



# CONTROLLING AND REGULATING DRUGS

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LAW·COMMISSION  
TE·AKA·MATUA·O·TE·TURE





# CONTROLLING AND REGULATING DRUGS

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

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# Controlling and regulating drugs

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# Terms of reference

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

The issues to be considered by the Commission will include:

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

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

# Call for submissions

Submissions or comments on this Issues Paper should be sent to the Law Commission by **Friday 30 April 2010**.

## Drugs Review submissions

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Any enquiries may be made to **Jo Dinsdale**, phone **04 914 4807**  
or **Andrea King**, phone **04 914 4824**.

There are questions set out in various chapters of this Issues Paper, and collected at the end of the Paper, on which we would welcome your views. It is not necessary to answer all questions. Your submission or comment may be set out in any format, but it is helpful to indicate the number of the question you are discussing, or the paragraph of the Issues Paper to which you are referring.

This Issues Paper is available on the Law Commission's website [www.lawcom.govt.nz](http://www.lawcom.govt.nz).

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## Official Information Act 1982

The Law Commission's processes are essentially public, and it is subject to the Official Information Act 1982. Thus copies of submissions made to the Law Commission will normally be made available on request, and the Commission may refer to submissions in its reports. Any requests for withholding of information on grounds of confidentiality or for any other reason will be determined in accordance with the Official Information Act 1982.

# Preface

In 2007 the Associate Minister of Health invited the Law Commission to review the Misuse of Drugs Act 1975. This invitation arose partly in response to the debate over the reclassification of benzylpiperazine (BZP) as a Class C controlled drug. A number of significant problems, particularly over the adequacy of the legislative framework to deal with new psychoactive substances, were identified alongside longstanding concerns over the Act's fitness for its purpose. As a consequence, the Government decided that a broad review of the Act was required.

There is concern that the Misuse of Drugs Act no longer provides a coherent and effective legislative framework for responding to the misuse of psychoactive drugs. The Act has become complex. It is difficult to understand and navigate because it has been amended on numerous occasions and is supported by two free-standing but closely linked amendment Acts. All three must be read together to understand how drugs are controlled. There are also problems in the way the Misuse of Drugs regime interacts with other legislation such as the Medicines Act 1981 and the Hazardous Substances and New Organisms Act 1996.

Most significantly, the Act's policy framework appears to be out of step with current drug policy. Although it has been amended numerous times to reflect new developments in drug use, there is concern that the Act is now outdated and does not reflect current knowledge and understanding about drug use and related health, social and economic harms. The Act pre-dates and does not seem to be well aligned to the National Drug Policy and its overarching goal of minimising drug-related harm. Although partly administered by the Ministry of Health, it is primarily a criminal justice statute, with little recognition of public health measures such as treatment and education programmes aimed at reducing drug harm.

The Law Commission's review is comprehensive and wide-ranging. A "first principles" approach has been taken. The review's objective is to propose a contemporary legislative framework for regulating drugs that supports and enhances the effectiveness of drug policy. The framework should be consistent with New Zealand's international obligations concerning illegal and other drugs and reflect up-to-date knowledge and understanding about drug use and the harm drugs cause. The terms of reference for the review are set out on page 5 of the Paper.

In the course of our work, we reached the view that the effective operation of a new legislative framework required an overhaul of the Alcoholism and Drug Addiction Act 1966. We also noted that the Government's Methamphetamine Action Plan requires a review of that Act. We therefore agreed with the Ministry of Health that we should include this Act within our project.

In this Issues Paper, we have therefore canvassed a wide range of options for reforming both the Misuse of Drugs Act and the Alcoholism and Drug Addiction Act, as well as suggesting possible amendments to related legislation such as the Medicines Act. We have sometimes put forward our preferred view. However, we have reached no final position on any of the issues in this Paper. Our final report and the recommendations in it will be shaped by the submissions we receive on the questions we have posed for public response.

# Part 1

## CURRENT APPROACH



# Chapter 1

## Introduction to the review

### SUMMARY

This chapter provides an introduction to the review and identifies what is known about the nature and extent of drug use in New Zealand.

- INTRODUCTION 1.1 The use of drugs for recreational purposes is an inherently divisive social issue. Public debate is frequently polarised and based on strong and sometimes emotional opinions. Reactions tend to be based more on fear or self-interest than sound social policy analysis.
- 1.2 At one end of the debate are those who believe that taking mind-altering substances which affect judgement and the functioning of the mind for recreational purposes robs an individual of their free will and essential humanity. James Q Wilson expressed this position eloquently when, in attempting to justify the United States' differential treatment of nicotine and cocaine, he argued:<sup>1</sup>
- We treat the two drugs differently, not simply because nicotine is so widely used as to be beyond the reach of effective prohibition, but because its use does not destroy the user's essential humanity. Tobacco shortens one's life, cocaine debases it. Nicotine alters one's habit, cocaine alters one's soul.
- 1.3 At the other end of the debate are those who believe that people should be free to use whatever substances they want, with any attempt by society to limit that use an unwarranted interference with personal autonomy and freedom of choice.
- 1.4 While many may have sympathy for James Q Wilson's view in relation to a number of drugs that are currently prohibited, most people would not apply that extreme view to all psychoactive substances. They would recognise some of them as having inherent benefits, at least if used in moderation. It is for that reason that

1 James Q Wilson "Against the Legalisation of Drugs" (1990) 89 Commentary 21, 26.



psychoactive substances have been used across the world for thousands of years.<sup>2</sup> At the same time, most would also recognise that all psychoactive substances may cause harm, not only to the individual but to society as a whole. Regulation of their use is therefore needed to minimise this harm.

- 1.5 The distinctions that societies throughout history have drawn in regulating drugs have not always been based on sound empirical evidence. In particular, distinctions between legal and illegal drugs have often been somewhat arbitrary. For example, from the point of view of the harm that they inflict, the regulation of alcohol as a legal drug is not consistent with the approach taken to illegal drugs.
- 1.6 However, we cannot turn back the clock. Our approach to various drugs including alcohol is inextricably linked to our history and culture. It is also constrained by our obligation to uphold our international obligations concerning illegal and other drugs, as reflected in three long-standing United Nations conventions. These things cannot be changed overnight. Our regulatory framework for psychoactive substances must recognise political and social realities.
- 1.7 It is for this reason that the report excludes from its scope two major drugs of choice in New Zealand – alcohol and tobacco. Our issues paper on New Zealand’s alcohol laws reviewed current evidence on alcohol-related harm.<sup>3</sup> It concluded that alcohol contributes to a wide range of harms, ranging from criminality and anti-social behaviour, through to an increased risk of injury, ill-health, death, and self-harm. The vast catalogue of harms attributable to alcohol has led the Commission to the view that greater regulation is needed to reduce the excesses and curb the harm. It follows that we think that the linkages between alcohol and other drugs (including those currently prohibited) need better recognition, and that in making our recommendations in this project we need to take into account the lessons that have been learned through the regulation of alcohol and tobacco. However, the history of, and social attitudes towards, alcohol and tobacco are profoundly different from those applying to many or most of the drugs currently subject to prohibition. They, therefore, require a quite different approach. Our review would have been unmanageably large if we had attempted to include alcohol and tobacco within it.
- 1.8 This will not please everyone. Many of those who regard the current approach to drugs as illogical, hypocritical, and based on double standards will no doubt want us to take a bolder approach. Law reform, however, is the art of the possible.

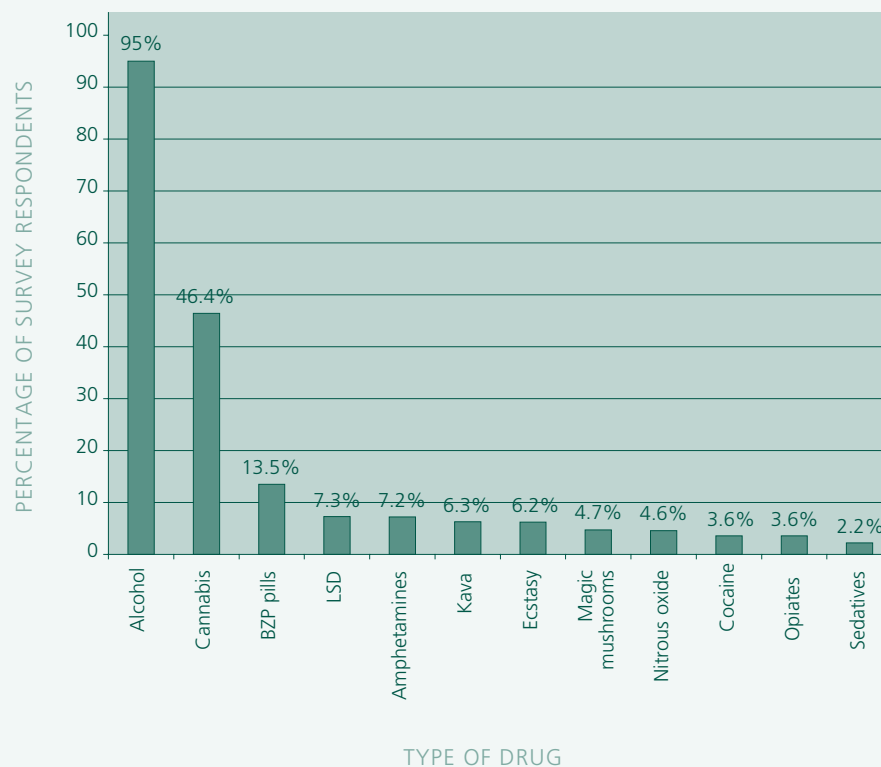
2 It has even been suggested that “there has never been a society that has not had some form of psychoactive drug or drugs used by at least some of its members”. See David Ryder, Noni Walker and Alison Salmon *Drug Use and Drug-Related Harm – A Delicate Balance* (2nd ed, IP Communications Ltd, Melbourne, 2006) 5.

3 New Zealand Law Commission *Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand’s Liquor Laws* (NZLC IP15, Wellington, 2009).

NEW ZEALAND'S  
DRUG SCENE

- 1.9 National household surveying on drug use, which has been undertaken for the Ministry of Health since 1998, provides some indication of those drugs that are currently the most prevalent in New Zealand.
- 1.10 The following two graphs identify the most commonly used drugs in the 2007/08 New Zealand Alcohol and Drug Use Survey.<sup>4</sup> They show the percentage of respondents in the 16–64 year age bracket who self-reported ever using a substance for recreational purposes (lifetime use) and those who had used the substance at least once during the preceding 12 months.<sup>5</sup> We have included alcohol in both graphs to provide a comparison with other drugs. The percentage of 15–64 year olds who currently use tobacco is provided for interest in the graph depicting last year drug use.<sup>6</sup>

2007/2008 PERCENTAGE OF SURVEY RESPONDENTS  
WHO HAD EVER TRIED DIFFERENT DRUG TYPES DURING  
LIFETIME (AGED 16–64)



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

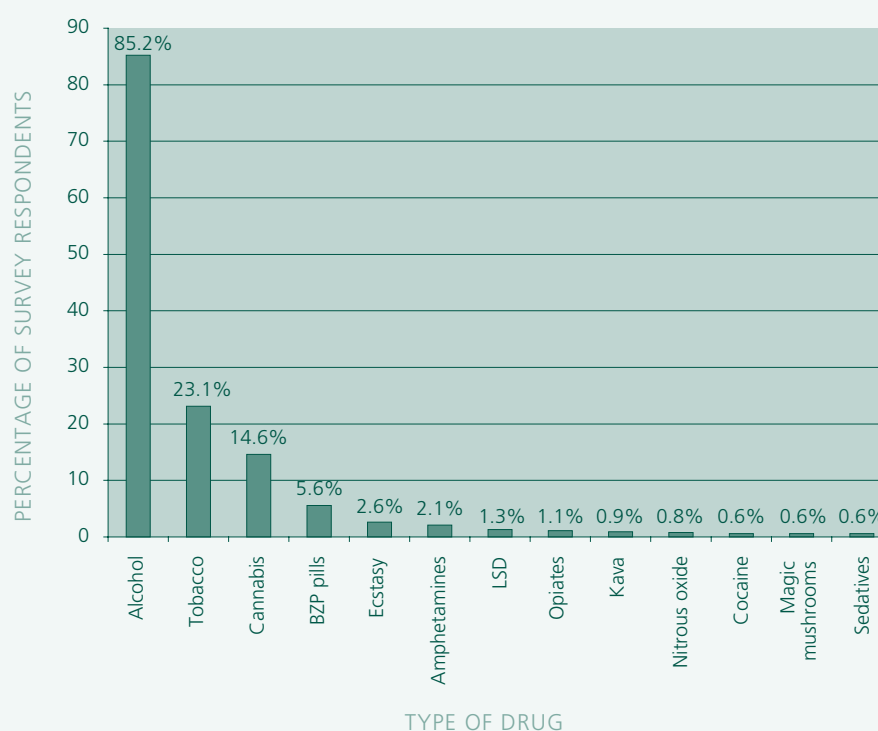
4 Ministry of Health *Drug Use in New Zealand: Key Results of the 2007/08 New Zealand Alcohol and Drug Use Survey* (Ministry of Health, Wellington, 2010) [Drug Use in New Zealand].

5 The survey was undertaken between August 2007 and April 2008.

6 Current tobacco use was reported in Ministry of Health *Tobacco Trends 2008: A Brief Update of Tobacco Use in New Zealand* (Ministry of Health, Wellington, 2009).



2007/2008 PERCENTAGE OF SURVEY RESPONDENTS WHO HAD USED DIFFERENT DRUG TYPES DURING PREVIOUS 12 MONTHS (AGED 16–64)

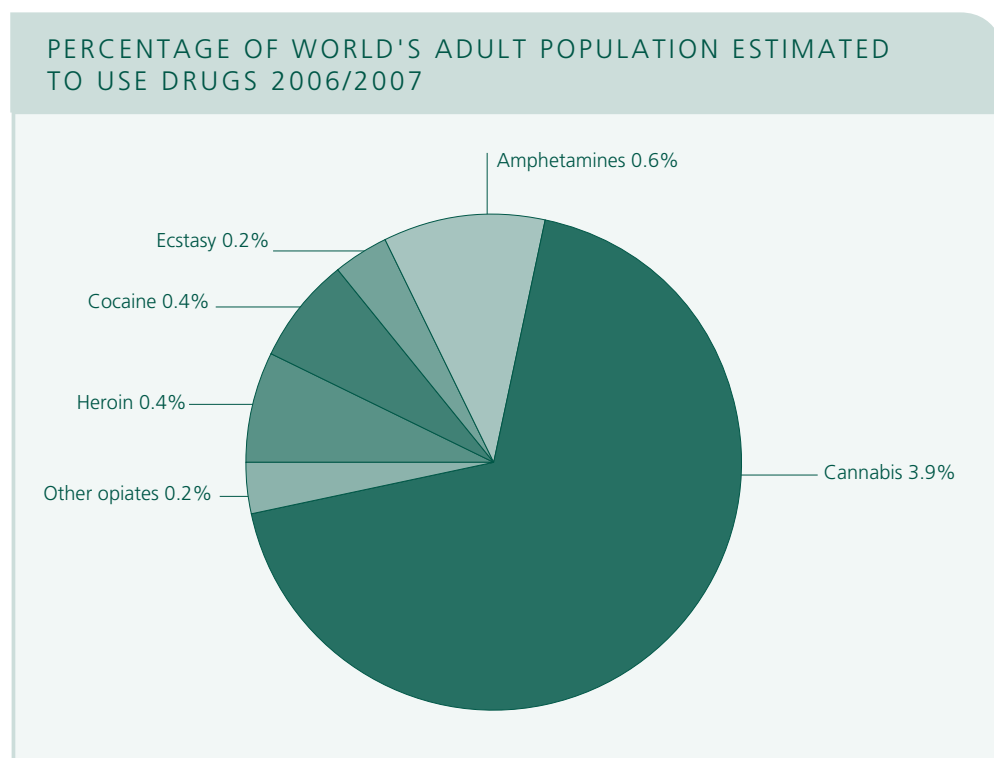


- 1.11 As illustrated by the second graph, cannabis is the third most widely used drug in New Zealand (and in the world).<sup>7</sup> In 2007/08, approximately 15 % of respondents had consumed cannabis in the previous 12 months, while over 46 % had consumed it at some point in their lives.
- 1.12 BZP was the fourth most widely used drug in 2007/08. 5.6 % of respondents used BZP in the previous 12 months, while 13.5 % had used BZP at some point in their lives.
- 1.13 Ecstasy was the fifth (2.6 %) and amphetamines were the sixth (2.1 %) most widely used drugs in 2007/08. However, a higher percentage of people had used LSD, amphetamines or kava at some stage during their lifetime than ecstasy. Therefore, based on lifetime use, LSD was the fifth most widely used drug (7.3 %), amphetamines the sixth (7.2 %), kava the seventh (6.3 %), and ecstasy the eighth (6.2 %).

<sup>7</sup> See the United Nations Office on Drugs and Crime (UNODC) *World Drug Report 2008* (United Nations, New York, 2008) 30.

## International patterns

- 1.14 The United Nations Office on Drugs and Crime (UNODC) estimates that approximately 4.9 % of the world's population aged 15 to 64 used prohibited drugs at least once over the 2006/07 year.<sup>8</sup> As illustrated in the pie graph below, UNODC identified cannabis, amphetamines, cocaine, heroin, ecstasy, and then other opiates as the most widely used illicit drugs in the world.<sup>9</sup> Most of the illegal drugs that are most commonly used in New Zealand are also most commonly used worldwide.



## Changes in drug use tracked through New Zealand surveys

- 1.15 The information collected over the various waves of national household surveys has been compared in a number of studies undertaken by the Centre for Social and Health Outcomes Research and Evaluation (SHORE) at Massey University.<sup>10</sup> These comparisons help identify changes in the prevalence of drug use.

<sup>8</sup> World Drug Report 2008, above n 7, 30.

<sup>9</sup> The graph has been prepared using the figures in World Drug Report 2008, above n 7.

<sup>10</sup> Surveys were undertaken in 1998, 2001, 2003 and 2006. Participants were randomly selected and computer assisted telephone interviews were conducted on a confidential basis for the Ministry of Health. Survey respondents were asked the same questions in each survey concerning whether they had ever used a drug type for recreational purposes and also whether they had used that drug type in the preceding 12 months. The sample size for the different surveys varied. In 1998, it was 5475; in 2001, it was 5504; in 2003, it was 3042; and in 2006, it was only 1902. The age range has also varied across surveys, so comparisons can only be made in the 15–45 year age bracket. See Chris Wilkins and Paul Sweetsur “Trends in Population Drug Use in New Zealand: Findings from National Household Surveying of Drug Use in 1998, 2001, 2003, and 2006” (2008) 121 New Zealand Medical Journal [Wilkins and Sweetsur]; see also Chris Wilkins, Paul Sweetsur and Sally Casswell “Recent Population Trends in Amphetamine Use in New Zealand: Comparison of Findings from National Household Drug Surveying in 1998, 2001 & 2003” (2007) 119 New Zealand Medical Journal.

The major changes that have been identified through repeated surveying up to and including 2006 are summarised below. These comparative figures cover people in the 15–45 year age bracket only. No comparison has yet been made between the latest data from the 2007/08 New Zealand Alcohol and Drug Use Survey and previous surveys. Caution should be taken to making any comparisons as the age range and methodologies are different.<sup>11</sup>

### Amphetamines

- 1.16 The use of stimulants like amphetamine sulphate, methamphetamine and crystal methamphetamine has increased in New Zealand since the late 1990s.<sup>12</sup> In the 2001 and 2003 national household surveys, amphetamines (including methamphetamine) were the second most widely used illegal drug in New Zealand after cannabis. This largely reflects an international trend that saw an increased prevalence of powerful amphetamines like methamphetamine since the late 1990s.<sup>13</sup>
- 1.17 Amphetamine use may have levelled off following a peak in 2001.<sup>14</sup> In 2001, 5 % of respondents said they had used amphetamines during the previous year. In 2003, this had dropped to 4 %, and, in 2006, to 3.5 %. There is also evidence of a levelling off in methamphetamine use in the recent results of the Illicit Drug Monitoring System conducted for the Police.<sup>15</sup>

### Ecstasy

- 1.18 Ecstasy use fluctuated over the period between 2001 and 2006. In 2001, 3.4 % said they had used ecstasy during the previous year. In 2003, this was 2.9 %, and, in 2006, it had increased to 3.9 %.<sup>16</sup> However, the figures may be unreliable because it seems that during 2006 drug dealers sometimes sold BZP party pills as ecstasy.<sup>17</sup> Recent results of the Illicit Drug Monitoring System indicate that the use of ecstasy appears to be increasing.<sup>18</sup> Ecstasy produces a mixture of stimulatory and psychedelic effects, so while it has some features in common

11 The 2007/08 New Zealand Alcohol and Drug Use Survey differs from previous surveys as it uses face-to-face and self-completed computerised interviews. For further details of the methodology and findings of this survey see *Drug Use in New Zealand*, above n 4.

12 Wilkins and Sweetsur, above n 10.

13 Chris Wilkins, Krishna Bhatta and Sally Casswell “The Emergence of Amphetamine Use in New Zealand: Findings from the 1998 and 2001 National Drug Surveys” 115 (2002) *New Zealand Medical Journal* 1. Quite similar figures have also been recorded in the 2004 Australian household survey, so the increased amphetamine use seems to reflect something of a broader trend of increasing supply and use of methamphetamine across South-East and East Asia. In the 2004 survey, 3.2 % had used methamphetamine or amphetamines in the preceding 12 months. Note the age group differs from that used to produce the New Zealand figures. See Australian Institute of Health and Welfare *2004 National Drug Strategy Household Survey: Detailed Findings* (Australian Institute of Health and Welfare, Canberra, 2005) 59.

14 Wilkins and Sweetsur, above n 10, 65.

15 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) 9 [IDMS].

16 Wilkins and Sweetsur, above n 10, 65.

17 Wilkins and Sweetsur, above n 10, 5.

18 IDMS, above n 15, 9.

with hallucinogens, it is commonly considered an amphetamine-type stimulant (ATS). The increased use of ecstasy can probably be seen to be part of an overall worldwide trend towards greater use of ATS drugs.

### *BZP party pills*

- 1.19 Party pills have become popular in New Zealand. Pills containing benzylpiperazine (BZP)<sup>19</sup> were widely available from retail outlets before April 2008. BZP party pills were the fourth most widely used drug in the 2006 survey. Their use was not surveyed in earlier years.
- 1.20 Commentators suggest that the extent of BZP use in New Zealand prior to its classification as a prohibited drug is probably unique in the world.<sup>20</sup> A report prepared for the Ministry of Health estimated that in total approximately 20 million doses of party pills containing BZP or trifluoromethylphenylpiperazine (TFMPP) and related substances were sold in New Zealand between 2002 and 2006.<sup>21</sup> BZP is now a controlled drug in New Zealand, and that change in status may now be having an impact on its prevalence. Frequent drug users surveyed as part of the Illicit Drug Monitoring System reported that fewer people they knew were using BZP in 2008 compared to 2007, that it was considerably more difficult to obtain, and that the price had increased.<sup>22</sup>

### *Cannabis*

- 1.21 New Zealand has high rates of cannabis experimentation and use. The 2007/08 household survey indicates that over 46 % of people have at least experimented with this drug.<sup>23</sup> According to UNODC figures, New Zealand has a higher annual prevalence rate for cannabis than the United States, Australia, or any country in Europe. The only western democracy with a higher annual prevalence rate than New Zealand is Canada.<sup>24</sup>
- 1.22 The 2006 household survey identified a decline in use of cannabis during the previous year compared to earlier survey waves. In 2003, 20 % of respondents said they had used cannabis within the preceding 12 months. In 2006, this had dropped to 18 %.<sup>25</sup>
- 1.23 In light of the different age range and methodologies of the latest household survey, it is not possible to confidently confirm the continuation of this downward trend, although the data would appear to support this. Stimulants are currently

19 BZP is a synthetic stimulant. It is considered to be similar in its action to amphetamine but is much less potent. The former Associate Minister of Health Hon Jim Anderton has stated that BZP was about one tenth as potent as amphetamine. See Hon Jim Anderton (11 September 2007) 642 NZPD 11714.

20 Wilkins and Sweetsur, above n 10, 67.

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

22 IDMS, above n 15, 11.

23 *Drug Use in New Zealand*, above n 4, and Ministry of Health *New Zealand Country Report: Report prepared for the 46th Session of the Commission on Narcotic Drugs Vienna* (Ministry of Health, Wellington, 2003) 3.

24 World Drug Report 2008, above n 7, 276–277.

25 Wilkins and Sweetsur, above n 10, 65.

more consistent with cultural trends among youth, so the emergence of a range of synthetic stimulant drugs over the past five years (that is, methamphetamine, ecstasy and BZP) may have resulted in reduced cannabis use.<sup>26</sup> Population surveys carried out in the United Kingdom and in Australia have also reported decreases in cannabis use in recent years.<sup>27</sup>

### Hallucinogens

- 1.24 The use of the hallucinogens (for example, LSD and magic mushrooms) appear also to be in decline. In 2006, only 1.8 % of respondents had used LSD in the preceding 12 months compared with 3.9 % in the 1998 survey. Similarly 1.6 % of people used hallucinogenic mushrooms in 2006 compared with 2.2 % in 1998.<sup>28</sup>

### Opiates

- 1.25 Opiates were not included in the comparison of household surveys conducted by SHORE. However, the prevalence of opiate use in New Zealand is relatively low by international standards. The latest figure for last year use for all opiates (including the non-medical use of prescription opiates) is 1.1 %. UNODC identifies the annual prevalence of opiate abuse in New Zealand as 0.4 % of the adult population, which is lower than the equivalent rates in Australia, the United States and much of Europe.<sup>29</sup>
- 1.26 The relatively low rate of opiate use is due mainly to New Zealand's geographical isolation and border controls that have made it difficult to import heroin and raw opium in bulk. The majority of opiates used recreationally in New Zealand are either diverted prescription drugs like morphine, codeine, or methadone; or are forms of "homebake" derived from these or from poppies grown in New Zealand.<sup>30</sup> Street morphine followed by street methadone is currently the most widely used opiate.<sup>31</sup> Homebake, according to the most recent figures from the Illicit Drug Monitoring System, is considered difficult to obtain.<sup>32</sup>

### Conclusion

- 1.27 The data on drug use shows that (although there are small shifts at the margins) the overall levels of use of psychoactive substances are significant (even when alcohol is excluded). Changes have clearly occurred in the level of use of different psychoactive drugs over time. However, there is some evidence that this is largely displacement (that is, the level of use of some substances has decreased as the use of others has increased) and that overall the portion of the population using drugs is not really changing.

