prohibited drugs that have some limited uses in industry, which also should be authorised.

10.3 Exemptions enabling the medical and industrial use of prohibited drugs seek to strike a balance between facilitating the availability of these drugs for legitimate purposes and minimising the risk of drugs being diverted into the illegal drugs market. If restrictions are too strictly drawn, inadequate supplies of prohibited drugs may be available for use in treatment. Health professionals may also be reluctant to prescribe them and people with medical problems that require treatment might not be able to access particular drugs even under medical supervision.

10.4 In this chapter we examine the authorisations needed to facilitate legitimate access to prohibited drugs, and consider the current restrictions and limits that have been imposed on them.

STATUTORY EXEMPTIONS

10.5 Statutory exemptions authorise the supply of otherwise prohibited drugs to patients and authorise the medical use of those drugs by patients. Section 8 of the Misuse of Drugs Act contains the main statutory exemptions. Further specific authorisations in the form of permissions are also contained in regulations made under the Act.

Application of Medicines Act

10.6 Though it is not apparent on the face of the Act, the operation and scope of these exemptions are affected by the provisions in the Medicines Act, which contains a separate licensing and exemption scheme. Thus, the therapeutic use of controlled drugs is regulated by both the Misuse of Drugs Act and the Medicines Act. The definition of "medicine" in the Medicines Act is broad and includes any substance that is manufactured, imported, sold or supplied wholly or principally for administration to a human being for a therapeutic purpose.[741] It follows that controlled drugs that fall within this definition (because they are principally manufactured, sold or supplied for one of these purposes) are also medicines.[742]

10.7 Section 109 of the Medicines Act governs the relationship between the two Acts. It provides that when a controlled drug is also a medicine, the requirements in the Medicines Act (other than those that require a person to hold a licence)[743] apply in addition to those imposed under the Misuse of Drugs Act, unless they are inconsistent with it. In the event of any inconsistency, the Misuse of Drugs Act prevails. An important caveat on this is that the statutory exemptions in the Misuse of Drugs Act do not authorise any person to deal with, possess or use a controlled drug that is also a medicine in a way that contravenes the provisions of the Medicines Act.

10.8 The exemptions for controlled drugs created in the Misuse of Drugs Act must therefore be read together with the requirements of the Medicines Act. To understand the combination of requirements that apply, it is necessary to briefly outline the broad scheme of the Medicines Act.

10.9 Section 20 of the Medicines Act requires, with some exceptions, that a medicine be assessed and approved or provisionally approved by the Minister before it can be sold or distributed as a medicine in New Zealand.[744] The underlying policy behind the section is to ensure that medicines or therapeutic drugs cannot be released on the New Zealand market until the Minister is satisfied that there are no unacceptable risks.[745]

10.10 However, it is essential to provide for some use of medicines before they have been approved. Sometimes a medicine will not have been approved for use or for a particular use in New Zealand but will still be the most effective treatment

741 The term "therapeutic purpose" is also defined broadly and covers the treatment, prevention, and diagnosis of disease, induction of anaesthesia, or any other intervention in the normal operation of a physiological function in the body.

742 There is some uncertainty as to whether a number of controlled drugs, which are not normally used therapeutically, are medicines when they are occasionally used to treat people.

743 In relation to licences, which we discuss later in paragraphs 10.97 – 10.117, s 109 provides that where a person is authorised by a licence under the Misuse of Drugs Act to manufacture, pack, or sell a controlled drug that is a medicine he or she is also deemed to be licensed under the Medicines Act to undertake that activity. In other words there is normally no need to also have a licence under the Medicines Act.

744 All medicines that became medicines for the first time when the Act was commenced, all older medicines that were not generally available in New Zealand before the Act came into force, and all older medicines that were not issued an approval under earlier legislation must be approved for use as medicines under the Act. A medicine that has been unavailable for a period of five years, even if it was generally available when the Act came into force will also need an approval under s 20.

745 *Ministry of Health v Pacific Pharmaceuticals Limited* HC Auckland A165/00, 8 December 2000, at [26].

for a patient with a particular condition.[746] To facilitate some closely controlled use of such medicines, the basic prohibition on dealing with medicines that have not been approved under section 20 is subject to exemptions that permit use of these medicines in limited circumstances.

10.11 Though it is by no means apparent on the face of the Misuse of Drugs Act, these exemptions apply also to controlled drugs that have not been approved as medicines. As a result the exemptions in the Misuse of Drugs regime operate differently depending upon whether a controlled drug is an approved medicine or an unapproved medicine. This lack of transparency over the ambit of the exemptions is unsatisfactory.

Prescriber and pharmacy exemptions

10.12 Prescribers and pharmacists must comply with all the relevant restrictions in both the Medicines Act and the Misuse of Drugs Act and regulations made under both Acts. The combined effect of both Acts seems to be that:

- Medical practitioners, dentists and veterinarians may, in the course of their professional practice or employment, procure, prescribe, produce, manufacture, pack and label, supply or administer controlled drugs that are approved medicines.[747]
- Registered midwives may procure, prescribe, supply or administer the controlled drug pethidine and any other controlled drugs specified in regulations.[748] Other groups of health professionals (termed "designated prescribers") may, if expressly authorised by regulation, prescribe, supply or administer any controlled drugs specified in regulation.[749]
- Medical practitioners and other authorised prescribers may procure, sell, supply and administer controlled drugs that are not approved drugs, but may not produce, manufacture, pack or label these controlled drugs and may only procure and supply them for particular and identifiable patients and not more generally.[750] In response to a specific request from a medical practitioner, a licensed medicine's supplier may supply that medicine to the medical practitioner.[751]
- Pharmacists and employees under their supervision may produce, manufacture or supply any controlled drug that is an approved medicine as required to fill a lawfully issued prescription for that drug. Pharmacists employed in hospitals are also authorised to produce, manufacture or supply any controlled drug that is needed within the hospital.[752]

746 Many medicines in this category will have already been assessed as effective and safe for use in other countries, although where medicines are being used under an exemption allowing for clinical trials of new medicines there will often be no overseas approval. In addition, some medicines have been approved but the approval has effectively lapsed after changes have been made to the medicine, and a new approval has not been obtained.

747 Misuse of Drugs Act 1975, s 8(2)(a) read consistently with Medicines Act 1981, ss 20 and 29.

748 Misuse of Drugs Act 1975, s 8(2)(aa) and (2A)(a).

749 Misuse of Drugs Act 1975, s 8(2A)(a).

750 Medicines Act 1981, s 25(1)and(3); although restrictions imposed on the supply of unapproved medicines by s 29 of the Act mean that suppliers of unapproved medicines are only authorised to supply them to medical practitioners and not to other authorised prescribers. This means that these other prescribers can only operate under the exemption if they can obtain an unapproved medicine from a medical practitioner responsible for the care of the patient.

751 Medicines Act 1981, s 29.

752 Misuse of Drugs Act 1975, s 8(2)(b) and (ba).

- Any pharmacy or other licensed medicines retailer may sell or supply any Class C6 controlled drug that is an approved medicine without a prescription as a pharmacy-only medicine.[753] Class C6 drugs contain only small amounts of controlled drugs like codeine that have been compounded in a way that means that either the controlled drug cannot be readily recovered, or if it can the yield is not at a level that would constitute a risk to health.[754]

10.13 The exemptions for prescribers set out above are all subject to an important restriction in section 24 which makes it an offence for a medical practitioner or other prescriber to administer, prescribe or supply a controlled drug solely to maintain someone's dependence, unless the prescriber or the hospital or clinic in which he or she works is expressly authorised by *Gazette* notice to do this. We look at whether this specific restriction that applies to treating drug dependency should be retained in paragraphs 10.71 to 10.79 of this chapter.

Other health care exemptions

10.14 The other statutory exemptions that apply to the medical use of controlled drugs in section 8 of the Act appear to apply to both approved and unapproved medicines. These exemptions are:

- Classes of health professionals authorised by standing orders may supply the specific controlled drugs in certain circumstances that are set out in the standing order.[755]
- Patients may procure and self-administer any controlled drugs that have been lawfully supplied or prescribed for them[756] and those responsible for the care of patients may administer controlled drugs to them in accordance with the directions given by the prescribing professional.[757] A similar exemption allows controlled drugs to be administered to an animal when they have been prescribed by a vet.[758]
- Any person may, when leaving or entering New Zealand, possess any controlled drug that has been lawfully supplied or prescribed for them. Carers may also possess drugs on these terms to administer to someone under their care or control.[759]
- Any person may procure and administer any C6 controlled drug.[760]
- District Health Boards, other certified hospitals and institutions and any manager or licensee of a certified hospital or institution that has the care of

753 Misuse of Drugs Act 1975, s 8(3)(b).

754 For example, in the case of codeine, the Act specifies not more than 100 milligrams of the controlled drug can be incorporated into each dosage. There is some concern that this level is actually too high and this may need to be looked at.

755 Misuse of Drugs Act 1975, s 8(2A)(b); the provision does seem to allow standing orders to be issued in respect of controlled drugs that had not been approved, although the position is not at all clear. This is a good example of a situation where the combination of provisions in the two Acts produces an ambiguous and uncertain outcome.

756 Misuse of Drugs Act 1975, s 8(2)(c).

757 Misuse of Drugs Act 1975, s 8(2)(d) and (da).

758 Misuse of Drugs Act 1975, s 8(2)(e).

759 Misuse of Drugs Act 1975, s 8(2)(l). This is restricted to one month's supply for many drugs, but in some circumstances it will be lawful for a person to possess up to three month's supply.

760 Misuse of Drugs Act 1975, s 8(3)(b).

- patients for whom controlled drugs are lawfully prescribed or supplied may possess those drugs to treat patients.[761]

Permissions in the Misuse of Drugs Regulations 1977

10.15 As already noted (above, paragraph 10.5), regulations have been made creating a number of additional exemptions which are described in the regulations as permissions. The permissions in the regulations seem to apply only to controlled drugs that have been approved as medicines under the Medicines Act. The main permissions are:

- Any person may sell without a prescription any Class C3 drug (other than one containing pseudoephedrine).[762]
- Pharmacies may sell Class C3 drugs that contain pseudoephedrine by retail as "pharmacy-only medicines".[763]
- Any person may procure without a prescription and use a Class C3 drug (including one that contains pseudoephedrine).[764]
- Hospital and care institution managers in hospitals and institutions that have been specifically approved by the Director-General for this purpose may possess supplies of any Class C2 drugs.[765]
- A controlled drug can be supplied in an emergency without a prescription provided this complies with other regulations governing emergencies.[766]
- The master of a ship within New Zealand's territorial limits may possess, import, export and administer any controlled drug legally allowed to be carried on that ship for the treatment of sick or injured people.[767]
- A person in charge of an aircraft within New Zealand's territorial limits may possess, import, export, and in an emergency administer any controlled drug legally allowed to be carried on the aircraft for the treatment of sick or injured people. [768]
- Approved first-aid kits may contain controlled drugs for use in the event of emergency and any person having control of an approved first-aid kit may possess and administer to any person any controlled drug included in that kit.[769] A controlled drug may also be supplied to a person who has control of an approved first-aid kit without a prescription.[770]

761 Misuse of Drugs Act 1975, s 8(2)(f).

762 Misuse of Drugs Regulations 1977, reg 20(2).

763 This will likely soon change because the Government has proposed a policy change that will see legislation reclassifying pseudoephedrine as a Class B drug. Once legislation implementing that decision is in place pseudoephedrine will only be available on prescription.

764 Once pseudoephedrine becomes a Class B drug it will only be available on prescription.

765 Misuse of Drugs Regulations 1977, reg 15.

766 Misuse of Drugs Regulations 1977, reg 34.

767 Misuse of Drugs Regulations 1977, reg 17.

768 Misuse of Drugs Regulations 1977, reg 18.

769 Misuse of Drugs Regulations 1977, reg 19.

770 Misuse of Drugs Regulations 1977, reg 19.

Significant matters of policy are in regulation

10.16 The inclusion of these permissions in regulations in this way raises an important issue, since they are simply further exemptions by another name. Some of them authorise activities with controlled drugs that are otherwise prohibited under the Act. This appears to have been contemplated by the regulation-making power which authorise regulations:[771]

> [P]ermitting the import, export, possession, production, manufacture, procuring, supply, administration or use of any controlled drugs, and the cultivation of prohibited plants, otherwise than pursuant to a licence…

10.17 The breadth of the current regulation-making powers in the Act has allowed significant matters of policy to be implemented by regulation. However, this type of broad regulation-making power is inconsistent with both contemporary standards of legislative practice and the Legislation Advisory Committee Guidelines. Generally, regulations are subservient to the authorising statute on the basis that the executive should not be able to override decisions made by Parliament.

10.18 Submitters supported having the exemptions in primary legislation rather than regulation.[772] Some stressed, however, the importance of retaining all the current exemptions. In particular a need was identified for retaining the exemption for emergencies, currently in regulation, that allows a pharmacist to supply, at the direction of a medical practitioner known personally to him or her, controlled drugs to a person under an orally communicated prescription from that practitioner.[773] This exemption is utilised regularly in practice as a practical way of dealing with emergency situations when it is not possible to obtain a prescription in the usual way.[774]

10.19 Consistent with the Legislation Advisory Committee Guidelines, we recommend that all the exemptions should be included in primary legislation. The regulation-making powers should be much more limited.

Consolidation of multiple exemptions

10.20 We queried in the Issues Paper whether the long lists of separate exemptions (set out above in paragraphs 10.12 to 10.15), all framed in slightly different terms for different groups of health care providers, are necessary. We suggested that many of them could be amalgamated into a far shorter, simpler and clearer list of exemptions.

771 Misuse of Drugs Act 1975, s 37(d).

772 For example, Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010) at 2; Submission of the New Zealand Drug Foundation (submission dated 29 April 2010).

773 Misuse of Drugs Regulations 1977, reg 34.

774 Submission of the New Zealand Law Society (submission dated 17 May 2010) at 25.

10.21 Submitters and other we consulted agree,[775] although a few have stressed the importance of not inadvertently removing exemptions or reducing their scope.[776] The view expressed by the Ministry of Health is that all the current exemptions are still needed and should be retained.[777]

Other specific issues about the scope of some exemptions

10.22 There are a few specific issues about the scope and wording used in some of the exemptions that need to be addressed.

Exemption to produce controlled drugs

10.23 First, one exemption currently authorises medical practitioners, dentists and veterinarians, in the course of their professional practice or employment, to produce or manufacture controlled drugs that are approved medicines. Another authorises pharmacists (and employees under their supervision) to produce or manufacture controlled drugs that are approved medicines to fill a lawfully issued prescription.

10.24 On their face, these exemptions are very wide because they authorise the manufacture of controlled drugs without a licence. In the Issues Paper we proposed restricting these exemptions to only those activities that these health practitioners actually need to perform with controlled drugs.

10.25 Submitters have identified a number of situations in which some practitioners (but normally pharmacists and those employed by them) do need authority to produce controlled drugs using other controlled drugs and other substances. An exemption is essential to enable compounding of appropriate formulations of controlled drugs to meet patient needs.[778] For example, if a particular controlled drug is required for paediatric use, but is not available in a liquid form or in a sufficiently low dose, or alternatively, the child will have difficulty swallowing it, the pharmacist may compound a different formulation.

10.26 These exemptions therefore need to be retained to allow pharmacists and prescribers to undertake these types of activities to produce new forms of controlled drugs for patients. In the case of prescribers the exemption only needs to authorise the production of new forms of controlled drugs when this is necessary for administration to a patient.

775 Submission of the New Zealand Drug Foundation (submission dated 29 April 2010).

776 Submission of the New Zealand Law Society (submission dated 17 May 2010) at 25.

777 Submission of the Ministry of Health (submission dated 30 April 2010) at 20.

778 Submission of the Pharmaceutical Society of New Zealand (submission dated 30 April 2010) at 3; Submission of the New Zealand Law Society (submission dated 17 May 2010) at 24; and Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010) at 1.

Exemption for certified hospitals and institutions

10.27 The scope of the exemption in section 8 for District Health Boards, certified hospitals and institutions is currently uncertain. It is not clear whether the exemption allows these institutions to hold general supplies of controlled drugs or whether they can only hold drugs that have been specifically prescribed for particular patients.

10.28 In addition, there is also uncertainty as to what types of care providers come within the ambit of "other institution". This is unsatisfactory because an offence under sections 6 or 7 will be committed if the scope of an exemption is exceeded.

10.29 In the Issues Paper we proposed that the exemption should simply be confined to District Health Boards and other certified hospitals. We also suggested that for practical reasons these institutions probably need to be authorised to hold general supplies of controlled drugs.[779]

10.30 The Ministry of Health has advised that the term "institution" currently provides authority for non-hospital institutions like prisons and hospices to hold supplies of controlled drugs for use under the other exemptions.[780] We accept that there is therefore a need for the exemption to apply to other institutions as well as District Health Boards and other certified hospitals. However, the scope of the exemption must be clear. We recommend that a clear definition of institutions be provided.

Additional exemptions

10.31 We asked in the Issues Paper whether any additional exemptions are needed.

10.32 One issue that was raised concerns drug test kits and other diagnostic test kits.[781] These are imported, distributed and supplied by a number of companies, primarily for drug testing employees. Because these kits contain miniscule amounts or traces of controlled drugs, which are included as a positive control for the purposes of comparison with actual samples, their import, distribution and possession currently needs to be licensed. This is because they are not otherwise exempted by the provisions of the Act.

10.33 The kits contain amounts of controlled drug that can only be measured in micrograms or nanograms, often suspended in liquid. The amounts of each drug are too miniscule to allow their removal and use for any other purpose. However, because the amounts are sufficient for use within the drug or diagnostic test kit

779 The Pharmaceutical Society of New Zealand said it was important that wards have authority to hold stocks that can be dispensed to a patient otherwise all stock must be held in hospital pharmacy; see Submission of the Pharmaceutical Society of New Zealand (submission dated 30 April 2010) at 3; the Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010) agreed that authority needs to cover general supplies.

780 Submission of the Ministry of Health (submission dated 30 April 2010) at 19 and Submission of the Medical Council of New Zealand (submission dated 14 April 2010) at 1.

781 Submission of the Ministry of Health (submission dated 30 April 2010) at 20; Submission of Diagnostic Bioserve Ltd (submission dated 3 August 2010); Submission of Susan Nolan & Associates Ltd (submission dated 13 August 2010); Submission of Inscience Ltd (submission dated 13 August 2010); Submission of Thermo Fisher Scientific (submission dated 13 August 2010).

for testing, they would seem to constitute "a usable quantity" of a drug.[782] It would therefore seem to be an offence for anyone to import, supply or possess these test kits without a licence or some other authority.

10.34 The licensing regime is an unnecessarily cumbersome process for managing the distribution of these products. It imposes far more controls than are necessary. All parties involved in the distribution have to be licensed to create an unbroken chain of authorisation.

10.35 The Ministry and other submitters have proposed that an exemption be included to cover these diagnostic test kits.[783] We agree, and recommend that a new exemption for drug testing kits and other diagnostic test kits be included in the new regime. The terms of the exemption need to be determined but they should authorise the importation, distribution, possession and use of diagnostic test kits without a licence.

Duplication of exemptions regime in Medicines Act

10.36 The question then is how these exemptions, with the amendments that we have proposed, should be given effect.

10.37 We think that dual exemptions in the Misuse of Drugs Act and the Medicines Act, which are largely duplicative but written in slightly different terms, are both unnecessary and inaccessible for those wishing to rely upon them. Although a person (such as a prescriber or pharmacist) must comply with all the conditions that apply in both regimes, it may be difficult to determine what these are.[784]

10.38 It would be less confusing and more transparent if the exemptions that apply to controlled drugs were all consolidated in one Act (with appropriate cross-references) and made subject to one consolidated set of conditions that was also contained in that Act. There was strong support for this from submitters.[785]

Options for consolidation

10.39 There are two ways this consolidation could be achieved.

10.40 First, a separate exemption regime for controlled drugs could be included in new legislation replacing the Misuse of Drugs Act and controlled drugs could be expressly excluded from the duplicating aspects of the Medicines Act (option one). The advantage of option one is that the prohibitions, offences, controls and

782 We discussed this provision in paragraphs 9.90 – 9.92 in ch 9.

783 Submission of the Ministry of Health (submission dated 30 April 2010) at 20; Submission of Diagnostic Bioserve Ltd (submission dated 3 August 2010); Submission of Susan Nolan & Associates Ltd (submission dated 13 August 2010); Submission of Inscience Ltd (submission dated 13 August 2010); Submission of Thermo Fisher Scientific (submission dated 13 August 2010).

784 In practice this can cause confusion for those for whom knowledge of the implications of the acts is vital to their work; Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010) at 1.

785 For example, Submission of the Ministry of Health (submission dated 30 April 2010); Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010) at 1; Submission of the New Zealand Drug Foundation (submission dated 29 April 2010); Submission of the New Zealand Nurses Organisation (submission dated February 2010).

exemptions on prohibited drugs would all be together in one place. There is also some symbolic value in separating controlled drugs from other substances that are used as medicines and having all the rules about them in one place.

10.41 However, even if this was considered the most desirable option, it is not actually achievable because all those aspects of the Medicines Act that regulate the safety and efficacy of medicines would continue to apply to controlled drugs. Controlled drugs would still need to be assessed and approved under section 20 of the Medicines Act before they could be distributed and supplied as approved medicines. Consequently, those additional restrictions in the Medicines Act, which apply to the use of medicines that have not been approved under section 20, would still need to apply and would overlay the exemptions.

10.42 We therefore think that, since all of the exemptions relate to the use of controlled drugs for medical purposes, a better option would be to move the exemptions for controlled drugs into the Medicines Act. Under this option (option two) there would be one set of rules governing the supply and use of all medicines (including controlled drugs).

10.43 Within option two it would still be appropriate to retain some specific restrictions and regulatory requirements for controlled drugs (or even different groups of controlled drugs). However, these would be included within the medicines regime and not in a separate Act, as they currently are.

10.44 The Medicines Act already contains a classification system which is used to group medicines for the purposes of determining the appropriate level of medical oversight and regulatory controls that should apply to their supply. Medicines are currently classified depending on whether they should only be available under the supervision of a prescriber (prescription only), available with advice and oversight from a pharmacist (restricted), or available from a pharmacy (pharmacy-only). A further grouping (subject to stricter controls) would be needed for controlled drugs to accommodate those additional controls on the production, supply or use of this group of medicines that do not generally apply to the other categories of medicine.[786]

10.45 A major advantage of this option is that it would effectively separate the grouping (or classification) of controlled drugs for the purposes of setting regulatory controls from their classification for the purposes of determining the seriousness of offending involving them. In chapter 6 we discussed the difficulties that have arisen because the three-tier ABC classification system (developed for law enforcement purposes) has been utilised for other unrelated regulatory purposes. We recommended in that chapter a complete separation between the ABC classification system and the imposition of regulatory controls.

10.46 If the access to and use of controlled drugs as medicines is regulated through the Medicines Act, this would enable a clear separation between the regulatory controls and the ABC classification system. The Medicines Classification Committee established under the Medicines Act already has the statutory function of assessing the degree of risk any approved medicine could pose and

786 For example, the international drug conventions require more detailed records of transactions to be kept for some controlled drugs, which might not need to be applied across other medicines.

recommending an appropriate classification to the Minister of Health.[787] This Committee is a much more appropriate body than the Expert Advisory Committee on Drugs (EACD) to determine the appropriate regulatory restrictions that should be imposed when controlled drugs are being used as medicines. Currently the EACD recommends a particular sub-classification for a drug, although there is no statutory basis for the allocation of substances to different parts of the schedule.

10.47 In conclusion, our assessment is that the best option is to move the exemptions and all other provisions regulating access to and the use of controlled drugs as medicines into the Medicines Act (option two). We recommend accordingly. This would produce a more transparent and coherent regulatory regime. It is supported by the Ministry of Health.[788]

10.48 However, we do acknowledge that this option requires significant amendment to the existing medicines regime. If the implementation of that recommendation would be unreasonably delayed by the time needed for a broader review of the Medicines Act, then as an alternative, or as an interim measure, the exemptions for controlled drugs should be consolidated within the new drugs regime (option one).

RESTRICTIONS ON THE EXEMPTIONS

10.49 Sections 20, 22, 23, 24 and 25 of the Misuse of Drugs Act contain a number of significant restrictions that limit the scope of the statutory exemptions. Regulations made under the Act also impose controls that further restrict the scope of activities that have been authorised by the exemptions. The objective behind such controls is to closely manage access to these medicines in order to limit the opportunities for their misuse or diversion into the recreational drug market.

10.50 We have recommended moving the exemptions regime for controlled drugs into the Medicines Act and consolidating all the exemptions and other authorisations applying to the medical use of these substances with the rest of the medicines regime together in that Act. If that recommendation is accepted, the restrictions discussed in this part of the chapter would also need to be shifted into the medicines regime since these operate as restrictions on those authorisations.

Limiting the opportunities for diversion of prescription drugs

10.51 The misuse of prescription drugs and their diversion into the recreational drug market is recognised as a worldwide issue by the International Narcotics Control Board (INCB). In its 2006 report, the INCB stated that:[789]

> In some regions, people abuse licitly produced prescription medicines in quantities similar to or greater than the quantities of illicitly manufactured heroin, cocaine, amphetamine and opioids that are abused.

787 Classifications are normally assigned by regulation made by Order in Council, although the Minister may, by notice in the *Gazette*, allocate a temporary classification under s 109. These remain in force for up to six months and (while in force) override any inconsistent classification contained in regulations; see Medicines Act 1981, s 106.

788 Submission of the Ministry of Health (submission dated 30 April 2010) at 21.

789 International Narcotics Control Board *Report of the International Narcotics Control Board for 2006* (United Nations, New York, 2007) at 6.

10.52 For example, the INCB reports that statistics for the United States suggest that the level of abuse of prescription medicines is second only to cannabis use. Some commentators predict that, over time, the misuse of prescription drugs will increase until it exceeds illicit drug use. Others suggest that some commonly abused prescription drugs like OxyContin have simply become the current drug of choice among recreational users and addicts, and that the levels of use may decrease over time when other drugs displace them.[790]

10.53 Until recently, there has been little information available on the extent of prescription drug misuse and diversion in New Zealand. A 2008 study[791] concluded that it is very difficult to estimate the scale of prescription drug misuse in New Zealand due to difficulties in how data is collected.[792] However, it is clear from the information obtained in national drug surveys and in the Illicit Drug Monitoring System (IDMS) that some prescription drug misuse and diversion occurs in New Zealand.[793]

10.54 In the 2008 study, opioids, benzodiazepines and stimulants were identified as the three main groups of prescription drugs used in primary healthcare that are currently targeted by drug seekers. A number of other drugs (such as ketamine) used in veterinary practice or in secondary health care are also targeted by drug seekers.[794]

10.55 Most of the opioids used by intravenous drug users are sourced from diverted prescription drugs. Frequent drug users in the IDMS identified morphine derivatives (MST, M-Eslon, Kapanol) as the opioids with which they were most familiar.[795] A portion of frequent drug users also reported using benzodiazepines and Ritalin as well as prescription opioids.[796] Information from other surveys similarly suggests a degree of prescription drug misuse is occurring. In a recent web-based survey on patterns of drug use, approximately 9.1 per cent of 18 to 30 year olds self-reported using prescription drugs for non-medical purposes,[797] although it should be noted that these types of self-selecting surveys may oversample certain populations.

10.56 Most of the drug-related harm arising from prescription drug misuse is similar to that for other types of drugs.[798] We canvassed these in chapter 2. One important difference, however, is the cost to New Zealand's public pharmaceutical budget.

790 See discussion on this issue in Janie Sheridan and Rachael Butler *Prescription Drug Misuse: Issues for Primary Care – Final Report of Findings* (University of Auckland, Auckland, 2008) at 22 – 33.

791 Ibid.

792 Currently data collected on prescription drugs covers only subsidised prescriptions, not all prescribed medication, and does not distinguish between medications prescribed for legitimate use and that obtained for misuse and diversion. Ibid at 10.

793 Ibid; 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) [IDMS 2008].

794 Sheridan and Butler, above n 790, at 32.

795 Ibid; IDMS 2008, at 105.

796 Ibid, at 32; ibid, at 38–39 respectively.

797 J Sheridan and others *Legally Available, Unclassified Psychoactive Substances and Illegal Drugs in New Zealand Before and After the Ban on BZP: A Web-Based Survey of Patterns of Use* (University of Auckland, Auckland, 2009).

798 The list of harms in the report is similar to those noted in Sheridan and Butler, above n 790, at 32.

Many of the controlled drugs that are diverted by drug seekers are publicly funded through Pharmac. The diversion and misuse of publicly funded drugs therefore waste funds that would otherwise be available for other medicines.

10.57 The problem of prescription drug diversion is a difficult one to address through legislative controls. Health professionals must be free to exercise professional and personal judgement in relation to controlled drugs when assessing and treating patients. Professional guidance, peer review, monitoring systems and reviews of prescribing practices are all important tools for ensuring that appropriate use is made of controlled drugs.[799] Legislative restrictions are important to underpin and support the proper exercise of professional and personal judgement in treatment decisions, but generally legislation is too blunt an instrument on its own for controlling the medical use of controlled drugs in treatment. A balance is needed between legislative restrictions and more flexible professional monitoring and review mechanisms.

Restrictions in the Act

10.58 The most significant legislative restrictions that limit the scope of the statutory authorisations are in sections 20, 22, 23, 24 and 25 of the Act.

Section 20 – Statements regarding drug dependent persons

10.59 Under section 20, a medical officer of health may publish statements about a person who he or she has reason to believe is or is likely to become dependent on any controlled drug. Subsection (1) authorises the medical officer of health to publish a statement about a person to prevent or restrict the supply of controlled drugs to the person to avoid or mitigate any risk of dependence. Statements about the person can be published to the following classes of people: employees of District Health Boards; hospital care operators; managers and superintendents of drug treatment facilities certified under the Alcoholism and Drug Addiction Act 1966; managers of prisons; medical practitioners; dentists; midwives; designated prescribers; police employees; and any persons who deal in controlled drugs in the course of business. Subsection (2) confers a qualified privilege from liability in defamation on a medical officer of health whenever he or she publishes a statement in the specified circumstances. The privilege is qualified because, just as under common law, the defence of privilege will fail if the plaintiff proves that the publication was made with malice.[800]

799 The 2008 study by Sheridan and Butler found that many primary care practitioners considered that there was not clear enough guidance on managing prescription drug misuse. The study proposed that clear national guidelines are needed covering prescribing and dispensing, support for patients with prescription drug misuse problems, strategies to minimise prescription drug misuse, and areas for training and education. The study also recommended that better education and informational resources are needed for primary care practitioners to help them manage drug seekers and drug misuse. Such education, it suggested, needs also to be aimed at increasing the opportunities for treatment and harm reduction interventions. In addition, the study recommended a range of improvements to the systems used for monitoring and reviewing prescribing. These included the better use of electronic and online systems to improve monitoring. These are but a few of the study's recommendations; see Sheridan and Butler, above n 790.

800 Section 19(1) of the Defamation Act 1992 uses different terminology, but essentially provides that the defence fails where a person publishes with malice. Section 19(1) provides that the defence of privilege will fail if the plaintiff proves that, in publishing the matter that is the subject of the proceedings, the defendant was predominantly motivated by ill will towards the plaintiff, or otherwise took improper advantage of the occasion of publication.

10.60 It is an offence for any person receiving a statement from the medical officer of health to further publish the information or comment on it except to the extent this is necessary as part of their work.[801]

10.61 There are a number of significant problems with section 20:

- The authorisation to publish statements is far wider than would seem to be necessary. On its face, it permits a medical officer of health to make any statement at all "to all or any of the members of all or any of the classes of person" provided that the statement is one "relating to" the person believed to be dependent.
- Consequently, the authorisation confers a far broader immunity from defamation than would seem necessary.
- The class of person to whom statements may be made is particularly broad including, without restriction, the police, managers of prisons, and all persons who deal with drugs in the course of their business. Disclosures should really be limited to members of these classes who might be reasonably considered to have a direct interest in the information.
- The threshold for triggering the power to make a statement is low. A medical officer of health need only have reason to believe that a person is likely to become dependent on any controlled drug. The medical officer of health is not required to exercise reasonable care when making a statement, as is normal when statutory immunity is conferred on an official. The other more general immunity provision in the Act (section 34) requires good faith and reasonable care.

10.62 More fundamentally, however, a specific statutory authority of this kind is not needed to authorise the transfer or disclosure of relevant health information within the health sector, provided it is done in compliance with the rules contained in the Privacy Act 1991 and the Health Information Privacy Code 1994 issued under it. Information concerning a patient who is suspected of having, or has, a dependence on drugs is health information and, like all other types of health information, should be dealt with under that regime. In our view, the need for section 20 has been superseded by the health information regime.

10.63 Generally, submitters who commented agreed that section 20 could be repealed and information on dependence could be managed in the same way as other health information.[802] Those who believed it should be retained were primarily concerned with the need for medical officers of health to be able to continue to publish and provide other health professionals with periodic lists of restricted persons.[803] We agree this is important, but think it is better addressed through the provisions relating to restricted persons. We discuss restricted persons below in paragraphs 10.80 to 10.87.

801 Misuse of Drugs Act 1975, s 20(5).

802 Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010) at 1; Submission of Community Alcohol & Drug Services Auckland Regional Consumer Advisor (submission dated 30 April 2010); Submitter 360 (dated 1 May 2010); Submission of The Drug Rights Project (submission dated 14 May 2010).

803 For example, the Submission of the Ministry of Health (submission dated 30 April 2010) at 21 and Submission of the New Zealand Law Society (submission dated 17 May 2010) at 27.

10.64 We recommend repealing section 20 and providing more explicitly for the provision of information to relevant health care professionals on people who are subject to restriction notices issued under section 25.

Section 22 – Prohibition notices

10.65 Under section 22, the Minister of Health may issue a notice prohibiting the production, distribution and use of any controlled drug.[804] Prohibition notices override authorisations in any licence issued under the Act as well as any applicable exemptions. There is some uncertainty about the purpose of this power, but it would seem to be treated essentially as a reserve power that is available to deal with unanticipated and urgent safety issues. There is a similar power under section 37 of the Medicines Act.

10.66 We think that there does need to be provision made to deal with unanticipated and urgent safety issues that arise in respect of medicines (including controlled drugs). Such powers should in practice only rarely be used, so that a high threshold for their use should be set in legislation. The Ministry of Health agrees with this view.[805]

10.67 For the reasons already discussed we think this power should be in the medicines regime and removed from the misuse of drugs regime.

Section 23 – Prohibition on prescribing and supply

10.68 Under section 23, the Minister of Health may, by notice in the *Gazette*, prohibit any specific prescriber from prescribing controlled drugs or prohibit any other specified person (such as a pharmacist) from exercising any of the rights conferred by an exemption in section 8.

10.69 In the Issues Paper we identified a number of problems with the powers given to the Minister by section 23 which need to be addressed:

- The Minister's power is very broad. For example, it could be used, at least in theory, to prohibit a patient from taking a medicine that has been lawfully prescribed.
- Similar powers are included as sections 48 and 48A of the Medicines Act. There is therefore unnecessary duplication. If the provisions are retained, there should be one set of provisions in the Medicines Act.
- The Minister cannot exercise the power in relation to a prescriber or a pharmacist except on the recommendation of their governing registration authority. The registration authorities have the same powers as a disciplinary tribunal to undertake an investigation into the prescribing or supply of controlled drugs by any member of their profession and to make a determination and recommendation to the Minister. The Minister's function is so circumscribed that it is difficult to see what objective his or her involvement might serve. In any event, it is not appropriate for the Minister to be involved in this way with a professional disciplinary matter involving an individual practitioner.

804 Note that s 22 also covers prohibition notices that prohibit the importation or supply of pipes or other utensils, other than needles and syringes. We discuss this issue in paragraphs 9.12 – 9.16 in ch 9.

805 Submission of the Ministry of Health (submission dated 30 April 2010) at 25.

10.70 We recommend repealing section 23. The powers of registration authorities to take appropriate disciplinary action under the Health Practitioners Competence Assurance Act 2003 should be strengthened, if necessary, to deal with cases where individual prescribers or pharmacists are found to be abusing their prescribing privileges under the exemptions. The Ministry of Health agrees with this view.[806]

Section 24 – Drug treatment for drug dependence

10.71 Medical practitioners, or the hospitals and clinics in which they work, may be expressly authorised by the Minister by *Gazette* notice to supply controlled drugs as a treatment for drug dependence.

10.72 Under section 24, as we have already noted, it is an offence for any other medical practitioner, or other prescriber, to provide controlled drugs, for the purposes of maintaining or managing dependence, to a person they know or suspect is dependent.[807] This effectively precludes all other medical practitioners from treating drug dependence with controlled drugs.

10.73 In contrast to the other exemptions, the exemption for treatment of dependence with controlled drugs is tightly drawn, so that the access of drug dependent patients to drugs can be limited and more closely monitored. One disadvantage is that this reduces the opportunity for general practitioners to be involved in drug and alcohol treatment. This in turn restricts the treatment options for people who are drug dependent. However, the restriction does ensure that specialist alcohol and drug clinics normally oversee treatment. General practitioners may also still prescribe and treat if they are authorised in writing to do this in respect of a specific patient under the authority of a specialist alcohol and drug clinic gazetted under section 24.

10.74 The majority of submitters we consulted within the treatment sector were firmly of the view that it is appropriate to restrict the supply and prescription of controlled drugs as a treatment for drug dependence to authorised specific specialist medical practitioners.[808] The view we have reached following that consultation is that the capability of general primary healthcare practitioners to manage drug dependence would need to be significantly improved before it would be appropriate to allow them to treat drug dependence with controlled drugs.[809] We therefore think that section 24 needs to be retained.

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806 Submission of the Ministry of Health (submission dated 30 April 2010) at 25.

807 Misuse of Drugs Act 1975, s 24(1) and (1A).

808 Submission of the New Zealand Drug Foundation (submission dated 29 April 2010); Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010); Submission of the Ministry of Health (submission dated 30 April 2010); Submission of the New Zealand Law Society (submission dated 17 May 2010); Submission of the New Zealand Law Society (submission dated 17 May 2010); Submission of Dr Simon Adamson, National Addiction Centre (submission dated 10 May 2010); and Submitter 360 (dated 1 May 2010).

809 Submission of the New Zealand Law Society (submission dated 17 May 2010).

10.75 Though the general tenor of submissions supported retaining section 24, many expressed concern that there were not stricter controls on, and closer monitoring of, prescribing controlled drugs for reasons other than the treatment of drug dependence. When opiates are prescribed for pain, for example, there are virtually no limits on the levels and amounts prescribed, but when they are prescribed to treat drug dependence section 24 applies. It was suggested by some submitters that this distinction is a largely artificial dichotomy, as many individuals concerned have overlapping conditions of chronic pain and substance dependence. If those individuals can establish a need for a prescription based on "pain" rather than "dependence", they are likely to be able to obtain ongoing prescriptions for large quantities of drugs with much more freedom and much less supervision.

10.76 We think, after discussing the issue with many working in the sector, that there needs to be a better link between prescribers of opiates for pain relief and addiction specialists treating drug dependence in cases where addiction is identified. Where a medical practitioner is prescribing or supplying a controlled drug to a person who the practitioner believes may be addicted or dependent, that practitioner should be required to consult with an addiction specialist who has authority under section 24 to treat drug dependence with controlled drugs. A definition of drug dependence or addiction may need to be included in the provision.

10.77 This would mean that if the practitioner who had been treating a patient's pain or some other condition identified that the patient had become dependent, he or she could continue to treat that patient but only after consulting a specialist in addiction. This would help ensure that the patient's dependence was identified and there was input from this specialty and a link made with drug and alcohol services.

10.78 In addition, we think that more effective monitoring of the levels and nature of prescribing of controlled drugs is needed within primary care and in other disciplines. Better monitoring systems are needed, particularly in respect of the long-term prescribing of opioids for chronic non-malignant pain. Effective monitoring of prescribing should identify individual prescribers whose prescribing patterns are out of step with their peers, and also identify individual patients whose patterns of drug use are or are likely to become problematic. We understand that the Ministry of Health is in the process of developing an electronic monitoring system that will begin to do this.

Section 25 – Restriction on supply to an identified person

10.79 Section 25 authorises a medical officer of health to impose restrictions on the supply of any controlled drug to a "restricted person" if he or she is satisfied that the person is a drug seeker who has been obtaining controlled drugs over a prolonged period and is likely to continue to do so. The medical officer of health issues a notice to relevant health professionals that may prohibit any further supply of controlled drugs to the restricted person or, alternatively, allow for some continued supply of controlled drugs by specified prescribers or from specified sources.

10.80 Section 25 is specifically directed at preventing or restricting the access that identified drug seekers have to controlled drugs. In contrast to the power to make privileged statements under section 20, the threshold for intervention is that the

medical officer of health must be satisfied that the person has been obtaining a controlled drug over a prolonged period. In contrast, section 49 of the Medicines Act, which is the equivalent provision covering drug seekers targeting prescription medicines, allows the medical officer of health to issue a notice where he or she is satisfied that the person has been obtaining any prescription medicine from several different sources and is likely to continue to do so. We think that this is a more appropriate test for controlled drugs and propose that the provisions be combined, with a single test to cover both controlled drugs and prescription medicines.

10.81 Under section 25, it is an offence, once a restriction notice has been issued, for any person who has been made aware of it to supply or prescribe any controlled drug to the restricted person in contravention of the notice. The maximum penalty is a term of imprisonment of three months or a fine of $500 or both.[810]

10.82 There was widespread support for retaining the restricted person regime.[811] Notices are used routinely in an attempt to curb misuse of prescription medicines.[812] There was also support for changing to the test in section 49 of the Medicines Act.[813]

10.83 Some submitters identified the need for improving the speed and method by which notices are communicated to relevant health professionals. The current method of publishing the details from notices in a national booklet issued quarterly seems cumbersome and archaic in an electronic age.

10.84 We recommend that medical officers of health should be authorised to provide the details of restricted notices and lists and details of people subject to restricted notices to all health practitioners and other people authorised to supply controlled drugs by any practicable means (including electronic communication). The information should also be provided regularly and kept up to date.

10.85 We suggested in the Issues Paper that the prescriber offence might not be necessary. Our preliminary view was that knowingly supplying or prescribing in breach of a notice should be dealt with as a disciplinary matter under the Health Practitioners Competence Assurance Act. We suggested that that Act was a more appropriate mechanism for dealing with these types of breaches of statutory restrictions.[814]

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810 Section 27 sets this general penalty for any offence under the Act where a specific penalty is not provided.

811 Submission of the New Zealand Law Society (submission dated 17 May 2010) at 27; Submitter 360 (dated 1 May 2010); Submission of the Ministry of Health (submission dated 30 April 2010); Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010).

812 Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010) at 2.

813 Submission of the Ministry of Health (submission dated 30 April 2010) and Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010).

814 There was strong support for this view from the Medical Council which considered that the mechanisms under the Health Practitioners Competence Assurance Act would be more effective in protecting public health and safety; see Submission of the Medical Council of New Zealand (submission dated 14 April 2010) at 1.