26 Ibid, 68.

27 IDMS, above n 15, 10.

28 Wilkins and Sweetsur, above n 10, 65.

29 World Drug Report 2008, above n 7, 273–274.

30 Ministerial Committee on Drug Policy *National Drug Policy 2007–2012* (Ministry of Health, Wellington, 2007), Appendix 1: Drug Use in New Zealand.

31 IDMS, above n 15, 10.

32 Ibid.

# Chapter 2

## The harms arising from drug use

### SUMMARY

This chapter discusses the nature and extent of drug-related harm, and the way in which that harm is best identified and measured. It includes a review of the evidence in relation to the particular harms caused by cannabis and methamphetamine use.

#### THE NATURE OF DRUG-RELATED HARM

- 2.1 It is unarguable that drug use causes substantial harm to and imposes major costs on the community. This is the case whether the drug used is a legal drug like alcohol or an illegal drug like cannabis or methamphetamine. However, while the harms and costs associated with alcohol are typically understated and misunderstood,<sup>33</sup> those associated with illegal drugs are often generalised and overblown.<sup>34</sup>
- 2.2 All psychoactive drugs can alter mood, perception, cognition and behaviour.<sup>35</sup> By doing so, they alter the body's biological function to create two different types of effects and possible harms:
- Toxicity (that is, intoxication) – the (usually) immediate effect of a drug when the blood-level concentration rises rapidly; and
  - Dependence – the delayed effect of a drug that produces a range of longer-term harms.<sup>36</sup>

33 See New Zealand Law Commission *Alcohol in our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws* (NZLC IP15, Wellington, 2009).

34 See, for example, G Thomas and CG Davis *Comparing the Perceived Seriousness and Actual Costs of Substance Abuse in Canada: Analysis drawn from the 2004 Canadian Addiction Survey* (Canadian Centre on Substance Abuse, Ottawa, 2007), which suggests that Canadians' perceptions of the harm caused by illegal drug use far outweighs the actual costs it imposes. The reverse is true for alcohol.

35 Greg Whelan "The Pharmacological Dimension of Psychoactive Drugs" in M Hamilton, T King, and A Ritter (eds) *Drugs in Australia – Preventing Harm* (2<sup>nd</sup> ed, Oxford University Press, Melbourne, 2004) 17.

36 Ibid.



- 2.3 Drug users may also experience a range of other less direct harms. These include the harms that arise from undertaking activities while intoxicated (for example, driving or operating machinery) or in order to obtain money for drugs (for example, theft, burglary, prostitution). The diversion of financial resources into funding drug use also causes harm.<sup>37</sup>
- 2.4 Drug use can also harm others, sometimes more than the user.<sup>38</sup> Family members and intimates may be harmed by risky or violent behaviour attributable to drug use, as well as emotional distress and financial hardship. Employers are affected by absenteeism and lost productivity. Other people are affected by activities such as driving under the influence of drugs or causing drug-related property damage and disorder. Drug use may also lead users to commit crime, either due to the immediate result of drug intoxication, the longer-term effect of drug use on the brain, or the need to finance a drug habit.<sup>39</sup> Society more generally must meet the cost to the health system of responding to drug-related injuries and conditions, and providing rehabilitative and treatment services.
- 2.5 There are a number of challenges in describing the harms and costs associated with illegal drugs. First, there is a lack of robust evidence on the full range of harms caused by drug use. The long-term health effects of using some drugs are unknown. Many users do not “specialise” in any one drug, but use a number of different drugs, including alcohol, often in combination. It can therefore be difficult to attribute a particular harm to a particular drug. Some harms, such as the effect of drug use on family relationships, are difficult to measure with any certainty.
- 2.6 Drug harm varies significantly from drug to drug and from individual to individual. The toxicity and the risk of dependence both differ enormously between drugs. In addition, the impact of a drug on a particular individual will depend on a wide range of factors including the user’s age, gender, and underlying state of health; the method of use (for example, whether taken orally, injected or inhaled); the quantity used; the frequency and duration of use; and the environment in which the drug is used.<sup>40</sup> Broad generalisations about the harm that drug use causes are thus liable to be misleading and unhelpful.

37 Margaret Hamilton “Addressing Drug Problems: The Case for Harm Minimisation” in M Hamilton, T King, and A Ritter (ed) *Drugs in Australia – Preventing Harm* (2<sup>nd</sup> ed, Oxford University Press, Melbourne, 2004) 131.

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

39 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).

40 Whelan, above n 35, 19.

- 2.7 Drug harm is not evenly distributed. Some drugs can be used in small quantities by many or most people with few adverse consequences, with harm restricted to a small subset of users who use repeatedly or excessively. Other highly toxic or addictive drugs are likely to cause harm even after modest levels of use.
- 2.8 The harm arising from drug use is often conflated with the harm arising from drug prohibition. This gives a misleading picture of drug harm. The development of a criminal black market in a prohibited drug (and the crime that goes with it), the impact on a drug user of a criminal conviction, and the cost to the State of enforcing drug prohibition are costs and harms of drug prohibition, not drug use.
- 2.9 Finally, discussions of the harm that arises from illegal drugs tend to ignore the benefits that may arise from their use. These benefits must not be lost sight of. For example, some would argue that, even when used only for recreational purposes, there are social benefits to drug use. These benefits may include the pleasurable effects of an altered state of consciousness (ranging from increased relaxation to increased energy), better social bonding with peers, or an escape from the realities of everyday life. Many of these benefits have parallels with the social benefits of alcohol (although the latter are more readily acknowledged than the former).
- 2.10 In addition, many drugs controlled under the Misuse of Drugs Act 1975 are first and foremost intended for use as medicines, or have recognised scientific and industrial purposes. Some were previously intended for use in this way. Heroin, for example, was available on prescription in New Zealand until the mid-1950s. Some consider the inability to develop and use illegal drugs like cannabis for medicinal purposes as a particular harm of drug prohibition. Indeed, one of the major adverse side effects of international efforts to control the supply of illegal drugs has been a denial of much needed pain relief to millions of people in developing nations.<sup>41</sup>

#### ATTEMPTS TO MEASURE DRUG-RELATED HARM

- 2.11 Notwithstanding these real challenges in describing and quantifying the harms and costs associated with drug use at an aggregate level, there have been a number of attempts to do so. Some of these have been done for the purposes of identifying the total cost of drug-related social harm at a particular point in time. For example, in a recent paper by the Business and Economic Research Limited (BERL) it was estimated that the total social costs resulting from the harmful consumption of illegal drugs was \$1.585 billion.<sup>42</sup> These costs comprised:
- Costs for tangible (monetary) harms (\$1,191.7 billion) borne by individuals (for example, lost wages, reduced productivity, medical treatment) and government (for example, crime costs, police and justice resources, health care costs, accident compensation, road crashes); and
  - Intangible (non-monetary) harms (\$393.6 million) (for example, pain and suffering as a result of accident, loss of life).

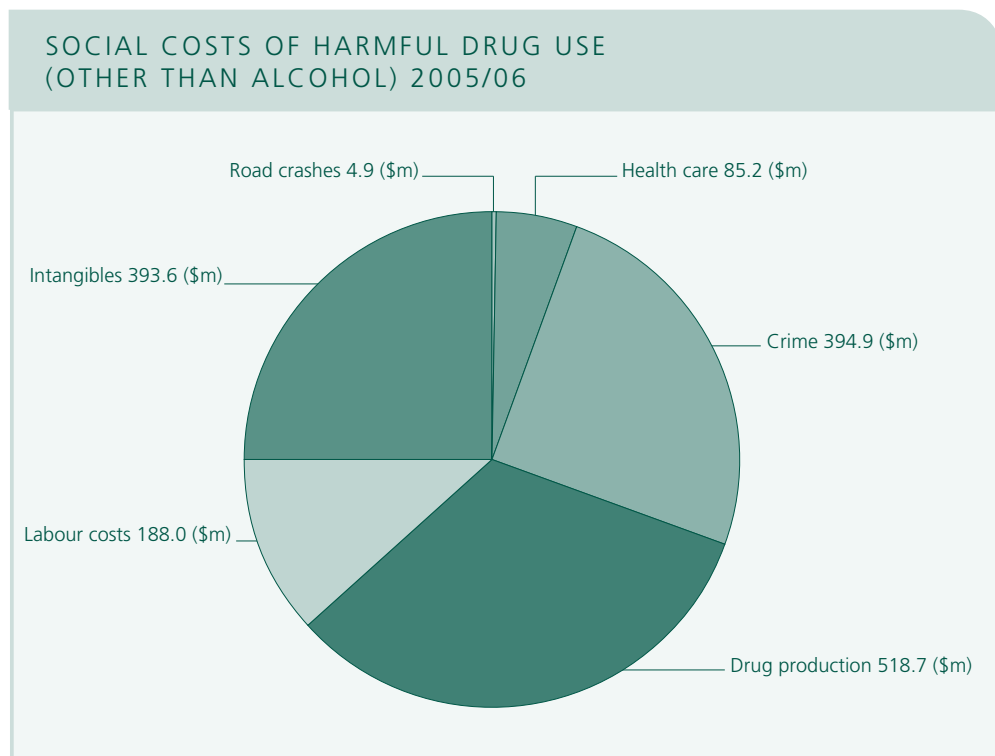
41 See Rachel Nowak "Comment: Out-of-date Drug Laws are Hurting People" (6 September 2008) *New Scientist* 22. See also International Narcotics Control Board "Report of the International Narcotics Control Board for 2008" (19 February 2009) E/INCB/2008/1, page 5, which estimates that up to 86 million people suffer from untreated moderate-to-severe pain annually.

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



2.12 The pie graph below shows the tangible and intangible costs identified in the study.<sup>43</sup> The tangible costs comprise the following:

- Drug production (\$518.7 million). This represents the value of resources that were diverted and used for the production of drugs. It is made up primarily of cannabis production (\$243.2 million) and amphetamine production (\$230.9 million).
- Crime (\$394.9 million). This includes all justice sector costs,<sup>44</sup> including police resource costs for drug offences and drug-related burglary and theft (\$105.7 million), the costs associated with imprisoning people for drug-related offences (\$129.7 million), and theft and property damage related to drug use (\$52.6 million).
- Labour costs (\$188 million). This is lost output as a result of excess unemployment, reduced quality of labour and the reduction in the workforce due to imprisonment for drugs offences and premature death linked to drug use.
- Health care costs (\$85.2 million). This includes all hospital costs for drug-related admissions, inpatient and community addiction and treatment services, ambulance costs and emergency services, and pharmaceuticals.
- Road crashes (\$4.9 million). These are any additional costs associated with road crashes that have not been counted elsewhere.



<sup>43</sup> The pie graph has been compiled from tables 5.6 and 5.7 in chapter 5 of BERL, *ibid*.

<sup>44</sup> Includes costs to the New Zealand Customs Service and the New Zealand Police, costs to victims, court costs, the cost of sentences imposed, and costs to the Defence Force arising from its contribution to drug eradication programmes. See BERL, *ibid*, 40–45.

- 2.13 Other tools have been developed to demonstrate the benefits of a particular enforcement approach. For example, BERL has also developed a Drug Harm Index for the New Zealand Police which provides a numerical estimate of the potential drug harm avoided annually due to drug seizures from 2000 to 2006 – in essence, the potential economic value to the community of drug seizures. That Index estimated that illegal drug seizures potentially avoided \$458 million of drug harm in 2006.<sup>45</sup> A similar index has been developed for the Australian Federal Police.
- 2.14 Finally, some tools have been developed to measure trends. For example, the United Kingdom Government developed a Drug Harm Index in 2005 to measure progress against its goal of reducing the harm caused by illegal drugs.<sup>46</sup> The Index reduces a wide range of drug-related harms (including health impacts, community harms, domestic drug-related crime, and commercial drug-related crime) to a single numerical measure, the trajectory of which can be forecast and tracked from year to year.
- 2.15 These sorts of attempts to identify aggregate costs have their uses, particularly in relation to measuring trends. However, they do not effectively meet the challenges we have outlined above and are of limited value in determining policy priorities. In particular, they are limited in the following respects.
- 2.16 The studies can only include harms that are quantifiable or for which proxies can be developed. As a consequence, they tend to be dominated by costs such as criminal justice costs, health care costs, and loss of productivity, with intangible harms only included if they can be readily converted into monetary terms. Intangible harms like pain, emotional suffering, fear of violence, and the impact on relationships of harmful drug use tend not to be included.<sup>47</sup> The studies can therefore only give an incomplete picture of drug-related harm.
- 2.17 The studies do not measure the benefits of drug use, including the enjoyment experienced by drug users and the social cohesion and bonding that some social forms of drug use may facilitate. These types of benefits are again intangible and difficult, if not impossible, to quantify.<sup>48</sup>
- 2.18 Some costs included in the studies are more accurately attributed to choices in drug policy settings (such as prohibition), rather than drug use itself. Consequently, the studies provide a misleading assessment of drug-related harm, or an assessment that essentially reflects the cost to the State of its drug policies, rather than the harm associated with drug use per se. Inclusion of such drug policy costs as a measure of drug-related harm can lead to a perverse result where drug-related harm decreases as government investment in drug policy decreases.

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

46 Home Office *Measuring the Harm from Illegal Drugs using the Drug Harm Index* (United Kingdom, 2005).

47 For example, the United Kingdom index does not include impact of illegal drug use on unemployment, educational attainment, financial stability, homelessness, productivity, absenteeism and social care. The developers of the United Kingdom index acknowledge that some relevant harms were excluded due to lack of data. See Home Office, *ibid*, 3.

48 We note in this respect that in BERL's estimate of the social costs of harmful alcohol and other drug use in 2005/06, it was assumed that 50 % of alcohol consumption was harmful, and all consumption of other drugs was harmful – see BERL, above n 42, 40.

- 2.19 In some cases, there will only be a tenuous causal connection between a particular harm and drug use. For example, a reduction in health care costs may relate more to unrelated advances in treatment and health care services, than a reduction in the actual health-related harm caused by drug use.<sup>49</sup> It is debatable whether this type of reduction in costs should be used to indicate a reduction in drug-related harm. More generally, it may be difficult to attribute a particular harm to drug use. For example, while few would dispute that drug-related harm should include the impact of a mental illness that has been exacerbated by drug use, only the impact that is directly attributable to drug use should ideally be counted as a drug-related harm.<sup>50</sup>
- 2.20 Despite increasing recognition that drug harm differs across different drugs, some studies do not take a drug-specific approach. This also has the potential to create a misleading impression of drug-related harm and may decrease the uses to which these studies can be put.<sup>51</sup>
- 2.21 We are therefore sceptical of the value of overarching attempts to describe and quantify the costs of all drug use. We think that it is more helpful, at least for our purposes, to present a more specific and detailed picture of harms by reference to particular drugs. In the discussion that follows, we do so by way of example in respect of the two drugs that tend to pre-occupy the public debate in New Zealand – methamphetamine and cannabis. In doing so, we make a clear distinction between the harms arising from the use and supply of the two drugs, and the harms arising from their prohibition.

## CANNABIS-RELATED HARM

### Cannabis and how it is used<sup>52</sup>

- 2.22 Cannabis comes from the plant *Cannabis sativa*. There are three main forms of cannabis: marijuana (the dried flowering tops and leaves of the plant); hashish (dried cannabis resin and the compressed flowers); and hash oil (an oil-based extract of hashish). Cannabis' primary psychoactive ingredient is THC (delta-9 tetrahydrocannabinol). The THC content can vary considerably and depends on how and where cannabis is grown, its genetic characteristics, and the part of the plant that is used. For example, THC concentration is highest in the flowering tops of the female plants, and hydroponically-grown marijuana tends to have a much higher THC content than outdoor-grown marijuana. There is some concern that the THC content has increased in recent years as growing methods

49 Marcus Roberts, Dave Bewley-Taylor, and Mike Trace *Measuring Drug Policy Outcomes: The Measurement of Drug-Related Crime* (Report 9, Beckley Foundation Drug Policy Programme, Beckley (UK), 2006) 5 cite a 2002 US study showing a reduction in the cost of caring for HIV/AIDS patients who had contracted the disease through intravenous drug use. However, the reduction in cost was due to the emergence of new treatments for HIV/AIDS and not changes/developments in drug policies.

50 Roberts, Bewley-Taylor and Trace, *ibid*, 6.

51 The approach taken to the New Zealand Drug Harm Index, which reports separately on cannabis, opioids, stimulants and LSD, is preferable. However, even more disaggregation by drug type seems required. For example, the "stimulant" category in the New Zealand index includes cocaine, amphetamine, methamphetamine, and ecstasy even though available evidence indicates that the harm caused by these four drugs differs markedly.

52 Unless otherwise stated, the discussion in the following two paragraphs draws on Wayne Hall and Rosalie Liccardo Pacula *Cannabis Use and Dependence: Public Health and Public Policy* (Cambridge University Press, Cambridge (UK), 2003) 13–17 and Robin Room and others *The Global Cannabis Commission Report – Cannabis Policy: Moving Beyond Stalemate* (The Beckley Foundation Global Cannabis Commission, Beckley (UK), September 2008) 16–17 [Global Cannabis Commission Report].

have become more refined.<sup>53</sup> Concerns about the increased potency of cannabis relate in part to the relative balance between THC and cannabidiol (CBD), which is a non-psychoactive substance found in most cannabis products that moderates the THC effect.<sup>54</sup>

- 2.23 Cannabis is usually smoked in a cigarette or a “reefer”, or through a water pipe or bong. It can also be “spotted”, taken via a vapouriser, or eaten. Smoking cannabis is the fastest way to absorb THC and to achieve a cannabis “high”, with THC entering the bloodstream within minutes. That high is short-lived, typically lasting between one and two hours. However, when used repeatedly, cannabis can be detected in the bloodstream for several days after use.
- 2.24 Cannabis is the most widely-researched illicit drug in the world. There is a significant amount of evidence about cannabis-related harm, although debate continues about aspects of its effect. A summary of the latest research follows.

## Health harms

### *Immediate effects of use*

- 2.25 The short-term or immediate effects of using cannabis include euphoria and relaxation, a loss of inhibition, altered perceptions, a heightened sense of sound and vision, and impairment of short-term memory and attention, motor skills, reaction time, and skilled activities. These effects tend to be expected, even sought after. However, some users experience more adverse short-term effects including anxiety, panic, and depression.<sup>55</sup>
- 2.26 Cannabis increases the heart rate, but not in a particularly harmful way unless the user has a pre-existing heart condition.<sup>56</sup> The effect of cannabis use on the heart and blood vessels is similar to the effects of moderate exercise.<sup>57</sup>
- 2.27 Cannabis use has a much lower risk of fatal overdose or other life-threatening conditions than many other psychoactive drugs. It has been estimated that a lethal dose of cannabis is in the range of 15 grams to 70 grams, which is many times greater than what even heavy users would consume in a day.<sup>58</sup>

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53 See Global Cannabis Commission Report, above n 52, 50.

54 Ibid, 51.

55 Ibid, 22.

56 Ibid, 37; Advisory Council on the Misuse of Drugs *Cannabis: Classification and Public Health* (Home Office, London, 2008) 9.

57 Advisory Council on the Misuse of Drugs, above n 56, 9.

58 Global Cannabis Commission Report, above n 52, 23. The New Zealand Drug Foundation ([www.nzdf.org.nz/cannabis](http://www.nzdf.org.nz/cannabis)) estimates that a lethal dose is 40,000 times that which is needed to become intoxicated. In total, two human deaths have been reported from cannabis poisoning worldwide. However, it is not clear that those deaths were the result of cannabis.

## Long-term effects of use

- 2.28 The risk of cannabis dependence<sup>59</sup> increases with the frequency and duration of use.<sup>60</sup> Overseas research suggests that approximately 9 % of all those who have ever used cannabis, and one in six of those who begin using cannabis in adolescence, become cannabis dependent.<sup>61</sup> In New Zealand, the Dunedin Multidisciplinary Health and Development Study<sup>62</sup> found that 18.3 % of cannabis users in its cohort were cannabis dependent at age 26.<sup>63</sup> This proportion was similar to that observed for alcohol (17.9 %) but lower than that observed for tobacco (34 %).<sup>64</sup> Both the Dunedin Study and the Christchurch Health and Development Study<sup>65</sup> found similar rates of cannabis dependence amongst their total cohort; at age 21, 9.6 % of the Dunedin cohort<sup>66</sup> and 9 % of the Christchurch cohort<sup>67</sup> were cannabis dependent.<sup>68</sup> Cannabis dependent users were more likely to be male and Māori.<sup>69</sup>
- 2.29 As with smoking tobacco, smoking cannabis can have an adverse effect on respiratory and other functions. Regular cannabis smokers are at increased risk of chronic bronchitis, respiratory infections, and pneumonia when compared to non-smokers. Cannabis may cause emphysema and cancers of the lung and aerodigestive tract.<sup>70</sup> Adults who continue to smoke cannabis into middle age may also be at increased risk of cardiovascular disease.<sup>71</sup>
- 2.30 Regular and long-term cannabis use may lead to some minor impairment in cognitive functioning, including deficits in verbal learning, memory and attention. Debate continues about the extent of these impairments, and whether they can be recovered after cannabis use stops.<sup>72</sup>
- 2.31 There is increasing evidence of a causal relationship between cannabis use and mental health disorders, particularly psychosis and schizophrenia. Research in this area is ongoing. Reaching a firm conclusion is made more complicated by the fact that the onset of schizophrenia usually occurs in the late teens and

59 Dependence is normally characterised by symptoms including an increased tolerance to a drug, withdrawal symptoms, more prolonged and intense use of a drug, and unsuccessful attempts to control use.

60 Hall and Pacula, above n 52, 75.

61 Global Cannabis Commission Report, above n 52, 33. Compared to 32 % for nicotine, 15 % for alcohol, and 11 % for stimulants.

62 This is a longitudinal study of 1037 children born in Dunedin during 1972–73.

63 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. Dependence was assessed as meeting the criteria for cannabis dependence in the DSM-IV.

64 Poulton and others, *ibid*, 545.

65 This is a longitudinal study of 1265 children born in the Christchurch urban region in mid-1977.

66 See Poulton and others, above n 63, 545.

67 David M Fergusson and L John Horwood “Cannabis Use and Dependence in a New Zealand Birth Cohort” (2000) 113 *New Zealand Medical Journal* 156, 157.

68 Poulton and others, above n 63, 545; Fergusson and Horwood, *ibid*, 157.

69 Fergusson and Horwood, *ibid*.

70 Global Cannabis Commission Report, above n 52, 35–37. Cannabis smoke contains many of the same carcinogens as tobacco smoke.

71 *Ibid*, 37.

72 *Ibid*, 39.



early twenties, which is when cannabis use may also be most prevalent.<sup>73</sup> However, it appears that heavy cannabis users are at increased risk of psychotic symptoms and disorders, particularly when the user has an existing history of or susceptibility to those symptoms or disorders, there is a family history of such disorders, or use has begun in the early teens.<sup>74</sup> Cannabis use by those with a mental health disorder may also exacerbate the disorder and make it more difficult to manage.<sup>75</sup>

- 2.32 In addition to the increased risk of psychotic symptoms and disorders, cannabis use in adolescence can lead to a range of other particular harms. These include an increased risk of cannabis dependence and impaired educational achievement.<sup>76</sup> However, apart from the immediate effects of cannabis intoxication on cognitive functioning, it is difficult to identify the extent to which cannabis use affects educational performance in isolation from other contributing factors (for example, friendships with peers who reject school).<sup>77</sup>
- 2.33 Teenagers who use cannabis are more likely than other teenagers to use other illegal drugs. The Christchurch Health and Development Study found that the increasing use of cannabis amongst 14–25 year olds was associated with the increasing use, and abuse of or dependence on other illegal drugs. The association between cannabis use and use of other illegal drugs was strongest for teenagers aged 14–15 who were using cannabis at least weekly, with the strength of this association declining markedly with increasing age and lower levels of use.<sup>78</sup> The reasons for this relationship remain unclear.<sup>79</sup>

### Social harms

- 2.34 The New Zealand Drug Harm Index estimated that the total social cost of cannabis use, excluding the cost to enforce cannabis prohibition, was \$314.3 million in 2005/06 (\$309.6 million tangible costs and \$4.7 million intangible costs).<sup>80</sup> The costs reflected in this estimate include the costs of cannabis-related crime, the resources diverted to drug production from beneficial consumption or investment, health care costs, and the costs of road accidents and lost output.
- 2.35 As discussed earlier in the chapter, there are some problems with relying too heavily on figures such as these. For example, some aspects of cannabis-related social harm are not measured in the Index. These include, for example, the harm that cannabis dependence may cause to a user's relationships with friends,

73 Advisory Council on the Misuse of Drugs, above n 56, 16.

74 Global Cannabis Commission Report, above n 52, 56.

75 Hall and Pacula, above n 52, 97.

76 Global Cannabis Commission Report, above n 52, 56.

77 Ibid, 42.

78 David M Fergusson, Joseph M Boden and L John Horwood "Cannabis Use and Other Illicit Drug Use: Testing the Cannabis Gateway Hypothesis." (2006) 101 *Addiction* 445.