10.86 However, we have been persuaded that removing the offence of supply in contravention of a notice would make it very difficult to enforce the restricted notice.[815] It would also influence the approach of the Health Practitioners Disciplinary Tribunal, because one of the grounds for discipline of a health professional is that they have committed an offence under the Misuse of Drugs Act. If the offence was to be removed, this would undermine the Tribunal's ability to use this as a basis for discipline. In addition, there may be some value in enabling practitioners, when confronted with difficult situations involving restricted persons, to be able to say that they would themselves commit an offence and be liable to imprisonment if they breached the restriction notice.[816]

Section 25 – Offence committed by restricted person

10.87 Section 25 also makes it an offence for a restricted person, if he or she knows he or she is restricted, to procure or attempt to procure a prescription or supply of a controlled drug in contravention of the notice. The maximum penalty is a term of imprisonment of three months or a fine of $500 or both.[817]

10.88 We think this type of offending is of a nature that broadly equates to the personal use offences discussed in chapter 8. The new enforcement approach (with emphasis on therapeutic interventions and treatment) taken to personal possession and use offences should therefore be applied here. We recommend accordingly.

Other limitations in regulations

10.89 Regulations made under the Act also contain other important restrictions on the supply of controlled drugs. Regulations, for example, limit the quantities of controlled drugs that may be prescribed on each occasion; impose requirements on the form of written prescriptions; and set requirements for the storage, custody and transportation of controlled drugs and for the keeping of drug registers and other records so that activities with controlled drugs can be monitored.

10.90 Restrictions that place significant restraints on the use of controlled drugs under the exemptions should have to be agreed to by Parliament. We discussed earlier in paragraph 10.16 to 10.19 the breadth of the regulation-making powers under the Act and the fact that a number of important matters of policy are dealt with in regulation rather than in primary legislation. There are currently a number of significant restrictions in the regulations that fall into this category and should be in the Act.

Regulation 21(6) – Multiple prescriptions

10.91 Regulation 21(6) provides that the exemption under which a patient is authorised to obtain and use any controlled drugs that have been prescribed for him or her will not apply if the patient has been prescribed the same drug for the same purpose by another practitioner and did not disclose this when obtaining the second supply or prescription for the drug. The effect of the regulation is that

815 This is the Ministry's view also; see Submission of the Ministry of Health (submission dated 30 April 2010).

816 Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010).

817 Section 27 sets this general penalty for any offence under the Act where a specific penalty is not provided.

the possession of those drugs obtained by deception, even if under a prescription or from a doctor, will constitute a possession offence. Depending on the quantity involved it may even amount to an offence of aggravated possession.

10.92 This limitation is appropriate but, given its significance, it should be in the Act itself and not left to regulation.

Regulation 22 – Ministerial approval required before prescribing

10.93 Regulation 22 states that the approval of the Minister of Health is required before a prescriber can prescribe, or a patient can use, any Class A controlled drug other than cocaine; any Class B1 drug or Class B2 drug other than morphine or opium; or any Class C1 drug.

10.94 Again, this is a significant restriction on the use of these controlled drugs and should be agreed to by Parliament.

10.95 In any case, as we have argued in the Issues Paper, a ministerial power of this type is not appropriate. The Minister can effectively veto the use of certain controlled drugs as medicines even where these are considered the most appropriate treatment and have been prescribed by a qualified health professional. In practice this means that certain types of medicine (including some like methylphenidate (Ritalin) and dexamphetamine) that are widely prescribed require an approval, while others like cocaine, which is now only rarely used therapeutically, and opium, which has no therapeutic use, do not.

10.96 We recommend removing this provision altogether.

LICENSING PRODUCTION AND DISTRIBUTION

10.97 The international drug conventions require the production and distribution of most prohibited drugs to be undertaken either by a government organisation or under licence. This is to ensure these activities are closely controlled by states. The licensing model provides a high degree of regulatory control over people who can lawfully deal in prohibited drugs. Applicants for licences can be individually scrutinised and assessed against specified criteria to ensure they are both appropriately qualified and bona fide. Specific conditions can also be imposed on licence holders which can be closely monitored and enforced. Licences can be revoked where a licence holder fails to comply with the statutory requirements and licensing conditions.

10.98 Section 14 of the Act provides for the granting of licences.

The purposes for which licences are available

10.99 The purposes for which licences may be granted are not defined in the Act, although in practice licences are available for three different purposes:

- Licences occasionally authorise the import, export, supply or cultivation of controlled drugs for use in an industrial or production process. A few controlled drugs (for example, gamma-hydroxybutyrate (GHB)) are used occasionally in food production processes. Licences are made available to authorise and control this. Licences also authorise the cultivation and processing of industrial hemp (that is, cannabis plant with a very low

tetrahydrocannabinol (THC) content)[818] into various products such as rope and cloth. Only a few licences are granted for these purposes – approximately 10 authorise the cultivation and processing of industrial hemp and 10 authorise use in other industrial processes.

- Licences are also made available on occasion for the purposes of undertaking research into drugs, drug trials and studies. Some licences issued for this purpose also allow cultivation for research purposes. Again, only a few licences are issued for these purposes – there are approximately 21 current research licences.
- Most licences are issued for the purpose of authorising the manufacture, import, export and distribution of controlled drugs for use as medicines or for use in the manufacture or production of medicines. This is by far the main purpose of licensing – with approximately 170 pharmaceutical manufacturers, wholesalers and distributors currently being licenced. A small handful of these authorise the production of controlled drugs, with the rest covering the distribution chain.

Types of licences

10.100 Currently, many significant aspects of licensing are contained in regulations rather than the Act. Regulations establish a number of different types of licence:

- Dealers' licences – these authorise pharmaceutical manufacturers, wholesalers and distributors to manufacture and distribute controlled drugs to those legally authorised to receive them.[819]
- Import and export licences – these authorise the holder to import or export controlled drugs.[820] Import and export licences are issued per consignment and persons must have a lawful authority to possess the controlled drugs before they will be granted such a licence. This means that they either need to hold another type of licence (for example, a dealer's licence) that entitles them to possess the drugs, or be a health practitioner authorised to possess and supply the drugs under a statutory exemption.
- Licences to possess (for research) – these authorise possession for the purposes of research.[821]
- Industrial hemp licences – licences are made available under a separate set of regulations[822] authorising the cultivation, processing, supply and possession of industrial hemp and for breeding hemp cultivars.
- Cultivation licences – these allow the cultivation and processing of prohibited plants (other than industrial hemp) for the purposes of extracting controlled drugs for use as medicines. A cultivation licence could, for example, be granted to authorise the cultivation of opium poppies (Papaver somniferum) for the purposes of manufacturing morphine or the cultivation of cannabis for the purposes of making a THC-based medicine. In practice, no cultivation

818 It must generally be below 0.35 % and not above 0.5 %. The fruit and seeds of plants that qualify as industrial hemp are included in the definition. See Misuse of Drugs (Industrial Hemp) Regulations 2006, reg 4.

819 Misuse of Drugs Regulations 1977, reg 4. "Dealing" as defined in the regulations covers manufacturing, use in manufacturing and also the supply of controlled drugs to those legally authorised to receive them.

820 Misuse of Drugs Regulations 1977, reg 7.

821 Misuse of Drugs Regulations 1977, reg 9.

822 Misuse of Drugs (Industrial Hemp) Regulations 2006.

licences have ever been granted for the purposes of cultivating cannabis, although cultivation licences have been granted for trials involving the cultivation of non-morphine Papaver somniferum poppies.

The licensing authority

10.101 Regulations appoint the Director-General of Health as the licensing authority. Licence holders must comply with all conditions that are imposed by the Act and the regulations and also with any other specific conditions that are imposed on their licence by the Director-General. All licences are issued for a specified time period and expire. Licences are personal and cannot be assigned to another person.

Restrictions on the licensing authority's powers

10.102 There are some general restrictions that apply to restrict the licensing authority's power to issue licences under the Act. Some are in the Act and some are imposed by regulations.

10.103 The restrictions in the Act are:

- Ministerial approval is required for the grant of a licence to a person who has been convicted of an offence against the Act (or its predecessors) or has had an earlier licence revoked.[823]
- Licences cannot authorise the consumption, injection or smoking of any controlled drug other than for research purposes.[824]
- Licences cannot be issued that would permit the import or export of opium for smoking.[825] (This special provision relating to opium appears to be a historical anachronism.)

10.104 In addition, the restrictions currently in regulation are:

- The written approval of the Minister of Health is needed before the Director-General can grant a licence authorising the manufacture, use in manufacture, supply, import or export of any of the following controlled drugs:[826]
  - any Class A drug other than cocaine or its isomers, esters, ethers or salts;
  - any Class B1 drug except morphine or opium, or their isomers, esters, ethers or salts; and
  - any Class C1 drug.
- Licences cannot authorise the cultivation of any plant of the species Lophophora williamsii or Lophophora lewinii for the purposes of producing mescaline or the plants Psilocybe mexicana or Psilocybe cubensis for the purposes of producing psilocine or psilocybine.[827]

10.105 We see two main problems with the current restrictions.

823 Misuse of Drugs Act 1975, s 14(4).

824 Misuse of Drugs Act 1975, s 14(3).

825 Misuse of Drugs Act 1975, s 14(2).

826 Misuse of Drugs Regulations 1977, reg 22.

827 Misuse of Drugs Regulations 1977, reg 8(2).

10.106 First, both of the restrictions currently imposed by the regulations are significant matters of policy so should be in primary legislation. Secondly, the current provisions unnecessarily involve the Minister in licensing matters. We think that decisions about individual cases should not be made at the ministerial level because these should not be political decisions. In our view, the decision-making criteria should be set out in legislation and licensing decisions applying those criteria should be made by the Director-General as the licensing authority.

Powers to revoke licences

10.107 Under the current provisions, the Director-General does not have any powers to revoke licences once issued. Instead, the Minister can revoke a licence by notice in the *Gazette* if:

- the licensee is convicted of an offence against the Misuse of Drugs Act or Misuse of Drugs Regulations 1977;
- the Minister is satisfied that the licensee has breached or not complied with any of the conditions pertaining to the licence; or
- the Minister is satisfied that the licence was granted in error or because of any misrepresentation or fraud, or was granted without the Minister's permission in circumstances where permission was required.

10.108 Again this is problematic. It is unusual that a licence can be granted only by a chief executive (in this case the Director-General) but revoked only by the Minister. For the reasons we have already outlined, we do not think it is appropriate to involve the Minister in licensing decisions at the individual level.[828]

Offences

10.109 As discussed in chapter 9, it is currently an offence under section 15 for any person to make a false statement for the purposes of obtaining a licence. Section 15 is quite broad and currently covers false statements made for any purpose under the Act. We recommended in chapter 9 retaining the offence but narrowing its scope so that it only applies to a false statement that is made for the purposes of obtaining a licence.

10.110 It is also currently an offence under section 14(6) for any person to contravene any conditions or fail to comply with any conditions applying to any licence issued under the Act. As no maximum penalty is specified in section 14 for this offence, the default maximum penalty in section 27 currently applies. We think this offence should be retained but that it would be desirable to specify a specific maximum penalty for it. The maximum penalty under section 27 is imprisonment of up to three months and/or a fine of up to $500. We think that three months imprisonment is still an appropriate maximum, bearing in mind the potential seriousness of the offending. However, it is not necessary to specify a maximum fine, as a fine may be imposed instead of imprisonment in accordance with the provisions of the Sentencing Act 2002 irrespective of whether a maximum is specified for the offence.[829]

828 All submitters who commented on this point agreed that the Minister should not be involved in individual licensing decisions.

829 Sentencing Act 2002, s 39(1).

Recommendations for a new licensing regime

10.111 In conclusion, we recommend that the Director-General should continue to be the licensing authority for controlled drugs and in that role should determine all licensing matters. The Director-General, and not the Minister, should have the power to revoke licences where the conditions of the licence are breached or where the person is convicted of a serious offence. Offending that would disqualify a person from retaining his or her licence should include conviction for serious offences under the Crimes Act 1961 or the Medicines Act.

10.112 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 also be repealed.

10.113 In order to comply with the Legislation Advisory Committee Guidelines, all matters of substantive policy that are currently included in regulation should be moved into primary legislation. The most important points that should be included in primary legislation are:

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

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

Transferring the regime into the Medicines Act

10.115 In contrast to the situation we have already discussed concerning the statutory exemptions and their regulation, the interface between the Misuse of Drugs Act and Medicines Act in respect of licensing is relatively clear. Section 109 of the Medicines Act provides, in relation to licences, that a person who is authorised by a licence under the Misuse of Drugs Act to manufacture, pack, or sell a controlled drug that is a medicine is also deemed to be licensed under the

Medicines Act to undertake that activity. In other words, there is normally no need for the person to also have a licence under the Medicines Act. There is therefore minimal duplication or overlap between the regimes.[830]

10.116 However, in order to give effect to our broader recommendation of having one regulatory regime governing access to all medicines (including controlled drugs), we think that the two licensing regimes should be combined in the Medicines Act. It is essential to ensure that appropriate conditions are imposed on licences for controlled drugs to address security issues as well as good manufacturing practice requirements. A combined licensing regime would also have the advantage of simplifying the situation for pharmaceutical manufacturers and distributors who are currently required to hold licences under both regimes because they deal in both controlled drugs and other medicines.

10.117 We note that a small category of other activities (mainly the production of industrial hemp and the use of controlled drugs in industrial processes) would be left to be licensed, largely on the same terms and conditions, within the drugs regime.

MEDICINAL CANNABIS

10.118 Cannabis and cannabis-based products have historically been used for medicinal purposes. Currently cannabis plant, seeds and fruit are Class C drugs, while cannabis preparations are Class B drugs. Cannabis and cannabis preparations are therefore (like other controlled drugs) only lawfully available for medicinal use if produced, supplied or used under one of the exemptions discussed in the earlier part of this chapter. In practice, these restrictions have completely precluded the lawful use of raw cannabis for therapeutic purposes and have restricted the development of cannabis-based medicines (cannabis preparations).

10.119 Below, we consider whether specific exemptions are desirable to authorise the medicinal use of cannabis and cannabis-based products. Medicinal cannabis is often misunderstood and consequently tends to be a far more controversial issue than it should be.[831]

830 Section 109 of the Medicines Act 1981 covers situations where controlled drugs are used as ingredients in the manufacture of medicines, but only partially. Where the resulting medicine is not a controlled drug but is another medicine, a licence authorising its manufacture must also be obtained under the Medicines Act. This second licence is not to authorise the use of the controlled drug, but is required to authorise the manufacture of the other medicine. Under the Medicines Act anyone manufacturing a medicine is required to be licensed unless he or she is covered by one of the exemptions that apply to health care professionals.

831 See the discussion on the history of the therapeutic use of cannabis and the approach taken to authorising its use in some European and North American jurisdictions in ch 13 of Law Commission *Controlling and Regulating Drugs* (NZLC IP16, 2010).

Therapeutic benefits

10.120 There is continuing debate about the nature and extent of the therapeutic benefits of cannabis. Some consider that cannabis or cannabis-based products can be effective in relieving the conditions of some chronic or debilitating illnesses, particularly when conventional treatment options have failed. These conditions include:[832]

- chronic pain for which other pain relief treatments are ineffective, or have adverse effects;
- neurological disorders, including (but not limited to) multiple sclerosis, tourette's syndrome, epilepsy and motor neurone disease;
- nausea and vomiting in cancer patients undergoing chemotherapy, for which existing drugs are ineffective, or have other harmful side effects;
- HIV-related and cancer-related wasting (cachexia).

10.121 Despite the increasing interest in the potential therapeutic effects of cannabis, it is not approved for use for such therapeutic purposes in many jurisdictions including New Zealand. The drug's illegal status creates barriers for those trying to access the drug, and leaves users vulnerable to criminal sanction. It also creates disincentives to pharmaceutical companies, and inhibits research into the use of cannabis for therapeutic purposes. Debate also continues about the harm that cannabis use may cause to the user, particularly if cannabis is used on a regular or long-term basis.

10.122 The traditional way that cannabis has been used for therapeutic purposes is in its raw or natural form. However, there is now increasing focus on the development of whole plant extracts and synthetic products, which contain extracts of THC and/or other cannabinoids. The most widely used of these is a buccal (mouth) spray, marketed as Sativex, containing cannabis extracts and cannabidiol.[833] Such products seek to overcome some of the problematic aspects of using raw cannabis (for example, through the ability to control toxicity and potency) and are more likely to meet medicinal manufacturing standards.

Current regulatory approach

10.123 The approach taken in New Zealand to cannabis-based medicines and raw unprocessed cannabis differs somewhat in practice, although the legal requirements are technically the same.

Cannabis-based medicines

10.124 Cannabis-based products, such as Sativex or other equivalents, are available in some circumstances on prescription. Because all cannabis preparations are Class B drugs, a licence is required before these can be manufactured or imported. Currently, a New Zealand pharmaceutical company holds a dealer's licence that allows it to distribute Sativex, and has obtained an import licence for each

832 New Zealand Drug Foundation (NZDF) *Evidence Review on Medicinal Cannabis* (NZDF, Wellington, 2006) at 4 – 6.

833 The other main cannabis-based medicine used in some other jurisdictions is Marinol, which has since fallen out of favour with users because it is seen as less effective than natural or raw cannabis, and because of its significant side effects. Ibid, at 19.

importation of the drug. Sativex has recently been approved as a medicine in New Zealand. It is available on prescription on the same basis as any other approved controlled drug.[834] Before it was approved, a small number of applications from practitioners to prescribe Sativex for use by individual patients with multiple sclerosis and chronic pain were approved by the Minister.[835] If other cannabis-based products are developed, they would also become available under the exemption for unapproved medicines until such time as they obtained approvals as medicines.

Legal access to raw cannabis

10.125 The legal approach to raw or unprocessed cannabis is the same as that for cannabis-based medicines. However, cannabis has not been assessed or approved as a medicine under section 20 of the Medicines Act. It could therefore only be accessed, if at all, under the limited exemptions in the Medicines Act which control access to medicines that do not have approvals. Medical practitioners can in some limited circumstances procure and supply medicines that have not been approved. A clinically untested product like raw cannabis would not satisfy these requirements. In addition, because it is a Class C1 drug, the Minister's approval is required before any prescriber can provide it, or any patient can use it.[836]

10.126 Licences have only ever been granted authorising the cultivation of cannabis for the purposes of research. Although the scheme in the Act would not rule out licences being granted to import, distribute or cultivate cannabis, licences could not be made available under the regime unless cannabis became an approved medicine.

Discussion

10.127 In our view, the current licensing scheme and exemptions, with the changes outlined earlier in the chapter, adequately deal with Sativex and other cannabis-based medicines. These are commercially produced pharmaceuticals and there is no reason to distinguish them from other medicines that are controlled drugs. The interest of pharmaceutical companies in cannabis-based products is likely to continue and it is likely that more cannabis-based products will be approved for use in New Zealand.

10.128 The more difficult issue to resolve has been whether some additional steps should be taken to enable access to unprocessed cannabis for therapeutic uses. Cannabis-based products, such as Sativex, may not be considered suitable for some who might benefit medically from cannabis use. Some patients who use cannabis medically argue that smoking raw cannabis is more effective than

834 Sativex is a Class B1 drug so currently because of reg 22 the Minister of Health's approval is required before it can be supplied, prescribed or administered. We discussed reg 22 in paragraphs 10.94–10.97 and recommended that it be repealed because it is inappropriate for the Minister to be involved in treatment decisions.

835 The Ministry of Health advised that as at December 2009 14 authorisations had been granted, although only three people had actually used the product by that date due to its not being funded.

836 Misuse of Drugs Regulations 1977, reg 22.

taking products derived from cannabis.[837] It is also argued that few users are able to afford the cost of a commercially produced pharmaceutical product, particularly if it is not subsidised and is required on a long-term basis. Sativex is not funded by Pharmac and it is estimated to cost approximately $900 to $1,000 a month.[838] Pharmac advise that it has not yet received an application for funding for Sativex. Only a handful of patients use the drug at this stage, mainly with funding through Accident Compensation.

10.129 Although there would seem to be a general agreement that cannabis and cannabis-based products can be an effective option for some patients when conventional treatment options have failed, smoking unprocessed cannabis carries a number of health risks. Some of these are caused by smoking. We have identified and discussed in chapter 2 the range of other health harms that can result from cannabis use. The risks associated with smoking may be reduced by the use of vapouriser devices, which are similar to nebulisers used for asthma treatment, although no long-term studies of the effectiveness of these devices have been reported.[839]

10.130 For patients who are suffering from chronic, debilitating or terminal illnesses these risks are probably not sufficient to rule out use altogether. Almost all substances used therapeutically have side effects. That is why access to them is carefully regulated and overseen by suitably qualified health professionals.

10.131 A related issue is the variability of unprocessed cannabis. While drugs like Sativex can deliver measured doses of THC and other active ingredients, it is more difficult to do this with raw cannabis. Raw cannabis leaf and products like hash oil are often of variable quality and potency. Dried cannabis and other products of that sort are not normally manufactured in a standardised quality-controlled process, so there are also issues of contamination.

10.132 Aside from health and efficacy concerns, the other major issue is the potential for medicinal cannabis to be misused or diverted into the illegal drugs market. The extent to which misuse and diversion would occur would depend largely on the type of regulatory model adopted. The relative ease with which cannabis can be grown and processed (dried) into a usable form means that there would probably be a higher risk of misuse and diversion into the recreational market with cannabis than with many other prohibited drugs that are more difficult to manufacture and process. The high risk of diversion suggests that a closely controlled licensing and exemption model would be needed.

10.133 Finally, the debate about allowing the therapeutic use of cannabis tends to get caught up in the debate about allowing the use of cannabis for recreational purposes. Some opponents of recreational cannabis use fear that allowing its

837 Presumably this is either because the active ingredients are absorbed into the blood more quickly or because the raw product has a higher concentration of active substances. The NZDF has said that users overseas have been resistant to using Marinol (a synthetic THC solution) because it is considered less effective than natural cannabis. It can also have significant side effects. See New Zealand Drug Foundation, above n 832, at 19.