79 A range of reasons have been suggested for the relationship including that the pharmacological effect of cannabis itself increases a user's responsiveness to other drugs, that cannabis users have more opportunity to use other drugs due to social interaction with other drug users and other illegal drug markets, or that cannabis users are more likely to use other drugs for reasons unrelated to their cannabis use. See further discussion in *ibid* and Global Cannabis Commission Report, above n 52, 43–45.

80 BERL, above n 45, 61.

family, and others.<sup>81</sup> In addition, some costs may be included in the Index when they should not. The cannabis-related crime costs, for example, do not distinguish between the costs of crime that is a result of cannabis intoxication from the crime committed to fund a drug habit. The latter is more arguably a cost of prohibition, rather than a cost of cannabis use itself.

- 2.36 Nevertheless, the figures do provide some indication of the extent of social cost that cannabis use causes. Particular aspects of cannabis-related social harm are discussed further below.

## Cannabis use and crime

- 2.37 It is clear from research conducted in New Zealand and overseas that many of those who engage in crime use cannabis, some on a reasonably regular basis. The 2006 New Zealand Arrestee Drug Abuse Monitoring programme (NZ-ADAM),<sup>82</sup> which measures drug and alcohol use amongst those apprehended by police, found that cannabis was the most commonly used illicit drug amongst programme participants.
- 2.38 However, there is little support here or elsewhere for the view that cannabis intoxication itself causes users to commit crime.<sup>83</sup> It is more likely that the same factors predispose people to commit crime and to use cannabis.<sup>84</sup> In New Zealand, NZ-ADAM findings were that only a small proportion of participants who had been using cannabis at the time of their arrest believed that their drug use had contributed to “some” or “all” of the activities which led to that arrest.<sup>85</sup> NZ-ADAM findings also support international research which suggests that cannabis generally inhibits aggression and violence in users.<sup>86</sup>
- 2.39 Lower levels of dependence, a milder withdrawal effect compared to other illicit drugs,<sup>87</sup> and the easier availability and lower cost of cannabis<sup>88</sup> when compared to other illicit drugs suggests that there should also be much less pressure

81 See D M Fergusson and J M Boden “Cannabis Use and Later Life Outcomes” (2008) 103 *Addiction* 969.

82 At four sites (Whangarei, Henderson, Hamilton and Dunedin) in 2005. 2206 detainees were eligible to participate in the survey. Of these 965 met the inclusion criteria and agreed to be interviewed, and 950 completed the entire interview process.

83 Hall and Pacula, above n 52, 236.

84 Stevens, Trace and Bewley-Taylor, above n 39, 1.

85 Jim Hales, Jennie Bowen and Jane Manser *NZ-ADAM: Annual Report 2006 (prepared for NZ Police, Health Outcomes International, Adelaide, 2006)* 28 [NZ-ADAM], 46. 193 participants (21 %) reported that they had been using cannabis at the time of their arrest. Of those, 25 % believed that their drug use had contributed between “some” and “all” to the activities which led to their arrest. In comparison, 355 participants (37 %) reported using alcohol at the time of their arrest and 69 % believed that alcohol use had contributed all, a lot, or some to their arrest.

86 Hall and Pacula, above n 52, 236. 67.8 % of NZ-ADAM cannabis users considered that using cannabis made them less or much less likely to get angry, with 30.1 % of the view that cannabis use had no effect on their likelihood to get angry – NZ-ADAM, above n 85, 41.

87 David Ryder, Noni Walker and Alison Salmon *Drug Use and Drug-Related Harm: A Delicate Balance* (2<sup>nd</sup> ed, IP Communications, Melbourne, 2006) 192.

88 A “tinny”, which typically contains enough cannabis for about three cigarettes or joints costs between \$15 and \$30 in NZ – See New Zealand National Drug Intelligence Bureau ‘*New Cannabis*’: *The Cornerstone of Illicit Drug Harm in New Zealand, 2007 Strategic Assessment* (New Zealand Police, Wellington, 2007) 52. See also Chris Wilkins and others “Estimating the Dollar Value of the Illicit Market for Cannabis in New Zealand” (2005) 24 *Drug and Alcohol Review* 227, 232 estimating that 50 % of cannabis users spend a median amount of \$100 per year on cannabis.

on cannabis users to commit crime to finance their cannabis habit. In addition, cannabis, more than any other illicit drug, appears to be acquired within social networks rather than through private purchases.<sup>89</sup> A United Kingdom report concluded that cannabis use did not appear to be a substantial cause of acquisitive crime.<sup>90</sup> However, studies in Australia and the United States have found a possible link between cannabis use and acquisitive property crime amongst young offenders.<sup>91</sup> Therefore, overseas research suggests that while adult cannabis users may generally not commit crime to fund their cannabis use, younger cannabis users may do so.

### Public health harms

- 2.40 There is increasing concern about the effect of cannabis use on motor vehicle accidents. Research suggests that cannabis use increases the risk of accident by two to three times.<sup>92</sup> This risk is much lower than the risk of accident after alcohol use;<sup>93</sup> cannabis-intoxicated drivers tend to drive more slowly and take fewer risks than alcohol-intoxicated drivers.<sup>94</sup> There may be a higher risk of accident from the combined use of cannabis and alcohol than from either drug used on its own.<sup>95</sup> The effect of cannabis use on accident risk is particularly significant given that young people are both high users of cannabis and have a greater accident risk generally.<sup>96</sup> A New Zealand study found that 41 % of cannabis users reported driving while under the influence of cannabis.<sup>97</sup>
- 2.41 Women who smoke cannabis while pregnant increase their risk of giving birth to a low birth weight baby.<sup>98</sup> However, the effect on birth weight from cannabis smoking during pregnancy appears less than the effect of tobacco smoking.<sup>99</sup> There is continuing debate about whether using cannabis during pregnancy causes any other harms, for example, birth abnormalities, childhood cancers, or developmental difficulties,<sup>100</sup> as well as the impact of cannabis use on fertility.<sup>101</sup>

89 Global Cannabis Commission Report, above n 52, 74. In one New Zealand study, 21 % of cannabis users reported buying most or all of their cannabis and 62 % of users received most or all of their cannabis for free. See Wilkins and others, above n 88, 229.

90 Advisory Council on the Misuse of Drugs, above n 56, 31.

91 Hall and Pacula, above n 52, 238.

92 Global Cannabis Commission Report, above n 52, 26.

93 However, see New Zealand Drug Foundation "Drug Driving in New Zealand: A Survey of Community Attitudes, Experience and Understanding" <http://www.nzdf.org.nz/report/drugs-and-driving> (accessed 16 December 2009) which suggests that drivers may be more likely to drive after using cannabis than alcohol.

94 Global Cannabis Commission Report, above n 52, 24.

95 Ibid, 26.

96 Ibid.

97 Chris Wilkins and others *Drug Use in New Zealand: National Surveys Comparison 1998 & 2001* (Alcohol and Public Health Research Unit, Auckland, 2002) 34.

98 Global Cannabis Commission Report, above n 52, 56.

99 Ibid, 29.

100 Ibid, 29–31.

101 Ibid, 28.



## Costs of cannabis prohibition

- 2.42 Cannabis prohibition imposes substantial costs. In particular, a significant amount of resource in the criminal justice system is dedicated to enforcing cannabis prohibition. The New Zealand Drug Harm Index estimated that cannabis enforcement costs comprised 38 % of all illegal drug enforcement costs in 2005/06 (\$116.2 million of a total \$303 million).<sup>102</sup> Over the same period, it estimated that police spent 333,684 hours dedicated to cannabis enforcement (of a total 598,000 hours dedicated to illicit drug enforcement).<sup>103</sup> Criminal justice statistics indicate that of the 12,542 convictions for drug offences in 2008, 9504 (76 %) related to cannabis offending, with 4596 (37 %) of those relating to cannabis use.<sup>104</sup>
- 2.43 In addition to the cost to the State of enforcing cannabis prohibition, a conviction for a cannabis-related offence has consequences for the individual over and above the fact of the conviction itself. These consequences may include difficulties in obtaining employment or accommodation or travelling overseas. Where the conviction relates to relatively minor offending, for example, possession of a small amount of cannabis for personal use, these consequences may be disproportionate to the harm that offending caused.
- 2.44 New Zealand's cannabis black market was estimated to have a dollar value of \$190 million in 2001.<sup>105</sup> There is some evidence of organised crime involvement in this black market,<sup>106</sup> with the Mongrel Mob identified as having the greatest involvement of all organised crime groups.<sup>107</sup> However, it is important not to over-state the associated criminality of the cannabis black market. The significant proportion of users who do not purchase their cannabis is likely to influence the extent of criminality.<sup>108</sup> In addition, although 30 % of NZ-ADAM participants considered that the cannabis market was very or fairly risky or violent,<sup>109</sup> the cannabis market was also perceived to be less violent or risky than the other drug markets covered (amphetamines, ecstasy, and heroin).<sup>110</sup> Overseas research tends to confirm that violence tends not to be a common problem in cannabis black markets.<sup>111</sup>

102 BERL, above n 45, 62.

103 Ibid, 26.

104 A further 7767 drug charges were prosecuted and resulted in an outcome other than conviction; 1898 of these related to cannabis offending.

105 Wilkins and others, above n 88, 232.

106 New Zealand Drug Intelligence Bureau, above n 88, 70–72. Of 1075 seizure incidents in 2006 in which 25,582 cannabis plants were seized, 68 incidents involving 6585 plants had confirmed or suspected links to organised crime. Of the 3545 seizure incidents involving cannabis heads or leaf in 2006 in which 674,944 kilograms of cannabis were seized, 80 seizure incidents involving 68,900 kilograms of cannabis had confirmed or suspected links to organised crime.

107 Ibid. The Mongrel Mob had confirmed or suspected links to 24 seizure incidents involving 2422 cannabis plants and to 29 seizure incidents involving 10,434 kilograms of cannabis head or leaf.

108 Wilkins and others, above n 88, 229.

109 NZ-ADAM, above n 85, 57.

110 NZ-ADAM, above n 85, 57. Compared to 69 % for amphetamines, 35 % for ecstasy, and 46 % for heroin.

111 Hall and Pacula, above n 52, 239.

- 2.45 Cannabis prohibition may also prevent the delivery of effective drug education. The Health Select Committee, in its 1998 inquiry into the mental health effects of cannabis, concluded that:

...the double standard which sometimes surrounds the cannabis issue [acts] as an impediment to effective anti-drug education. Attempts by users of legal drugs to deter the use of illegal drugs often affect the credibility of the message. The younger generation perceive a double standard in the social acceptance of alcohol and tobacco despite their obvious negative health and social repercussions, while cannabis is clearly prohibited and its harms are less apparent.<sup>112</sup>

- 2.46 Finally, cannabis prohibition has arguably inhibited the development and use of cannabis for medicinal purposes. Although there is increasing interest in New Zealand and elsewhere in the medicinal use of cannabis, its illegal status makes it difficult to access the drug for medicinal purposes, leaves medicinal cannabis users vulnerable to criminal sanction, creates disincentives for pharmaceutical companies, and inhibits medical research. Debate about allowing the medicinal use of cannabis tends to get caught up in the debate about allowing use of cannabis more generally. The medicinal use of cannabis is a matter that we return to in chapter 13.

#### METH- AMPHETAMINE- RELATED HARM

#### Methamphetamine and how it is used

- 2.47 Methamphetamine is a synthetic psychostimulant drug. There are several forms of methamphetamine: powder or speed (typically of a low purity); pure (“P”) or base (locally manufactured with a higher purity than powder); ice or crystal meth (a high purity imported form of methamphetamine); and pills (containing a small amount of methamphetamine which is often combined with ketamine). Although imported crystal methamphetamine is often thought to be more potent than locally manufactured methamphetamine, recent analysis suggests there is little difference in purity between the two.<sup>113</sup>
- 2.48 Methamphetamine can be taken intranasally (snorted), taken orally, smoked, or injected. Injecting or smoking methamphetamine has a faster onset and stronger effect than other modes of administration.<sup>114</sup> The rate of injecting methamphetamine is low in New Zealand, although it may now be becoming a more popular method. Methamphetamine’s effects can last for several hours for speed, and up to 24 hours for crystal methamphetamine.<sup>115</sup>

112 Health Committee “Inquiry into the Mental Health Effects of Cannabis” [2003] AJHR I 6C, 39.

113 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 (IDMS)* (Centre for Social and Health Outcomes Research and Evaluation, Massey University, Auckland, 2009) 59 [IDMS].

114 The Expert Advisory Committee on Drugs (EACD) *Advice to the Minister on: Methamphetamine* (2002) 8 [EACD Report]. See also McKetin and others “Characteristics and Harms Associated with Injecting versus Smoking Methamphetamine Treatment Entrants” (2008) 27 Drug and Alcohol Review 277.

115 F Castro and others “Cocaine and Methamphetamine Differential Addiction Rates” (2000) 14 Psychology of Addictive Behaviours 390, cited in EACD Report, above n 114, 8.

- 2.49 In comparison to cannabis, methamphetamine is a relatively new drug on the illegal drugs market, only coming to prominence in New Zealand in the late 1990s.<sup>116</sup> Evidence about its related harms is therefore less available and more contested. A summary of the available evidence follows.

## Health harms

### *Immediate effects of use*

- 2.50 The short-term effects of using methamphetamine can include euphoria, increased activity and energy levels, disinhibition, a sense of well-being, increased confidence, decreased appetite, and agitation.<sup>117</sup> New Zealand's Illicit Drug Monitoring System (IDMS) for 2008, which reported on frequent drug use and its related harms, found that frequent methamphetamine users also reported experiencing insomnia (85 %), blurred vision (56 %), and chest pains (33 %).<sup>118</sup>
- 2.51 There are no known deaths due to methamphetamine overdose in New Zealand. However, large doses can cause potentially life-threatening conditions, such as hyperthermia, renal and liver failure, cardiac arrhythmias, heart attacks, cerebrovascular haemorrhages, strokes and seizures.<sup>119</sup> Toxic reactions can occur irrespective of "dose, frequency of use or route of administration, and have been reported with small amounts and on the first occasion of use".<sup>120</sup>

### *Long-term effects of use*

- 2.52 Methamphetamine use can cause a number of psychological harms. The 2008 IDMS found that the most common psychological problems reported by frequent methamphetamine users in New Zealand from their methamphetamine use were short temper (72 %), strange thoughts (70 %), anxiety (62 %), and paranoia (45 %).<sup>121</sup> Long-term users of methamphetamine may also experience a number of psychotic symptoms including paranoia, auditory hallucinations, mood disturbances and delusions.<sup>122</sup> These symptoms can last from hours up to days,<sup>123</sup> with those who have pre-existing psychotic disorders at greater risk of experiencing them.<sup>124</sup> Methamphetamine can also cause depressive symptoms, suicidal thoughts, and anxiety disorders.<sup>125</sup>

116 See chapter 1.

117 EACD Report, above n 114, 8.

118 IDMS, above n 113, 139.

119 Irina N Krasnova and Jean Lud Cadet "Methamphetamine Toxicity and Messengers of Death" (2009) 60 Brain Research Reviews 379, 380. See also EACD Report, above n 114, 9 and 10 and Shane Darke and others "Major Physical and Psychological Harms of Methamphetamine Use" (2008) 27 Drug and Alcohol Review 253, 255.

120 Darke and others, above n 119, 255.

121 IDMS, above n 113, 141.

122 EACD Report, above n 114, 9; see also Darke and others, above n 119, 257 and Christopher C Cruickshank and Kyle R Dyer "A Review of the Clinical Pharmacology of Methamphetamine" (2009) 104 Addiction 1085, 1091.

123 Darke, above n 119, 257; EACD Report, above n 114, 9.

124 Darke, above n 119, 257.

125 Ibid, 257.

- 2.53 Frequent methamphetamine users may be at increased risk of adverse impacts to their physical health, including respiratory problems, stroke, irregular heartbeat, extreme anorexia, and neurotoxicity.<sup>126</sup> Cardiovascular health may also be affected.<sup>127</sup> There is evidence that methamphetamine use causes changes to the brain,<sup>128</sup> and this may impair cognitive functioning.<sup>129</sup> In addition, methamphetamine use may often lead to teeth and skin problems.<sup>130</sup>
- 2.54 In New Zealand, the 2008 IDMS classified 63 % of frequent methamphetamine users as methamphetamine dependent.<sup>131</sup> There is evidence to suggest that methamphetamine dependence has a faster progression than dependence on other stimulants such as cocaine.<sup>132</sup> Users withdrawing from methamphetamine may experience fatigue, lethargy, sleep disturbances, appetite disturbances, depressed mood, irritability, psychomotor retardation or agitation, and strong cravings for the drug.<sup>133</sup> Heavy users of methamphetamine typically use the drug on extended binges. This lasts for several days and is followed by a “crash” which amplifies the effects of withdrawal.
- 2.55 There is evidence that methamphetamine users are at increased risk of transmission of communicable diseases. Injecting users who share needles are at a high risk of HIV/AIDS, and hepatitis B and C.<sup>134</sup> Methamphetamine has also been found to increase sexual arousal and this can lead to risky sexual behaviour and disease transmission.<sup>135</sup>

### Social harms

- 2.56 The New Zealand Drug Harm Index estimated that the total social cost of stimulant use, excluding the cost to enforce stimulant prohibition, was \$400.2 million in 2005/06 (\$392.8 million tangible costs and \$7.4 million intangible costs).<sup>136</sup> However, the Index does not distinguish the cost of methamphetamine from the cost of other stimulants such as cocaine, amphetamine and ecstasy. This affects

126 EACD Report, above n 114, 9.

127 Darke, above n 119, 255 and Cruickshank and Dyer, above n 122, 1091.

128 Krasanova and Cadet, above n 119; Linda Chang and others “Structural and Metabolic Brain Changes in the Stratum Associated with Methamphetamine Abuse” (2007) 102 *Addiction* 16.

129 Darke, above n 119, 259.

130 IDMS, above n 113, 139.

131 *Ibid*, 155.

132 Castro and others, above n 115; A Kalechstein and others “Psychiatric Comorbidity of Methamphetamine Dependence in a Forensic Sample” (2000) 12 *Journal of Neuropsychiatry Clinical Neuroscience* 480 cited in EACD report, above n 114, 11.

133 Darke, above n 119, 256.

134 EACD Report, above n 114, 12 and Darke, above n 119, 256.

135 *Ibid*.

136 BERL, above n 45, 61.

the usefulness of its findings. For example, ecstasy is generally considered to cause less harm than methamphetamine,<sup>137</sup> and cocaine is not prevalent in New Zealand.<sup>138</sup>

- 2.57 Methamphetamine use may impact negatively on many aspects of the user's life, which in turn may have a negative effect on others. For example, in the 2008 IDMS, frequent methamphetamine users reported that their drug use had harmed their financial position (76 %), their health (71 %), and their relationships and social life (61 %). Frequent methamphetamine users also reported involvement in a range of drug-related harmful incidents including losing their temper (67 %), arguing with others (63 %), doing something under the influence of drugs that they later regretted (55 %), reduced work/study performance (55 %), or having unprotected sex (50 %).<sup>139</sup>

### *Methamphetamine and crime*

- 2.58 In 2006, the New Zealand Arrestee Drug Monitoring (NZ-ADAM) programme found that methamphetamine was the second most commonly detected illicit drug after cannabis amongst programme participants.<sup>140</sup> 62 % of methamphetamine users reported that their use of methamphetamine had contributed to some extent to their current criminal activity, with 47 % saying it had contributed "all/a lot" and 15 % saying it had "some" contribution.<sup>141</sup>
- 2.59 Of particular public concern is the perceived link between methamphetamine intoxication and violent crime. There is some evidence to support the assertion that violent behaviour is common among methamphetamine users.<sup>142</sup> In New Zealand, NZ-ADAM identified that methamphetamine was the most likely of all drugs covered to increase users' likelihood of getting angry.<sup>143</sup> The 2008 IDMS also identified a high likelihood that methamphetamine use would lead to a short temper.<sup>144</sup>

137 For example, see Expert Advisory Committee on Drugs *Advice to the Minister on: 3, 4 Methylenedioxymethamphetamine (MDMA)* (prepared for the Associate Minister of Health, 2004), which suggests that the public health risks of ecstasy are relatively low and the risk of dependence is not high, paras 33 and 53. See also IDMS report, above n 113, where the results regarding methamphetamine and ecstasy are compared.

138 For example, in the 2008 IDMS only 8 % of respondents felt confident to comment on the price, purity and availability of cocaine. This compares to 50 % of the respondents who commented on the price, purity and availability of methamphetamine and 49 % who commented on ecstasy. IDMS, above n 113, 44, 72, and 119.

139 Ibid, 146–147.

140 NZ-ADAM, above n 85, 28. 12 % tested positive to methamphetamine. See page 23 – 23 % of participants reported using methamphetamine in the last 30 days and 9 % in the last 48 hours. See also page 35 – 34 % of participants had used methamphetamine on 11 or more days out of the last 30 days, with 18.1 % using it on 20 or more days.

141 Ibid, 46–7.

142 See Darke, above n 119, 258.

143 Ibid, 41. 33.2 % of methamphetamine users said using methamphetamine was more or much more likely to make them get angry, followed by alcohol (30.1 %) and amphetamines (29.9 %).

144 IDMS, above n 113, 142. 72 % of frequent methamphetamine users reported that using methamphetamine gave them a short temper.



- 2.60 According to a 2006 New South Wales study, a connection between methamphetamine use and violent crime is plausible because:<sup>145</sup>
- experimental evidence has shown that methamphetamine may exacerbate hostility in individuals predisposed to violence and increase aggression; and
  - methamphetamine increases the risk of psychosis and people suffering from psychosis are more likely than the general population to behave violently.
- 2.61 However, it is unclear whether the violence is due to the effects of methamphetamine itself or can be attributed to other factors that relate to methamphetamine use. These factors include, for example, the violence inherent in the drug market, polydrug use, or the predisposing personality of the methamphetamine user.<sup>146</sup>
- 2.62 There is also some evidence that methamphetamine users commit property crimes to fund their drug habit. In the 2008 IDMS study, frequent methamphetamine users mostly paid for their drugs through gifts from friends, paid employment, unemployment/social welfare benefits, and selling drugs for cash profit.<sup>147</sup> However, 23 % admitted to acquiring drugs through property crime and, for 6 % of users, this was the main way that drugs were acquired.<sup>148</sup>

### Methamphetamine manufacture

- 2.63 The manufacture of methamphetamine brings with it particular and serious social harms. These harms include risks to public health, as well as the costs associated with the clean-up and decontamination of methamphetamine laboratories or “clan labs”.
- 2.64 The chemicals used to manufacture methamphetamine are generally highly flammable, corrosive, and explosive.<sup>149</sup> The risk of explosion, chemical burns or poisoning is high. This creates a dangerous situation for those involved in the manufacturing process, others living in or near the clan lab (including children), law enforcement officials, emergency service personnel, and medical practitioners treating those exposed to toxic chemicals.
- 2.65 The building that contained the clan lab can be contaminated by the gases and chemicals used for some time after the completion of the manufacturing process, creating risks for future residents and costs for property owners.<sup>150</sup> The soil and water table can also be contaminated by the manufacturing process.<sup>151</sup>

145 Rebecca McKetin and others “The Relationship between Methamphetamine Use and Violent Behaviour” (2006) 97 Crime and Justice Bulletin 10. Cited in Darke, above n 119, 258–259. A later study found no evidence that being charged with an amphetamine offence increased the later risk of being charged with a violent offence: Nadine Smith and Laura Rodwell “Does Receiving an Amphetamine Charge Increase the Likelihood of a Future Violent Charge?” (2009) 126 Crime and Justice Bulletin 7.

146 Ibid, 10.

147 IDMS, above n 113, 216.

148 Ibid, 221.

149 EACD Report, above n 114, 13.

150 EACD Report, above n 114, 14. See also *Housing New Zealand Corporation v Tareha & Ors* (7 April 2009) DC NP CIV 2006-085-000963, in which Housing New Zealand took civil action against past tenants and associates to recover the costs of demolishing a house that had been contaminated by methamphetamine manufacture.

151 EACD Report, above n 114, 14.

### Other public health harms

- 2.66 The NZ-ADAM programme found that 18.4 % of methamphetamine users reported doing all or most of their driving under the influence of methamphetamine.<sup>152</sup> The 2008 IDMS also found that 90 % of frequent methamphetamine users had driven under the influence of a drug other than alcohol in the past six months.<sup>153</sup> Research on the effect of methamphetamine use on driving is mixed.<sup>154</sup> However, high proportions of frequent methamphetamine users reported risky driving behaviour while under the influence of drugs, including driving too fast, losing their temper at another driver, losing concentration, or nearly hitting something.<sup>155</sup>
- 2.67 The effects of using methamphetamine while pregnant are unclear; however, it has been suggested that children who are exposed to methamphetamine prenatally are likely to be adversely developmentally affected.<sup>156</sup> There may also be a risk of prenatal complications.<sup>157</sup>

### Costs of methamphetamine prohibition

- 2.68 Along with cannabis, enforcement of methamphetamine prohibition appears to make up the bulk of prohibition enforcement costs in New Zealand. The New Zealand Drug Harm Index estimates that stimulant enforcement costs<sup>158</sup> comprised 48 % of all illegal drug enforcement costs in 2005/06 (145.5 million of a total \$303 million).<sup>159</sup> Over the same period, it estimated that police spent 257,140 hours on stimulant enforcement (of a total 598,000 hours dedicated to illicit drug enforcement).<sup>160</sup>
- 2.69 Methamphetamine prohibition is likely to have many of the same consequences for users as cannabis prohibition including, for example, the consequences of a conviction on their ability to find employment or accommodation, or to travel. These consequences may be exacerbated for methamphetamine users due to the greater social stigma that is attached to methamphetamine use as compared to cannabis use. A particular cost of methamphetamine prohibition is likely to be the barrier it presents to methamphetamine users accessing drug treatment.

152 NZ-ADAM, above n 85, 42.

153 IDMS, above n 113, 192. Frequent methamphetamine users most commonly drove under the influence of cannabis, methamphetamine, methadone, ecstasy, and crystal methamphetamine.

154 New Zealand Drug Foundation, above n 93, 51.

155 Ibid, 199. Note that these findings cannot be entirely attributed to methamphetamine use; although the drivers were frequent methamphetamine users, they were not necessarily under the effect of methamphetamine when the risky behaviour occurred.

156 Trecia Woulds and others “Maternal Methamphetamine Use During Pregnancy and Child Outcome: What Do We Know?” (2004) 117 Journal of the New Zealand Medical Association 1206.

157 See Cruickshank and Dyer, above n 122, 1093.

158 Includes costs to the New Zealand Customs Service and the New Zealand Police, court costs, the cost of sentences imposed – see BERL, above n 45, 62.

159 Ibid.

160 Ibid, 26.

In the 2008 IDMS, almost a quarter of frequent drug users identified fear of the police as a reason for not finding help for their drug use.<sup>161</sup> 22 % of the frequent methamphetamine users had sought but not received help for their drug use.<sup>162</sup>

- 2.70 Finally, the New Zealand Police have noted that methamphetamine production is strongly linked to organised crime.<sup>163</sup> Other reports have concluded that organised crime, often gangs, controls the methamphetamine market.<sup>164</sup> NZ-ADAM participants identified the amphetamine black market (including methamphetamine) as being more violent or risky than the other drug markets covered (cannabis, ecstasy, and heroin).<sup>165</sup>

## CONCLUSION

- 2.71 The above discussion illustrates the value that a drug-by-drug consideration of harm can have, as opposed to considering drug harm at a more global level. The nature and extent of harm that cannabis and methamphetamine use causes differs substantially. Responses to address those harms must differ accordingly.
- 2.72 The policy and regulatory approach to cannabis, for example, must take account of the fact that most cannabis-related harms are caused when use is regular and long-term; the greatest harm is caused when cannabis use begins in adolescence and continues at least weekly for years during young adulthood.<sup>166</sup> It is clear that cannabis can cause substantial harm to that small group of users. However, studies that attempt to rank the harmfulness of different drugs consistently rank cannabis behind most other illegal drugs, as well as behind alcohol.<sup>167</sup>
- 2.73 In contrast, methamphetamine can cause a range of more serious harms, both at the time of use and over the longer term. However, the effect of methamphetamine use on individuals' tendency to commit violent crime, an issue of significant public concern, remains unresolved. Another concern unique to methamphetamine is the risks involved in its manufacture; there is high potential for this process to cause significant harm to a wide range of members of our community. It is critical to find the most cost-effective policy and regulatory approach to address these harms. This is a matter that we return to throughout the remainder of this issues paper.

<sup>161</sup> IDMS, above n 113, 162.

<sup>162</sup> Ibid, 160.

<sup>163</sup> New Zealand Police *Illicit Drug Strategy to 2010* (New Zealand Police, Wellington, 2008) 7.

<sup>164</sup> EACD Report, above n 114, 15. Ministerial Action Group on Drugs *Methamphetamine Action Plan* (Ministry of Health, Wellington, 2003) 14.

<sup>165</sup> NZ-ADAM, above n 85, 57.

<sup>166</sup> Global Cannabis Commission Report, above n 52, 21.

<sup>167</sup> A useful discussion of some of these studies is included in Global Cannabis Commission Report, above n 52, 52–55.



# Chapter 3

## Drug policy

### SUMMARY

This chapter introduces current drug policy based on the principle of harm minimisation. It considers the different approaches that are taken to harm minimisation and then examines the three pillars of supply control, demand reduction and problem limitation.

**INTRODUCTION** 3.1 The objective of the Law Commission's review is to develop a contemporary legislative framework for regulating drugs that properly supports the Government's drug policy and enhances its effectiveness.

**THE NATIONAL DRUG POLICY** 3.2 The Government's drug policy is contained in the National Drug Policy 2007–2012.<sup>168</sup> A National Drug Policy was first adopted in 1998 to set the overall direction for drug policy in New Zealand. Within the framework provided by the national policy, central and local government agencies and non-government organisations involved in the alcohol and drug sector set their priorities and develop their work programmes. The implicit expectation is that the priorities of all the relevant agencies in the sector are aligned with the National Drug Policy and that their work plans implement strategies and measures that support the policy.

3.3 The National Drug Policy accepts that drug use is primarily a health issue and should therefore be addressed, at least partially, through health-based responses. New Zealand's drug policy is based on the principle of harm minimisation:<sup>169</sup>

The overarching goal of the National Drug Policy is to prevent and reduce the health, social, and economic harms that are linked to tobacco, alcohol, illegal and other drug use.

<sup>168</sup> Ministerial Committee on Drug Policy *National Drug Policy 2007–2012* (Ministry of Health, Wellington, 2007). 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*.

<sup>169</sup> Ibid, 4.

### What is harm minimisation?

- 3.4 Harm minimisation is an approach that is designed to limit the overall harms that result from the consumption of drugs. Strategies that are designed to reduce or eliminate consumption, to provide treatment to users, or to make the conditions under which drugs are consumed safer are therefore a means to an end rather than ends in themselves. The ultimate question to be asked in respect of any drug policy measure is whether it is a cost effective means of minimising harm, however defined.
- 3.5 Putting the issue in these terms is often seen as a thinly disguised attempt to adopt a more liberal approach to drugs, or to legalise them altogether. Indeed, in the international debate on harm minimisation, the concept has too often been seen as a proxy for the legalisation of a particular drug or of drugs in general, and for that reason has been the focal point of competing ideologies in drug control policy. This is unfortunate and illustrates how easily semantics can divert attention from the real issues.
- 3.6 In reality, contemporary harm minimisation policies do not take current levels of drug use for granted and do not simply target current drug users. Supply control measures that are aimed at reducing the overall availability of drugs in the community form part of the broader policies that fall within a harm minimisation framework.<sup>170</sup> So too do demand reduction strategies such as community action, education or treatment,<sup>171</sup> and strategies that minimise the health, social and economic consequences of drug use when it occurs.<sup>172</sup>
- 3.7 The polarisation that the language of harm minimisation has produced is a distraction. Its use in the National Drug Policy does not imply a particular view of the merits or otherwise of prohibition, or when it is an appropriate strategy. It does imply, however, that the choice between strategies should simply be determined by their relative costs and benefits. Moreover, the harm that is eliminated by any strategy needs to be greater than the harm that it imposes.
- 3.8 It is, of course, a difficult task to make these sorts of calculations. As we have discussed in chapter 2, there are significant difficulties with quantifying drug harm. We note, in passing, that some of the literature on quantifying drug harm is quite different from some of the equivalent literature on the costs and benefits of alcohol use and the strategies to regulate it.
- 3.9 Moreover, contrary to the views of some,<sup>173</sup> the task is not value free. Choices have to be made between the types of harms that we are seeking to minimise and the relative weight that should be given to them. Decisions also have to be made about the extent to which it is justifiable to adopt strategies involving regulation or prohibition that remove individual choice. Ultimately these are value judgments that the National Drug Policy does not explicitly address.

170 David Ryder, Noni Walker and Alison Salmon *Drug Use and Drug-Related Harm: A Delicate Balance* (2nd ed, IP Communications Ltd, Melbourne, 2006) 15.

171 Although it is often identified internationally as a demand reduction strategy, treatment is included as a problem limitation measure in the New Zealand Drug Policy.

172 Ryder, Walker and Salmon, above n 170, 12.

173 Ryder, Walker and Salmon, above n 170, 18.

- 3.10 Notwithstanding these difficulties, we are of the view that the objectives underlying the language of harm minimisation are appropriate and that the National Drug Policy should continue to be based upon them. On the other hand, we are not wedded to particular terminology. While we have continued to use the language of harm minimisation in this paper as a matter of convenience, we would be interested in views as to whether some alternative terminology would be preferable and if so what terminology is appropriate.

### THE THREE PILLARS OF DRUG POLICY

- 3.11 Since 1990, when the United Nations launched the decade against drug abuse, it has recommended that member states develop integrated and balanced drug policies that address:<sup>174</sup>

[A]ll aspects of the drug problem, including illicit demand, cultivation of illicit drug crops, trafficking, misuse of the banking system, and treatment and rehabilitation of drug abusers.

- 3.12 In recent years the United Nations Office on Drugs and Crime (UNODC) has again stressed the need for drug policy to achieve a balance between strategies and measures aimed at eliminating drugs and reducing demand through prevention and treatment. The Executive Director of UNODC, Antonio Maria Costa, has suggested that there has been an imbalance in both resourcing and policy priorities between supply control measures and measures aimed at reducing demand and treating drug dependency and addiction.<sup>175</sup> He has argued that the balance should be redressed so that more resources are put into prevention and treatment, as well as research to better understand what makes people vulnerable to addiction. Measures aimed at reducing the adverse health and social consequences of drug use are also necessary.<sup>176</sup> According to Antonio Maria Costa:<sup>177</sup>

What is needed is a comprehensive package of measures to reduce vulnerability, treat the drug illness, and prevent the spread of diseases that precede or accompany drug use, like HIV and hepatitis.

- 3.13 Consistent with the balanced approach proposed by the United Nations, New Zealand's National Drug Policy comprises three groups of strategies, or three "pillars" as they are called in the policy itself.<sup>178</sup> A broad and integrated approach to minimising the harm caused by the consumption of drugs is envisaged under the pillars of:

- supply control – measures that control or limit the availability of drugs;
- demand reduction – measures that seek to limit the use of drugs by individuals, including abstinence; and
- problem limitation – measures that reduce the harm that arises from existing drug use.

174 UNGA Resolution 2 (XVII) (23 February 1990), annex.

175 Antonio Maria Costa "Health: The First Principle of Drug Policy" (18 March 2008) Costas Corner [www.unodc.org](http://www.unodc.org) (accessed 15 December 2009).

176 United Nations Office on Drugs and Crime "Reducing the Adverse Health and Social Consequences of Drug Abuse: A Comprehensive Approach" (22 January 2008) 5.

177 Antonio Maria Costa, above n 175.

178 These are described as the three pillars of the policy. See Ministerial Committee on Drug Policy, above n 168, 3.

- 3.14 The overall aim of the National Drug Policy is to reduce the health, social, and economic harms linked to tobacco, alcohol, illegal, and other drug use by adopting an appropriate balance of strategies and measures that support the three pillars.<sup>179</sup> Although in the section below we outline the range of strategies and measures that are available to support each pillar, some strategies and measures may support more than one pillar. There can also be a degree of tension between strategies that support different pillars.

### Supply controls

- 3.15 Supply controls are aimed at minimising harm by reducing the overall availability of drugs in the community. For legal drugs like alcohol and tobacco, supply controls take the form of restrictions that apply to circumstances under which they can be sold or consumed.<sup>180</sup> For other drugs the objective is to eliminate their supply altogether, so they are prohibited and it is illegal to supply them. Law enforcement activities are undertaken to support the prohibition on supply. In New Zealand, both the police and customs are engaged in law enforcement that disrupts the illegal importation, manufacture, supply and possession of drugs. Drugs are seized and taken out of circulation. Illegal drug cultivation, illegal drug manufacture and importation operations, when discovered, are closed down. Together these activities seek to reduce the amount of various drugs that are available within the community. Supply controls have also over recent years focused on the importation and distribution of precursor substances like pseudoephedrine used in the manufacture of methamphetamine and have targeted clandestine “P” labs.
- 3.16 As a result of police and customs law enforcement activities, significant quantities of some drugs are seized. Between 2000 and 2006, these two agencies collectively seized just over 453,746 kilograms of cannabis compared to 408 kilograms of stimulants and less than 14½ kilograms of opiates.<sup>181</sup> In the Drug Harm Index developed for the New Zealand Police by Business and Economics Research Limited (BERL), it was estimated that drug seizures potentially avoided \$458 million of drug harm in 2006 and \$3.67 billion in total over the seven years from 2000 to 2006 inclusive.<sup>182</sup> But these figures are questionable because they have been derived by multiplying the social cost per kilogram of drugs by the number of kilograms seized by law enforcement. This assumes that seized drugs are not replaced, but no evidence of reduced consumption is provided to support this assumption.<sup>183</sup> If more drugs are produced to replace quantities seized, seizures will have little or no effect on levels of drug harm.

179 Ibid, 4.

180 Similar restrictions would also apply to any drug that was scheduled as a restricted substance under the Misuse of Drugs Amendment Act 2005.

181 Business and Economic Research Limited (BERL) *New Zealand Drug Harm Index* (Report prepared for the New Zealand Police, Wellington, 2008) 63.

182 Ibid, 1.

183 See, for example, Alison Ritter “Where Angels Fear to Tread” (2008) 18 *Matters of Substance*.

- 3.17 In the 2005/06 year, approximately \$134.30 million was spent on law enforcement related to drugs. Police spent \$106.9 million in the 2005/06 financial year on all law enforcement activity related to drugs and drug-related offending.<sup>184</sup> This included all activities undertaken by police to detect drug offences and arrest and process drug offenders, and any other activities undertaken to intercept and disrupt the import, manufacture or supply of drugs. Customs spent approximately \$27.4 million in the 2005/06 financial year on drug enforcement.<sup>185</sup> This included spending on drug detector dog teams, drug investigations units, mail centre interception operations and intelligence targeting.<sup>186</sup>

## Demand reduction

- 3.18 Demand reduction focuses on reducing an individual's desire to use drugs. Demand reduction strategies target current drug users by encouraging them to reduce or stop their drug use and potential drug users by encouraging them not to begin or to delay any use of drugs.<sup>187</sup> Initiatives aimed at preventing or delaying the uptake of drugs or encouraging a reduction in drug use help minimise harm by reducing the overall use of drugs. Demand reduction strategies encompass drug education, health promotion, social marketing, and community action. Taxation and restrictions on sale and advertising might also be used to reduce the demand for drugs.<sup>188</sup>
- 3.19 Complete prohibition may also act as a demand reduction strategy in two ways:
- to the extent that the law acts as a tool to shape social attitudes and culture, prohibition may maintain and reinforce the view that the use of particular drugs is wrong or harmful and should be avoided;
  - prohibition may deter people from using drugs because of the risks associated with engaging in illegal activities (for example, the risk of detection and censure) or with finding and purchasing an illegal substance.
- 3.20 Drug education and drug-related health and lifestyle education programmes form another type of demand reduction strategy. The principal target group for most education programmes is young people. Broader public social marketing and lifestyle campaigns, such as those undertaken by the Alcohol Advisory Council about the way New Zealanders drink, also fall within the broad range of educative initiatives that can be undertaken as a demand reduction measure.
- 3.21 Lifestyle based initiatives that encourage community action and resilience like the Community Action on Youth and Drugs (CAYAD) programme is another demand reduction measure. These are aimed at building resilience through promoting healthy lifestyles and positive activities and addressing some of the underlying reasons why young people engage in harmful patterns of drug use.

184 BERL, above n 181, 61.

185 Customs have advised that this includes a proportionate figure for overheads to reflect the multiple functions preformed by most customs staff.

186 BERL, above n 181, 22.

187 Ryder, Walker and Salmon, above n 170, 101.

188 Ibid, 101.



### Problem limitation

- 3.22 The term “problem limitation” is used in the National Drug Policy to describe strategies and measures that are directed at reducing the harm that results from existing drug use including emergency services and drug treatment as well as harm reduction services that are not aimed at reducing drug use.

### Drug treatment

- 3.23 Treatment may be available to those who are either dependent on drugs or engage in harmful drug use. Such services directly assist and support individuals who wish to stop using drugs or wish to reduce their use of drugs. The provision of drug treatment is considered in New Zealand as a problem limitation strategy, but in the international literature is often discussed as a demand reduction strategy because its aim is to reduce an individual’s demand for drugs.<sup>189</sup>
- 3.24 Drug treatment covers a broad range of interventions and approaches. It may include advisory and information services and other low level interventions, detoxification facilities and services, pharmacotherapies, counselling and psycho-social therapies, community-based treatment programmes, residential treatment programmes, post-treatment care and ongoing social support, and fellowship based self-help programmes. 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.

### Harm reduction

- 3.25 The National Drug Policy states that:<sup>190</sup>
- Some problem limitation interventions do not seek to eliminate or reduce drug use in the short to medium term, but instead aim to reduce the related harm to the individual and community.
- 3.26 There are a wide range of harm reduction strategies and approaches that have developed internationally for reducing harm from existing drug use to the individual and community. Some of these initiatives have been relatively controversial because of the tacit tolerance of ongoing drug use implicit in such measures. Many harm reduction measures are therefore currently aimed primarily at people who are dependent on harmful drugs (such as opiates) that they use intravenously.
- 3.27 There may also be a degree of tension between measures that make ongoing drug use safer and strategies aimed at demand reduction. There is concern in the alcohol and drug treatment field that providing services that reduce the hardship

189 For example the United Nations uses the term “demand reduction” to include all policies (including treatment) that aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse. See The Declaration on the Guiding Principles of Drug Demand Reduction: UNGA Resolution 20/3 (8 September 1998) A/RES/S-20/3.

190 Ministerial Committee on Drug Policy, above n 168, 5.



associated with drug use will delay a user's decision to become abstinent.<sup>191</sup> Moreover, when drug use has been prohibited, special exceptions are normally needed to support or tolerate the degree of drug use that is tacitly acknowledged under most problem limitation measures.

- 3.28 In New Zealand, harm reduction measures currently include needle and syringe exchange programmes and opioid substitution treatment programmes. Needle and syringe exchange programmes were introduced in 1988 following the emergence of the HIV virus and concern over the risk of its spread among intravenous drug users. A reduction in the reuse or sharing of injecting equipment also reduces the risk of other blood borne illnesses (for example, hepatitis) and may also reduce the risk of infections and related complications for intravenous drug users.
- 3.29 The aim of opioid substitution is to significantly reduce the harm associated with opioid dependence by substituting a safer legally provided drug like methadone. Opioid substitution treatment largely eliminates the health risks associated with intravenous drug use, the unpredictability of supply, the variability and risk of adulteration with street drugs, the risks associated with interaction with the illegal drugs market, and also the financial and emotional stresses associated with obtaining illegal opiates.
- 3.30 In a number of overseas jurisdictions harm reduction initiatives also include the provision of supervised injecting facilities for intravenous drug users<sup>192</sup> and limited state provision of heroin to addicts where other opioid substitution treatment is not effective.<sup>193</sup>
- 3.31 Another type of measure that is sometimes canvassed as a harm reduction approach is the provision or sanctioning of drug testing facilities. It is argued that some of the health harm caused to drug users is attributable to accidental overdose or poisoning caused by adulterated drugs. If people were able to have their drugs tested before use, some of this harm could be avoided. In contrast to the other types of harm reduction measures discussed above, the provision of drug testing facilities is an example of a measure aimed at a much broader range of drug users than those with a drug dependency. This type of measure is therefore particularly controversial.

191 Alex Stevens, Christopher Hallam and Mike Trace *Treatment for Dependent Drug Use: A Guide for Policymakers* (R 10, The Beckley Foundation Drug Policy Programme, Beckley (UK), 2006) 4.

192 For example, there are such facilities in some states in Australia now and they are well established in Switzerland.

193 For example, this occurs in the United Kingdom.

# Chapter 4

## The history and development of drug regulation

### SUMMARY

This chapter traces the history of drug regulation in New Zealand and examines the main features of the Misuse of Drugs Act 1975 and subsequent amendments to it. It also identifies some of the problems with the current Act and considers the relationship between the Misuse of Drugs Act and the National Drug Policy. The chapter concludes that the much amended Act has become somewhat outdated and is not well aligned with the harm minimisation objectives of the National Drug Policy or with current knowledge and understanding about drug use. The Act no longer provides an effective or coherent framework for regulating drugs.

**INTRODUCTION** 4.1 Legislation changes over time in response to the emergence of different social and economic issues and problems. In the first part of this chapter, we trace the history of drug regulation in New Zealand and identify the domestic factors and international obligations that led to the Misuse of Drugs Act 1975. In the second part, we examine the key features of the Act, identify some issues with the Act, and consider the relationship between the Misuse of Drugs Act and New Zealand's current drug policy based on the principle of harm minimisation.

**HISTORY OF DRUG REGULATION** 4.2 Drug regulation began in New Zealand with the regulation of opium in the later half of the 19<sup>th</sup> century. Opium was widely available and was used medicinally in Europe and America during the 18<sup>th</sup> and 19<sup>th</sup> centuries. After morphine was first derived from opium in 1803, it too was liberally used as a strong palliative.<sup>194</sup> Similarly heroin, which was synthesized in 1874, was used to treat a broad range of ailments. It was only just before the turn of the 20<sup>th</sup> century that the medical world concluded, after protracted debate, that these drugs were addictive and dangerous.<sup>195</sup>

<sup>194</sup> Margaret P Battin and others *Drugs and Justice: Seeking a Consistent, Coherent, Comprehensive View* (Oxford University Press, New York, 2008) 31.

<sup>195</sup> *Ibid.*

- 4.3 Gold miners, who came to New Zealand from California, are credited with first introducing opium and morphine into New Zealand. Some of these early miners were veterans of the American Civil War and some were addicted to opium or morphine, which had been liberally used to treat wounded soldiers during that war.<sup>196</sup> Opium and morphine, and later heroin, were also used in many of the patented medicines and various tonics that were imported and became increasingly available in New Zealand towards the end of the 19<sup>th</sup> century.<sup>197</sup>

### Early regulation of opium and morphine

- 4.4 Opium was first regulated under the Sale of Poisons Act 1866. Bottles or packets of opium laudanum powder and other poisons covered by the Act had to be “clearly and distinctly” labelled and the word “poison” had to appear on the label.<sup>198</sup> From 1871, vendors of opium had to be registered. They were also required to keep records of their sales.<sup>199</sup> By 1908, poisons legislation covered morphine and mixtures that contained morphine or opium.<sup>200</sup> The approach of early legislation was to regulate rather than prohibit access to these substances.
- 4.5 The Sale of Poisons Act 1908 placed, by current standards, quite minimal restrictions on access to opium<sup>201</sup> and morphine and mixtures and preparations containing these drugs. For example, a person could lawfully purchase approximately 24 grains of opium a week from a licensed vendor without a prescription. With a prescription, he or she could obtain up to 16 fluid ounces a week. There were similarly minimal restrictions on the quantities of other regulated drugs that could be lawfully obtained from registered vendors. Records kept during this time indicate that some people did in fact purchase significant quantities of what are now Class A and B drugs.<sup>202</sup>
- 4.6 Many other drugs that are now prohibited, including heroin, cocaine and other coca derived products, and cannabis, were not regulated at all at this stage of New Zealand’s history. It was not until the 1920s that heroin, cocaine, and cannabis began to be regulated.

196 Veterans who became habituated to opium or morphine suffered from what was euphemistically called “army disease”. See Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report* (New Zealand Board of Health Report Series, No 14, Wellington, 1970) Appendix VIII [Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*].

197 Ibid, Appendix VIII.

198 See Sale of Poisons Act 1866, cl 4.

199 See the Sale of Poisons Act 1871 and later amendments. The Customs Law Consolidation Act 1882 also imposed restrictions on the importation of opium. It is suggested that these had a dual role and were not only intended to protect the revenue but were also designed to restrict the lawful import and distribution of opium. See Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*, above n 196, 15.

200 The Sale of Poisons Act 1908 consolidated earlier legislation and covered opium, laudanum and morphine and any mixtures or medicines containing these.

201 This was subject to the prohibition on any opium prepared for smoking.

202 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*, above n 196, Appendix VIII.

### Prohibition on smoking opium

- 4.7 A different type of measure was introduced by the Opium Prohibition Act 1901.<sup>203</sup> This Act contained New Zealand's first prohibition on drugs. It seems to have been directed primarily at Chinese immigrants. The Government at the time was concerned that the practice of opium smoking by Chinese migrants would spread if it was not banned.<sup>204</sup> The Opium Prohibition Act prohibited the smoking of opium. It also prohibited the importation of opium in a form that was suitable for smoking. Although it did not prohibit other imports of opium, a permit issued by the Minister of Customs was needed before any opium could be imported or exported.
- 4.8 The Opium Prohibition Act discriminated against Chinese. Firstly, they could not obtain permits to import or export any opium at all. Secondly, the Act allowed the police to search premises occupied by Chinese without a warrant if they had reasonable cause to suspect that opium was being smoked in those premises.<sup>205</sup> In contrast, the police had to obtain a search warrant before they could search other premises. After 1910, a Chinese person could not lawfully buy any opium at all without a doctor's prescription or an authority from the Minister of Customs,<sup>206</sup> while other people were still free to purchase opium without these restrictions.

### Early opium conventions and the Opium Act 1908

- 4.9 The development of New Zealand's drug law during the 20<sup>th</sup> century has largely been shaped by international drug conventions. International action aimed at controlling the distribution of opium and later other drugs began with the Shanghai Declaration in 1909 and the first Opium Convention at The Hague in 1912. New Zealand, along with many other countries, acceded to the Opium Convention after the First World War. The Opium Convention required parties to regulate the importation and distribution of opium and certain other drugs. New Zealand had already consolidated earlier legislation relating to opium in the Opium Act 1908, and implemented the Convention by extending the controls in the Opium Act to the importation and distribution of morphine, heroin, codeine and other opium preparations, and cocaine.
- 4.10 Later New Zealand also acceded to the International Convention relating to Opium and Other Dangerous Drugs 1924 and subsequent amending protocols. These required parties to impose controls on the manufacture, importation and exportation, sale and distribution of a growing range of drugs. In 1925, cannabis, which was known then as Indian hemp, was added to the list of drugs which

203 The Act was amended in 1902 and 1906 and later consolidated as the Opium Act 1908.

204 According to the *First Report* of the Committee on Drug Dependency and Drug Abuse in New Zealand the measure was introduced by R J Seddon who was reported in Hansard as stating the intention of the measure in these terms. The report also suggests that smoking opium was principally an issue on the South Island goldfields and in Wellington but was not a widespread problem. See Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*, above n 196, 15.