838 Estimate of the cost to a patient supplied by the Ministry of Health.

839 See New Zealand Drug Foundation, above n 832, at 8.

therapeutic use "will be the thin edge of a wedge to legalise cannabis".[840] This seems to be based on a perception that authorising some medicinal use might lead to a greater acceptance of recreational use. However, this does not logically follow. It has not happened with other controlled drugs that are used medically. A drug like morphine is widely used for medical purposes but it is not consequently accepted as safe and appropriate for use as a recreational drug. In any event, cannabis is already widely used as a recreational drug. It is difficult to see why authorising some limited and carefully controlled medical use by people suffering from chronic and debilitating illness would have any impact on the use and prevalence of cannabis recreationally.

The views of submitters

10.134 There was significant support from submitters for the establishment of a scheme so that patients suffering from chronic or debilitating illnesses can access and use raw cannabis without breaking the law.[841] Many of the submissions received from individuals on this issue were written by people currently using cannabis medically. Many said they had chronic or debilitating illnesses and found cannabis beneficial for managing pain and other symptoms. Some cited long lists of prescription medicines (many of which are addictive or have other far worse side effects than cannabis) which they are, or could be, lawfully prescribed. A strong theme in many of these submissions was the distress (and in some cases danger) these chronically ill people said they experienced because they were required to break the law if they wished to obtain or cultivate a drug that they all believed was the most effective treatment for their condition.

10.135 Some submitters considered that a special scheme was not needed for medicinal cannabis. Their view is that Marinol and other synthetic medications like Sativax are adequate.[842] The New Zealand Nurses Organisation also favoured the use of standardised, safe, pharmaceutical grade, non-smoked cannabis derivatives for defined medical conditions.[843]

10.136 A significant degree of concern was also expressed in a number of submissions, particularly from those in the health sector, over the lack of robust evidence on the effectiveness of cannabis as a form of pain relief. A submission made on behalf of a number of addiction medicine specialists said that many doctors would not think it ethically responsible to endorse the use of a raw natural product (like cannabis) when its composition is uncertain and it has not been subjected to a formal evaluation of its effectiveness.[844] The New Zealand Medical Association took the position that the use of cannabis for medicinal purposes would be acceptable provided it was subject to the same evidence-based testing

840 Wayne Hall, Louisa Degenhardt and Michael Lynskey *The Health and Psychological Effects of Cannabis Use* (Monograph Number 44, National Drug Strategy (Australia), 2001) at 137.

841 Approximately 65 % of all original submissions and 3415 NORML form submissions supported the use of medicinal cannabis.

842 For example, Submission of Pauline Gardiner, former executive officer of WellTrust (submission dated 12 April 2010).

843 Submission of New Zealand Nurses Organisation (submission dated February 2010).

844 Submission of Lee Nixon, following a discussion of this issue by a group of addiction medicine specialists at the NZ Branch meeting of the Chapter of Addiction Medicine of the Royal Australasian College of Physicians (submission dated 11 March 2010).

as other drugs used for the same reasons.[845] The Ministry of Health also does not support the use of unprocessed leaf cannabis for the treatment of serious medical conditions for similar reasons.[846]

10.137 Others in the health sector, including the Alcohol Drug Association New Zealand, submitted that the law should authorise the medicinal use of cannabis by people suffering from chronic or debilitating illness. The Association's view is that unprocessed cannabis for medical use should be more readily available than it is currently.[847] Individual prescribers would always need to be satisfied it was the most appropriate treatment in all the circumstances. We also received submissions from a few individuals in the health sector who have patients using raw cannabis. They were supportive of it being made available in some situations.[848]

10.138 A number of other submissions from health professionals suggested that unprocessed cannabis could be made available as an unapproved medicine, but under the same strict conditions applying to other medicines that have not been approved.[849] However, it would be quite unprecedented to make something that is essentially unrefined plant material of varying quality and composition available through the current exemption for unapproved medicines. While medicines which have not been subjected to full clinical assessment can be used under the exemptions, these are available and prescribed in a pharmaceutical dose form. The composition and strength of the medicines is therefore known even if their efficacy, risks and side effects have not been fully tested. If a largely standardised dose form of cannabis plant matter did become available, the exemption could be used by medical practitioners who were willing to prescribe it.

10.139 We have considered all the different views expressed in this debate. Until randomised control trials are undertaken, we do not think it will be possible to resolve these 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 all other prohibited 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.

10.140 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 this approach to the Government.

10.141 If clinical trials do demonstrate that cannabis can be effective to treat certain conditions, and if it is sufficiently safe for those purposes, there is no reason why it could not be made available on prescription under the exemptions discussed earlier in this chapter, in the same way as other controlled drugs. The production and distribution could then be licensed in the same way as it is for other controlled drugs.

845 Submission of the New Zealand Medical Association (submission dated 23 April 2010).

846 Submission of the Ministry of Health (submission dated 30 April 2010).

847 Submission of the Alcohol Drug Association New Zealand (ADANZ) (submission dated April 2010).

848 For example, Submitter 145 (submission dated 25 April 2010).

849 Submission of Senior Pharmacists, Community Alcohol & Drug Services, Methadone Services, Auckland (submission dated 29 April 2010).

10.142 In the meantime, while trials are being conducted, we think that it would be appropriate for the police to adopt a policy of non-prosecution in cases where they are satisfied that cannabis use is directed towards pain relief or managing the symptoms of chronic or debilitating illness.

RECOMMENDATIONS > Continued next page

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.

RECOMMENDATIONS

> Continued next page

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.

RECOMMENDATIONS

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
Enforcement

INTRODUCTION

11.1 The general criminal law contains a number of enforcement powers available to police and other law enforcement officers in respect of all criminal offences across the statute book. However, some legislative schemes, such as the Misuse of Drugs Act 1975, contain specific enforcement powers that are tailored to the nature of the criminal offending involved.

11.2 The Search and Surveillance Bill 2009 will implement the Law Commission's report on search and surveillance powers.[850] That Bill brings together the law on search and surveillance into a coherent and comprehensive framework. One of the key features of the proposed regime is standardised procedural provisions relating to the application process for issuing of warrants, the exercise of search and inspection powers, and post-execution procedures including the treatment of privileged and confidential material. The Bill also brings together in one place all core police powers of search which are currently scattered across the statute book, with some being founded in the common law. This includes the search powers currently located in the Misuse of Drugs Act.

11.3 We do not propose any changes beyond those contained in the Search and Surveillance Bill, except in relation to warrantless powers of search. We also propose some changes to the powers in the Misuse of Drugs Amendment Act 1978 that enable a person who is suspected of secreting drugs within his or her body to be searched.

11.4 This chapter deals mainly with *law enforcement* powers. These are powers that contain a threshold of reasonable grounds to believe or suspect commission of an offence. Such powers are primarily aimed at the gathering of evidence of offending so that the law can be enforced through the imposition of criminal sanctions. *Regulatory* powers, which generally permit inspection for the purposes of monitoring compliance with the Act, do not require such a level of belief or suspicion before they may be exercised. Rather, they create incentives for those operating in the regulated environment to comply with the applicable rules and conditions.

850 Law Commission *Search and Surveillance Powers* (NZLC R97, 2007) [*Search and Surveillance Powers*]. The Bill was reported from the Justice and Electoral Committee on 4 November 2010.

General search warrant power authorising search of places, vehicles and other things

11.5 Section 198 of the Summary Proceedings Act 1957 makes a search warrant available in respect of all offences punishable by imprisonment. Under this provision, any person (usually a police officer) may apply to a District Court judge, justice, community magistrate or registrar for a search warrant.

11.6 The prospective search must relate to a particular search site (being a building, aircraft, ship, carriage, vehicle, box, receptacle, premises or place). A search warrant may authorise searches for and seizure of things upon or in respect of which the offence has been or is suspected of having been committed, where there is a reasonable ground to believe that those things are evidence of the offence, or are intended to be used for the purpose of committing the offence.[851]

11.7 Under the Search and Surveillance Bill, this general search warrant power is retained, but is amended in several important ways:

- the ability to apply for a warrant is limited to police officers;
- the threshold to be met is a two-stage test involving reasonable grounds to suspect that an imprisonable offence has been, is being, or will be committed; and reasonable grounds to believe that the search will find evidential material in respect of that suspected offence;
- a search warrant is able to be issued to search a place, vehicle (defined broadly) or other thing.[852]

11.8 The application for, issue of and execution of the warrant are subject to the detailed generic procedural provisions set out in Part 4 of the Bill.

11.9 We do not consider that any further changes to these provisions, as they apply to drug offending, are required.

Specific warrantless powers of search in relation to drugs

Warrantless searches of places, vehicles and people

Places and vehicles

11.10 Section 18(2) of the Misuse of Drugs Act provides a warrantless power of search for police officers where there are reasonable grounds to believe that there is a specified controlled drug or precursor substance in or on any building, aircraft, ship, hovercraft, carriage, vehicle, premises or place, and that an offence against

851 Also of relevance is s 198A of the Summary Proceedings Act 1957 which provides that a police officer executing a search warrant may require a specified person to provide information or assistance that is reasonable and necessary to allow the police officer to access data held in, or accessible from, a computer that is on the premises specified in the warrant.

852 Search and Surveillance Bill 2009 (45–2), cl 6.

the Act has been or is suspected of having been committed in respect of that drug or precursor substance. The controlled drugs covered by the power are all Class A drugs, Class B1 drugs, Class C1 drugs and ephedrine and pseudoephedrine. The power authorises the police officer and any assistants accompanying him or her to enter and search the particular site and to search any person found in or on the search site.

11.11 The power to search places and vehicles in section 18(2) has been carried over to the Search and Surveillance Bill with the following changes:[853]

(a) the threshold now reflects the approach taken across the Bill so that a police officer must have reasonable grounds:
   (i) to believe that it is not practicable to obtain a warrant and that a specified drug or precursor is in or on a place or vehicle; and
   (ii) to suspect that in or on the place or vehicle an offence against the Act has been committed, or is being committed, or is about to be committed in respect of the drug or precursor substance; and
   (iii) to believe that, if entry and search is not carried out immediately, evidential material relating to the suspected offence will be destroyed, concealed, altered or damaged; and
(b) the description of the places that may be searched has been simplified (as with the replacement for section 198 of the Summary Proceedings Act) so that the power may be exercised in respect of a place or vehicle rather than the very specific list of places and vehicles which are included in section 18(2) at present.

People

11.12 Section 18(3) of the Misuse of Drugs Act permits a warrantless search of a person where a police officer has reasonable grounds to believe that the person is in possession of a Class A drug, Class B1 drug, Class C1 drug or ephedrine or pseudoephedrine, and that an offence against the Act has been, or is suspected of having been, committed in respect of that drug or precursor. The power enables the officer to detain and search the person and to take possession of any drug or precursor found.

11.13 Section 18(3) is replicated in Part 2 of the Search and Surveillance Bill that contains police powers.[854] Again, the threshold for the power has been amended to ensure consistency with the approach adopted throughout the Bill so that a police officer must have reasonable grounds to:

(a) believe the person is in possession of a specified drug or precursor substance; and
(b) suspect that an offence against the Misuse of Drugs Act has been committed, is being committed, or is about to be committed in respect of that drug or precursor.

853 Search and Surveillance Bill 2009 (45–2), cl 19.

854 Search and Surveillance Bill 2009 (45–2), cl 21.

Proposed changes to warrantless search powers

11.14 The Commission's report on search and surveillance powers concluded that the requirement for enforcement officers to obtain a warrant authorising a search is of such importance that departures from it can only be justified in exceptional circumstances. One of the areas where warrantless powers have traditionally been granted is to search for evidence of specific offences where the nature of the offending justifies it. Typically this has been in the areas of drugs and arms:[855]

> Ensuring that controlled drugs and firearms do not circulate in the community is very much in the public interest. So far as controlled drugs are concerned, prompt enforcement action is often called for to prevent drugs being used or distributed: they are easily concealed and readily disposed of.

11.15 We broadly continue to hold this view. However, our proposal to remove subparts from the drug classification structure means that, if nothing is done, the warrantless search power will be broader than it is currently – that is, it will apply to all controlled drugs and potentially all precursor substances. Some changes to the warrantless search powers contained in the Misuse of Drugs Act are therefore required.

11.16 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.

11.17 The approach that should be taken to Class C drugs is more difficult. It is clear from submissions that there is concern about the scope of the current warrantless search powers and how they are used by the police, particularly in relation to individuals carrying small amounts of cannabis. However, we have not been able to develop any new approach that addresses these concerns in a way that is practicable and recognises the reality of law enforcement. For example, we considered whether the warrantless search powers, particularly in relation to Class C drugs, could be limited to suspected dealing offences. We do not consider this to be workable – in particular, it is unlikely to be clear in a sufficient number of instances, at least where searches of persons or vehicles are in contemplation, that a dealing offence rather than a personal use offence is being committed. Nor do we consider it realistic for the warrantless search powers in relation to Class C drugs to be removed altogether; given the mobility of persons and vehicles, any requirement to obtain a warrant in advance would generally render the search futile.

11.18 We therefore consider that the current warrantless search power in relation to Class C drugs 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.

855 Law Commission *Search and Surveillance Powers*, above n 850, at [5.64].

11.19 However, we recommend that 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 will 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. Warrantless searches of places therefore become difficult to justify when the suspected offence merely involves personal use of a Class C drug. Assuming appropriate classification, Class C drugs are not sufficiently harmful and their use does not involve sufficiently serious offending to justify the intrusion that a warrantless search involves.

Internal searches of people under arrest

11.20 Section 18A of the Misuse of Drugs Act authorises internal searches of persons under arrest for an offence under sections 6 (dealing), 7 (possession and use) or 11 (theft of controlled drugs) of the Act. The threshold for exercise of the power is that the police officer has reasonable grounds to believe the person has secreted within his or her body evidence of the offence for which he or she has been arrested, or anything the possession of which constitutes an offence against any of those provisions. The search is carried out by a medical practitioner nominated by the officer and is performed either by use of an x-ray machine or other similar device, or by the medical practitioner carrying out a manual or visual search (which may be facilitated by any instrument or device) of any body orifice.

11.21 Section 18A(3) prohibits an internal examination where the medical practitioner considers that it would be prejudicial to the suspect's health, or where he or she is satisfied that the suspect is not prepared to permit the internal examination to be carried out. Where the suspect refuses to permit an internal examination to be carried out and subsequently applies for bail, section 18A(4) empowers the court hearing the bail application to decline to hear the application for up to two days unless the suspect permits the examination to be carried out in this period. The court may also order that the suspect continue to be detained in police custody for this two day period.

11.22 Section 18A(1) makes it clear that a police officer may search a person's mouth with the person's consent.

11.23 The Commission recommended the retention of section 18A in its search and surveillance report due to the overriding public interest in ensuring drugs are not in circulation in the community.[856] Section 18A has been carried over in Part 2 of the Search and Surveillance Bill.[857] We do not consider any further changes to these provisions are required.

Power to search persons at a place or vehicle being searched

11.24 Under current New Zealand law, where a place or vehicle is the subject of a lawful search, it is generally unclear whether there is a power to search people who are found in them.[858]

856 Law Commission *Search and Surveillance Powers*, above n 850, at [8.25].

857 Search and Surveillance Bill 2009 (45–2), cls 22 and 23.

858 Law Commission *Search and Surveillance Powers*, above n 850, at [8.10].

11.25 However, section 18(1) of the Misuse of Drugs Act essentially acts as an exception to this general position, in that it provides a power to search anyone found in a place for which a search warrant has been issued for an offence against the Act. Section 18(2) provides a corresponding power in relation to persons found in or on a building, aircraft, ship, hovercraft, carriage, vehicle, premises or place, in respect of which the police officer has grounds to conduct a warrantless search. There is no requirement in either case for the police officer to have reasonable grounds to believe or suspect that drugs are on the person (as distinct from being generally in the area in which the person is located).

11.26 In its search and surveillance report, the Commission recommended reform of the law in this area, so that wherever there is a power for the police to search a place or vehicle with or without a warrant, a person who is found in that place or vehicle or who arrives there during the search can be searched, but only where there are reasonable grounds to believe that the object of the search is on the person.[859] This is to be implemented by way of the Search and Surveillance Bill.[860]

11.27 The Commission also considered whether any change to sections 18(1) and (2) of the Misuse of Drugs Act was warranted and concluded that these exceptions to the general position should be retained:[861]

> We accept the view put to us by the police that in cases where there is authority to search premises or vehicles for controlled drugs, it will rarely be possible to establish reasonable grounds to believe that drugs are on any one person, especially in situations where several people are on premises where drug manufacturing or dealing is taking place or has recently occurred. Drugs are easily concealed on the person. A requirement to meet any threshold before a person present could be searched would often frustrate the exercise of the power. We therefore recommend that section 18(1) and 18(2) of the Misuse of Drugs Act 1975 be retained in their current form in this respect.

11.28 Accordingly, these provisions are retained in Part 2 of the Search and Surveillance Bill.[862] We do not consider any further changes to these provisions are required.

Controlled deliveries and related search powers

11.29 The concept of controlled deliveries is recognised by article 11 of the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances:

> If permitted by the basic principles of their respective domestic legal systems, the Parties shall take the necessary measures, within their possibilities, to allow for the appropriate use of controlled delivery at the international level, on the basis of agreements or arrangements mutually consented to, with a view to identifying persons involved in offences established in accordance with article 3, paragraph 1, and to taking legal action against them.

859 Law Commission *Search and Surveillance Powers*, above n 850, rec 8.2.

860 Search and Surveillance Bill 2009 (45–2), cl 115(1).

861 Law Commission *Search and Surveillance Powers*, above n 850, at [8.16].

862 Search and Surveillance Bill 2009 (45–2), cls 18A and 20.

According to the Convention, a "controlled delivery" is:

> … the technique of allowing illicit or suspect consignments of [drugs or other prohibited substances], or substances substituted for them, to pass out of, through or into the territory of one or more countries, with the knowledge and under the supervision of their competent authorities, with a view to identifying persons involved in the commission of offences….

11.30 Sections 12 to 12D of the Misuse of Drugs Amendment Act 1978 regulate the operation of controlled deliveries in New Zealand and provide the necessary search powers to ensure that the objectives of identifying the persons participating in drug trafficking, and recovery of all drugs and precursor substances involved, are met.

11.31 A controlled delivery usually follows a customs officer intercepting a drug delivery coming into New Zealand, with the officer then being empowered by section 12 to allow the package containing the drug or other substance (or a substitute substance) to be collected or delivered for the purpose of the investigation.

11.32 International controlled deliveries are dealt with by section 12D and involve allowing a controlled drug or precursor substance (or a substitute substance) to pass through or into the territory of one or more countries with the agreement of the relevant law enforcement agencies of the countries involved and with a view to identifying persons involved in the commission of offences.

11.33 The effect of sections 12 to 12D is that officers are authorised to allow a parcel containing drugs or precursor substances to be delivered or collected without committing what would otherwise be an offence under the Misuse of Drugs Act.

11.34 Police and customs officers have the power to detain and search any person involved in a delivery under section 12, and are empowered to enter any building, craft, carriage, vehicle, premises or place in order to carry out the search of the person. The threshold for exercise of the search power is that the officer believes on reasonable grounds that the person is in possession of a controlled drug, a precursor substance, a package in which a customs officer has replaced any drug or precursor substance, or evidence of the commission of an offence under sections 6(1)(a) or 12AB of the Misuse of Drugs Act. Section 12B authorises seizure of any such things found on the person.

11.35 The Commission concluded in its report on search and surveillance powers that the powers of search associated with the controlled delivery provisions in the Misuse of Drugs Amendment Act should be retained, although it considered some deficiencies identified by the New Zealand Customs Service should be addressed.

11.36 First, Customs pointed out that although section 12A authorises entry to a building (for example), there is no power for a customs officer to search the building itself, only a person involved in the controlled delivery. This means that a person could secrete the package elsewhere than upon his or her body, or could leave it in the building for collection by another person. This leaves the customs officer reliant on the police attending and exercising their warrantless search power under section 18(2) of the Misuse of Drugs Act. Accepting that the dynamics of such operations are unpredictable and that it is unrealistic to expect

police officers always to be available to assist, the Commission recommended that section 12A should be amended to include a power for a customs officer to search places and vehicles on the basis of a reasonable belief that they contain controlled drugs, precursor substances, a substituted package, or other evidential material relating to the offence.[863]

11.37 Customs also pointed out that whilst the description of a controlled delivery in section 12 is appropriate in most cases, there are circumstances that fall outside of it (such as the supervised delivery of a substituted package by a courier who has agreed to co-operate). Accordingly, the Commission also recommended that section 12 be amended to accommodate such circumstances.[864]

11.38 The search power in section 12A has been carried over into the Search and Surveillance Bill, including the power for customs officers to search vehicles and places.[865] The Bill also amends section 12 to deal with changes in controlled delivery operations, as the Commission recommended.[866]

11.39 We do not consider any further changes to these provisions are required.

Powers in relation to internal concealment

Detention under the Misuse of Drugs Amendment Act and associated powers

11.40 Sections 13A to 13M of the Misuse of Drugs Amendment Act potentially authorise detention of a person for up to 21 days where there is reasonable cause to believe that a person has any Class A or B drug secreted within his or her body for any unlawful purpose. An "unlawful purpose" in this context means the commission of an offence against the principal Act and the concealment of the commission of any such offence. The regime applies where the person is believed to have secreted the drug within any of his or her body cavities or to have swallowed the drug so that it may pass through the body or be regurgitated intact.

11.41 There are three stages in the procedures: the initial detention by police or a customs officer;[867] detention under judicial warrant for up to seven days commencing with the day on which the initial detention began; and detention under a renewed warrant for further periods of up to seven days until 21 days of detention have elapsed in total.