205 Despite other changes to New Zealand's drug laws, the power to search premises occupied by Chinese people in such circumstances was retained in subsequent drugs legislation through to 1965.

206 Don Mathias *Brookers Misuse of Drugs* (Loose leaf, Brookers, Wellington, 1998) para 005 (last updated 30 November 2007) [www.brookersonline.co.nz](http://www.brookersonline.co.nz) [*Brookers Misuse of Drugs*].

countries adhering to the 1924 Convention agreed to control. Further international agreements and conventions during the subsequent years extended the range of substances that parties were required to control.<sup>207</sup>

## The Dangerous Drugs Act 1927

- 4.11 New Zealand complied with its obligations under the 1924 Convention by enacting the Dangerous Drugs Act 1927. The Dangerous Drugs Act was based on English legislation,<sup>208</sup> and introduced tighter regulatory controls for drugs covered by the Convention. The Minister of Health said when introducing the legislation that there was “no evidence available suggesting any extensive use in New Zealand of narcotic drugs of an addict-forming nature”. However, there was concern over international gangs in Europe and America trafficking in dangerous drugs.<sup>209</sup>
- 4.12 The Dangerous Drugs Act, like the earlier Opium Act, imposed a complete prohibition on all dealing in opium prepared for smoking. The manufacture, sale, possession and use of opium that had been prepared for smoking, and also the smoking of opium, continued to be prohibited. Other dangerous drugs, which were listed in a schedule to the new Act,<sup>210</sup> could be imported and exported with a customs permit, but only by a licensed manufacturer or distributor. Licences were required to manufacture, sell or distribute all dangerous drugs. All licences under the Act were issued by the Director-General of Health. Regulations made under the Act provided that the drugs included in the schedule of dangerous drugs could only be purchased or supplied to the public directly by a doctor or by a registered chemist if they had been prescribed by a doctor. A longer list of psychoactive substances, which included cannabis for the first time, was contained in the schedule of dangerous drugs. Additional psychoactive substances were added to the schedule of the Dangerous Drugs Act during subsequent years to reflect other international agreements and conventions during this period.
- 4.13 It was an offence under the Dangerous Drugs Act for any person who did not hold the necessary licence to import or export any dangerous drug.<sup>211</sup> It was also an offence to produce, manufacture, sell, distribute or otherwise deal in any dangerous drug except under a licence or under some other lawful authority.<sup>212</sup> As required by the Convention, the Act also introduced offences of aiding, abetting, counselling, or procuring the commission of corresponding offences outside New Zealand.
- 4.14 It should be noted here also that many of the drugs regulated under the Dangerous Drugs Act had medical uses and, despite the restrictions, were readily available on prescription. Health records from this period suggest that various drugs covered by the Act were liberally prescribed, particularly once prescriptions

207 These were all later consolidated and replaced by the Single Convention on Narcotic Drugs 1961.

208 *Brookers Misuse of Drugs*, above n 206, para 005.

209 *Ibid.* Quoted from (1927) 212 NZPD 644 and (1927) 212 NZPD 646.

210 New drugs could be added to the schedule of drugs regulated under the Act by Order in Council.

211 Dangerous Drugs Act 1927, s 5.

212 Dangerous Drugs Act 1927, s 9.



were publicly funded after 1941.<sup>213</sup> Heroin was, for example, readily available on prescription in an oral dose form and was used widely in linctuses until the mid-1950s in New Zealand. Regulations made under the Dangerous Drugs Act during the 1940s permitted doctors to prescribe up to 16 oral doses of heroin in one prescription. By the end of the 1940s New Zealand was one of the highest users of heroin per capita in the world.<sup>214</sup>

### Regulation of poisons

- 4.15 Less restrictive controls than those contained in the Dangerous Drugs Act applied to drugs that were not covered by the international conventions. The poisons regime discussed earlier was retained and applied to therapeutic drugs that were not covered by the conventions.<sup>215</sup> Preparations containing morphine and cocaine below the strength specified under the Dangerous Drugs Act regime also fell within the ambit of the Poisons Act 1934. From 1937, the poisons regime included the concept of “prescription poisons”. These were substances that could only be legally obtained on a doctor’s prescription. Barbiturates and lower strength morphine and cocaine preparations were regulated as prescription poisons.
- 4.16 Again health records from this period suggest that liberal prescribing practices were fairly commonplace. For example, doctors wrote prescriptions in broad terms authorising a continuing supply of a prescription poison for an indefinite period of time.<sup>216</sup> Barbiturate use in New Zealand increased markedly during the 1940s.<sup>217</sup> Over time more drugs – for example, amphetamines in 1957 – came to be controlled as prescription poisons.

### The Narcotics Act 1965

- 4.17 In the 1960s the United Nations consolidated and broadened all earlier drug treaties. The Single Convention on Narcotic Drugs 1961 (the 1961 Convention) came into force in 1964 after 40 countries, including New Zealand, acceded to it.<sup>218</sup>

213 From 5 May 1941, the Social Security (Pharmaceutical Benefits) Regulations 1941 provided for the free supply of medicines and drugs on the prescription of any registered medical practitioner. The scheme was carried out by contracts between the Minister of Health and individual chemists who supported their claims with the prescriptions, which had been signed by the patients as evidence of receipt of the medicine. The range of free pharmaceutical requirements was defined in a document known as the “drug tariff”, issued under the hand of the Minister of Health. The tariff imposed limits on the quantities of drugs which, as a charge on the Fund, could be issued on one prescription, and it sets out the prices and fees payable from the Fund to contracting chemists. See A H McLintock (ed) *An Encyclopaedia of New Zealand* (1966) [www.TeAra.govt.nz](http://www.TeAra.govt.nz) (accessed 20 January 2009).

214 The Drug Supervisory Board of the United Nations (the predecessor of the International Narcotics Control Board) asked New Zealand for an explanation of its high level of heroin use and this set in train an investigation and then a campaign to reduce prescribing of heroin. By 1955 prescribing of heroin was virtually eliminated except in hospital practice: Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*, above n 196, 21.

215 The Dangerous Drugs Act 1927 amended the Sale of Poisons Act and removed opium, laudanum, morphine and preparations of these substances from the schedule of poisons.

216 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*, above n 196, Appendix VIII.

217 In 1950, for example, 35 times more barbiturates were consumed than in 1941. See *ibid*.

218 New Zealand ratified the 1961 Convention in 1963.



The Convention, which covered over 100 drugs,<sup>219</sup> was significantly influenced by the prohibitionist approach that was beginning to dominate drug policy in the United States<sup>220</sup> and culminated in President Nixon's formal initiation of America's "War on Drugs" in 1971.<sup>221</sup>

- 4.18 New Zealand implemented the Convention in the Narcotics Act 1965. Despite the term "narcotics",<sup>222</sup> both the Convention and the domestic Act also covered various psychomotor stimulants like cocaine. They also covered cannabis and later covered hallucinogens like LSD, mescaline and peyote.<sup>223</sup>
- 4.19 The Narcotics Act introduced for the first time a distinction between offenders who dealt in narcotics and those who simply possessed or used them. A significantly higher maximum penalty applied to offences involving dealing in narcotics rather than simple possession or use.<sup>224</sup> In support of this, the Act introduced a presumption of possession for the purposes of supply. Where a person was caught in possession of an amount of a scheduled drug that exceeded the specified level, the burden of proof shifted to the accused person to prove that the drugs were for personal use and not for supply to others.<sup>225</sup> If the person could not discharge this burden, he or she could be convicted of the more serious offence of dealing in narcotics. According to the Minister of Police at the time, the original quantities set in the Act were intended to be equivalent to "100 shots or doses" of a drug.<sup>226</sup>
- 4.20 The Narcotics Act also extended the powers of the police to search for drugs. The police could search any premises without a warrant if they suspected the premises contained drugs. They could also search any person within such premises who was suspected of unlawfully possessing a drug covered by the Act.<sup>227</sup> The police power, held since 1901, to search premises occupied by Chinese without a warrant if they had reasonable cause to suspect that opium was being smoked in those premises, was finally repealed by the Narcotics Act.

219 These were divided into four schedules with some differences in the controls that applied to the drugs in the different schedules. This is discussed in chapter 6.

220 Bans were imposed on depressants, stimulants, and any substance with a "hallucinogenic effect on the central nervous system". See Battin, above n 194, 34.

221 Bell Wallace-Wells "How America Lost the War on Drugs" (December 13 2007) 1041 *Rolling Stone Magazine* [www.rollingstone.com](http://www.rollingstone.com) (accessed 7 December 2009).

222 The term "narcotic" in medical contexts is used only for opiates.

223 LSD, mescaline and peyote all came under the Narcotics Act in 1967 by virtue of the Narcotics Order (No 2) 1967 (1967/156).

224 The maximum penalty for dealing in a narcotic was 14 years imprisonment while the maximum penalty for illegal possession or use was up to three months imprisonment and a fine of up to \$400 or both. See Narcotics Act 1965, ss 5 and 6.

225 Narcotics Act 1965, s 5(4).

226 *Brookers Misuse of Drugs*, above n 206, para 005 quoting the Minister of Police from (1965) 344 NZPD 2557.

227 See Narcotics Act 1965, s 12.

### The Poisons Act 1960

- 4.21 Drugs that were not covered by the 1961 Convention continued to be regulated through the poisons regime. The Poisons Act 1960 imposed conditions on the sale and distribution of therapeutic drugs that were not covered by the Narcotics Act. Substances that were classified as prescription poisons under the Poisons Act were only available on prescription.

### The Blake-Palmer Policy Review

- 4.22 In 1968, New Zealand established a Board of Health Committee chaired by the Deputy Director-General of Health, Geoffrey Blake-Palmer, to:<sup>228</sup>

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

The Committee was established to examine the issues and formulate recommendations to address what was perceived as a growing problem with drug abuse and dependence in New Zealand. The 1960s had brought significant changes to patterns of drug use in the West. Recreational drug use had become more widespread during the 1960s with the growth in youth counterculture and the emergence of psychedelic drugs.<sup>229</sup> Originating in the youth movement in the United States, the psychedelic “hippie” counterculture spread to other western countries through the 1960s and 1970s.<sup>230</sup> This counterculture promoted experimentation with cannabis and hallucinogens like LSD, mescaline and peyote to explore alternative states of consciousness.<sup>231</sup> Despite the adoption of strong prohibition policies at both the international and national level, the use of such drugs had increased and became almost synonymous with youth culture, protest and social rebellion.<sup>232</sup>

- 4.23 The Blake-Palmer Committee undertook a comprehensive review of drug policy and law over several years and produced its final report in 1973. The review found that patterns of drug use and abuse in New Zealand generally reflected broader international patterns. There had been an increase in the use, misuse and trafficking of prohibited drugs and other psychotropic substances by the early 1970s.<sup>233</sup> The number of people charged with drug offences in New Zealand had, for example, increased significantly by the early 1970s. Between 1955 and 1963,

228 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*, above n 196, 3.

229 Battin, above n 194, 4.

230 For a history of the hippie movement see Wikipedia [http://en.wikipedia.org/wiki/History\\_of\\_the\\_hippie\\_movement](http://en.wikipedia.org/wiki/History_of_the_hippie_movement) (accessed 19 January 2010).

231 The catch phrase coined by Dr Timothy Leary in 1966 captures this well; “turn on, tune in, drop out”. The phrase is derived from part of Leary’s speech at a press conference in New York on 19 September 1966. “Like every great religion of the past we seek to find the divinity within and to express this revelation in a life of glorification and the worship of God. These ancient goals we define in the metaphor of the present – turn on, tune in, drop out”: See Timothy Leary *Turn On, Tune In, Drop Out* (Berkeley, California, 1999).

232 Battin, above n 194, 4.

233 See Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report* (New Zealand Board of Health Report Series, No 18, Wellington, 1973) 155 [Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report*].

the number of people charged with a drug offence never rose above 40,<sup>234</sup> but, in 1972, 700 people were charged with drug offences.<sup>235</sup> The review found that the type of drugs involved in offending had changed. While most offending during the earlier part of the 20<sup>th</sup> century had involved opium, by the mid-1960s most charges related to cannabis, heroin and the newer psychedelics like LSD. The number of people hospitalised for drug dependence also doubled during the 1960s.<sup>236</sup>

- 4.24 At the international level, the United Nations Convention on Psychotropic Substances 1971 (1971 Convention) was agreed in response to the growth in the production and use of hallucinogens, amphetamines and barbiturates, many of which were not covered by the 1961 Convention.<sup>237</sup> The 1961 Convention was also amended by a protocol in 1972. These changes required New Zealand to make changes to its legislative framework and proposals addressing these obligations were incorporated into the Blake-Palmer Committee's review and report.

### *The Committee's recommendations*

- 4.25 The Committee concluded that a new Act was needed to update and consolidate New Zealand's drug law and implement New Zealand's expanded international obligations under the 1971 Convention.<sup>238</sup> The Committee recommended a single Act to control all drugs and similar substances (other than alcohol and tobacco) that had a significant potential for misuse. It recommended that drugs controlled by the Act should be divided into schedules that broadly indicate their relative potential for harm and the degree of controls deemed necessary.<sup>239</sup> It considered that maximum penalties for offences under the Act should also reflect the relative degree of harm the different classes of drugs had the potential to cause.<sup>240</sup>
- 4.26 The Committee said that full recourse to the criminal law was required for offences of illegal distribution and supply of drugs, but the police should use their discretion in deciding what action to take where people were using rather than dealing in drugs. It considered that an increased use of alternatives to prosecution would be desirable, particularly with younger offenders.<sup>241</sup> The Committee argued that, whether the aim was to protect the individual or society from the harm caused by drug use, "there are kinder and more effective methods than reliance on the criminal law alone to deal with the misuse

234 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*, above n 196, 24.

235 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report*, above n 233, 240.

236 In 1965, 43 people were admitted, but by 1968 this had increased to 110, and there was a slight decrease to 90 in 1969. See Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *First Report*, above n 196, 26.

237 *Brookers Misuse of Drugs*, above n 206, para 005.

238 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report*, above n 233, 37.

239 *Ibid*, 100.

240 *Ibid*, 100.

241 *Ibid*, 52.

of drugs”.<sup>242</sup> The Committee therefore suggested that educational, therapeutic, social and supportive measures were needed to a much greater extent than had previously been the case.

- 4.27 The Committee recommended improving the treatment options and support for those dependent on drugs and argued for high quality community education about the risks of drug abuse and dependence.<sup>243</sup> It stressed that one of the most effective sanctions would always lie in the provision of good, soundly based, unemotive educational programmes within the broader context of healthy living aimed at moderating the overall use of chemical substances.<sup>244</sup>

[A]ttitudes of moderation as a norm in our society would, it is believed, do more to reduce the illicit misuse of drugs than over-reliance on criminal sanctions by themselves.

- 4.28 The Committee’s recommendations that proposed an increased emphasis on prevention and treatment were not matters that necessarily needed legislation. These proposals did not consequently feature in the new Act. The suggestions for the diversion of young offenders and other drug users away from the criminal justice system also did not feature in the new Act.

#### THE MISUSE OF DRUGS ACT 1975

- 4.29 The Misuse of Drugs Act was enacted on 10 October 1975, although it did not come into force until 1 June 1977. The Act implemented the recommendation of the Blake-Palmer Committee for a harm-based classification system for drugs. As proposed by the Committee, the Act also updated and consolidated the law controlling the use and misuse of drugs and addressed New Zealand’s expanded international obligations.<sup>245</sup>

#### Features of the Act

- 4.30 The Act prohibits the manufacture, import or export, supply, possession, or use of a controlled drug unless the activity is expressly authorised by the Act, by regulations, or by a licence issued under the Act. Authorisations in the Act establish a prescribing regime and this, together with a licensing scheme established under the Act, allows many of the drugs controlled by the Act to be used for medical and scientific purposes. These and other key features of the Act are briefly outlined below.

#### *Classification based on harm*

- 4.31 As has been noted, the Blake-Palmer Committee recommended that drugs controlled by the Act be allocated to schedules that broadly reflect their relative potential to cause harm.<sup>246</sup> Accordingly, drugs controlled by the Act have been classified as Class A, B or C and listed in Schedules 1, 2 or 3 respectively. An amendment to the Act in 2000 clarified that substances classified as Class A

<sup>242</sup> Ibid, 49.

<sup>243</sup> Ibid, 89.

<sup>244</sup> Ibid, 52.

<sup>245</sup> See Parliamentary debates from 25 June to 22 July 1975: (25 June – 22 July 1975) 299 NZPD.

<sup>246</sup> Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report*, above n 233, 100.

drugs are considered to pose a very high risk of harm, while Class B drugs pose a high risk, and Class C drugs a moderate risk.<sup>247</sup> Another amendment in 2000 established the Expert Advisory Committee on Drugs, with the mandate to evaluate substances, assess their potential for harm against criteria set out in the Act, and recommend appropriate classifications.<sup>248</sup>

- 4.32 Despite the changes in 2000, the classification of most controlled drugs already under the Act has never been reviewed. Only drugs that have been classified or reclassified since the Act was amended in 2000 have been assessed against the criteria for determining harm. Consequently the current classifications of a number of drugs may not accurately reflect current knowledge and understanding about their risks.

### *Offences involving dealing in drugs*

- 4.33 A key feature of the Act is its emphasis on deterrent penalties for offences that involve “dealing” in drugs.<sup>249</sup> Dealing is importing, exporting, producing, manufacturing, selling or otherwise supplying or administering a controlled drug to another person.<sup>250</sup> It also includes the possession of a controlled drug for one of these purposes.<sup>251</sup> The Act introduced a sliding scale of maximum penalties for unlawful dealing in different classes of controlled drugs. This is intended to reflect the relative degree of harm associated with the different classes of drugs. A presumption in favour of imprisonment for offences that involve dealing in Class A drugs reinforces the significance of a drug’s classification for determining penalty. The maximum penalties in the Act were increased in 1979 and have not been changed since. The maximum penalty for dealing in Class A drugs is imprisonment for life; a Class B drug 14 years; and a Class C drug eight years.

### *Presumption of supply*

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

### *Possession and use of drugs*

- 4.35 As recommended by the Blake-Palmer review, the Act sets much lower maximum penalties for offences of possession and personal use.<sup>252</sup> Penalty levels again reflect the relative harm of the different classes of drug. The maximum penalty

247 Misuse of Drugs Act 1975, s 3A.

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

249 Misuse of Drugs Act 1975, ss 6 and 7(1)(b).

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

251 Section 6 of the Misuse of Drugs Act 1975 contains the possession and use offences.

252 Misuse of Drugs Act 1975, s 7(1)(a) and (b).



for possession or personal use of a Class A drug is six months imprisonment and a fine of \$1000 or both; a Class B or C drug three months imprisonment or a fine not exceeding \$500 or both. The Act also contains a presumption against imprisonment for possession or use of a Class C drug.<sup>253</sup> The Act did not incorporate the types of alternatives to prosecution and criminal sanction for drug users suggested by the Blake-Palmer Committee.

#### *The power to search without a warrant*

- 4.36 The Narcotics Act had permitted the police to search any premises and any persons inside such premises without first obtaining a warrant where the police had reasonable grounds to suspect an offence was being committed on those premises.<sup>254</sup> Under the Misuse of Drugs Act the power to search without warrant is restricted so that it only applies to offences involving Class A drugs, Class B drugs listed in Part 1 of Schedule 2, and Class C drugs listed in Part 1 of Schedule 3.<sup>255</sup> The Act also gives the police a power to search any person without a warrant, regardless of his or her location, where they have reasonable grounds for believing the person is in possession of a drug falling into one of the categories noted above.

#### *Authorisations and licences permit use of drugs for medical and scientific purposes*

- 4.37 Many drugs controlled by the Act have medical and scientific uses. The Act, like the earlier Narcotics Act, provides for medical and scientific use by creating exemptions to the offence provisions and establishing a licensing scheme for the lawful manufacture, import and distribution of controlled drugs.<sup>256</sup> Exemptions are necessary to allow health professionals and others responsible for the care of patients and patients themselves to lawfully obtain and use controlled drugs as prescribed for therapeutic purposes. Exemptions also allow certain medical practitioners working in drug treatment to prescribe drugs (for example, methadone) in opioid substitution treatment.

#### **Subsequent amendments**

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

#### *Misuse of Drugs Amendment Act 1978*

- 4.39 The search, surveillance and detection powers in the Act were supplemented by additional enforcement powers contained in the Misuse of Drugs Amendment Act 1978. Special provisions allow police and customs officers to undertake deliveries of controlled drugs imported into New Zealand. Controlled deliveries

253 Misuse of Drugs Act 1975, s 7(2)(b). This was also a recommendation of the review. See Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report*, above n 233, 101, recommendation 2(j).

254 Narcotics Act 1965, s 12(2).

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

256 Under the Narcotics Act 1965 the exemptions were all contained in regulations made under the Act. In contrast, the Misuse of Drugs Act itself contains many of the exemptions that allow for prescribing and other medical use.



allow drugs crossing the border to be tracked to the end recipient. Provisions also permit officers to enter premises and conduct searches without warrant in relation to the controlled deliveries. Other provisions authorise the detention of a person for up to 21 days without being charged where there is reasonable cause to believe the person has concealed a Class A or B controlled drug within his or her body. Interception powers relating to private communications were also introduced at this time. All of the current enforcement powers are considered in detail later in chapter 14.

### *Amendments to facilitate needle and syringe exchange measures*

- 4.40 The Act, like its predecessor, includes a provision that makes it an offence for any person to have any needle, syringe, pipe or other utensil for the purposes of using drugs. However, an exemption in section 13 that took effect from 12 January 1988 permits the possession of needles and syringes that have been obtained through authorised needle exchange programmes.<sup>257</sup> The exchange programmes were established to try and reduce the risk of blood borne infection from dirty or shared needles. The amendment was prompted by concern over the risk of the HIV virus spreading among intravenous drug users. This and the provision for opioid substitution treatment mentioned above are the two main harm reduction measures in the Act.

### *Extension of the controls to drug analogues*

- 4.41 Another important amendment in 1988 introduced the concept of a controlled drug analogue. An analogue was defined as a substance that had a structure substantially similar to that of any controlled drug but was not itself listed in Schedules 1 or 2 or in Parts 1–7 of Schedule 3.<sup>258</sup> Analogues were specifically listed in Part 7 of Schedule 3 and were consequently Class C drugs.<sup>259</sup> However, only those analogues included in Part 7 were Class C controlled drugs under the Act. A subsequent amendment in 1996 amended the definition of Class C drug to include all controlled drug analogues, which dispensed with the need to list them in Part 7.<sup>260</sup>
- 4.42 This amendment was made to address the emergence of new synthetic designer drugs that had been developed by subtle chemical changes to prohibited drugs as a way of avoiding the provisions of the Act. The definition of analogues has caught a number of substances that would otherwise have had to be separately scheduled.
- 4.43 While the inclusion of analogues addresses the issue of subtle changes in a drug's chemistry, it does not address the emergence of new synthetic drugs with distinct chemistry. Such substances need to be separately assessed and classified before they come under the Act.

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

258 Analogues that were classified medicines under the Medicines Act 1981 were also excluded from the definition.

259 Misuse of Drugs Amendment Act (No 2) 1987.

260 Misuse of Drugs Amendment Act 1996.

*Money laundering and other trafficking related amendments*

- 4.44 The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 (1988 Convention) imposed a number of further obligations including the need for international cooperation in law enforcement. New Zealand ratified the Convention in 1998 and subsequently amended the Misuse of Drugs Act to comply with the Convention. The offence of laundering the proceeds of drug offences was introduced<sup>261</sup> and police powers of surveillance were broadened to allow the interception of private communications. The extraterritorial jurisdiction of the Act was also extended so that someone in New Zealand can be charged in respect of acts done overseas when those acts constitute an offence in New Zealand.<sup>262</sup> The range of offences under the Act that are subject to extradition was also extended.

*Controlling access to precursor substances*

- 4.45 As required by the 1988 Convention, New Zealand also introduced new measures in 1998 to control precursor substances used in the manufacture of synthetic drugs like methamphetamine. It became an offence to supply, produce or manufacture any equipment or material that is capable of being used for the commission of an offence or any precursor substance knowing that it will be used to commit such an offence.<sup>263</sup> In 2005, the controls on precursor substances were tightened further so that it became an offence to import or export a precursor substance without a reasonable excuse.<sup>264</sup> The objective was to deter the import and export of precursor substances that were being used in the manufacture of methamphetamine.

*Restricted substances*

- 4.46 A new type of psychoactive substances in the form of “party pills” became widely available in New Zealand around 2000.<sup>265</sup> Most of this generation of party pills contained benzylpiperazine (BZP), often used in combination with trifluoromethylphenylpiperazine (TFMPP). BZP is a synthetic stimulant that induces effects similar to ecstasy.<sup>266</sup> These new psychoactive substances posed a challenge to the way drugs were classified under the Act because they were

261 Misuse of Drugs Act 1975, s 12B.

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

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

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

265 A report prepared for the Ministry of Health estimated that approximately 20 million doses of party pills containing BZP and TFMPP were sold in New Zealand between 2002 and 2006. See Beastly and others *Report for the Ministry of Health – The Benzylpiperazine (BZP)/Trifluoromethylphenylpiperazine (TFMPP) and Alcohol Safety Study* (Medical Research Institute of NZ, Wellington 2006) 3.