11.42 When a person is initially detained by the police or a customs officer under section 13A, he or she must be informed of the reason for the detention and given a prescribed Statement of Rights. The police or customs officer must arrange for a medical practitioner to attend and, in the presence of that practitioner, ask the detainee if he or she wishes to undergo an examination.

863 Law Commission *Search and Surveillance Powers*, above n 850, rec 5.12.

864 Ibid.

865 Search and Surveillance Bill 2009 (45–2), cls 78 and 79.

866 Search and Surveillance Bill 2009 (45–2), cl 305.

867 A customs officer may only exercise powers conferred by ss 13A to 13I in respect of offences against the Misuse of Drugs Act involving the importation into or the exportation from New Zealand of any Class A or Class B controlled drug – Misuse of Drugs Amendment Act 1978, s 13J.

The kinds of examination permitted are those set out in section 13C – a physical examination conducted by a medical practitioner, an x-ray either with or without a contrast agent, or an ultrasound scan. The officer must also apply to a District Court judge for a warrant authorising the continued detention of the person.[868]

11.43 The detained person must consent to an examination before it can be carried out. The medical practitioner or person conducting the examination must certify the results of the examination – that, in his or her opinion, the person has something or nothing secreted that could be or could contain a drug, or that the results of the examination are inconclusive.[869]

11.44 A District Court judge may issue a warrant authorising the person's continued detention for seven days where:

- there has been compliance with the requirements of section 13B;
- there is reasonable cause to believe that the detainee has secreted within his or her person any Class A or B drug for any unlawful purpose; and
- the premises where the person is being or is to be detained are suitable for the purpose.[870]

11.45 Once a detention warrant has been issued under section 13E, a member of the police or a customs officer may undertake a rub-down search, a strip search, or both, if he or she has reasonable cause to suspect the detainee has hidden on or about his or her person any Class A or B drug.[871] Sections 13EB and 13EC prescribe what may be done for the purpose of conducting rub-down and strip searches. Section 13ED sets out restrictions on the conduct of rub-down and strip searches that are intended, as far as possible, to preserve the privacy and dignity of the person being searched. This includes a requirement for a strip search to be conducted by a person of the same sex and out of the view of any person not of the same sex or who is also detained or being searched.

11.46 When a judge issues a warrant under section 13E, he or she is also required to appoint or arrange for the appointment of a barrister or solicitor and a medical practitioner to report to the court on various matters related to the rights and physical health and welfare of the detainee.[872]

11.47 Under section 13I, a District Court judge may grant a renewal of a detention warrant permitting the detention of the person for up to a total of 21 days.

11.48 Detention ceases where:

- the detainee is arrested;
- a medical practitioner or other person carrying out an examination gives a certificate to the effect that the detained person has nothing secreted within his or her person that could be or could contain a Class A or B drug;

868 Misuse of Drugs Amendment Act 1978, s 13B.

869 Misuse of Drugs Amendment Act 1978, s 13D.

870 Misuse of Drugs Amendment Act 1978, s 13E.

871 Misuse of Drugs Amendment Act 1978, s 13EA.

872 Misuse of Drugs Amendment Act 1978, s 13F.

- the officer in charge of the case forms the view that there is no longer reasonable cause to believe that the detainee has any Class A or B drug secreted within his or her body for an unlawful purpose;
- an application for renewal of the warrant is declined; or
- an appeal against the warrant is successful.[873]

Recommended changes to internal concealment regime

Circumstances in which a person may be detained

11.49 Currently, a person may be detained if there is reasonable cause to believe that he or she is concealing a Class A or B drug for an "unlawful purpose". That term is broadly defined in section 13A(3) to mean the commission of any offence against the Act and the concealment of the commission of any such offence. Our Issues Paper proposed that the circumstances in which a person may be detained should be limited to situations where a dealing offence is suspected.[874]

11.50 The New Zealand Police and Customs disagreed with this proposal. Both considered that the term should remain broadly defined to encompass any offence under the Act.[875] The Police argued that it was not typically in a position to know whether a drug was concealed for personal use or dealing purposes. Customs raised a number of concerns about the proposal. Like the Police, it was concerned that the circumstances in which a drug was being concealed would not always be apparent to customs officers. It was concerned that limiting these powers to suspected dealing situations meant its officers would have no powers to deal with a person coming into New Zealand who was suspected to be concealing a quantity of drugs that was consistent with personal use. It also raised concern that people would tailor the amount of drugs concealed to fit within established personal use quantities, and that the ability to carry small quantities of drugs without being subject to internal concealment powers would encourage people to do so. Finally, it argued that internally concealing controlled drugs risked causing a high level of harm to the person concerned, and that current powers enabled the person to "receive a level of medical care that the person would not otherwise receive in the community".

11.51 We do not think that any of these arguments justifies retention of the status quo. We acknowledge that there will be some situations where it will be unclear whether the drugs suspected of being concealed are for dealing or personal use purposes. However, given the invasive nature of the powers, where there is uncertainty over this issue, the search should simply not take place. In the customs context, we note that persons who conceal controlled drugs on their body when they are leaving or entering New Zealand are, by definition, committing an import or export offence. They will therefore fall within the proposed regime, since "dealing" includes import or export. Thus the powers available to customs officers will, in practice, not change from their current powers. The need to assess whether the context suggests personal use or dealing will only ever arise for police officers.

873 Misuse of Drugs Amendment Act 1978, s 13H.

874 Law Commission *Controlling and Regulating Drugs* (NZLC IP16, 2010) at [14.59]–[14.60] [*Controlling and Regulating Drugs*].

875 Submission of the New Zealand Police (submission dated 18 June 2010) at 8; Submission of the New Zealand Customs Service (submission received 29 April 2010) at 16–17.

11.52 We do not think that broad powers to deal with concealment can be justified on the basis that this is required to reduce the risk to a person's health from concealing drugs. This kind of protective justification has no place in a criminal enforcement context.

11.53 As discussed in the Issues Paper, our proposals regarding personal possession and use would make it incongruous to permit individuals to be detained for up to 21 days, and to be searched and asked to undergo highly invasive procedures, when the only offence they had committed was one of possession of a small quantity of drugs (albeit that those drugs are those classified as Class A or B). We therefore confirm our view in the Issues Paper that "unlawful purpose" should be limited to situations where dealing is suspected.

11.54 An additional reason to limit the regime in this way is the cost and resources involved in such detentions. One of the factors that led to the demise of New South Wales' now repealed internal concealment regime was the sheer cost associated with detention (which under that legislation was to be in a medical facility). The New South Wales Police estimated that the cost of detaining a person for the maximum 11 day period would have been $12,140.[876] It would seem inappropriate for these resources to be expended where the offence is relatively minor.

Maximum period of detention

11.55 During consultation over the Commission's report on search and surveillance powers, the Police raised concerns about the adequacy of the current 21 day maximum period of detention. The specific concerns raised by the Police related to the fact that the detainee must consent to an examination. If a person were able to continue to conceal the drugs for 21 days, he or she could effectively wait out the period of detention, with the police having no way of recovering the drugs.[877]

11.56 In its submission on this review, the Police indicated it no longer wished to pursue a longer period of detention.[878] However, Customs considered that a longer period of detention was appropriate.[879] It was particularly concerned about cases involving vaginal insertion but also discussed other circumstances in which individuals could retain controlled drugs in their body beyond 21 days.

11.57 We are not persuaded that the retention of concealed drugs beyond 21 days is of sufficient concern to warrant an extension of what is already a very significant detention period. To extend the period of potential detention might serve only to provide an incentive for detainees to try to conceal drugs for longer and longer periods, something which would certainly carry health-related risks. We therefore propose no change to the maximum period of detention.

876 Ibid, at 18.

877 The Police referred us to the cases of *Police v Isitt* DC Nelson M87–97, 24 December 1997 and *O v S* (1994) 11 CRNZ 427 (HC), which involved vaginal and anal retention respectively.

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

879 Submission of the New Zealand Customs Service (submission received 29 April 2010) at 17–18.

Requirement for detainee to consent to an examination before it may be performed

11.58 The Police had also proposed in the search and surveillance context that it should be possible to force a detainee to undergo an examination under a court order. We do not support this proposal. There is already a power to conduct a rub-down or a strip search without the consent of the detainee where there is cause to suspect that he or she has any Class A or B drug hidden on or about his or her person. Such searches may involve the use of reasonable force if necessary. We do not think that the case has been made out for dispensing with consent when searches of a more intrusive nature are undertaken. Nor have we been provided with any evidence that law enforcement is significantly impeded by the current consent requirement. Finally, requiring consent for examinations under section 13C is consistent with the ability of a person to refuse to submit to an internal search by a medical practitioner under section 18A of the principal Act. The Police now agree with our view.[880]

Use of medical imaging techniques and technologies

11.59 We recommend that the internal concealment regime be amended to permit the use of a wider range of medical imaging techniques and technologies. We think that the now repealed New South Wales legislation provided a good model in this regard, as it allowed for the use of ultrasound, MRI, x-ray, CAT scan or "other form of medical imaging". Such a change would provide for the development of new imaging technologies or improvements in current ones, in light of experience in their use and the reliability of the evidence obtained.

SURVEILLANCE POWERS

11.60 As the Commission noted in its report on search and surveillance powers, New Zealand statute law has not sought to put the regulation of surveillance on any kind of comprehensive footing, other than in the form of the protection against unreasonable search and seizure in section 21 of the New Zealand Bill of Rights Act 1990. Of particular note is the fact that there is virtually no statutory regulation of visual or video surveillance or other non-auditory and non-trespassory forms of surveillance.[881]

11.61 However, there is currently some statutory regulation of audio surveillance and the use of tracking devices. This regulation, which was reviewed in detail in our Issues Paper, encompasses:[882]

- Part 9A of the Crimes Act 1961, which prohibits the use of interception devices to intentionally intercept any private communication;[883]

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

881 Law Commission *Search and Surveillance Powers*, above n 850, at ch 11.

882 Law Commission *Controlling and Regulating Drugs*, above n 874, at [14.66]–[14.83].

883 Crimes Act 1961, s 216B.

- the Misuse of Drugs Amendment Act, which creates an exemption to the general prohibition in Part 9A and permits interception by the police in relation to drug dealing offences and dealing in cannabis on a substantial scale;[884]
- sections 200A to 200P of the Summary Proceedings Act, which govern the installation, use and removal of tracking devices.[885]

Proposed surveillance device warrant regime in Search and Surveillance Bill

11.62 The Commission's report on search and surveillance powers recommended that a new generic surveillance device regime be created, which would replace the current interception and tracking device regimes. The Commission envisaged that a judge issuing a warrant under this proposed regime would be able to authorise the use of a multi-function surveillance device, as well as multiple surveillance devices within the terms of a single warrant.[886]

11.63 The detailed recommendations regarding the features of this proposed scheme were accepted and are reflected, with some significant modifications subsequently made by the Select Committee, in the Search and Surveillance Bill. The key features of the proposed regime are:

- A surveillance device warrant may be obtained where there are reasonable grounds to:
  - suspect that an offence has been committed, is being committed, or will be committed in respect of which a search warrant (being a search warrant subject to the Bill) could be obtained; and
  - believe that the proposed use of the surveillance device will obtain information that is evidence of the suspected offence.[887]
- There are additional restrictions on the use of interception devices and visual surveillance that involves trespass onto private property ("trespass surveillance"). An application for a surveillance device warrant in these circumstances may only be made by a police officer or an enforcement officer employed or engaged by an approved enforcement agency.[888] In addition, trespass surveillance and interception devices can only be used to obtain evidence of a suspected offence that is punishable by a term of seven years imprisonment or more or that is a specified Arms Act 1983 offence.[889]
- An enforcement officer must obtain a warrant for any of the following activities:
  - use of an interception device to intercept a private communication;
  - use of a tracking device;

884 See Misuse of Drugs Amendment Act 1978, ss 14–29. For the purposes of the interception scheme, "drug dealing offence" is defined to mean an offence against section 6 of the Misuse of Drugs Act in relation to a Class A or Class B controlled drug. "Dealing in cannabis on a substantial scale" is defined to mean dealing with a substantial amount of a Class C drug listed in Part 1 of sch 3 of the Misuse of Drugs Act (other than catha edulis plant or coca leaf) or a prohibited plant of the genus Cannabis, or cultivating such a drug or plant on a substantial scale (Misuse of Drugs Amendment Act 1978, s 10).

885 A tracking device is a device that may be used to help ascertain (by electronic or other means) the location of a thing or person and/or whether a thing has been opened, tampered with, or dealt with in some other way – Summary Proceedings Act 1957, s 200A.

886 Law Commission *Search and Surveillance Powers*, above n 850, recs 11.3 and 11.4.

887 Search and Surveillance Bill 2009 (45–2), cl 46.

888 Search and Surveillance Bill 2009 (45–2), cls 45(5) and cl 45A.

889 Search and Surveillance Bill 2009 (45–2), cl 42AA.

- observation (and any recording) of private activity using a visual surveillance device warrant;
- use of a surveillance device that involves trespass onto private property;
- observation (and any recording) of private activity in the curtilage of private premises, involving any use of a visual surveillance device, where the duration of the observation is more than three hours within any 24 hour period or eight hours in total.[890]

- An enforcement officer does not require a warrant for:
  - entering private premises lawfully and recording what is seen or heard there; or
  - covert audio recording of a voluntary oral communication between two or more persons made with the consent of at least one of them.[891]
- In certain circumstances of urgency a surveillance device may be used without warrant for up to 48 hours.[892]
- Procedures relating to applications for and issue of surveillance device warrants are aligned as far as possible with those applying to search warrants under the Bill.
- There are requirements for enforcement officers to report to a judge on the use of surveillance devices, both under the authority of a warrant and without a warrant.[893]
- A judge in receipt of such a report is empowered to do several things in response to the report, including ordering that the subject of the surveillance be notified where the judge considers that the use of the surveillance device was unlawful and the public interest in notification outweighs any potential prejudice to relevant law enforcement interests.[894]

11.64 The key areas of change, therefore, are in the broadening of criminal offences in respect of which surveillance devices may be employed, the opening up of the use of surveillance devices beyond the police (and in the case of tracking devices, customs) to other agencies with an ability to obtain a search warrant, and the alignment of procedural provisions with those applying to search warrants as far as possible.

11.65 We support the provisions in the Bill as they have been amended by the Select Committee. Given their comprehensive coverage, we do not see any need for further provision for surveillance powers specific to the investigation of drug-related offending.

ARREST POWER FOR CUSTOMS OFFICERS

11.66 Section 26 of the Misuse of Drugs Act confers a power of arrest on customs officers where they have reasonable cause to believe or suspect that any person has imported into or exported from New Zealand any controlled drug in contravention of the Act. The power to arrest also applies in relation to persons concerned in such an import or export.

11.67 We do not propose any change to this power.

890 Search and Surveillance Bill 2009 (45–2), cl 42.
891 Search and Surveillance Bill 2009 (45–2), cl 43.
892 Search and Surveillance Bill 2009 (45–2), cl 44.
893 Search and Surveillance Bill 2009 (45–2), cls 53 and 54.
894 Search and Surveillance Bill 2009 (45–2), cls 55 and 56.

REGULATORY POWERS

Current powers

11.68 Section 19(1) of the Misuse of Drugs Act confers a regulatory inspection power on the police and other persons authorised by the Minister of Health for the purposes of "the enforcement of the provisions of [the] Act". It allows entry to the premises of any person who is producing, manufacturing, selling or distributing any controlled drug or who otherwise undertakes the supply or administration of any controlled drug. Section 19(1) allows the police and inspectors to demand the production of, and to inspect, any documents relating to dealings in any controlled drug, and to inspect, weigh, measure and record the stocks of controlled drugs.

11.69 Section 19(2) confers a production power on a medical officer of health where he or she has reasonable grounds to suspect that any person is in possession of any controlled drug for the purpose of sale, for manufacturing any preparation for sale, or for use in or in connection with a profession, trade, calling or any occupation. The person may be required to produce documents dealing with the reception, possession, purchase, sale or delivery of the controlled drug.

11.70 It is an offence under section 19(3) to refuse or neglect to comply with any demand or requisition made under section 19.

Requirements under our proposals

11.71 We consider that an inspection power in relation to the production, manufacture, sale, supply and use of controlled drugs will be necessary to ensure compliance with statutory exemptions and with licences issued in accordance with our proposals in chapter 10. This is the role currently carried out by section 19.

11.72 We propose retaining the existing section 19 power, which would permit entry to premises (other than a private dwelling house) in order to inspect documents and stocks of controlled drugs. Part 4 of the Search and Surveillance Bill would apply to such a power, with the exclusion of provisions relating to the detention of persons found on the premises.

11.73 As recommended in chapter 5, a regulatory inspection power will also be required to monitor compliance with our proposed regime for non-convention drugs.

RECOMMENDATIONS

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
Drug treatment

INTRODUCTION

12.1 Treatment services provided to treat alcohol and drug addiction or dependence are a key component of the *National Drug Policy*.[895] They are characterised as a problem limitation strategy under the *Policy*. However, since these services are designed to assist people in stopping or reducing their drug use, in the international context they are sometimes considered a demand reduction measure.[896]

12.2 One of the most persistent themes that emerged during feedback on the Law Commission's issues papers, *Controlling and Regulating Drugs*[897] and *Alcohol in Our Lives*,[898] is the need for greater emphasis to be given to treatment both in response to offending and more generally.

12.3 In this chapter we consider options that would increase the emphasis on the appropriate use of treatment as a disposition option within the criminal justice system. We suggest that the answer is not just to increase the number of treatment programmes available for offenders, but also to ensure that an appropriate range of treatment interventions (based on an understanding of the relationship between criminal behaviour and alcohol and drug use) is available to the courts. While improving access to treatment through the court is important, it should not come at the expense of delivering services to other people in the community with drug and alcohol problems.

895 Ministerial Committee on Drug Policy *National Drug Policy 2007–2012* (Ministry of Health, Wellington, 2007) at [4]. In 1998, New Zealand formally launched the *National Drug Policy 1998–2003*. The policy was updated following consultation and re-launched in 2007 as the *National Drug Policy 2007–2012*.

896 For example, the United Nations use the term "demand reduction" to include all policies (including treatment) that aim to prevent the use of drugs and reduce the adverse consequences of drug abuse. See *Declaration on the Guiding Principles of Drug Demand Reduction* GA Res 20/3, A/RES/S-20/3 (1998).

897 Law Commission *Controlling and Regulating Drugs* (NZLC IP16, 2010) [*Controlling and Regulating Drugs*].

898 Law Commission *Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws* (NZLC IP15, 2009) [*Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws*].

DRUG DEPENDENCE AND TREATMENT – A SHORT OVERVIEW

12.4 Alcohol and drug use is often depicted across a continuum from no use through to severe dependence.[899] Conceptually this provides a useful tool because appropriate treatment depends on the nature and severity of use.[900] The continuum below illustrates the treatment response appropriate for different levels of use and dependence.[901]

Figure 1: The abstinence to addiction continuum

No use	No treatment required. Public or population health initiatives apply.
Low risk use	
Hazardous use	Likely to benefit from less intensive treatment options, need treatment but do not necessarily need specialist treatment.
Harmful use	
Mild dependence	
Severe dependence	Need intensive, specialist treatment options.

12.5 Hazardous use, harmful use and all levels of dependence are likely to benefit from some form of drug treatment, although intensive specialist treatment is normally only necessary to address severe dependence.[902] When considering questions around the development and shape of treatment services, it is important to understand that, of those who use alcohol or drugs in a harmful or hazardous way, only a small portion are actually dependent. The New Zealand Mental Health Survey 2006 estimated that 2.6 per cent of the population experienced alcohol abuse and 1.2 per cent other drug abuse, while 1.3 per cent were dependent on alcohol and 0.7 per cent were dependent on other drugs.[903]

12.6 The continuum is also a useful way of illustrating the need for a broad range of drug treatment services that meet the differing levels of need for intervention efficiently. Intensive residential programmes are expensive to deliver and are not needed for the vast majority of users. Intensive out-patient programmes, such as

899 Dependence can be mild or severe and its causes are complex; see the discussion in Law Commission *Compulsory Treatment for Substance Dependence: A Review of the Alcoholism and Drug Addiction Act 1966* (NZLC R118, 2010) at [1.2] – [1.3].

900 National Addiction Centre *Orientation to the Addiction Treatment Field Aotearoa New Zealand* (National Addiction Centre, Christchurch, 2008) at 3.

901 The table is a slightly modified version of that produced by the National Committee for Addiction Treatment; see National Committee for Addiction Treatment (NCAT) *Investing in Addiction Treatment – A Resource for Funders, Planners, Purchasers and Policy Makers* (NCAT, Christchurch, 2008) at 7.

902 National Addiction Centre, above n 900, at 3.

903 For the survey, "abuse" is defined as a "maladaptive pattern of substance use that involves recurrent and significant adverse consequences" and would therefore seem to cover both harmful and hazardous use on the continuum. See JE Wells, J Baxter and D Schaaf (eds) *Substance Use Disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey Final Report* (Alcohol Advisory Council of New Zealand, Wellington, 2006) at 12.

day programmes, are a viable and less costly alternative to residential treatment. To be efficient, the health sector needs to provide a balance of less intensive interventions as well as more intensive specialist treatment programmes.

Alcohol and drug treatment

12.7 Addiction treatment covers a wide spectrum of treatment types and services. The range of programmes and services that are currently available in New Zealand reflects the need to match the nature and intensity of an intervention with a person's needs. Defined broadly, the term "treatment" includes the application of any intervention that aims to have a beneficial impact upon the behaviour and welfare of a drug user. Treatment encompasses interventions that operate at the medical, psycho-social and spiritual level and includes interventions that focus on different objectives, such as safer drug use, stabilisation of behaviour and abstinence.[904]

12.8 Low-level interventions currently available include the Alcohol and Drug helpline, which received almost 20,000 calls last year.[905] Many people accessing helplines are seeking information to self-manage their substance misuse issues. They may not need to attend specialist treatment. Other low-level and brief interventions can be provided in a generalist setting (for example, primary care) rather than by addiction treatment specialists, and are appropriate at an early stage when drug use is first identified as hazardous or harmful.

12.9 Where a person is assessed as severely dependent on alcohol or drugs, he or she is likely to require specialist addiction treatment. This will normally consist of withdrawal management (often called detoxification) and then access to specialist community-based alcohol and drug services. In some cases attendance at an intensive day programme or residential treatment programme will be the most desirable option for severe dependence. Specialist addiction treatment in any of these contexts may involve pharmacotherapies, counselling and psycho-social therapies. Post-treatment care may also be required on an ongoing basis.[906]

12.10 Voluntary peer support fellowships such as Alcoholics Anonymous and Narcotics Anonymous also play a role in the treatment sector and have a long tradition of helping and supporting people managing addiction.

Dependence is a chronic relapsing condition

12.11 Many people who receive treatment for dependence will experience relapses. Addiction is recognised by specialists as a chronic relapsing disorder.[907] It is estimated that about one third of people treated for alcohol dependence will achieve and maintain abstinence in the short to medium term.[908] However,

904 Alex Stevens, Christopher Hallam and Mike Trace *Treatment for Dependent Drug Use: A Guide for Policymakers* (Report 10, The Beckley Foundation Drug Policy Programme, Beckley (UK), 2006) at 2.

905 The Ministry of Health advised that the Alcohol Drug Helpline received 19,912 calls in the 2009/2010 financial year.

906 See also the discussion summarising the evidence available for various forms of treatment in our earlier issues paper; Law Commission *Controlling and Regulating Drugs*, above n 897, at [15.4]–[15.43].

907 Doug Sellman "The Ten Most Important Things Known About Addiction" (2009) 105 Addiction 6 at 8.

908 Ibid.

continuous ongoing abstinence is relatively unusual. It has been estimated, for example, that fewer than 10 per cent of people with alcohol or opioid dependence experience continuous abstinence following treatment over the long term.[909] Most people with such addictions experience relapses at times, although many do also have significant periods of stability and improvement. The relapsing nature of the condition has implications for the way services are designed and how treatment outcomes should be measured.

12.12 Alcohol and drug treatment can be viewed as a pathway that provides access to an ongoing mix of different interventions and services. Typically a person with substance dependence will need to engage with a range of different treatment services over a number of years. For this reason, easy access to well-linked services is likely to offer the best potential for positive treatment outcomes. The more a treatment plan addresses the individualised broad-based needs of a person, the more effective it will be.[910]

The effectiveness of drug treatment

12.13 Measuring the effectiveness of different episodes or aspects of a treatment pathway can prove difficult. Benefits may be cumulative and may occur following a series of different interventions and services over an extended period of time, rather than as the result of one particular intervention or programme.

12.14 However, notwithstanding such issues, there is a large body of evidence to demonstrate that many people with drug dependence benefit from some form of drug treatment. A wide range of studies show that specialist alcohol and drug treatment is effective at reducing substance use and improving health and well-being.[911]

12.15 The effectiveness of alcohol and drug treatment is measured in terms of its ability to reduce the harms associated with alcohol and drug dependence rather than its ability to "cure" participants. Degrees of improvement are a better measure of success than complete recovery because of the chronic relapsing nature of substance dependence. In addition, many social factors operating outside of treatment, such as housing, family support and employment, can have a significant impact on a participant's ability to utilise the opportunities presented by treatment.

909 Ibid.

910 Ibid, at 10.

911 For example, see A Swan and S Alberti *The Alcoholics and Drug-dependent Persons Act (ADDPA) 1968: A Review* (Turning Point Alcohol and Drug Centre, Melbourne, 2004). See also the discussion summarising the evidence available for various forms of treatment in our earlier issues paper; Law Commission *Controlling and Regulating Drugs*, above n 897, at [15.4] – [15.43].

Cost-effectiveness of treatment

12.16 There is clear evidence that treatment can be cost-effective.[912] Most reviews consistently find that addiction treatment yields net economic benefits to society.[913] 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.[914] Similarly, reports prepared by both the Beckley Foundation and the United Nations Office on Drugs and Crime reviewing the research evidence on drug treatment have concluded that drug treatment can be cost-effective.[915]

12.17 The evidence on cost-effectiveness of treatment has persuaded us that more weight ought to be placed on treatment as a harm minimisation strategy, particularly in the criminal justice sector.

12.18 In chapter 8 (personal possession and use) we recommended the implementation of a mandatory cautioning scheme for personal possession and use offences. Under that scheme, users would be required to attend a preliminary screening and brief intervention to identify the risks around their drug use and whether they would benefit from assessment and treatment. Responding to minor drug use offences with interventions of this type may help to shift the balance towards treatment.

12.19 However, those recommendations rely on appropriate brief interventions being available. If these are provided by existing community drug and alcohol treatment services, this will increase the demand placed on already stretched services. A number of issues around access to and funding of treatment services must therefore be addressed before those recommendations can be implemented.

ACCESS AND SERVICE DELIVERY

12.20 Alcohol and drug treatment are combined in many countries, including New Zealand, largely because many participants in treatment programmes are poly-drug users and a separation would therefore be counterproductive and artificial. Specialist alcohol and drug services are provided by approximately 150 specialist agencies spread across the 20 District Health Boards (generally called Community Alcohol and Drug Services or CADS) and 16 large non-government organisations. There are also alcohol and drug treatment practitioners in Māori services and in specialist services catering for young people. It is estimated that approximately 28,000 people receive some assistance from specialist alcohol and drug treatment services annually.[916]

912 T Babor and others *Alcohol: No Ordinary Commodity* (Oxford University Press, New York, 2003); A Ritter and N Lintzeris "Specialist Interventions in Treating Clients with Alcohol and Drug Problems" in M Hamilton, T King and A Ritter (eds) *Drugs in Australia – Preventing Harm* (2nd ed, Oxford University Press, Melbourne, 2004) at 225.

913 National Committee for Addiction Treatment (NCAT), above n 901, at 2.

914 These figures, cited by the NCAT, seem to be based on information from National Institute on Drug Abuse (NIDA) on evaluations in the United States rather than in New Zealand. See National Committee for Addiction Treatment, above n 901, at 2.

915 Stevens, Hallam and Trace, above n 904; and United Nations Office on Drugs and Crime *Contemporary Drug Abuse Treatment: A Review of the Evidence Base* (United Nations, New York, 2002).

916 The Ministry of Health estimates that 28,000 people were seen by alcohol and drug services funded through Vote Health in the 2009/2010 financial year. That figure represents over 350,000 contacts to services.

12.21 Specialist alcohol and drug treatment services comprise:

- *Comprehensive assessments* – these determine the nature of the addiction problem, and co-existing problems, including mental and physical health, spiritual well-being, family, social and cultural strengths and issues, employment or housing issues, offending and legal problems. Assessments include a full assessment of the risks of self-harm and relapse and result in a plan for treatment.
- *Withdrawal management (detoxification)* – this focuses on managing the process of physical withdrawal from drugs (which typically takes up to one week). This is normally undertaken as an in-patient in a hospital, but can also be undertaken in the community provided there are no medical issues that necessitate intensive medical supervision.
- *Pharmacotherapies (including methadone)* – these include the use of medications that promote abstinence, help prevent relapse and assist detoxification, as well as methadone, other opiate substitution treatment and medications such as antabuse to deter people from drinking.
- *Psychosocial therapies* – these include cognitive behavioral therapy, motivational interviewing, relapse prevention, social work and family and employment counselling. Outpatient services of this kind are largely provided in the community.
- *Residential programmes/intensive day programmes* – these provide a more intensive package of comprehensive assessment services, psychosocial therapies, group-based treatment and continuing care. Intensive day programmes provide these services without a residential component. Some residential programmes also include withdrawal management (detoxification).
- *Kaupapa Māori addiction treatment* – there are some treatment programmes aimed specifically at Māori. These seek to integrate cultural and clinical processes and take a holistic view working with whānau ora.

12.22 In the 2009/10 year, $120.7 million of Vote Health was spent on alcohol and drug treatment, comprising:[917]

- $9.2 million on withdrawal management (being $5.9 million on in-patient medical detoxification; $2.5 million on community-based detoxification; and $0.8 million on the detoxification component of residential treatment programmes);
- $80.5 million on community alcohol and drug treatment;
- $14.1 million on methadone substitution programmes; and
- $16.9 million on residential treatment.

12.23 Some of the non-government organisations providing alcohol and drug treatment also receive funding from other sources, including a small amount from government departments for specific interventions, and from charitable trusts, corporates and donations.

917 Figures provided by the Ministry of Health.

12.24 In response to our issues papers, *Controlling and Regulating Drugs*[918] and *Alcohol in Our Lives*,[919] both users and those working in treatment services or professions dealing with people with substance dependence and abuse problems consistently expressed significant concern that access to treatment is currently inadequate and that there is a significant unmet need.

12.25 The apparent inadequate capacity of treatment services is not only seen as an issue for the health sector. Submitters were clear that better access could improve outcomes in multiple sectors, including justice, corrections, transport, social development and labour. Many argued that all those sectors therefore need to have a role in ensuring services are available, accessible and integrated to reduce duplication and frustration for service users.

12.26 One clear message was that an increase in the level of available services requires more funding.[920] We agree, and will return to the issue of funding treatment for offenders later in the chapter.

12.27 Many of the submissions we received, particularly from those in the treatment sector, focused also on options for improving the delivery of existing services. The key messages were:

- an overall addiction treatment strategy is needed;
- services are fragmented – there is a lack of an effective structure for delivering treatment, both in the criminal justice sector and more generally for the rest of the population;
- specialist services for specific population groups, including Māori, Pacific people and Asian people in some regions are needed;
- there are gaps in specialist services available for youth;
- a better geographical spread of services is needed; and
- greater cooperation is needed between the criminal justice system and alcohol and drug services to make the best possible use of opportunities for delivering treatment through the justice sector.

A coherent framework for delivery

12.28 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.

12.29 We support the plans on which the Government is already working,[921] but suggest that more needs to be done.

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918 Law Commission *Controlling and Regulating Drugs*, above n 897.

919 Law Commission *Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws*, above n 898.

920 For example, Submission of Waitemata District Health Board Community Alcohol and Drug Services (submission received 30 April 2010). Under a regional contract, CADS Auckland, TUPU and Te Atea for the Auckland region are provided by the Waitemata District Health Board, so CADS Auckland is the largest provider of DHB based specialist alcohol and drug services in New Zealand.

921 For example, Minister of Health *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Ministry of Health, Wellington, 2006) at 52 [*Te Kōkiri: The Mental Health and Addiction Action Plan*]; Department of Prime Minister and Cabinet *Tackling Methamphetamine: An Action Plan* (Policy Advisory Group, October 2009) at 3 [*Tackling Methamphetamine: An Action Plan*].

Blueprint for addiction services

12.30 The Commission's report on alcohol[922] 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.

12.31 We suggested that the development of such a blueprint needed to include active involvement from all the government agencies and sectors whose outcomes could benefit from improved access to treatment and should not be seen as solely the health sector's responsibility. We noted that cross-sectoral commitment would be necessary[923] and consequently recommended that the work on the blueprint should be undertaken with support from key groups including the Alcohol Advisory Council and the National Addiction Centre, along with all government agencies whose outcomes could benefit from improved access to addiction treatment services.

12.32 We do not propose to make further recommendations on these broader issues in this report. 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.

12.33 Our focus here instead is on utilising treatment as a disposition option within the criminal justice system. This is our focus because we think that legislation to replace the Misuse of Drugs 1975 should be more clearly directed towards treating rather than punishing addiction.

Dealing with offenders' drug and alcohol treatment needs

12.34 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.[924] Department of Corrections' research in 2008 found that 65 per cent of New Zealand prisoners had ongoing drug or alcohol problems.[925]

12.35 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.

922 Law Commission *Alcohol in Our Lives: Curbing the Harm* (NZLC R114, 2010) at 421.

923 Minister of Health *Te Kōkiri: The Mental Health and Addiction Action Plan*, above n 921, at 52; Department of Prime Minister and Cabinet, above n 921, at 52.

924 Judges in the District Courts reported to the Law Commission that they estimate that at least 80 % of defendants appearing in the District Courts have alcohol or other drug dependence or abuse issues. They believed that in at least 80 % of these cases alcohol was the drug involved. See the letter prepared on behalf of the Chief District Court Judge by Judge John Walker included as appendix 1 in Law Commission *Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws*, above n 898.

925 Department of Corrections *Drug and Alcohol Treatment Strategy 2009–2014* (Department of Corrections, Wellington, 2009) at 3.

Screening at police stations

12.36 The Mental Health/Alcohol and Other Drug Watch-house Nurses Pilot Initiative began operating at the Christchurch Central and Counties Manukau police stations on 1 July 2008 and 1 August 2008 respectively. Under the pilot, nurses who specialise in mental health and alcohol and drug issues were located in the two police watch-houses, which were selected because they are two of the busiest in the country. The objective of the initiative was to improve the identification of mental health needs and alcohol and drug problems at an early stage and help police to manage the risks of those in their custody with alcohol and drug or mental health problems. The nurses assessed and assisted in the management of detainees who were experiencing drug, alcohol and mental health-related problems while in custody. In doing this they reduced the immediate risks of harm by appropriate clinical management of intoxication, withdrawal and mental health disorders.[926] They also liaised with other service providers and made referrals of detainees to treatment providers.

12.37 Following a favourable evaluation last year,[927] the initiative has become an ongoing project within these two watch-houses. There are no immediate plans for a national rollout of the watch-house initiative to other stations. However, the service model that has been tested has been shown to be beneficial for police, health providers and the detainees themselves. It is a model that could at some stage be adopted and utilised in other locations.

Diversion into treatment

12.38 A number of people are also diverted into alcohol and other drug assessment, counselling, and other treatment as a condition of diversion under the Police Adult Diversion Scheme. In broad terms, the Scheme is available to first offenders when the offence is minor or a conviction would be out of all proportion to the offence's seriousness. The Scheme is not generally available for drug offences involving Class A and B drugs, but is available for minor instances of offending involving Class C drugs. Diversion into assessment, counselling, and treatment is also utilised for other types of minor offending where alcohol or drug abuse or dependence may be identified as a contributing factor. Approximately 1,000 people a year have conditions requiring drug and alcohol assessment, counselling, or other treatment imposed as part of the terms of their diversion.[928]

926 Judy Paulin and Sue Carswell *Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative: Interim Report* (New Zealand Police, Wellington, 2009).

927 Judy Paulin and Sue Carswell *Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse Pilot Initiative* (New Zealand Police, Wellington, 2010).

928 Department of Prime Minister and Cabinet *Tackling Methamphetamine: Baseline Indicators Report* (Policy Advisory Group, October 2009) at 27.

Alcohol and drug assessment in court

12.39 Where a person comes before the court and substance abuse or dependence is identified as a contributing factor in offending, the judge may obtain an alcohol and drug assessment during the remand and sentencing process.[929] The judge may then take into account treatment needs when deciding on how to deal with an offender.

In-court screening

12.40 A number of steps have been taken to more effectively identify and address the drug and alcohol treatment needs of offenders at an early stage in the court process. The Ministry of Health has funded alcohol and drug clinicians to provide in-court brief assessments for judges in six courts.[930] Five other District Courts[931] have similar schemes as a result of local collaboration between health service providers, including District Health Boards, justice sector agencies, and the local community.

12.41 Under these different schemes, alcohol and drug clinicians are on site in court to undertake screening and report to judges, assisting them to identify offenders with potential substance use disorders and to make decisions on whether further assessment and treatment is appropriate.[932] A review of the pilots conducted by the Ministry of Health in July 2009 found that the identification of offenders with mental health and alcohol and drug treatment needs was enhanced through the in-court clinicians and their preliminary assessment work. However, the availability of continued funding and of suitable clinical service providers in different locations will determine whether the pilots continue and whether the preferred model for alcohol and drug clinicians in courts, developed as part of the Government's Methamphetamine Action Plan to increase referrals of users from the justice system into treatment,[933] is extended to other courts.

12.42 It will also be important, if the in-court screening is continued, to ensure that there is no unnecessary duplication between it and other screening and assessment services. At present in-court screening is funded by Vote Health. As we discuss later in paragraphs 12.58 to 12.65, we think that this should be funded through the justice sector.

Pre-sentence report screening test

12.43 The Community Probation Service undertakes as a matter of course a pre-sentence alcohol screening for all offenders who are referred for a pre-sentence report. The standard alcohol screening tool called AUDIT (Alcohol Use Disorder Identification Test) is used to identify alcohol and drug-related risk factors that

929 As we have already noted in ch 2 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).

930 These are the Whangarei, Kaikohe, Wellington and Porirua District Courts and the Hamilton and Rotorua Youth Courts.

931 These are in Tauranga, Masterton, Gore, Invercargill and Whakatane.

932 Department of Prime Minister and Cabinet, above n 921, at 43.

933 Ibid.

may lead to offending. Where risk factors are identified, an alcohol and drug assessment may be recommended as part of an offender's sentence plan, or the report may recommend that the offender attends alcohol and drug counselling or a programme. We understand that the AUDIT screening tool is used for all offenders who have a pre-sentence report completed.

Specialist assessment reports

12.44 A court may adjourn proceedings under section 25 of the Sentencing Act 2002 to enable inquiry to be made or to determine the most suitable method of dealing with the case. Judges sometimes use the power of adjournment under this section to request full specialist alcohol and drug assessments. However, there are differences between courts in the extent to which full assessments are ordered, who they are provided by and the form they take.

12.45 A pilot introducing a standardised framework to try and improve the quality and content of specialist assessment reports was introduced in the Wellington courts in 2008. The framework introduced criteria for approving report writers to ensure appropriate qualifications and experience, guidelines as to the report content and a standard timeframe for reports (10 days).

12.46 Notwithstanding the importance of assessment, it needs to be done in a cost-effective way. For most offenders, quick screening on the basis of a standardised tool such as AUDIT is all that is required; full assessments may well be justified only if longer and more intensive treatment is envisaged.

Adjournment to treatment programme and deferral of sentence

12.47 Where a defendant is an identified substance abuser and appropriate treatment is available, a judge may use the power of adjournment under section 25 of the Sentencing Act to defer sentencing and remand the defendant on bail to provide him or her with an opportunity to undergo treatment on a voluntary basis. The defendant's progress with treatment may then be taken into account in the sentencing process.

12.48 There is scope here for active judicial involvement during the adjournment or remand period to monitor the offender's progress. This occurs in the Youth Drug Court.

Youth Drug Court

12.49 Since 2002 a Youth Drug Court has been operating at the Christchurch Youth Court. The Youth Drug Court targets young offenders with moderate to severe alcohol and/or other drug dependence that is linked to their offending.[934] Young offenders are expected to follow an alcohol and drug treatment plan and are monitored by the same judge throughout the process. Participation is voluntary and sentencing is deferred while young offenders undertake the treatment programme. Services to young offenders are coordinated via a multidisciplinary team that includes the judge, a social worker, the youth justice coordinator, a

934 Wendy Searle and Philip Spier *Christchurch Youth Drug Court Pilot: One Year Follow-up Study* (Ministry of Justice, Wellington, 2006) at 21.

police prosecutor, the youth advocate, and health and education workers.[935] The youth justice coordinator is funded by Child, Youth and Family Services. The Christchurch Youth Drug Court is no longer a pilot, but is now part of the structure of the Youth Court.

Intensive Monitoring Group

12.50 An intensive monitoring programme has been initiated by the judiciary in the Auckland Youth Court. It is based on the Christchurch Youth Court approach and targets young people who are identified as in need of intensive monitoring because they are not complying with their Family Group Conference plans or have been identified as having moderate to severe alcohol and drug dependence. Up to 15 young people can be under the monitoring programme at any time. An interagency group, consisting of representatives from Police, Child Youth and Family Services, Health, Education, Youth Advocates and Youth Court staff and Youth Court judges, oversees and monitors the young people on the programme. The programme is supported by Odyssey House. It emphasises coordinating services and support for programme participants.

Participation in treatment programme as part of sentence

12.51 Under the Sentencing Act, people under sentences of supervision, intensive supervision and home detention may be required to participate in a programme that may reduce the likelihood of reoffending.[936] A programme can include any psychiatric or other counselling or assessment, or attendance at any medical, psychological, social, therapeutic, cultural, educational, employment-related, rehabilitative or re-integrative programme, which can include an alcohol and drug treatment programme.[937]

Drug treatment in prison

12.52 Drug treatment is also available for offenders sentenced to imprisonment. Drug treatment units have been established in six New Zealand prisons, with units in a further three prisons planned.[938] These units have had some demonstrated success in reducing reoffending amongst participants.[939] A short-term condensed alcohol and drug treatment programme is being developed and rolled out so that offenders serving shorter sentences can also undertake treatment.

Access to treatment services and funding

12.53 Notwithstanding the many initiatives discussed above, 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.

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935 Ibid, at 20–21.

936 See ss 50 and 54E.

937 See ss 51, 54H and 80D.

938 Drug treatment units have been established in Waikeria, Christchurch Men's, Hawkes Bay, Rimutaka, Springhill and Arohata Women's prisons. A further three units are now planned for Otago, Wanganui and Northland prisons.

939 A 2006 evaluation of the 24-week programmes in a prison showed a reduction in the re-conviction rate of about 10–14%. Department of Corrections, above n 925, at 8.

12.54 This is largely because the courts are reliant on obtaining access to generic drug and alcohol assessment and treatment services rather than services that are earmarked and funded for offenders. The only drug treatment that is funded by the justice sector is that provided in drug treatment units in prisons. In addition, specialist alcohol and drug assessments ordered by judges under section 25 are funded by the Community Probation Service, although the assessors are clinicians working in the health sector. As noted already, the Community Probation Service also undertakes some basic alcohol screening using the AUDIT tool as part of its pre-sentence report preparation.