266 Expert Advisory Committee on Drugs “Advice to the Minister on Benzylpiperazine (BZP)” (April 2004).

not controlled drug analogues and so were not covered by the Act. In response, the Expert Advisory Committee on Drugs recommended that provision be made within the Misuse of Drugs Act for the control of substances which had a low risk of harm but needed some degree of control. The Committee proposed that age restrictions and other restrictions on sales should be applied to such psychoactive substances.<sup>267</sup>

- 4.47 This proposal was given effect in the Misuse of Drugs Amendment Act 2005, which provides for a new restricted substances regime to regulate access to psychoactive substances that pose a less than moderate risk of harm. The Expert Advisory Committee on Drugs has a statutory responsibility to evaluate and assess substances and make recommendations to the Minister as to whether any substance should be classified as a restricted substance.<sup>268</sup>

### Issues with the Act

- 4.48 A number of issues with the Act have emerged over the 30 years since its enactment and it is questionable whether it now provides a coherent or effective legislative framework. For example, what substances should the Act cover? How should new psychoactive substances be treated? Should drugs continue to be subject to the current classification system or should they be categorised in some other way? If the current system remains, are the present classifications an accurate reflection of substances' relative harm?
- 4.49 There are also questions about the appropriateness of the current offence and penalty regime and the law enforcement powers contained in the Act. The current offence and penalty structure dates from the 1970s. It has been in place, largely unchanged, for approximately 30 years. It may need modification to take account of other changes that have occurred in criminal law over that period. The law enforcement powers in the Act may similarly be in need of updating in relation to a couple of issues not considered in the Commission's report *Search and Surveillance Powers*.<sup>269</sup> The main issue is the enforcement powers relating to the internal concealment of drugs. There is also a question over whether the existing statutory presumption of possession for supply should continue to apply in light of the Supreme Court's decision in the *Hansen* case.<sup>270</sup>

### Alignment with current drug policy

- 4.50 But by far the most fundamental issue with the Act is that it seems poorly aligned with New Zealand's current drug policy based on the principle of harm minimisation. The Act is a criminal justice statute. The policy underpinning it is to eliminate the illegal importation, production and supply of drugs by prohibiting these activities, providing powers for enforcing that prohibition

<sup>267</sup> Ibid.

<sup>268</sup> Misuse of Drugs Amendment Act 2005, s 32.

<sup>269</sup> New Zealand Law Commission *Search and Surveillance Powers* (NZLC R97, Wellington, 2007). There is a Search and Surveillance Bill currently before the House that will implement the Law Commission's proposals.

<sup>270</sup> *R v Hansen* [2007] NZSC 7.

and imposing severe penalties. The use of drugs, even by those who are dependent on them, is treated as a matter solely for the criminal law rather than health policy.<sup>271</sup>

- 4.51 In contrast, the current drug policy aims to prevent and reduce health, social and economic harms by an appropriate balance of strategies directed at supply control, demand reduction and problem limitation. Of course, legislation inevitably has a particular focus on law enforcement, because it is necessary to create offences and to provide law enforcement powers. In contrast, legislation may not be necessary, or even particularly appropriate, for establishing education programmes or voluntary treatment options.
- 4.52 However, there is a risk that the criminal law and its enforcement, because these are contained in legislation, can become the main focus of drug policy. They may also dominate the debate around drug policy at the expense of other measures that may better minimise harm. As a result insufficient support, attention, or resources may be devoted to education, treatment strategies, and harm reduction measures aimed at reducing demand and limiting the problems associated with drug use. The Blake-Palmer Committee's recommendations for improved treatment and support for those dependent on drugs and for high quality preventive community education were not matters that necessarily needed legislation to implement, so do not feature in the Act. Perhaps as a result, these aspects of the Committee's recommendations have not received the attention they deserved.
- 4.53 The Act, by making drug use an offence, also places some significant legal and practical impediments in the way of measures that might otherwise be adopted to support the pillars of demand reduction and problem limitation. Drug users are stigmatised and suffer various social and other harms because drug use is illegal. The illegal status of drug use may make it more difficult for drug users to access treatment at an early stage. It may even deter some people from seeking help in life threatening situations when they have overdosed or otherwise suffered an adverse reaction to drugs. Because all drug use is a criminal activity there are also limitations on the type of lifestyle education and social marketing strategies that can be pursued to reduce demand. Social marketing campaigns like those run by the Alcohol Advisory Council that target harmful alcohol use rather than use per se are difficult to pursue; they might be seen to condone other use, or indirectly to criticise the law, both of which undermine respect for the law.<sup>272</sup>

271 One exception is that it is not an offence for someone who is drug dependent to use drugs prescribed or supplied as part of a drug treatment programme.

272 For example, a campaign like: "It's not the drinking. It's how we are drinking" could not be adopted for an illegal substance.

- 4.54 The current Act also places legal barriers in the way of harm reduction measures that accept the possession and use of some drugs in some situations. Others, such as needle and syringe exchange programmes or safe injecting facilities, require the state to fund and provide equipment and facilities of a type that are otherwise prohibited. Before most harm reduction measures of this type can be adopted, an express statutory authorisation is therefore required. The Act does currently provide a lawful basis for needle and syringe exchange programmes and authorises opioid substitution in the treatment of drug dependence. But other measures, such as the provision of supervised injecting facilities or the provision of drug testing facilities, are currently unlawful. These types of strategies could not be implemented, if they were adopted, without some significant changes to the legislative framework.
- 4.55 We think that these changes can only be effected by a completely new Act and the repeal of the existing Act is therefore necessary. A key issue for the current review is how any new legislative framework might better support the pillars of demand reduction and problem limitation in drug policy.

# Chapter 5

## Current approach to drug regulation

### SUMMARY

This chapter identifies and discusses the different regulatory schemes under which psychoactive substances are currently regulated and explores how these apply. It concludes that psychoactive substances that may be harmful are all currently regulated as controlled drugs, other psychoactive medicines, hazardous substances, or food and cannot consequently be included in the restricted substances legislative scheme established by the Misuse of Drugs Amendment Act 2005. It also concludes that the role the Medicines Act 1981 plays in regulating controlled drugs is not transparent and it is difficult to determine the true extent of the authorisations that provide for the therapeutic use of controlled drugs. There are difficulties also in determining whether a substance is a medicine, a food, or a hazardous substance.

**INTRODUCTION** 5.1 Most drugs other than alcohol and tobacco are controlled and regulated under the Misuse of Drugs Act 1975. However, the Medicines Act 1981, the Hazardous Substances and New Organisms Act 1996, and to a lesser extent the Food Act 1981 also currently play a role in regulating the production, distribution and use of different groups of psychoactive substances that fall within the scope of the Commission's review. In this chapter we examine the regulation of:

- controlled drugs;
- other psychoactive medicines;
- hazardous substances;
- restricted substances; and
- psychoactive substances that have been incorporated into food.

Our main objective is to identify the regulatory issues and problems that arise at the interface between the Misuse of Drugs Act and these other legislative schemes, rather than to provide a detailed exploration of all of the relevant Acts. We do, however, examine the regulatory controls that apply to controlled drugs in some detail since these are central to our review.



## CONTROLLED DRUGS

- 5.2 The most important group of psychoactive substances for our review are those that are currently regulated as controlled drugs.
- 5.3 A controlled drug is defined in the Misuse of Drugs Act as a substance, preparation, mixture, or article identified or described in Schedules 1, 2, or 3 of the Act. A controlled drug analogue is also a controlled drug under the definition.<sup>273</sup> An analogue of a controlled drug is any substance that has a structure substantially similar to that of a controlled drug but is not itself specified or described as a controlled drug in Schedules 1, 2, or Parts 1 to 6 of Schedule 3. Any analogue of a controlled drug that is a pharmacy-only medicine, a restricted medicine or a prescription medicine under the Medicines Act is excluded from the definition of controlled drug analogue.<sup>274</sup>
- 5.4 Controlled drugs are regarded as the most harmful psychoactive substances and are therefore the most strictly controlled. Sections 6 and 7 of the Act prohibit all dealing in, or use of, a controlled drug that is not expressly authorised by the Act, by regulations made under it, or by a licence.

### Authorisations

- 5.5 The Act provides for two types of authorisation: licences and statutory exemptions. The purposes for which licences may be granted are not defined in the statute and most of the detail of the licensing regime is left to the regulations. However, in practice there are three broad purposes for which licences are available: industrial use, research and therapeutic purposes. Of these, licensing for therapeutic purposes is by far the largest category. Most of the statutory exemptions relate to the use of controlled substances for therapeutic purposes.

#### *Licences for industrial use and cultivation for industrial use*

- 5.6 Licences are occasionally granted for the manufacture, import, export, supply or cultivation of a controlled drug for use in some industrial or production process. For example, licences authorise the cultivation and processing of industrial hemp (that is, cannabis plant with a very low THC content).<sup>275</sup> Another example is licences relating to the Class B controlled drug gamma-hydroxybutyrate (GHB) commonly known as fantasy. Substances from which GHB can be derived are also Class B controlled drugs and are occasionally used in food production.

<sup>273</sup> See section 2 of the Misuse of Drugs Act 1975 for the definition.

<sup>274</sup> For the purposes of the definition of controlled drug analogue a pharmacy-only medicine, prescription medicine, and restricted medicine all have the same meaning as in the Medicines Act 1981. We discuss these classifications of medicines later in paragraphs 5.65–5.67 of this chapter.

<sup>275</sup> 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.

- 5.7 However, the use of controlled drugs in industrial processes is fairly rare and few licences are issued for this purpose. Currently there are approximately 10 licences that allow the cultivation and processing of industrial hemp and 10 licences for use in other industrial processes.

#### *Licences for research*

- 5.8 Licences are also granted authorising the importation, supply, possession and use of controlled drugs in research and drug studies.<sup>276</sup> Cultivation licences can also be granted for the purposes of research. Again, this is a very small category of authorisation; there are currently approximately 21 research licences.

#### *Authorisations for therapeutic purposes*

- 5.9 Licences and statutory exemptions that authorise the manufacture, import or export, supply, possession and administration of controlled drugs for therapeutic purposes fall into three different categories:
- **licences** that authorise the manufacture, import, export, and supply of controlled drugs for use as medicines or for use in the manufacture or production of medicines;
  - **statutory exemptions** that authorise specified classes of institutions and people to produce, supply and use all controlled drugs that are approved as medicines under the Medicines Act; and
  - **statutory exemptions** that authorise medical practitioners, certain other authorised health practitioners, and suppliers to procure, sell, supply and administer controlled drugs that are unapproved medicines for the purposes of treating specific patients.
- 5.10 We describe the three categories of authorisations and the restrictions that apply to them in more detail below.

#### *Application of Medicines Act*

- 5.11 Before doing so, however, it is necessary to explain in general terms the relationship between the Misuse of Drugs Act and the Medicines Act. The therapeutic use of controlled drugs is regulated by both Acts. 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.<sup>277</sup> 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.<sup>278</sup>

276 A licence granted for research is the only type of licence that can authorise the consumption, injection or smoking of a controlled drug. See Misuse of Drugs Act 1975, s 14(3).

277 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.

278 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. These issues are considered later in paragraph 5.60.

- 5.12 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) 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.
- 5.13 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 deemed to be licensed under the Medicines Act to undertake that activity. In other words there is no need to also have a licence under the Medicines Act.

### Licensing for therapeutic purposes

- 5.14 Licences are granted for two purposes:
- to import, export, manufacture, and supply controlled drugs for use as medicines; and
  - to manufacture any medicine that contains a controlled drug.<sup>279</sup>
- 5.15 An exemption in the Misuse of Drugs Act authorises the import, export and supply of Class C drugs contained in Schedule 3, Part 6 (Class C6 drugs) without a licence issued under the Act. Class C6 drugs contain 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.<sup>280</sup> However, a licence is still required under the Medicines Act to pack and label or supply by wholesale such a drug because it is a medicine and the licensing requirements in the Medicines Act therefore apply.<sup>281</sup> It should also be noted that the exemption for Class C6 drugs does not cover manufacturing, so a licence under the Misuse of Drugs Act is required to manufacture a Class C6 drug.

<sup>279</sup> 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.

<sup>280</sup> 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. The exemption for Class C6 drugs may need to be looked at.

<sup>281</sup> Class C6 controlled drugs are classified as pharmacy only medicines under the medicines regime.

*Licensing practice under the Misuse of Drugs Act*

- 5.16 Regulations under the Misuse of Drugs Act provide for three types of licences:
- **Dealers' licences** allow the holder to deal in controlled drugs.<sup>282</sup> They are required by pharmaceutical manufacturers, wholesalers and distributors. There are currently approximately 170 dealers' licences in New Zealand. Only four of these licences authorise the manufacture or use of controlled drugs in manufacturing. The rest cover the supply chain.
  - **Import and export licences**, as the name suggests, authorise the holder to import or export controlled drugs.<sup>283</sup> Under section 14 conditions may be attached to any licence to export drugs to ensure that the laws of the country receiving the export are not contravened.<sup>284</sup> Import and export licences are issued per consignment. A person must, however, have a lawful authority to possess the controlled drugs before they will be granted an import or export 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 by a statutory exemption.
  - **Cultivation licences** allow the holder to cultivate and process prohibited plants 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 like Sativex®. In practice no cultivation licences have ever been granted for the purposes of cultivating cannabis, although recently cultivation licences have been granted for trials involving the cultivation of non-morphine *Papaver somniferum* poppies.
- 5.17 Applications for licences are made to the Director-General of Health and licensing is closely controlled by the Ministry of Health. Regulations require the careful vetting of the suitability of applicants and also require premises at which controlled drugs are used or stored to be secure and closely controlled. 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. All licences that are issued are for a specified time period and expire. Dealers' licences are issued for one year, so applications must be made annually to have them renewed. Licences are personal and cannot be assigned to another person.
- 5.18 The Director-General does not have the power to revoke a licence but the Minister of Health can revoke a licence at any time 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

282 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.

283 Misuse of Drugs Regulations 1977, reg 7.

284 Misuse of Drugs Act 1975, s 14(5).

- 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.

5.19 We note the grounds on which a licence can be revoked are limited and do not, for example, include convictions for serious offences under the Crimes Act 1961 or the Medicines Act. It also seems odd that a licence can be granted by the Director-General but revoked only by the Minister. If the involvement of the Minister is intended to signal the seriousness of the decision, it would seem more logical to apply the requirement to the issuing of licences rather than their revocation, but why the Minister is involved at all is open to question.

### *Restrictions imposed on granting licences*

5.20 There are some general restrictions that apply to licensing under the Misuse of Drugs Act. Some of these are in the Misuse of Drugs Act and some are imposed by regulations made under it.

5.21 The statutory restrictions 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.<sup>285</sup>
- Licences cannot authorise the consumption, injection or smoking of any controlled drug other than for research purposes.<sup>286</sup>
- Licences cannot be issued that would permit the import or export of opium for smoking.<sup>287</sup> (This special provision relating to opium appears to be a historical anachronism.)

5.22 The regulatory restrictions 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:
  - any Class A drug other than cocaine or its isomers, esters, ethers or salts;
  - any Class B drug in Part 1 of Schedule 2 (Class B1 drug) except morphine or opium, or their isomers, esters, ethers or salts; and
  - any Class C drug in Part 1 of Schedule 3 (Class C1 drug).<sup>288</sup>
- 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.<sup>289</sup>

5.23 We note that the restrictions imposed by the regulations are significant. They would, for example, preclude licences for the import or supply of cannabis for medicinal use without the approval of the Minister of Health. In our view, restrictions as fundamental as these should be in primary legislation rather than in regulations.

285 Misuse of Drugs Act 1975, s 14(4).

286 Misuse of Drugs Act 1975, s 14(3).

287 Misuse of Drugs Act 1975, s 14(2).

288 Misuse of Drugs Regulations 1977, reg 22.

289 Misuse of Drugs Regulations 1977, reg 8(2).



### Statutory exemptions

- 5.24 Section 8 of the Misuse of Drugs Act contains a number of statutory exemptions that allow certain types of institutions and certain classes of people to undertake various authorised activities with controlled drugs. Further specific authorisations in the form of permissions are contained in regulations made under the Misuse of Drugs Act. These provisions give the impression that any person who falls within the terms of one of these exemptions is permitted to deal with or use controlled drugs in the ways authorised by the exemption, but that is not the case.
- 5.25 As we have already noted, the Medicines Act also applies to controlled drugs that are also medicines. The exemptions in section 8 of the Misuse of Drugs Act must therefore be read together with the requirements of the Medicines Act. It is necessary, therefore, to briefly explain the scheme of the Medicines Act before considering the section 8 exemptions.
- 5.26 Section 20 of the Medicines Act requires, with some exceptions, that medicines be assessed and approved or provisionally approved by the Minister before they can be sold or distributed as a medicine in New Zealand.<sup>290</sup> 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.<sup>291</sup>
- 5.27 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 for a patient with a particular condition. 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.<sup>292</sup>
- 5.28 There are also a number of specialist hospital medicines, including some psychoactive medicines used as anaesthetics, which never get approved in New Zealand because the market for such medicines is too small to justify the costs associated with obtaining an approval. Other 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. To facilitate some closely controlled use of such medicines, the basic prohibition on dealing with unapproved medicines is subject to exemptions that permit use of unapproved medicines (either new or changed medicines) in limited circumstances.
- 5.29 Though it is by no means apparent on the face of the Misuse of Drugs Act, the section 8 exemptions operate differently depending upon whether the medicine is an approved medicine or an unapproved medicine. This lack

290 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 section 20.

291 *The Ministry of Health v Pacific Pharmaceuticals Limited* (8 December 2000) HC AK A165/00, para 26.

292 Exemptions covering clinical trials of new medicines are provided for in section 30 of the Medicines Act 1981. We do not discuss these further.



of transparency is unsatisfactory. The difficulty is compounded by the fact that the exemptions in the Misuse of Drugs Act and the exemptions in the Medicines Act are in different terms which sometimes makes it difficult to determine the precise scope of the exemptions.

### Section 8 – exemptions and approved medicines

5.30 The main statutory exemptions that apply to controlled drugs that are approved as medicines are:

- Medical practitioners may, in the course of their professional practice or employment, prescribe, produce, manufacture, supply, or administer controlled drugs for treating conditions other than drug dependence.<sup>293</sup>
- Dentists or veterinarians may, in the course of their professional practice or employment, prescribe, produce, manufacture, supply, or administer controlled drugs.<sup>294</sup>
- Midwives may prescribe, supply, or administer the controlled drug *pethidine* and any other controlled drugs specified in regulation but may not do so for treating drug dependence.<sup>295</sup>
- Other groups of health professionals (termed “designated prescribers”) may, if expressly authorised by regulation, prescribe, supply or administer any controlled drugs specified in regulation but may not do so to treat drug dependence.<sup>296</sup>
- Medical practitioners specified by name in a *Gazette* notice issued by the Minister may prescribe, administer or supply controlled drugs for the purposes of treating a person for drug dependence. Medical practitioners working in hospitals and clinics that have been specified by the Minister in a *Gazette* notice may also prescribe, administer or supply controlled drugs as a treatment for drug dependence.<sup>297</sup>
- Other 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.<sup>298</sup> Standing orders are written instructions issued by medical practitioners, dentists, midwives and veterinarians.<sup>299</sup> A commonly used standing order allows ambulance crews to carry and administer morphine and certain other controlled drugs for pain relief.
- Pharmacists and employees under their supervision may produce, manufacture or supply any controlled drug required to fill a lawfully issued prescription for that drug, and pharmacists employed in hospitals are also authorised to produce, manufacture or supply any controlled drug that is needed within the hospital.<sup>300</sup>

293 See Misuse of Drugs Act 1975, s 8(2)(a).

294 Ibid.

295 Misuse of Drugs Act 1975, s 8(2)(aa) and (2A)(a). To date no regulations have been made authorising midwives to prescribe any additional drugs.

296 Misuse of Drugs Act 1975, s 8(2A)(a). To date only one group of designated prescribers, designated prescriber nurses, have been authorised to prescribe up to three days supply of certain controlled drugs listed in Schedule 1A to the Misuse of Drugs Regulations 1977.

297 Misuse of Drugs Act 1975, s 24(2).

298 Misuse of Drugs Act 1975, s8(2A)(b).

299 Section 2 of the Misuse of Drugs Act 1975 provides that “standing order” has the same meaning as it has in section 2(1) of the Medicines Act 1981.

300 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 without a prescription.
  - Patients may procure and self-administer any controlled drugs that have been lawfully supplied or prescribed for them<sup>301</sup> and those responsible for the care of patients may administer controlled drugs to them in accordance with the directions given by the prescribing professional.<sup>302</sup> A similar exemption allows controlled drugs to be administered to an animal when they have been prescribed by a vet.<sup>303</sup>
  - Any person may, when leaving or entering New Zealand, possess up to one month's supply of 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.<sup>304</sup>
  - Any person may procure and administer any C6 controlled drug.
  - District Health Boards and other certified hospitals and other institutions and any manager or licensee of a certified hospital or institution that has the care of patients for whom controlled drugs are lawfully prescribed or supplied may possess those drugs for the purposes of treatment of those patients.<sup>305</sup>
- 5.31 The scope of this last exemption for District Health Boards and other institutions is uncertain. It is not clear whether the exemption allows these institutions to hold general supplies of controlled drugs for the purposes of treating patients (as practicality may dictate) or whether they can only hold drugs that have been specifically prescribed for particular patients. There is also uncertainty as to what types of care providers fall within the definition of "other institutions". Does it include certified rest homes, for example? This is unsatisfactory. It is important that the exemptions are clear, since an offence under sections 6 or 7 will be committed if the scope of an exemption is exceeded.

### *Permissions in the Misuse of Drugs Regulations*

- 5.32 Regulations create a number of other exemptions which are described in the regulations as permissions.
- 5.33 The main permissions in the regulations are:
- Any person may sell by retail or wholesale any Class C drug in Part 3 of Schedule 3 (Class C3 drug) (other than one containing pseudoephedrine).<sup>306</sup>
  - Pharmacies may sell Class C3 controlled drugs that contain pseudoephedrine by retail as "pharmacy-only medicines".<sup>307</sup>
  - Any person may procure and administer a Class C3 drug (including one that contains pseudoephedrine).<sup>308</sup>

301 Misuse of Drugs Act 1975, s 8(2)(c).

302 Misuse of Drugs Act 1975, s 8(2)(d) and (da).

303 Misuse of Drugs Act 1975, s 8(2)(e).

304 Misuse of Drugs Act 1975, s 8(2)(l).

305 Misuse of Drugs Act 1975, s 8(2)(f).

306 Misuse of Drugs Regulations 1977, reg 20.

307 Misuse of Drugs Regulations 1977, reg 20. This will soon change because the Government has adopted 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.

308 Misuse of Drugs Regulations 1977, reg 20.

- Hospital and care institution managers in approved hospitals and institutions that have been specifically approved by the Director-General for the purpose may possess supplies of any Class C drug in Part 2 of Schedule 3 (Class C2 drug).<sup>309</sup>
- A controlled drug can be supplied in an emergency without a prescription, provided that this complies with other regulations governing emergencies.<sup>310</sup>
- 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.<sup>311</sup>
- 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.<sup>312</sup>
- 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 the approved first-aid kit. A controlled drug may also be supplied to a person who has control of an approved first-aid kit without a prescription.<sup>313</sup>

5.34 We note that some of the permissions listed above 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:<sup>314</sup>

[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...

5.35 However, the breadth of this regulation-making power goes beyond that stipulated as appropriate by 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. The inclusion of significant matters of policy in regulations is also inconsistent with contemporary standards of legislative practice as set down in the Legislation Advisory Committee Guidelines, which require that such matters are in primary legislation.

### *Exemptions in the Medicines Act*

5.36 The Medicines Act also has exemptions for facilitating the use of medicines. These apply to controlled drugs that are approved medicines and must be read along with the section 8 exemptions. These are:

- Any medical practitioner, dentist, registered midwife, or designated prescriber may manufacture, pack and label, procure, sell, supply or administer any controlled drug that is a medicine for the purposes of generally treating their patients.<sup>315</sup>

309 Misuse of Drugs Regulations 1977, reg 15.

310 Misuse of Drugs Regulations 1977, reg 34.

311 Misuse of Drugs Regulations 1977, reg 17.

312 Misuse of Drugs Regulations 1977, reg 18.

313 Misuse of Drugs Regulations 1977, reg 19.

314 Misuse of Drugs Act 1975, s 37(d).

315 Medicines Act 1981, ss 25 and 27. The exemption also allows them to do these things at the request of another authorised prescriber: see Misuse of Drugs Act 1975, s 25(1)(d), (e) and (f).

- Any pharmacist may manufacture, and pack and label a controlled drug or supply a controlled drug that is a medicine under a prescription.<sup>316</sup>

The Medicines Act and regulations made under it impose various conditions on these exemptions.

- 5.37 In so far as they apply to controlled drugs, these exemptions duplicate some of those in the Misuse of Drugs Act. The existence of two exemptions authorising similar activities, but on the different conditions stipulated in the different sets of regulations, is problematic. Section 109 of the Medicines Act requires a prescriber or pharmacist to comply with all the conditions that apply to both groups of exemptions. But what this means in practice may be difficult to determine in some situations. The current situation is confused and lacks transparency. The law would be simpler and more straightforward if the exemptions that applied to controlled drugs were in one Act and were subject to one consolidated set of conditions. It would probably be sensible for these to be in the Medicines Act and regulations since that Act covers all medicines including controlled drugs.

#### *Exemptions for unapproved medicines*

- 5.38 Section 25 of the Medicines Act provides a limited exemption for medical practitioners from the requirement under that Act that a medicine be approved by the Minister before it is sold or distributed in New Zealand. This exemption is considerably narrower than the exemptions in section 8 of the Misuse of Drugs Act and therefore imposes some additional restrictions on controlled drugs that are unapproved medicines.
- 5.39 The main additional restrictions are:<sup>317</sup>
- Medical practitioners cannot produce, manufacture, or pack and label these medicines.
  - Only medical practitioners, dentists, registered midwives<sup>318</sup> and designated prescribers can procure, supply or administer them.
  - They may only be procured and supplied for particular and identifiable patients and not more generally.
- 5.40 Section 29 of the Medicines Act provides a related exemption for suppliers. Before a supplier can supply an unapproved medicine (either a new or changed medicine) a medical practitioner must request it for the treatment of a particular patient. This means that other groups or authorised prescribers can only obtain an unapproved medicine from the medical practitioner responsible for the care of the patient and not directly from a supplier.
- 5.41 An authorised supplier who provides a medicine to a medical practitioner under section 29 is required to provide the Director-General with a written report every month on any sales or supply in accordance with the exemption. The report must

<sup>316</sup> Medicines Act 1981, s 26.