12.55 All other assessment and treatment services that are accessed by the courts are funded and provided by the health sector. Even in courts running in-court clinician pilots, practitioners are funded by and drawn from the health sector. Where offenders are required to participate in a programme of treatment as part of their sentence, they are referred either to community-based alcohol and drug treatment services funded through District Health Boards, or to publicly funded residential or intensive day programmes provided by community organisations. Similarly, where people are diverted into drug and alcohol treatment or undertake treatment on remand, they access these same services funded through the health sector. There are not separate programmes or streams of funding for offenders. Treatment programmes publicly funded through Vote Health are expected to accept offenders referred through the court system on the same basis as other participants.

Health sector prioritises access based on clinical need

12.56 Because of the limited capacity within the health sector, access to alcohol and drug treatment is prioritised on the basis of clinical need. The courts can consequently experience 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.[940] Less intensive community-based or out-patient treatment options provided through community-based alcohol and drug services are normally more readily accessible, but these will not necessarily be considered a suitable option by judges for some offenders.

12.57 These difficulties often prevent treatment from being utilised as a disposition option within the criminal justice system. The courts cannot direct that treatment be provided to an offender, so the use of treatment as a disposition option at all stages of the court process is dependent on what programmes and facilities are available in the community at any given time.

Separate funding for offenders

12.58 There are both advantages and disadvantages in not having a separate funding stream for treating offenders.

940 In October 2009 the reported waiting times for residential beds for providers in the northern region ranged from approximately six to 24 weeks for adults and 12 weeks for youth: See Department of Prime Minister and Cabinet, above n 928, at 28.

12.59 First, prioritising access to services on the basis of clinical need should mean that the best use is made of the existing treatment capacity. While there is evidence that alcohol and some drug use contributes to some forms of offending, this does not mean the offender in question necessarily has a drug or alcohol problem of a nature or magnitude that warrants specialist treatment and the costs associated with it. Only a portion of offenders who are engaged in alcohol and drug-related offending would be clinically diagnosed as dependent.

12.60 On this argument, specialist treatment services should be accessed through the courts only in respect of offenders who would have qualified for those services without offending. An integrated funding and service model helps ensure that the same standard applies to everyone accessing services and that some do not get preferential access by committing offences.

12.61 Secondly, there are obvious advantages, given New Zealand's population size, in having a single integrated addiction treatment workforce. There are already severe capacity and capability constraints. Separate funding for services, with competitive claims on those services from two different government sectors, would potentially drive up costs and exacerbate existing constraints.

12.62 These arguments must be weighed against the obvious disadvantage in having a single funding stream. The reality is that, on the basis of 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 and will fail to gain access to it. However, there is a wider public interest in ensuring that those offenders (for example, recidivist drunk drivers) receive treatment, so that the harms caused by their associated offending are reduced. Viewed from this perspective, offenders should be referred into treatment when they would not otherwise qualify on the basis of relative clinical need, and that treatment is an issue for the justice sector rather than the health sector.

12.63 Without additional funding for treatment from the justice sector, better access to treatment services by offenders as a consequence of their offending must inevitably reduce the availability of treatment to non-offenders. That would be unjustified.

12.64 On balance, we think that this justifies separate funding for offenders through the justice sector. Without this, courts will continue to be frustrated in their attempts to address the alcohol and drug problems they confront, rehabilitative sentences will be unavailable or ineffective, and the public will continue to be exposed to more recidivism than they would otherwise be.

12.65 We recognise that this has implications for workforce capacity and capability which would need to be worked through carefully in the process of implementation. In this regard, we note that many offenders use alcohol and drugs in a harmful or hazardous manner but are only mildly dependent, and therefore require lower-level interventions that do not necessarily involve specialist treatment.

DRUG COURTS

12.66 There is growing interest in New Zealand in the development of drug courts. Research into drug courts in other jurisdictions suggests that the creation of dedicated courts overseeing drug treatment programmes can, in some circumstances, produce greater benefits than more traditional courts.

International development of drug courts

12.67 The drug court concept emerged in the United States in the late 1980s. Drug courts and other court-based drug diversion programmes have since proliferated and spread to other jurisdictions. Over 2,000 drug courts are now in place in the United States.[941] Drug courts have also been established, often initially as a pilot, in Australia, Canada, the United Kingdom, Ireland and parts of Europe.[942]

12.68 Initially drug courts in the United States dealt with less serious offending, but over time, both in the United States and elsewhere, they have evolved into a mechanism typically for managing recidivist offenders with more entrenched drug problems. For example, the New South Wales Drug Court targets individuals who would otherwise be facing a term of imprisonment and have drug dependence issues that are linked to their offending.[943]

12.69 As already noted, a Youth Drug Court was established in Christchurch in 2002 and is now part of the structure of the Christchurch Youth Court.

12.70 The drug court model has taken different forms in different jurisdictions but, while there are variations, all drug courts have some core features in common.

Key features of drug courts

12.71 The central feature of all drug courts is that they aim to reduce drug misuse and associated offending through active ongoing judicial supervision of a programme of treatment. It is this feature of active supervision by a judge or other judicial officer that distinguishes drug courts from other court-ordered treatment programmes.

12.72 Drug courts have specialist judges. Most also try to maintain continuity of judicial contact so that the same judge, wherever possible, oversees the supervision of a participant right through the drug court programme.

12.73 Drug courts also typically bring together an interdisciplinary team of specialists and agencies. This team takes a collaborative approach and supports the judge in determining the appropriate treatment plan and monitoring it.[944] It ideally brings together and coordinates a broad range of social and life skills support around the participant as well as support for the core drug treatment programme, in order to address the complex range of factors that contribute to drug-related offending and to encourage the adoption of a law-abiding lifestyle.

941 "Summary of Drug Court Activity by State and County: Bureau of Justice Assistance Drug Court Clearinghouse Project" (2009) Justice Programs Office <www1.spa.american.edu/justice/>.

942 Ministry of Justice *Dedicated Drug Court Pilots: A Process Report* Research Series 7/08 (Ministry of Justice, London, 2008) at 2.

943 See the definition of an eligible person in the Drug Court Act 1998 (NSW), s 5.

944 Joy Wundersitz *Criminal Justice Responses to Drug and Drug-Related Offending: Are they Working?* (Technical and Background Paper 25, Australian Institute of Criminology, Canberra, 2007) at 20–21.

12.74 Drug court programmes are normally abstinence-based, although participants on methadone and other drug substitution programmes are sometimes accommodated. Some drug courts only accept participants with illegal drug problems, although other drug courts include participants with alcohol and other substance abuse problems.

12.75 Drug court programmes also normally utilise a system of graduated rewards and sanctions. Participants are required to undergo periodic tests for drug use[945] and to regularly report for review by the court on their progress. They are normally closely monitored to ensure they are complying with programme conditions and not using drugs. Progress is praised or rewarded and non-compliance incurs sanctions and ultimately removal from a programme. In some drug courts, a significant number of participants drop out and fail to complete the programme.[946]

12.76 The length of a drug court programme will vary. Drug court programmes in the United States seem to range from six to 18 months. In Australia programmes tend to be longer. The New South Wales and Victorian programmes take from one to two years to complete.

12.77 It is common for programmes to be broken into discrete phases or stages that a participant "graduates" through. The programme run in New South Wales, for example, has three stages: initiation; consolidation; and reintegration. The rehabilitative focus changes and broadens as a participant works through the stages. The frequency of court appearances and drug tests will normally be reduced as a participant moves through the stages towards completion of the programme.

Why are drug courts perceived as an improvement on other approaches?

12.78 Active supervision of treatment by the judge and regular interaction between the judge and the offender is perceived to add value that is unavailable under other approaches. The gravitas that the judge's supervision brings is believed to increase the likelihood that the offender will successfully undertake the treatment programme. Because of his or her status within the court system, the pivotal role of the judge can also bring together and focus the efforts of the relevant agencies on each participant's specific problems. This also enhances the prospect that the opportunity provided by treatment will be taken up successfully.

Evidence of effectiveness

12.79 The evidence of drug court effectiveness, however, seems to be somewhat mixed. Evaluations tend to indicate that they can reduce drug use by participants and have a positive impact on participants' general health and wellbeing,[947] but evidence about their impact on rates of re-offending is more mixed.[948]

945 Ibid.

946 For example, in the New South Wales Drug Court 56% of all those offenders placed in the drug court programme did not complete it. See Don Weatherburn and others "The NSW Drug Court: A Re-evaluation of its Effectiveness" (2008) 121 Crime and Justice Bulletin 1 at 10.

947 Wundersitz, above n 944, at 105 and 107; Searle and Spier, above n 934, at 78.

948 Wundersitz, above n 944, at 107–108 and Ryan S King and Jill Pasquarella *Drug Courts: A Review of the Evidence* (The Sentencing Project, Washington, 2009) at 5.

12.80 For example, the United States Government Accounting Office reported in its 2005 review of drug courts that most evaluations undertaken showed evidence of significant reductions in re-offending.[949] However, other reviewers are cautious about the validity of this evidence, since only a few of the reported studies utilised direct control comparisons in randomised trials.[950] There are also concerns over the robustness of some of the evaluations. Depending on the programme design, drug courts can also be heavily resource-intensive.[951]

12.81 Two randomised trial evaluations on the effectiveness of the New South Wales Drug Court pilot have been undertaken by the Bureau of Crime Statistics and Research. The first in 2002 found little difference between the Drug Court and conventional sanctions in terms of their effectiveness in increasing the time to the first further offence. However, there was a larger difference between the Drug Court and the conventional approach in terms of their effectiveness in reducing the overall rate of re-offending.[952] Although the differences between the treatment group (Drug Court) and the control group (conventional sanctions) were not very large, the overall conclusion was that the Drug Court was more effective than conventional court sanctions in reducing the risk of re-offending.[953]

12.82 Following the evaluation in 2002, changes were made to the Drug Court programme to try to improve its effectiveness. In 2008 the effectiveness of the revised programme was re-evaluated by the Bureau. It found that the programme's effectiveness at reducing recidivism had increased. The treatment group were: (a) 17 per cent less likely to be reconvicted of any offence; (b) 30 per cent less likely to be convicted of an offence against the person; and (c) 38 per cent less likely to be reconvicted of a drug offence.[954] The only outcome not to show a positive result was reconviction for a property offence. The result here slightly favoured the treatment group but the difference was not statistically significant.[955] The Bureau's overall conclusion was that these results show clear evidence that the Drug Court programme is more effective than conventional sanctions in reducing the risk of recidivism among offenders whose crime is drug-related.[956]

Case for pilot drug courts in New Zealand

12.83 We think there is enough evidence from the international experience with drug courts to justify further exploration of the approach in New Zealand, if funding is available for a pilot. The New South Wales evaluation, in particular, provides reasonably robust evidence that drug courts can be more effective at reducing recidivism than some of the alternative options.

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949 Government Accountability Office (GAO) *Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes* (GAO, Washington, 2005) cited in Ryan S King and Jill Pasquarella *Drug Courts: A Review of the Evidence* (The Sentencing Project, Washington, 2009) at 5.

950 Ryan S King and Jill Pasquarella, above n 948, at 7.

951 Wundersitz, above n 944, at 11–12.

952 Bronwyn Lind, Don Weatherburn and Shuling Chen "New South Wales Drug Court Evaluation: Cost-effectiveness" (NSW Bureau of Crime Statistics and Research, Sydney, 2002) at 57–59.

953 Weatherburn and others, above n 946, at 2.

954 Ibid, at 9.

955 Ibid, at 12.

956 Ibid.

12.84 Drug courts are a resource intensive option. The cost per day for an individual placed on the New South Wales Drug Court programme in the 2002 evaluation ($143.87) was slightly less than the cost per day ($151.72) for offenders placed in the control group and sanctioned by conventional means (mostly imprisonment).[957] However, since the average length of time that individuals spent on the programme (321 days) exceeded the length of time the control group were subject to sentences (258 days),[958] the cost per offender was actually higher than it was for the control group. In addition, the New South Wales evaluation involved a comparison with a control group who received no treatment as part of their sentence; the cost for that group would no doubt have been higher if they had.

12.85 We are therefore cautious about drawing any conclusions from these studies on the cost-effectiveness of drug courts. Although there are risks with the proliferation of pilots, we think that, given the substantial costs associated with drug courts, it is important for a pilot to test their relative cost-effectiveness in comparison with other options that utilise treatment.

12.86 The design of the pilot should take into account the need for evaluation. The most robust evidence would be provided by a randomised control trial within one court. However, this may be regarded as problematic both ethically and practically. The next best alternatives would be either a before and after comparison within the court operating the pilot, or a comparison between the drug court pilot and a matched group of offenders subject to a conventional court approach in another geographical area.

12.87 We recommend that a monitoring and evaluation methodology be developed and implemented as part of any drug court pilot.

Potential risks to be avoided

12.88 International research has identified a number of factors that appear to be critical to the effectiveness of drug courts.[959] The more successful drug court pilots in other jurisdictions seem to be characterised by:

- clear, realistic and measurable objectives;
- effective judicial leadership;
- effective working relationships across the departments and agencies involved producing interdisciplinary collaboration;
- good understanding and knowledge of addiction, treatment and recovery and offender motivation across the team of staff delivering the drug court programme;

957 Lind, Weatherburn and Chen, above n 952, at 57–59.

958 Ibid.

959 The United Nations expert group on drug courts have identified a number of success factors drawn from reviewing the international experience with drug courts. An evaluative review of drug court pilots undertaken under the Ministry of Justice framework in the United Kingdom identified many of the same factors as being critical to success when implementing a drug court; see Ministry of Justice, above n 942, at 5. In addition, in the United States, Douglas B Marlowe has developed a list of 10 key components for successful drug courts; see Douglas B Marlowe, Hearing on *Quitting Hard Habits: Efforts to Expand and Improve Alternatives to Incarceration for Drug-Involved Offenders* before the United States House of Representatives Committee on Oversight and Government Reform (Subcommittee on Domestic Policy), 22 July 2010.

- ready access to drug and alcohol assessment and treatment services and other social and support services of a kind that are adequate to deliver all the different components of the programme;
- clear eligibility criteria for selection and participation; and
- the capacity to undertake objective drug testing and, consequent on that, to deliver swift, certain and consistent sanctions and rewards to support the integrity of the programme.

Distorting the access to treatment services of others

12.89 The pilot courts need to have adequate access to assessment and treatment services. As we have noted already, current treatment services are insufficient to meet existing demand. There is consequently a risk that drug court pilots could, if established without additional funding for treatment programmes and services, simply distort the provision of existing treatment services by drawing those services away from people who have higher priority needs but are not assigned to the programme.

12.90 The delivery of assessment and treatment services to offenders through a drug court pilot must not be provided at the expense of services in geographical areas where such a pilot programme is not operating, or at the expense of the delivery of services to users who have not offended and are seeking to access services on a voluntary basis.

Potential for net-widening

12.91 There is a risk that the drug court could result in "net-widening", by exposing relatively minor offenders to its resource-intensive, lengthy and intrusive monitoring. This would be undesirable. Offenders should not be exposed to a disproportionate response to their offending, with the inevitable element of coercion that this entails notwithstanding any requirement for their consent, merely because the response is perceived to be beneficial to them.

Objectives of the pilot

12.92 A number of drug courts have had multiple, confused and poorly articulated aims. This impedes the coherent delivery of services and a robust evaluation.

12.93 We recommend that the objectives for the drug court pilot be to:

- reduce alcohol and drug dependence among participants in the programme; and
- reduce the risk of re-offending among participants.

Options for pilot model

12.94 A few overseas drug courts utilise a pre-adjudication model under which participants are diverted into the drug court supervised programme to undertake and complete their treatment before being required to plead to any charges. Once they have completed the treatment programme they plead to the charges. If they plead guilty or are found guilty they receive credit for having undertaken and successfully completed the programme when being sentenced.

12.95 However, this approach is not the norm for drug courts. It is the model that is more typically used for other court-based diversion programmes such as MERIT in New South Wales. Under that programme, adult defendants with drug problems appearing in the Magistrates' Court are given the opportunity, if they are eligible for bail, to undertake an individualised drug treatment programme through the court for three months under the supervision of a case worker.

12.96 Most drug courts operate a post-plea model. Participants are normally required to plead guilty or to be found guilty before they are able to enter a drug court programme.

12.97 Within the post-plea model there are three options:

(a) post-sentence by way of a suspended prison sentence;
(b) pre-sentence by way of adjournment and deferral of sentencing;
(c) post-sentence by way of other sanctions short of imprisonment.

Post-sentence by way of a suspended prison sentence

12.98 In some drug courts participants are sentenced, normally to a term of imprisonment, which is then suspended while they take part in the drug court programme. On completion or discharge from the programme their notional or initial sentence is then reviewed. This suspended sentence model is used in the New South Wales Drug Court, in Victoria and in Queensland.[960]

12.99 Suspended sentences were abolished in New Zealand by the Sentencing Act. They were replaced by alternative community-based sentences and broader powers allowing judges to adjourn sentencing to give offenders an opportunity to complete a rehabilitation programme. Legislative change would therefore be needed to reintroduce them even for the limited purpose of providing a framework for the drug court.

12.100 The reasons for abolishing suspended prison sentences still stand. We think it is undesirable, and also unnecessary, to reintroduce them. There would be a significant risk of net-widening if a suspended sentence model was adopted. A prison term might be imposed and then suspended in cases where the offending would not normally attract a sentence of imprisonment because it would be a necessary pre-requisite to participation in the drug court. Where the person failed to complete the programme they would generally be required to serve the original sentence and a cumulative sentence for any new offence. Significant numbers of participants drop out and fail to complete drug court programmes. For example, 56 per cent of all offenders placed in the New South Wales Drug Court programme did not complete it.[961] The net-widening implications of a suspended sentence regime are therefore substantial. We think it is much better to adopt a model that leaves the court with greater flexibility as to the appropriate response to failure in light of the circumstances of the individual case.

960 For example, Drug Court Act 1998 (NSW), s 5A; Sentencing Act 1991 (Vic), s 18Z; Drug Court Act 2000 (Qld), s 19.

961 See Weatherburn and others, above n 946, at 10.

Pre-sentence by way of adjournment and deferral of sentencing

12.101 In some drug courts sentencing is deferred until the treatment programme is delivered and completed. Participants come before the judge periodically and progress is monitored. Sentencing does not take place until the participant has either completed the programme or has been removed from or voluntarily discontinued it. When later sentencing a participant, the court takes into account progress on the programme and gives credit for participation.

12.102 This is the model used, for example, in South Australia and in West Australia.[962] It is also the model that is used for the Youth Drug and Alcohol Court in New South Wales and the Christchurch Youth Drug Court. It is also very similar to the approach that currently operates in Family Violence Courts in parts of New Zealand.

12.103 Implementation of this model would be possible under section 25 of the Sentencing Act, which enables the court to adjourn the proceedings before an offender has been sentenced to enable the offender to undertake a treatment programme. The court then gauges the offender's response to the programme before imposing sentence.

Post-sentence by way of other sanctions short of imprisonment

12.104 The third option is for the drug court to operate post-sentence and monitor and implement sanctions short of imprisonment. This approach is being taken in drug court pilots in England and Wales under their sentencing legislation. The legislative regime allows courts to impose a drug or alcohol rehabilitation requirement as part of a community-based sentence.[963] Under a rehabilitation requirement an offender must attend treatment, be tested regularly for drug use and attend regular court reviews. Rehabilitation requirements can also be imposed together with a suspended prison sentence in England and Wales. The courts involved in the drug court pilots utilise these general sentencing provisions to deliver the drug court programme.

12.105 In New Zealand the Sentencing Act provisions, with some modification, would allow for a similar approach. The sentence of intensive supervision could be used in the pilot to deliver a treatment programme, drug testing and supervision. Intensive supervision is available to address complex rehabilitative needs. A sentence of intensive supervision can be imposed in combination with a sentence of reparation, a fine, community work and community detention. It may be for a period from six months to two years.

12.106 The standard conditions imposed with the sentence require an offender to report to a probation officer at least once in each week during the first three months of the sentence and at least once in each month during the remainder of the sentence. The offender must also report as and when required to do so by the probation officer. The court may impose any special conditions including requiring the offender to undertake a residential or non-residential treatment

962 For example, Youth Drug and Alcohol Court (NSW); South Australian Drug Court (which operates pre-sentence but post-plea); Western Australia's Drug Court Regime.

963 See Criminal Justice Act 2003, s 177.

programme. The court may also impose a requirement for judicial monitoring as well as any other conditions that the court thinks fit to reduce the likelihood of further offending by the offender. This could, we suggest, include a requirement of attendance for regular drug testing.

12.107 It could also be appropriate in some cases to use home detention as the basis for participation in the drug court programme. Home detention has a punitive dimension, but it includes a standard condition of supervision by a probation officer and can be accompanied by special conditions requiring the offender to participate in a treatment programme both during the period of the detention and after its expiry. As with intensive supervision, the court may also impose a requirement for judicial monitoring or any other conditions that the court thinks fit to reduce the likelihood of further offending by the offender.

12.108 However, while many of the key features of a drug court could be delivered through these existing sentencing provisions, legislative change is required to allow greater judicial monitoring. Under the current provisions, a judicial monitoring condition requires the supervising probation officer to provide the sentencing judge with written progress reports at regular intervals (of no less than three months). Judges cannot require ongoing attendance at court on a weekly basis after sentence. They may only require the offender to appear before them for a review of the sentence after considering a progress report.

12.109 In England and Wales where a drug rehabilitation requirement has been imposed on an offender as part of a community order or suspended sentence, it may include a condition requiring periodic court review hearings at intervals of not less than one month. The offender is required to attend each review hearing, and the responsible probation officer is required to provide the court with a written report on the offender's progress before the hearing.[964] If this option were preferred, the Sentencing Act would need to be amended to include a similar provision.