<sup>317</sup> Medicines Act 1981, s 25(2).

<sup>318</sup> The restrictions in the Misuse of Drugs Act also apply. Registered midwives can therefore only supply pethedine or drugs specified in regulations. Similar restrictions apply to other designated providers.

name the medical practitioner, the medicine in question and the patient. It must also identify the date and place of sale. If the supplier fails to do so, the Minister may prohibit that person from supplying unapproved medicines.

### *Restrictions on distribution of changed medicines*

- 5.42 If material changes are made to an approved medicine, the Medicines Act prescribes a notification process and certain restrictions apply to the subsequent use of that drug.<sup>319</sup> This process therefore applies to controlled drugs that have been approved medicines before changes were made to them.
- 5.43 Firstly, the importer or manufacturer responsible for the changed medicine must give written notification to the Director-General of Health of the changes made and their potential impact on the safety and efficacy of the drug.<sup>320</sup> During a period of at least 90 days following the notification it is an offence for any person to sell or supply the controlled drug, except under the exemptions that apply to unapproved medicines or with the written permission of the Director-General. The earlier approval remains in force, but the changed product cannot be sold until it is approved or the 90 days has elapsed.<sup>321</sup>
- 5.44 If the Director-General determines during the 90 day assessment period that the change is of such a character or degree that the controlled drug requires a fresh approval, the importer is notified and the drug is treated as an unapproved medicine until the approval is obtained. If a new approval is not required, the drug can again be used under the broader section 8 exemptions.

### *Restrictions apply to all exemptions*

- 5.45 Sections 22, 23 and 25 of the Misuse of Drugs Act and regulation 22 of the Misuse of Drugs Regulations contain some general restrictions that apply across all of the statutory authorisations and impose some further limitations on the classes of people and the authorised activities that they may undertake with controlled drugs.

### *Section 22 – prohibition notices*

- 5.46 Under section 22 of the Misuse of Drugs Act or section 37 of the Medicines Act, the Minister may issue a prohibition notice prohibiting the importation, manufacture, production, procurement, possession, supply, administration or other use of any controlled drug.<sup>322</sup> Prohibition notices override authorisations in a licence and statutory exemptions that would otherwise permit the prohibited activity with the prohibited drug.

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319 Medicines Act 1981, s 24.

320 Alternatively, the importer of the medicine or the New Zealand manufacturer responsible for the medicine may form the view that the medicine is so changed it is actually a new and different medicine and apply for an approval for this new medicine, which could not be distributed until the approval had been obtained.

321 See Medicines Act 1981, s 24(3).

322 Note that section 22 of the Misuse of Drugs Act also covers prohibition notices that prohibit the importation or supply of pipes or other utensils, other than needles and syringes.



*Section 23 – prohibition on specified prescribers*

- 5.47 Under section 23 of the Misuse of Drugs Act, the Minister may, by notice in the *Gazette*, prohibit any specific prescriber from prescribing controlled drugs or may prohibit any other specified person (such as a pharmacist) from exercising any of the rights conferred by an exemption in section 8.
- 5.48 There are some issues over the application of section 23:
- It is very broad. For example, it allows the Minister to prohibit any person from exercising the rights conferred by section 8.<sup>323</sup> Section 8 permits patients to take controlled drugs that are prescribed for them. The power in section 23 could therefore be used, at least in theory, to prohibit a patient taking a medicine that has been lawfully prescribed.
  - The Minister cannot exercise the power in relation to a prescriber or a pharmacist except on the recommendation of their governing registration authority. The Minister is circumscribed and it is unclear what objective the Minister's involvement serves.
  - Similar powers are included as sections 48 and 48A of the Medicines Act. This appears to involve unnecessary duplication. There probably should be one set of provisions, probably in the Medicines Act, providing for the therapeutic use of controlled drugs and imposing restrictions on that.

*Section 25 – restrictions on supply to a particular person*

- 5.49 Under section 25, a Medical Officer of Health can 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 notice is issued to relevant health professionals and prohibits any further supply of controlled drugs to the restricted person. Alternatively, the notice may allow for some continued supply of controlled drugs by specified prescribers or from specified sources. For example, it may allow a restricted person to obtain a particular controlled drug like methadone only from a specified clinic.
- 5.50 After a notice has been issued, it is an offence 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.
- 5.51 The restricted person also commits an offence if he or she attempts to procure a prescription or a supply of the drug in contravention of the notice. Any person who is aggrieved by the issue of a notice or by the refusal of the Medical Officer of Health to revoke, vary or modify any condition in it, may appeal to the Minister, whose decision is final.

*Regulation 22 – restriction on the supply of certain controlled drugs*

- 5.52 Regulation 22 of the Misuse of Drugs Regulations provides that certain controlled drugs may not be prescribed, supplied or administered except to the extent and in the circumstances approved by the Minister. These are:

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<sup>323</sup> Misuse of Drugs Act 1975, s 23(1)(c).



- any Class A controlled drug other than cocaine;
- any Class B1 drug or Class B drug in Part 2 of Schedule 2 (Class B2 drug) other than morphine or opium; or
- any Class C1 drug.

In practice this means for example that any cannabis based medicine such as Sativex® cannot be prescribed or supplied or used by patients without Ministerial approval because it is a Class B1 drug. It also means that some drugs that are widely used for therapeutic purposes, like Methylphenidate (Ritalin®) and dexamphetamine, need these approvals, while other substances like cocaine, which is now only rarely used therapeutically, and opium, which has no therapeutic use, are not.

- 5.53 In any event restrictions such as these should be in the Act rather than in regulations because they place significant restraints on the use of certain controlled drugs that have not been agreed to by Parliament.

### Classification system for controlled drugs

- 5.54 As we have already noted, controlled drugs are classified under the Misuse of Drugs Act as Class A, B or C drugs and listed in Schedules 1, 2 or 3 respectively. Classification of a drug as “A, B or C” is primarily for the purpose of determining the maximum penalty that applies to an offence under sections 6 and 7 of the Act.
- 5.55 Class B and C drugs are divided into sub-classifications. Class B drugs in Schedule 2 are divided into the sub-classifications B1, B2 and B3 and listed in Parts 1 to 3 of that Schedule. Class C drugs in Schedule 3 are divided into seven sub-categories and are listed in Parts 1 to 7 of that Schedule.<sup>324</sup>
- 5.56 The only statutory reference to these sub-classifications 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.
- 5.57 The main purpose of the sub-classifications appears to be to regulate matters such as prescribing, storage and record-keeping by persons authorised to deal in controlled drugs, these matters being dealt with in regulations. For example, Class C6 drugs can lawfully be sold over the counter without prescription. Suppliers of Class C2 drugs can be held by approved managers or hospitals. Drugs listed in Part 5 of Class C (Class C5 drugs) are exempted from certain custody requirements. 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.
- 5.58 Moreover, there are significant risks in using a classification system for both 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

<sup>324</sup> Parts 1 to 3 of Schedule 2 and Parts 1 to 6 of Schedule 3 were included in the Act when it was passed, while Part 7 of Schedule 3 was added by section 10 of the Misuse of Drugs Amendment Act (No 2) 1987.

powers are quite different from those that apply to matters such as prescribing, storage and record-keeping. In our view, the law requires clarification to make it accessible and the regulatory controls on drugs and the law enforcement powers that apply to them dealt with separately.

#### OTHER PSYCHOACTIVE MEDICINES

- 5.59 Another group of psychoactive substances are psychoactive medicines that are not controlled drugs. As we have already discussed, the Medicines Act controls the manufacture, distribution, and supply of all medicines.

#### Problems determining whether some substances are medicines

- 5.60 Some interpretative difficulties may arise in applying the definition of medicines in the Medicines Act. The definition of medicine depends on whether a substance is imported, manufactured, sold or supplied wholly or principally for administering for a therapeutic purpose. The difficulty is that it may not always be clear what the principal purpose of dealing with a substance is and whether a purpose can be said to be therapeutic. We discuss this issue further in relation to herbal remedies.

#### Authorisations

- 5.61 Medicines, including those that are psychoactive, can only be manufactured, supplied, possessed and used on the conditions provided for in the Act. There are three categories of authorisation in the Act:
- **licences** that authorise the manufacture, sale by wholesale, packaging and labelling of medicines, or authorise the operating of a pharmacy;
  - **statutory exemptions** that authorise specific classes of people to produce, supply and use medicines that have been approved for use as medicines under the Act; and
  - **statutory exemptions** that authorise medical practitioners, certain other authorised health practitioners and suppliers to produce, supply and administer unapproved medicines for the purposes of treating specific patients.

Each of these categories is considered separately.

#### Licensing for therapeutic purposes

- 5.62 As we have already noted, anyone manufacturing any medicine or packing or labelling any medicine, or supplying any medicine by wholesale, or operating a pharmacy must be licensed unless they are covered by one of the statutory exemptions. A few licences are also issued under the Act to retailers in remote locations where there are no pharmacies. These authorise the retail sale of classes of medicine that can normally only be sold by a pharmacy.<sup>325</sup>

325 Pharmacy-only medicines can be sold pursuant to a licence to sell medicines by retail which can be issued to a retail outlet in an area where there is no pharmacy in a 10 km radius: Medicines Act 1981, ss 18(1)(c)(ii) and 51(2). The effect of such a licence is to allow the sale of pharmacy-only medicines, but not restricted or prescription medicines.

- 5.63 The Director-General of Health is the licensing authority under the Medicines Act and assesses the suitability of applicants and the adequacy of premises. Licences specify the classes of medicine and the activities that can be undertaken under the licence. Licence holders must comply with any terms that are imposed on their licences by the Act, or regulations, or by the licensing authority.

### Exemptions for medicines approved under section 20

- 5.64 We have already discussed the requirement in section 20 of the Medicines Act that medicines be approved before they are sold or distributed in New Zealand. This requirement applies to all medicines, including psychoactive medicines that are not controlled drugs.

### *Classification system for medicines*

- 5.65 Before a medicine is approved for distribution and supply under section 20 it is assessed and if appropriate classified under the classification system established by the Medicines Act. Medicines may be classified as prescription-only, restricted, or pharmacy-only.
- 5.66 The Act establishes a ministerial advisory committee, the Medicines Classification Committee, to assess the degree of risk any approved medicine may pose and recommend whether restrictions should be applied to the retail sale, supply and administration of the medicine. The Committee makes recommendations to the Minister of Health, who in turn recommends classifications for each medicine. These are normally assigned by regulation made by Order in Council. The Medicines Regulations 1984 contain a list of classified medicines in Schedule 1. Prescription medicines are listed in Part 1 of the Schedule; restricted medicines in Part 2; and pharmacy-only medicines in Part 3. Under section 109 of the Act the Minister may also, by notice in the *Gazette*, declare any medicine to be a prescription medicine, restricted medicine or pharmacy-only medicine. When issued, a section 109 notice overrides any inconsistent classification contained in regulations. Notices remain in force for up to six months and provide an interim mechanism for quickly changing classifications.<sup>326</sup>
- 5.67 We note here that many approved medicines are not classified. This is because they are assessed as posing little risk of harm if misused. These medicines are called general sale medicines<sup>327</sup> and fewer restrictions are imposed by the Act on the retail sale or supply of these medicines.<sup>328</sup> Small quantities of paracetamol and aspirin and various cough mixtures, for example, all fall within this group. However, psychoactive medicines are all classified medicines.

<sup>326</sup> Medicines Act 1981, s 106.

<sup>327</sup> Section 99 of the Medicines Act 1981 defines general sale medicines to mean medicines that may be lawfully sold in New Zealand, other than prescription medicines, restricted medicines, and pharmacy-only medicines. Under that section the Director-General of Health is required to publish a list of such medicines.

<sup>328</sup> There is also a prohibition on selling these from vending machines and on auctioning medicines.

*Exemptions for classified medicines*

- 5.68 The classification of a medicine determines the extent to which the sale, supply, or use of the medicine is restricted under the Act. Exemptions under the Act authorise specific classes of people to undertake specific activities with specific classes of classified medicines.<sup>329</sup> Unless one of the exemptions applies, it is an offence under the Act for a person to sell, supply or distribute a classified medicine in contravention of these restrictions. The most serious offence is committed where the breach involves a prescription medicine.<sup>330</sup>
- 5.69 The main statutory authorisations can be summarised as follows:
- Medical practitioners and other authorised prescribers may manufacture, pack and label, procure, sell, supply or administer any classified medicine for the purposes of treating patients.<sup>331</sup>
  - A veterinarian may manufacture, sell, supply, or administer a classified medicine for the treatment of an animal under veterinary care.<sup>332</sup>
  - A registered optometrist may pack and label, sell or supply a classified medicine used in conjunction with contact lenses.<sup>333</sup>
  - A pharmacist may manufacture, pack, label and supply any medicine, including a classified medicine, although prescription medicines may only be sold by retail or supplied by a pharmacist pursuant to a prescription issued by a medical or dental practitioner, midwife, veterinary surgeon, or a designated prescriber.<sup>334</sup> A restricted medicine may also only be sold by retail by a pharmacist, who must personally oversee the sale. Although a prescription is not required, regulations require the pharmacist to keep a record of sales of restricted medicines.<sup>335</sup>
  - Pharmacies and also licensed retail outlets in remote areas may sell pharmacy-only medicines by retail.<sup>336</sup>
  - Patients may take, and others may administer, prescription medicines in compliance with the directions of an authorised prescriber or in accordance with any standing order.<sup>337</sup>
  - People may procure and administer restricted and pharmacy-only medicines without a prescription.

329 As has already been discussed, some of these activities can be undertaken under a licence.

330 See section 18(5) of the Medicines Act 1981 which provides a maximum penalty of six months imprisonment and a \$40,000 fine for selling, supplying or distributing a prescription medicine in contravention of section 18(1). The maximum penalty for selling, supplying or distributing a restricted or pharmacy-only medicine is three months imprisonment and a fine of \$500: see Medicines Act 1981, s 78.

331 Other authorised prescribers are dentists, registered midwives and designated prescribers.

332 Medicines Act 1981, s 27(a).

333 Medicines Act 1981, s 27(b). This is in addition to their rights as designated prescribers under the first bullet point of the list.

334 See Medicines Act 1981, s 18(1)(a)(i), (2) and (2A). In addition, section 18(1)(a)(ii) allows for the supply of prescription medicines pursuant to a standing order.

335 See Medicines Act 1981, s 18(1)(b).

336 Pharmacy-only medicines can also be sold pursuant to a licence to sell medicines by retail which can be issued to a retail outlet in an area where there is no pharmacy in a 10 km radius: See Medicines Act 1981, s 18(1)(c)(ii) and s 51(2). The effect of such a licence is to allow the sale of pharmacy-only medicines, but not restricted or prescription medicines.

337 A standing order is similar to a prescription, in the sense that it is written by an authorised prescriber, but it is a general permission which authorises the administration of any specified medicines to any specified group of people by any specified health professional in certain circumstances.

- 5.70 Psychoactive medicines (assuming they are not controlled drugs) are almost always classified as prescription medicines, although on occasion mildly psychoactive medicines have been classified as restricted medicines and pharmacy-only medicines.<sup>338</sup> Consequently very few psychoactive medicines can be purchased over the counter from a pharmacy without a prescription. When they can be purchased without a prescription, the sale must be personally overseen by a pharmacist who determines whether it is appropriate to sell the medicine. The more stringent controls outlined above will therefore normally apply to the supply of psychoactive medicines.

### Exemptions for new or unapproved medicines

- 5.71 We have already outlined the limited exemptions that authorise some closely controlled use of unapproved medicines. There are two further exemptions which apply to psychoactive medicines but not controlled drugs. These are exemptions for herbal remedies and exemptions for natural therapists.

#### Exemptions for herbal remedies

- 5.72 Section 28 contains two exemptions that apply to herbal remedies. These may, at least in theory, cover unapproved medicines that have psychoactive effects. Firstly, any person may, without a licence, manufacture, pack and label, or supply in the course of their business any herbal remedy provided it is for administration to a particular person who has requested treatment from the herbal practitioner. Secondly, section 28 also authorises the manufacture, packing, labelling, sale and supply of any herbal remedy without a licence if the remedy is identified simply by reference to the plant from which it is made and the process to which the plant was subjected during production. For this exemption to apply no other name may be given to the product and there must not be any labelling or accompanying written material recommending the use of the remedy. If therapeutic claims are made for the herbal material or it is packaged and presented under some brand name, the exemption does not apply.
- 5.73 A “herbal remedy” is defined in the Act as a medicine consisting of any substance produced by subjecting a plant to drying, crushing, or any other similar process, or a mixture of two or more such substances. The only other ingredients that can be included are water, ethyl alcohol or any other inert substance. The Act prohibits any herbal remedy from containing any prescription medicine, restricted medicine or pharmacy-only medicine.
- 5.74 The exemption may possibly allow psychoactive herbs to be dried, packaged and sold. Whether it does turns on whether the herb is principally a therapeutic substance. For example, the herb *salvia divinorum* (diviner’s sage) has purportedly been used historically both for its psychoactive properties and as a herbal treatment for various conditions.<sup>339</sup> Might *salvia divinorum* consequently be packaged and

<sup>338</sup> Some sedating antihistamines (chlorpheniramine, diphenhydramine and promethazine), dextromethorphan and atropinic agents could be regarded as mildly psychoactive and some of these are restricted medicines and pharmacy-only medicines.

<sup>339</sup> The Mazates Indians used the herb remedially at sub-visionary doses to treat a variety of conditions including arthritis, headache, and eliminatory complaints. See D J Siebert “Localization of Salvinorin A and Related Compounds in Glandular Trichomes of the Psychoactive Sage, *Salvia Divinorum*” (2004) 93 *Annals of Botany* 763, 763.



sold under this exemption as a herbal remedy? This illustrates the problematic nature of the definition of “medicine”, which depends on whether a substance is manufactured or sold wholly or principally for therapeutic purposes.

### *Exemption for natural therapists*

- 5.75 Section 32 also contains an exemption for natural therapists. Any natural therapist, or indeed any person, may manufacture, pack, label, or supply by retail any medicine providing it is not, or does not contain, a prescription medicine, a restricted medicine, or a pharmacy-only medicine and is supplied for administration to a particular person who has requested the therapist to use his or her judgement and determine the appropriate treatment for the person requesting the remedy. The purpose of the exemption is to allow natural therapists like homeopaths, naturopaths, herbal practitioners and others to prepare remedies. However, on its face the exemption is broader than this, and authorises without restriction the manufacture, packing, labelling or supply of an unapproved medicine provided it does not contain one of the categories of medicine described above. At least in theory, psychoactive medicines that have not been approved and classified fall within this exemption and can therefore be supplied under it. We wonder whether the exemption is intended to be so broad, given the strict controls that are in place elsewhere in the Act to restrict the use of such substances by medical practitioners.

### HAZARDOUS SUBSTANCES

- 5.76 The Hazardous Substances and New Organisms Act 1996 (HSNO) also applies to many psychoactive substances. The Act provides that no hazardous substance may be imported or manufactured otherwise than in accordance with an approval under the Act.<sup>340</sup> If a substance is not hazardous, it is not regulated by the Act and no approval is needed. Although the Act does not directly regulate sales of hazardous substances, indirectly it regulates sales because only hazardous substances that have been imported or manufactured in accordance with an approval can be distributed and sold in New Zealand.
- 5.77 A “hazardous substance” is a substance that has one or more of the properties listed in the definition in section 2 of the Act. The listed property relevant to drugs or psychoactive substances is “toxicity including chronic toxicity”. A substance is “toxic” if it is “capable of causing ill health in, or injury to, human beings”.<sup>341</sup>
- 5.78 The Hazardous Substances (Minimum Degrees of Hazard) Regulations 2001, authorised and made under the Act, provide that a substance is not a hazardous substance unless it meets the minimum degree of hazard for at least one of the intrinsic properties. Schedule 4 of the Hazardous Substances (Minimum Degrees of Hazard) Regulations prescribes the minimum degree of hazard for toxic substances. The relevant part of Schedule 4 requires as a minimum degree that:
- (s) data for the substance indicates, in the opinion of an expert, evidence of a significant adverse biological effect or a significant toxic effect other than an effect referred to in any of paragraphs (a) to (r) on the function or morphology of an organ or on the biochemistry or haematology of an organism or human being as a result of exposure to the substance and in the case of a significant adverse biological effect the change is relevant to health.

<sup>340</sup> Hazardous Substances and New Organisms Act 1996, s 25(1).

<sup>341</sup> “Toxic” is defined in section 2 of Hazardous Substances and New Organisms Act 1996.



## Psychoactive substances meet the minimum degree of hazard

- 5.79 Most, if not all, psychoactive substances are likely to meet the minimum degree of hazard specified above, since they will have a significant adverse biological effect on health, at least if used to excess. People ingest psychoactive substances because they impact on physiology in a way that induces a change. To be pleasurable, a substance must cause physiological changes and these will almost invariably be sufficient to meet the threshold of toxicity.<sup>342</sup> However, some psychoactive substances are not hazardous substances because they are medicines or food and these have been expressly excluded from the scope of HSNO.

### *Medicines are not hazardous substances*

- 5.80 Regulation 5 of the Hazardous Substances (Minimum Degrees of Hazard) Regulations provides that a “medicine” is not a hazardous substance unless it is:
- a new medicine that is an ingredient for use in another medicine, rather than a ready to consume medicine; or
  - a new medicine for which an application for registration as a veterinary medicine under the Agricultural Compounds and Veterinary Medicines Act 1997 has been made.<sup>343</sup>
- 5.81 The definition of “medicine” in HSNO is the same as that in the Medicines Act except in one respect. The HSNO definition does not include a gas contained at a pressure greater than 170kPa in a container larger than 100ml, at any time between its containment and its being administered to a patient for a therapeutic purpose. Anaesthetic gases like nitrous oxide are therefore hazardous substances while they are contained and stored but cease to be hazardous substances at the point at which they are administered to a patient. At that point they come within the definition of “medicine” as the term is used in HSNO and are not hazardous substances. In contrast the definition of “medicine” in the Medicines Act does include these substances.
- 5.82 The vast majority of medicines, including most psychoactive medicines and controlled drugs that are medicines, will fall squarely within the exclusion for medicines and are not hazardous substances. All psychoactive medicines and controlled drugs that are approved medicines are regulated under the Medicines Act and the Misuse of Drugs Act and not under HSNO. However, as we discussed earlier there can be difficulties in determining whether a particular psychoactive substance falls within the definition of medicine in the Medicines Act. As a result it may also be difficult to determine whether these substances are excluded from HSNO. This creates the potential for some substances to slip between the cracks.

342 If a psychoactive substance was so mild it did not trigger the threshold then there would be little point in regulating its use.

343 Also any medicine that might have been regulated under the transitional provisions in Parts 13, 14, or 15 of the Hazardous Substances and New Organisms Act 1996 is not excluded from the definition of hazardous substance. These transitional provisions have now expired.

### When the Medicines Act and HSNO both apply

- 5.83 There are some psychoactive substances that are covered by both the Medicines Act and HSNO. This is because they are medicines as defined in the Medicines Act but, because they fall within the exceptions for certain new medicines or take the form of a pressurised gas in storage, they are also hazardous substances. Nitrous oxide and anaesthetic gases are examples.
- 5.84 Sections 5A and 110 of the Medicines Act deal with the relationship between the Medicines Act and HSNO when a substance falls within both regulatory schemes. Section 5A says that the requirements of the Medicines Act are additional to the requirements of HSNO for any medicine that is or contains a hazardous substance or new organism. Section 110 provides that in the event of any inconsistency between the provisions of HSNO and the Medicines Act, or regulations made under them, the Medicines Act and regulations made under it will prevail. None of the provisions in the Medicines Act otherwise affect or derogate from HSNO.
- 5.85 We take this to mean that the regulatory regimes are cumulative. For example, a new medicine that is an ingredient for use in another medicine can only be imported in circumstances that comply with the Medicines Act and if an approval under HSNO has been obtained. The conditions in that approval also need to be complied with.

### *Psychoactive substances that are technically “food” are excluded from the definition of hazardous substance*

- 5.86 Regulation 6 of the Hazardous Substances (Minimum Degrees of Hazard) Regulations provides that a “food” is not hazardous for the purposes of the Act. “Food” has the same meaning as in the Food Act 1981 except that it does not include a food additive if that additive has not been mixed with or added to any other food or drink.<sup>344</sup> This means that a food additive, such as the propellant nitrous oxide, is a hazardous substance until it is mixed into food, for example, when it is included as a propellant in an aerosol container with cream.
- 5.87 In contrast, the definition of “food” in the Food Act includes unmixed food additives. As a consequence, this small group of substances, “unmixed food additives”, are regulated as both “hazardous substances” under HSNO and as “food” under the Food Act. Included in that group is at least one psychoactive substance, nitrous oxide.

### Controls imposed by HSNO

- 5.88 The Act places responsibility for determining whether something is a hazardous substance on those who intend to manufacture or import the substance. It is an offence to manufacture or import an unapproved hazardous substance. Where there is an approval in place, a manufacturer or importer must comply with any conditions imposed by the approval. Where there is uncertainty as to whether

344 Also any food that might have been regulated under the transitional provisions in Parts 13, 14, or 15 of the Act is not excluded from the definition of hazardous substance. These transitional provisions have now expired.

a substance is a hazardous substance, an application may be made under section 26 to have the Environmental Risk Management Agency (ERMA) determine whether the substance is a “hazardous substance”. Any person may make an application under section 26. This includes government departments or officials.