12.110 In the event that the offender did not comply with the conditions of the sentence, or it became unavailable or unsuitable for other reasons, the Sentencing Act[965] would give the drug court judge the power, on application from either the offender or a probation officer, to vary the sentence or to cancel it and substitute another sentence. In the context of the drug court, it would perhaps be preferable for the judge to have a power to vary or cancel on his or her own motion. However, in practice the absence of such a power is unlikely to matter; the probation officer would almost always lodge an application if invited to do so by the judge. Given that we would not favour a general "own motion" power, we therefore do not think that it is necessary to provide one solely to cater for the drug court.

Advantages and disadvantages of the second and third options

12.111 One likely advantage of the pre-sentence approach is that it provides a more powerful incentive for offenders to complete the programme. Because the sentencing process has not been completed, the offender has a greater incentive to do well on the programme to gain the most credit and positively influence his

964 Criminal Justice Act 2003 (UK), s 210.

965 Section 54K in relation to intensive supervision and s 80F in relation to home detention.

or her sentence. Such an offender is likely to feel that he or she has more influence over the eventual sentence, so may also be more likely to develop a positive relationship with the drug court team.

12.112 It may be argued that a similar incentive is provided under a post-sentence model, since the drug treatment sentence can be cancelled and another sentence substituted if the offender does not comply and make progress on the programme. However, it may be that offenders will perceive these two situations differently and that the "carrot" of a more lenient sentence as a reward will have more influence than the "stick" of cancellation and substitution. We are not in a position to assess the extent to which this is so, but it does suggest that a positive relationship between the offender and the drug court is a likely prerequisite for success.

12.113 The second advantage of the pre-sentence model is the greater degree of flexibility judges have when dealing with breaches. Offenders working through a treatment programme within the drug court, like others grappling with addiction, will inevitably backslide and relapse from time to time. Realistically, the court needs to be able to accommodate and tolerate some breach of programme conditions on occasion. It would be much easier to accommodate this within a pre-sentence model than a post-sentence model, where the conditions would be part of a sentence imposed by the court and there would be much greater pressure upon both probation officers and judges to respond to breaches of those conditions with formal sanctions.

12.114 Thirdly, a pre-sentence model may also more easily accommodate any victim concerns about undue leniency. Because the sentence would not be imposed until the end of the programme, victims could be kept informed of progress and, in the event that the offender successfully completed the programme, might be more accepting of the eventual sentence than they would have been if a treatment programme had been imposed as a sentence. However, this does point to the need under a pre-sentence model to ensure that there is a robust process for keeping victims informed before, during and after the drug court process.

12.115 Fourthly, a pre-sentence model could be implemented more rapidly, since it could be done without legislative change. In contrast, a post-sentence model would require legislative change to the judicial monitoring provisions in the Sentencing Act before it could be implemented.

12.116 These significant advantages of a pre-sentence model need to be weighed against a number of obvious disadvantages.

12.117 First, there is a risk that some offenders, particularly those who do not successfully complete the programme, could end up with greater sanctions than their offending would have otherwise attracted. They would be required to comply with the terms of the programme (in itself a sanction) and then, because of their failure to complete it, could receive a sentence similar to what they would have otherwise received. In contrast, a post-sentence model would be more transparent and be subject to ordinary sentencing principles, thus ensuring a degree of proportionality between the offence and the proposed programme from the outset.

12.118 Secondly, because sentencing under a pre-sentence model would need to be adjourned for more than a year while an offender completed his or her drug court programme, there would potentially be adverse consequences for victims in some cases. Although the power to adjourn proceedings under section 25 is a wide one, it does not permit the court to impose part of a sentence before adjourning the proceedings. All parts of the sentencing process need to be completed on the one occasion.[966] Delay in sentencing would consequently delay the award of reparation to victims in appropriate cases (since reparation is part of the sentence). More generally, victims would not receive timely closure.

12.119 Finally, there would be some practical problems in identifying and mandating an appropriate agency to coordinate services and provide support to the court and participants under this model. Prior to sentence, the statutory role of the Community Probation Service is limited to preparing pre-sentence reports and obtaining other specialist reports as directed by the judge. It does not have any broader supervisory role in relation to offenders. A legislative change would be required to enable its involvement in the drug court prior to sentencing.

12.120 As no other agency currently has any such mandate, a coordinator or caseworker would need to be employed and funded for the specific purpose of both coordinating the provision of information to the court, including all progress reports on offenders, and overseeing the implementation of all parts of the programme. While this makes the model appear more expensive, it should be noted that under the post-sentence model the Community Probation Service would still need to allocate resources for coordination and casework which, if not additionally funded, would be diverted from its other functions.

Our preferred option

12.121 We are persuaded that collectively the arguments in favour of the pre-sentence model substantially outweigh the arguments against it. The negative impact that delaying sentence (including reparation) might have on victims could be mitigated by a requirement that, where the offence has caused loss or damage, offenders with means at their disposal must pay compensation to the victim as a condition of their entry into the drug court. A robust process would also be required for keeping victims informed both before, during and after the drug court process.

12.122 We think the concern over the risks of net-widening and over-punishment of offenders who are unsuccessful can be addressed through imposing clear and appropriate eligibility criteria for participation.

12.123 Subject to a full cost benefit assessment of both models (which we have not been able to undertake on the information available to us), we therefore propose that a drug court, if established, should operate under a pre-sentence model.

966 As there may be a number of components to a sentence, it is necessary to ensure the ultimate combination reflects the gravity of the case and the circumstances of the offender. If the end sentence is not imposed by the same judge on the same occasion, there is a risk that this will not occur; see *Patelesio v Police* (2010) 24 CRNZ 816 (HC) at 820.

Eligibility criteria

12.124 Eligibility criteria for selection and participation in the pilot must be clear. It should include both justice and health criteria.

12.125 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 recommend that it should include offenders with both alcohol and other drug dependence. The threshold for dependence should be defined. A suitable definition might be adapted from the definition that will be used in replacement legislation for the Alcoholism and Drug Addiction Act 1966.

12.126 We suggest a definition along the following lines: a compulsive state (whether continuous or intermittent) of using alcohol or other drugs or substances that is characterised by two or more of the following features: (a) neuro-adaptation of the substance (that is, tolerance or withdrawal symptoms); (b) craving for the substance; (c) dyscontrol concerning use; and (d) continued use of the substance despite harmful consequences.

12.127 The justice criteria should focus on the sentence that the offender might otherwise receive – for example, it might be confined to offenders who would otherwise receive a moderate to low-end prison sentence (perhaps up to three years), or home detention or a high-end community-based sentence.

12.128 Those offenders seen as most suitable for the pilot would include chronic repeat drink drivers, but also dishonesty and drug offenders whose offending is driven by their alcohol or drug dependency. There would also be exclusion criteria for some offenders (such as sexual offenders).

12.129 Potential participants should be given clear and accurate information on the drug court programme, including the treatment and other rehabilitative components and the court's expectations of participants. Only offenders who have agreed to participate on that basis should be eligible.

Recommended drug court process under proposed model

12.130 The key features of our proposed Drug Court pilot under the pre-sentence model are:[967]

(a) Following the entry of a guilty plea (or when resolution of the charges is imminent), an alcohol and drug clinician in the usual criminal court's list court would screen all those referrals who satisfied the justice criteria. The clinician would also be able to direct those offenders who were not clinically suitable for entry into the Court, but still requiring assistance, towards another suitable pathway to address their alcohol and drug issues. Thus there is a triage aspect to this role.

(b) There would also be a thorough social needs assessment of offenders meeting the criteria. Access to a social needs assessor might be met by developing the role of the existing Community Link in Court (CLiC) scheme already operating

967 We wish to acknowledge that the features of this proposed model have been developed with substantial input from Judges Tremewan and Aitken from the Waitakere and Auckland District Courts.

in some family violence courts.[968] Thus issues such as accommodation crises and other pressing social needs would be flagged and, if the offender was selected for the Drug Court, would be incorporated into his or her treatment plan.

(c) A cultural needs assessment would also be carried out, in order to ensure that the proposed treatment programme was appropriate to the individual needs of the offender and the one most likely to engage him or her.

(d) If the presiding judicial officer in the criminal list court determined that the offender appeared to meet the relevant criteria for entry into the Court, and the offender agreed to participate, the matter would be immediately referred to the next sitting of the Court for initial consideration.

(e) If the Court team regarded the offender as potentially suitable for entry, the offender would then be remanded to reappear in the Court at its next sitting. In the interim, the offender would be referred to the Court's alcohol and drug clinician for an assessment and opinion as to his or her suitability for the Court's process and the development of the individual treatment plan.

(f) If the Court's judge was satisfied on the basis of the clinician's report and other relevant criteria that the offender was suitable for the Court, the offender would be formally offered entry into the Court and asked to commit to the proposed treatment plan. Offenders would have it clearly explained to them that they would be required to be tested for abstinence from alcohol and other drugs throughout the programme, with the clear aim of complete sobriety, and that the proposed treatment would be a fundamental requirement of the programme.

(g) Obtaining work skills and/or taking advantage of study and other opportunities for addressing criminogenic needs would be an integral part of the programme, so that participants would find themselves not only "clean" at the end of their programme but in a different and more positive situation with increased opportunities for future success.

(h) Courses such as parenting and/or safe driving programmes would be promoted wherever possible during treatment, depending on the individual circumstances of the participant. Other positive pro-social activities would also be promoted, including sports and outdoor educational pursuits, kapa haka and mau rākau among others.

(i) Wherever appropriate (in other words, where it would not interfere with treatment), the Court's participants would also be encouraged to engage in meaningful community service while still before the Court. Ideally this would involve local work projects working alongside role models who would provide a positive influence.

(j) If the offender was declined entry or refused to commit to the treatment plan (or entered but later withdrew his or her consent to participate or was exited from the Court), he or she would immediately proceed to sentencing in the usual manner.

(k) The Court would comprise a professional "team" including the judge, a prosecutor, defence counsel, an alcohol and drug clinician and a case worker. At a minimum, both the prosecutor and defence counsel would need to be

968 The Community Link in Court scheme operates in family violence courts in the Auckland, Masterton and Porirua District Courts. Under the scheme, which is funded through the Ministry of Social Development, a caseworker is available at the court to assist with identifying offenders' social needs and assisting offenders to access appropriate social services.

involved in proceedings where consideration was being given to expelling the offender from the programme. They would also need to be involved in the initial Drug Court hearing when the treatment plan was developed and the offender's consent to the programme was being sought, and in the hearing that would impose the final sentence on graduation. However, we doubt that they would need to be involved in the other routine appearances.

(l) The Court would also expect the active participation and utilisation of suitable community resources/agencies to offer support to participants wherever appropriate (for example, the Salvation Army, kuia/kaumātua and mārae-based programmes, and Alcoholics Anonymous/Narcotics Anonymous).

(m) The total length of the Drug Court process would be a minimum of 12 months, although it might be longer depending on the progress of the participant. As all programmes would be abstinence-based, every participant would be subjected to regular and random drug testing. Although it would need to be recognised that absolute abstinence might take some time to achieve, failure of participants to satisfy the Court that they were clearly demonstrating their commitment to abstinence would result in an exit hearing being convened by the Court with a view to their exclusion from the programme.

(n) There would be three stages of the programme, coinciding with the participant's progress with the treatment plan: a first stage, lasting three months or so, in which the participant would be seen very regularly (typically weekly) with more regular and frequent testing for alcohol or drug use; a second stage in which court appearances would become less frequent but testing would continue; and a third stage in which the participant would be seen only every couple of months, although perhaps with more regular reports and an appearance if progress reports indicated a problem. Testing would be likely to be less frequent by this stage. It would be possible for participants to return to an earlier stage of the programme if indications were that closer monitoring and testing had become appropriate.

(o) At each court appearance (as in other drug treatment courts), the team would meet in the morning before the Court began, to discuss each case appearing that day. There would be a progress report from the caseworker and the treatment provider. Any issues arising could be canvassed and consideration given to approaches to be taken. The cases would later be called in open court with the participant in attendance and issues resolved or progressed by the judge. The monitoring hearings would be an integral aspect of the programme, allowing the participant to be acknowledged for continued successes but also to be held accountable for any behavior inconsistent with the treatment plan.

(p) Wherever possible, family/whānau would be made welcome and encouraged into the process so that a holistic approach could be taken to the recovery of the participant. The "downstream" benefits of such an approach are considerable.

(q) At the conclusion of the programme, the offender would graduate and receive a sentence that would reflect his or her success in completing the programme (in some cases, perhaps a conviction and an order to come up if called upon – effectively a suspended sentence which would also serve to encourage continued compliance after the programme was completed).[969]

969 Sentencing Act 2002, s 110.

Resourcing implications

12.131 The resourcing implications of the proposed Drug Court pilot are significant.

12.132 There would need to be access to suitable alcohol and drug clinicians in each of the referring criminal list courts so that the preliminary screening and assessment could be undertaken on the spot. A suitable alcohol and drug clinician would also need to be available on a part-time basis in each Drug Court. It may be that current in-court screening arrangements could be utilised. The offenders who would be eligible for the Court are, we suggest, largely those for whom specialist assessment reports are currently being ordered. There would therefore be some savings in that area for the Community Probation Service which should be allocated to funding the in-court alcohol and drug clinicians.

12.133 There would need to be a caseworker for the Court. Access to a social needs assessor would also be required, but some of these requirements might be met out of the existing CLiC scheme if the pilot were undertaken in Auckland, Masterton or Porirua.

12.134 Each offender would have a substantially greater number of court appearances, with corresponding demands on both courtroom space and judge time. Prosecutors and defence counsel, too, would be faced with the demands of those additional court hearings.

12.135 Finally, there are also substantial costs associated with regular random drug and alcohol testing. These would vary across the three stages of the Court programme. Where participants are in residential programmes, for example, it would not be necessary to undertake testing. However, regular and random testing is an integral part of the drug court approach so would need to be resourced. Consideration should also be given, depending on the availability of the technology, to the relative cost-effectiveness of using electronic bracelets that use the SCRAMx system to accurately monitor alcohol or drug use as an alternative to regular and random testing.

12.136 Although the resourcing implications of a Drug Court pilot are significant, it should be recognised that the offenders who 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.

12.137 Notwithstanding that, we think that a full cost benefit analysis needs to be undertaken on the preferred model before the pilot can proceed, given the level of resources that would seem to be needed.

RECOMMENDATIONS

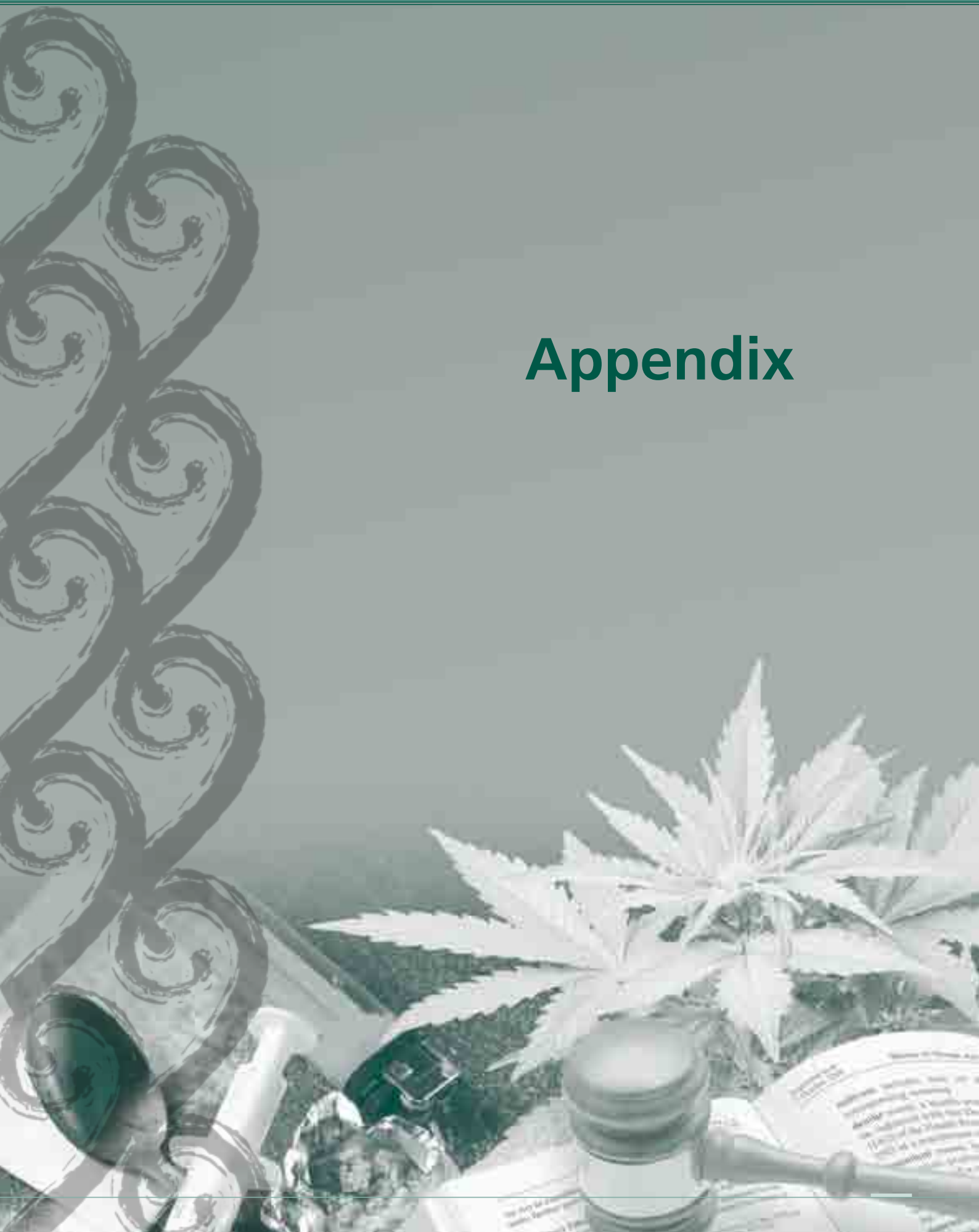
R141 There should be separate funding through the justice sector for the treatment of offenders with alcohol and drug problems.

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.

Appendix



Appendix

LIST OF SUBMISSIONS

Submissions on the Issues Paper

Alcohol Drug Association of New Zealand

Alliance Party

Aotearoa Legalise Cannabis Party

Auckland District Law Society

Auckland Drug Information Outreach Trust

CADS (Community Alcohol and Drug Services) Auckland

Candor Trust

CARSL Consulting

CAYAD (Community Action on Youth and Drugs) Auckland City

CAYAD Clendon/Manurewa

CAYAD Otautahi

CAYAD Te Ika Whenua Hauora Inc

CAYAD Te Tai Tokerau Region

Child and Youth Mortality Review Committee

Children's Commissioner

Citizens Commission on Human Rights

Diagnostic Bioserve Ltd

Drug Rights Project

Dunedin Community Law Centre

Family Planning

Fight Against P and Sensible Sentencing Trust

GreenCross

Hamilton Needle Exchange

Health Action Trust

Hemp Store

Inscience Ltd

Libertarianz

Medical Council of New Zealand

Mental Health Commission

Ministry of Health

Murupara Community Board

National Addiction Centre (NAC), University of Otago

National Committee for Addiction Treatment

National Community Action on Youth and Drug Advisory Group

National Council of Women of New Zealand

Nelson Bays Community Law Centre

Nelson Marlborough DHB

NETS Needle Exchange

New Zealand Customs Service

New Zealand Drug Foundation

New Zealand Law Society

New Zealand Medical Association

New Zealand Nurses Organisation

New Zealand Police

New Zealand Police Association

New Zealand Red Cross

NORML Blenheim

NORML New Zealand

Odyssey House

Pharmaceutical Society of New Zealand

Rodger Wright Centre

SHORE (Centre for Social and Health Outcomes Research and Evaluation), Massey University

Stargate International

Stellar Trust

Susan Nolan & Associates Ltd

Taranaki DHB

Thermo Fisher Scientific

Timaru Needle Exchange

Victory Community Health Centre

Waitemata DHB

WellTrust

Whitireia Community Law Centre

Young Labour NZ

Submitters who are individuals and who have not made a submission on behalf of an organisation have not been separately listed. The Commission received 275 submissions from individuals.

3508 NORML form submissions were received.

Targeted consultation meetings

Arohata Women's Prison

Auckland University (Janie Sheridan, Maree Jensen, Peter Adams and David Newcomb)

CADS Waitemata (Robert Steenhuisen and Sheridan Pooley)

CAYAD Central

CAYAD Northern

CAYAD Southern

David Fergusson, Christchurch School of Medicine

Doug Sellman and Simon Adamson

Expert Advisory Committee of Drugs

Geoff Noller and Bryce Edwards, Otago University

Higher Ground

Institute of Environmental Science and Research Limited (Keith Bedford and Jill Vintner)

Medical Officers of Health

Matua Raki leadership day

Moana House

National Association of Opioid Treatment Providers

National Committee for Addiction Treatment

Needle Exchange New Zealand (Charles Henderson and Stephen Farquhar)

Nelson Alcohol, Drug and Co-occurring Disorders Service

Nelson Branch of the Aotearoa Legalise Cannabis Party

Nelson Hub (hosted by Health Action Trust)

New Zealand Drug Foundation Consultation Group

New Zealand Drug Foundation Pacific Consultation Group

NORML Auckland

NORML Wellington

Nova Lodge

Odyssey House

Otago University Students' Association

Red Cross Community Services

Rimutaka Prison Drug Treatment Unit

SHORE (Chris Wilkins and Sally Casswell)

Stargate International Ltd (Matt Bowden and James Williamson)

Tasman District Council

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