- 5.89 Under section 26 of the Act, ERMA has the power by notice in the *Gazette* on application by any person to determine whether or not any substance is a “hazardous substance”. Before doing so ERMA must take into account:

- any information held by the Authority;
- any information held by a department listed in Schedule 1 of the State Sector Act 1988 and any Crown entity;
- any information provided by the applicant.

It is relevant to note that ERMA has access to a significant volume of international research material about a range of substances which may help to inform a section 26 determination.

### *Precautionary approach*

- 5.90 Also relevant is section 7 of the Act which requires a “precautionary” approach when ERMA determines whether a substance is hazardous. It provides:

All persons exercising functions, powers and duties under this Act, including but not limited to functions, powers and duties under sections 28A, 29, 32, 45 and 48 shall take into account the need for caution in managing adverse effects where there is scientific and technical uncertainty about those effects.

- 5.91 The HSNO process is available for assessing and imposing controls on psychoactive substances that are used recreationally as drugs although it has only recently begun to be used.<sup>345</sup> If a substance, including a psychoactive one, is assessed as hazardous it cannot be manufactured or imported until an approval is obtained.

### *Approvals for “hazardous substances”*

- 5.92 Approvals are issued by ERMA in accordance with the processes laid out in Part 5 of the Act. Section 29 of the Act gives ERMA the power to approve or decline applications for approval. ERMA must take into account:

- any controls that may be imposed on the substance;
- all effects of the substance during the lifecycle of that substance;
- the likely effect of the substance being unavailable.

If the positive effects of the substance outweigh the adverse effects the application can be approved, but if the adverse effects outweigh the positive effects it can be declined. An application can also be declined if the applicant fails to provide sufficient information for the assessment.

<sup>345</sup> We understand that the Ministry of Health has asked ERMA to undertake an assessment of *salvia divinorum*.

*Conditions imposed on approvals*

- 5.93 Where an approval is given under Part 5 there are a broad range of controls that may be imposed. These include controls relating to retail sales and supply, labelling, storage and use of the hazardous substance. Section 77A of the Act enables the Authority to apply controls that it “thinks fit”. When determining what controls to impose, ERMA considers the predominant use of the substance. Currently ERMA sets exposure levels and other controls for toxic substances based on the intended and predominant use.
- 5.94 The legislation allows appropriate conditions to be imposed when there is evidence that a hazardous substance is being misused. For example, when setting conditions for methylated spirits ERMA took into account evidence that it was being drunk. The controls that have been imposed reflect this. Controls on solvents are currently set to ensure safe exposure when used correctly. They do not currently address the hazard such substances pose when deliberately inhaled for their psychoactive effects, although there is nothing to prevent ERMA from doing so.

RESTRICTED  
SUBSTANCES

- 5.95 The Misuse of Drugs Amendment Act 2005 established a regime for regulating psychoactive substances that are not so harmful that they should be scheduled as controlled drugs and prohibited under the Misuse of Drugs Act. Restricted substances are substances that are assessed as posing a less than moderate risk of harm. They continue to be legally available under the regime but subject to regulatory controls.
- 5.96 Restricted substances are listed in Schedule 4 to the Amendment Act. However, there are presently no restricted substances. The regime was briefly used to regulate BZP. However, BZP was subsequently reclassified as a Class C controlled drug.<sup>346</sup> The schedule has since remained empty.

**The definition of “restricted substance” and “substance”**

- 5.97 Only substances that fall within the definition of “substance” in section 31 of the Amendment Act may be added to Schedule 4 and regulated as “restricted substances”. A “restricted substance” is defined as any “substance” specified or described in Schedule 4 that is not a preparation, concentration, form or use exempted from being a restricted substance by regulations. The term “substance” is defined as:
- (a) any mixture, preparation, or article that is manufactured for the primary purpose of being administered, ingested, inhaled, or injected to induce a psychoactive response; but
  - (b) does not include any –
    - (i) agricultural compound or veterinary medicine (as defined in section 2(1) of the Agricultural Compounds and Veterinary Medicines Act 1997);
    - (ii) controlled drug, controlled drug analogue, or precursor substance (as defined in section 2(1) of the principal Act);

<sup>346</sup> When the Misuse of Drugs Amendment Act 2005 was first enacted BZP was listed as the first restricted substance under the regime. However it was subsequently removed from the schedule of restricted substances in 2008 when it was classified as a Class C controlled drug by the Misuse of Drugs (Classification of BZP) Amendment Act 2008.

- (iii) dietary supplement (as defined in regulation 2(1) of the Dietary Supplements Regulations 1985);
- (iv) food (as defined in section 2 of the Food Act 1981);
- (v) hazardous substance (as defined in section 2(1) of the Hazardous Substances and New Organisms Act 1996);
- (vi) herbal remedy (as defined in section 2(1) of the Medicines Act), medicine (as defined in section 3 of that Act), or related product (as defined in section 94 of that Act);
- (vii) liquor (as defined in section 2 of the Sale of Liquor Act 1989); or
- (viii) tobacco product or herbal smoking product (as defined in section 2(1) of the Smoke-free Environments Act 1990).

- 5.98 Any substance that falls within one of the exclusions listed in subsection (b) cannot be a restricted substance if it is primarily intended to induce a psychoactive response. The exclusions were inserted in the Bill when it was reported back by the Select Committee. The policy objective was to ensure that psychoactive substances that had other legal uses but might also be used recreationally for their psychoactive effects were not scheduled as restricted substances. The Committee considered that existing legislation, rather than the new regime, should be used to regulate such substances.<sup>347</sup> The Committee wished to avoid unnecessary overlap between the restricted substances regime and other regulatory schemes.
- 5.99 The exclusions achieve this objective. Any substance that falls within the definition of one of the excluded substances cannot also be scheduled as a restricted substance. The difficulty is that **all** harmful psychoactive substances fall into one or other of the exclusions. There are therefore no substances that can come within the regime. The problem stems largely from the broad and inclusive way “hazardous substance” is defined in section 2(1) of HSNO which captures all harmful substances that are not medicines or food. If any psychoactive substances exist that do not meet the minimum degree of hazard, they would be relatively harmless so that there would be no reason to regulate them as restricted substances. If the restricted substances regime is retained, this problem needs to be fixed.
- 5.100 The problem could be fixed by making regulations under HSNO specifically excluding psychoactive substances that are “manufactured for the primary purpose of being administered, ingested, inhaled or injected to induce a psychoactive response”<sup>348</sup> from the definition of hazardous substance under that Act. However, that would leave such substances unregulated until they were brought under the restricted substances regime.<sup>349</sup> Alternatively, the problem could be fixed by making regulations under HSNO excluding only specific named substances at the same

<sup>347</sup> (9 June 2005) 626 NZPD 21232.

<sup>348</sup> This is the first part of the definition of substance in section 31 of the Misuse of Drugs Amendment Act 2005.

<sup>349</sup> Regulation making powers under HSNO allow regulations to be made excluding substances from the definition of hazardous substance. We have noted already that the Hazardous Substances (Minimum Degrees of Hazard) Regulations expressly exclude food and medicines, so similarly certain psychoactive substances could also be excluded by regulation. Excluding all substances that are not food or medicines but have been manufactured for the primary purpose of being administered, ingested, inhaled or injected to induce a psychoactive response would be possible but this would leave these potentially harmful substances unregulated until they are brought within the restricted substances regime.



time as an Order in Council is made bringing those substances within the restricted substances scheme. While this alternative avoids substances falling between the two regimes, it does introduce additional complexity into the legislation. A better alternative may therefore be an amendment to the Misuse of Drugs Amendment Act 2005.

### Controls that apply to restricted substances

5.101 When substances are scheduled as restricted substances they can be manufactured, imported, distributed, sold and used as recreational drugs provided the provisions of the Misuse of Drugs Amendment Act 2005 and regulations made under it are complied with. The Amendment Act prohibits the sale or supply of a restricted substance to any person under the age of 18 years.<sup>350</sup> It also prohibits any person under the age of 18 years from selling any restricted substance.<sup>351</sup> Manufacturers, distributors, importers, and retailers of restricted substances may not distribute or supply restricted substances free of charge or as promotional gifts to encourage purchase and use.<sup>352</sup> Finally, the Act also prohibits the advertising of a restricted substance in the media.<sup>353</sup>

5.102 The Misuse of Drugs (Restricted Substances) Regulations 2008 prohibit:<sup>354</sup>

- restricted substances from being sold from premises that sell or supply alcohol to the public or from premises that sell petrol;
- restricted substances from being sold from places where children or minors gather such as schools or sports centres or from non-fixed premises such as tents or vehicles;
- the advertising of restricted substances except within the premises from which they are sold or supplied (although the restriction does not apply to advertising on the Internet).

Regulations also prescribe labelling, packaging, storage and display requirements. Labels on restricted substances must, for example, contain the statement that: "It is illegal to sell or supply a restricted substance to any person under the age of 18". This statement must also be displayed in all premises selling or supplying restricted substances. Packaging must be tamper-proof and child-proof and restricted substances must be stored or displayed in a manner that does not allow public access.

5.103 The Misuse of Drugs Amendment Act 2005 provides also for manufacturing codes of practice to be issued by the Director-General of Health.<sup>355</sup> Where a code is in place, only restricted substances that comply fully with the applicable parts of the code can be manufactured or imported into New Zealand.<sup>356</sup> There are currently no licensing requirements that apply to the manufacture, importation,

350 The Misuse of Drugs Amendment Act 2005, ss 36 and 39: section 39(1)(b) also prohibits supply to any other person with the intention that it be supplied to a person under 18 years.

351 The Misuse of Drugs Amendment Act 2005, s 38.

352 The Misuse of Drugs Amendment Act 2005, s 42.

353 The Misuse of Drugs Amendment Act 2005, s 43.

354 The regulations came into force on 6 November 2008.

355 Section 63 of the Misuse of Drugs Amendment Act 2005 contains the process for issuing a code.

356 The Misuse of Drugs Amendment Act 2005, ss 49 and 50.



distribution or wholesale supply of restricted substances. There are currently no manufacturing codes of practice, so no specific restrictions apply to the manufacture or importation of restricted substances.

## PSYCHOACTIVE SUBSTANCES IN FOOD

- 5.104 The Food Act and regulations and standards made under it play a more peripheral role than the other regimes we have considered in regulating psychoactive substances. The Food Act is relevant only because of recent developments that have seen psychoactive substances, including BZP before it became a restricted substance, sold in the guise of energy drinks and dietary supplements. We consequently need to briefly consider the way food is regulated.

### Controls imposed by the Food Act

- 5.105 The Food Act regulates the manufacturing, preparation and packaging for sale, and the sale of food. The regulatory scheme established by the Food Act regulates substances that are used in the preparation of food for sale and also determines which substances may be incorporated into food or drink that is produced, marketed and sold. All manufacturers, importers, producers, suppliers and sellers of food have a responsibility to ensure that their products are safe and comply with the legal requirements imposed by the Food Act and by food standards and regulations made under it.
- 5.106 Under section 11C the Minister of Food Safety has the power to issue food standards setting minimum requirements for the quality and safety of food for sale. Food standards set requirements or standards for food that is manufactured or prepared for sale or sold in New Zealand or imported into New Zealand. Standards set under the Act cover all aspects of food production.
- 5.107 Section 9 of the Act imposes a general prohibition on selling food that does not meet any standard that has been set for food of that kind. It also imposes a complete prohibition on preparing or packing for sale or selling any food that is unsound or unfit for human consumption or any food that has been contaminated or contains anything that is injurious to health or harmful or offensive.<sup>357</sup> No one may prepare or pack for sale or sell food in any packaging material or using any appliance that would render the food injurious to health or otherwise taint the food.

### Definition of food and application of the Food Act

- 5.108 “Food” is defined as anything that is used or represented for use as food or drink for human beings. It includes any ingredient or nutrient or other constituent of any food or drink, whether that ingredient is consumed as a food in itself, mixed with other ingredients or used in the preparation of food or drink.
- 5.109 The definition is imprecise and somewhat circular. While it is relatively clear in most cases whether a substance is or is not a food, there are grey areas. One of these surrounds psychoactive substances incorporated into drinks or tablets that are marketed as stimulants and energy enhancers. These products

<sup>357</sup> Food Act 1981, s 9(4).

are consumed orally; they contain some psychoactive ingredients but also other ingredients and nutrients that are commonly used in food. Do they fall within the broad definition of “food” in the Act?

- 5.110 It seems reasonably clear that energy drinks containing high levels of caffeine and sometimes other stimulants are food and are regulated under the Food Act. A food standard (standard 2.6.4), Formulated Caffeinated Beverages, covers such products.<sup>358</sup> However, the position is not so clear when psychoactive substances are incorporated as an ingredient in a tablet form and marketed as energy or party pills. There is less certainty over whether or not the Food Act applies to these types of products. This has resulted in potentially harmful psychoactive substances falling between regimes.
- 5.111 In 2005, BZP was used as an ingredient in pills labelled and sold as “dietary supplements”. Dietary supplements are a group of foods that are regulated under the Dietary Supplements Regulations 1985. These pills were later withdrawn on the basis that they were not a permitted additive under the Dietary Supplements Regulations. This illustrates that there may be some uncertainty at the margins as to whether particular substances are foods, medicines or hazardous substances.
- 5.112 In the case of BZP, this became a moot point once the Misuse of Drugs Amendment Act 2005 came into force. However, the broader definitional issues at the interface between medicines, food and HSNO still may require attention. There is still a degree of uncertainty over which regime applies to some types of products containing psychoactive substances. We stress that the regulation schemes relating to food, medicines and hazardous substances appear to contain adequate controls for regulating these types of products and they must fall within one or the other. The uncertainty over which scheme applies to which products should be addressed because in practice it seems to result in neither regime being applied to some substances.

#### PROBLEMS WITH THE CONTROLLED DRUGS REGIME AND ITS INTERFACE WITH OTHER REGIMES

- 5.113 Psychoactive substances are all currently regulated as controlled drugs, other psychoactive medicines, hazardous substances, or as food.<sup>359</sup> There are a number of problems with the interface between these various regulatory regimes. In summary:
- The regulation-making powers in the Misuse of Drugs Act are very broad. They permit regulations that override the statute and deal with significant matters of policy. While we acknowledge that there is a need for flexibility in this area to deal with new and changing circumstances, in our view too much is left to regulation.
  - The relationship between the Misuse of Drugs Act and the Medicines Act lacks transparency. There is also considerable overlap and duplication between the two regimes. This makes the law inaccessible. It would be improved if the exemptions that applied to controlled drugs were in one Act, probably the Medicines Act (with appropriate cross references), and subject to one consolidated set of conditions.

358 An interesting case arose in April 2005 when a “herbal” energy drink called Ammo that contained BZP was voluntarily recalled after the Food Standards Agency determined that the product breached the Food Code.

359 As has been noted already the regulatory schemes covering alcohol and tobacco have been excluded from our review.

- The powers of the Minister to override statutory authorisations to deal in controlled drugs are too broad. While there may be a need for powers to override licences and exemptions to deal with emergency situations, it is certainly not appropriate for the Minister to have powers that are so wide that they can override the prescriptions of medical practitioners.
- There is some inconsistency between the roles of the Minister of Health and the Director-General of Health. It does not make sense for the Director-General to have power to issue licences and the Minister to have the power to revoke them. In practice most of the powers of the Minister under the Act are delegated to the Director-General and it is questionable whether the Minister rather than the Director-General should continue to have the authorisation to make revocation decisions.
- The sub-classification system in the Misuse of Drugs Act is obscure. Moreover, it seems inappropriate because it serves both law enforcement and regulatory purposes which are not necessarily consistent with each other.
- There are difficulties at the margins in the definitions of “medicine” and “food”. This has the potential for some substances to slip between the cracks of the various regulatory regimes. While the overall regulatory framework relies on HSNO to catch potentially harmful substances that are not food or medicine, if it is unclear what a substance is, it may go unregulated.
- The restricted substances regime can have no content unless regulations are made under HSNO excluding psychoactive substances that might be brought within the restricted substances scheme from the definition of hazardous substance. Though intended as a regime for recreational psychoactive substances that pose relatively little harm, these substances are already controlled either as medicines, food or hazardous substances.

# Chapter 6

## New Zealand's international obligations

### SUMMARY

This chapter summarises the international legal framework and the obligations that New Zealand must take into account in formulating domestic drug policy. One of the key issues is the extent to which the conventions require parties to criminalise personal use of controlled drugs.

**INTRODUCTION** 6.1 As a party to three United Nations drug conventions, New Zealand has undertaken to impose controls on narcotic drugs and psychotropic substances in its own territory and to co-operate with other countries to combat the trafficking of drugs. In many areas, the obligations are specific and reasonably clear-cut. In other areas, including some obligations to prohibit conduct through the criminal law, there is both more latitude and less certainty.

6.2 This chapter summarises the international legal framework and the obligations that New Zealand must take into account in formulating domestic drug policy. One of the key issues is the extent to which the conventions require parties to criminalise personal use of controlled drugs.<sup>360</sup>

### THE UNITED NATIONS CONVENTIONS

6.3 New Zealand is a party to the following United Nations drug conventions:

- Single Convention on Narcotic Drugs 1961, as amended by the 1972 Protocol (the 1961 Convention);
- Convention on Psychotropic Substances 1971 (the 1971 Convention);
- Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 (the 1988 Convention).

<sup>360</sup> In this chapter, “controlled drugs” is used as a collective term for both “narcotic drugs” governed by the Single Convention on Narcotic Drugs (30 March 1961) 520 UNTS 151 [1961 Convention] and “psychotropic substances” governed by the Convention on Psychotropic Substances (21 February 1971) 1019 UNTS 175 [1971 Convention].

## Single Convention on Narcotic Drugs 1961

- 6.4 In the first half of the 20<sup>th</sup> century, several international treaties were adopted to control addictive drugs such as opium, cocaine and derivatives. Following the establishment of the United Nations (UN) after World War II, the UN's Economic and Social Council began to develop a single treaty that would consolidate all previous drug treaties<sup>361</sup> and provide a durable framework for international co-operation in drug control. The result was the Single Convention on Narcotic Drugs 1961.
- 6.5 The Convention, which covers over 100 drugs,<sup>362</sup> essentially consolidated a policy of prohibition at the international level and committed parties to adopting additional measures to implement prohibition in respect of a broader range of drugs. It requires parties to establish controls over the production, cultivation, supply, import, export, possession and use of narcotic drugs. There is specific regulation of the opium poppy, the coca bush and the cannabis plant.<sup>363</sup> Co-operative action against illicit traffic is mandated. The Convention requires parties to establish criminal offences for specified conduct contrary to its provisions.<sup>364</sup> Parties must take all necessary measures to limit the use of specified narcotic drugs<sup>365</sup> to medical and scientific purposes and to co-operate in doing so.<sup>366</sup>
- 6.6 The Convention also establishes the UN's organisational framework for oversight and administration of the Convention, including specific functions for the World Health Organisation (WHO),<sup>367</sup> the Commission on Narcotic Drugs (CND)<sup>368</sup> and the International Narcotics Control Board (INCB).<sup>369</sup> Countries are required to report annually to the INCB on the quantities of drugs to be produced, stocked and consumed for legitimate purposes<sup>370</sup> and to provide other information as requested by the CND.<sup>371</sup>
- 6.7 The 1972 Protocol amending the Single Convention restated the importance of international co-operation against illicit traffic and stressed the need for treatment and rehabilitation services for drug addicts.

361 Article 44 of the 1961 Convention, *ibid*, lists the treaties that the Convention replaced.

362 These were divided into four schedules with some differences in the controls that applied to the drugs in the different schedules. This is discussed in chapter 5.

363 1961 Convention, above n 360, arts 21–28.

364 *Ibid*, art 36.

365 Drugs covered by the 1961 Convention are listed in Schedules I–IV to the Convention and are known as the “Yellow List”. See [www.incb.org/incb/yellow\\_list.html](http://www.incb.org/incb/yellow_list.html) (accessed 27 January 2010) for the current list.

366 1961 Convention, above n 360, art 4.

367 *Ibid*, art 3.

368 *Ibid*, art 8.

369 *Ibid*, arts 9 and 14.

370 *Ibid*, art 19.

371 *Ibid*, art 18.

### Convention on Psychotropic Substances 1971

- 6.8 The 1971 Convention responded to the rapid growth in the production and use of hallucinogens (such as LSD and mescaline), stimulants (such as amphetamines), and depressants (such as barbiturates, sleeping pills and tranquillisers), most of which were not covered or able to be brought under the 1961 Convention. The 1971 Convention established a companion control regime for the substances listed in its four Schedules.<sup>372</sup>
- 6.9 The Preamble to the Convention expresses the parties' determination to combat illicit traffic and abuse of such substances, while recognising that their use for medical and scientific purposes remains "indispensable". Parties are required to adopt appropriate measures to limit manufacture, export, import, trade, distribution, use and possession to such purposes.<sup>373</sup> Like the 1961 Convention, the controls adopted by each country are to be supported by criminal offences.<sup>374</sup> WHO, CND and INCB also have similar functions as under the 1961 Convention.<sup>375</sup>

### Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988

- 6.10 The 1988 Convention represented a major change of emphasis by the UN. Parties to the 1988 Convention resolved to adopt a wide range of criminal law measures directed specifically at illicit traffic and the economic base that supports it. At the forefront of the Convention are strengthened penal provisions that expressly require criminalisation of the organisation and financing of drug crime, and of money laundering.<sup>376</sup> Parties are required to adopt further measures to extend jurisdiction over their nationals,<sup>377</sup> ensure all serious offences are extraditable,<sup>378</sup> confiscate profits,<sup>379</sup> provide mutual legal assistance,<sup>380</sup> and maintain high levels of communication and co-operation.<sup>381</sup>
- 6.11 The Convention also extended the scope of international drug control by requiring parties to impose controls over specified precursor substances<sup>382</sup> commonly used in the creation of controlled drugs – for example, ephedrine and pseudoephedrine.<sup>383</sup> The CND and INCB were also given additional responsibilities.<sup>384</sup>

372 The list of psychotropic substances covered by the 1971 Convention is referred to as the "Green List". See [www.incb.org/incb/green\\_list.html](http://www.incb.org/incb/green_list.html) (accessed 27 January 2010).

373 Compared to article 4 of the 1961 Convention, this central obligation is stricter in respect of Schedule I substances (see 1971 Convention, above n 1, art 5(2)) and arguably weaker in respect of substances listed in Schedules II-IV (see 1971 Convention, above n 360, art 7).

374 1971 Convention, above n 360, art 22.

375 See *ibid*, arts 2, 3 and 17–19.

376 Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances (20 December 1988) 1582 UNTS 95, art 3 [1988 Convention].

377 *Ibid*, art 4.

378 *Ibid*, art 6.

379 *Ibid*, art 5.

380 *Ibid*, art 7.

381 *Ibid*, art 9.

382 Precursor substances that are subject to the 1988 Convention are listed in the "Red List": [www.incb.org/incb/red\\_list.html](http://www.incb.org/incb/red_list.html) (accessed 27 January 2010).

383 1988 Convention, above n 376, art 12.

384 *Ibid*, arts 22 and 23.



- 6.12 The UN system of international drug control is administered by a number of organisations. The United Nations Economic and Social Council (ECOSOC) is responsible for developing and maintaining the international drug control system. ECOSOC can call international conferences and prepare draft conventions for submission.<sup>385</sup> The three conventions and the 1972 Protocol were adopted by conferences called by ECOSOC.
- 6.13 The CND, established by ECOSOC, is the principal body responsible for drug control policy in the UN system. It is elected by and reports to the member states of ECOSOC. It monitors the world drug situation, develops proposals to deal with it, and advises ECOSOC on all matters relating to drug control. That may include developing new treaties or recommending changes to existing treaties. The CND makes decisions, on the basis of recommendations by the WHO, to amend the Schedules of narcotic drugs and psychotropic substances.<sup>386</sup> It also decides on additions and changes to the Tables of precursor substances in the 1988 Convention based on INCB recommendations.<sup>387</sup>
- 6.14 The WHO is responsible under each of the conventions for providing expert advice on which narcotic drugs and psychotropic substances should be brought under international control.<sup>388</sup>
- 6.15 The INCB was established under the 1961 Convention.<sup>389</sup> It is an independent body and has a mandate to monitor implementation of all three conventions and promote compliance with them. It receives and examines regular statistical reports and other information from all parties to the conventions. The INCB may require a party to provide explanations for apparent non-compliance, and may recommend that a government take remedial measures to address that non-compliance. The INCB cannot issue binding interpretations of the conventions and cannot itself enforce the conventions' provisions. However, the nature of the INCB's role is such that its interpretations of the conventions' requirements nevertheless may be politically, if not legally, persuasive.
- 6.16 The United Nations Office on Drugs and Crime (UNODC) was established in 1997 (as the Office for Drug Control and Crime Prevention) and has broad responsibilities to provide member states with technical assistance, research, analysis and policy development in the fields of illicit drugs, crime and terrorism. UNODC also carries out much of the day-to-day work of the INCB and houses the CND and INCB secretariat.

- 6.17 The three conventions are not self-executing. Each party must take steps by way of domestic law, enforcement, and administrative measures to comply with the conventions' provisions. Parties must co-operate with each other according to the terms of the conventions.

<sup>385</sup> United Nations Charter, arts 62(3) and (4). The three Conventions and the 1972 Protocol were adopted by plenipotentiary conferences called by ECOSOC.

<sup>386</sup> 1961 Convention, above n 360, art 3; 1971 Convention, above n 360, art 2.

<sup>387</sup> 1988 Convention, above n 376, art 12.

<sup>388</sup> 1961 Convention, above n 360, art 3; 1971 Convention, above n 360, art 2.

<sup>389</sup> 1961 Convention, above n 360, art 9.

- 6.18 Countries must therefore each assess not only what the conventions mean, but how their implementation should be expressed in legislative, administrative and operational terms. In many areas, there is considerable scope for parties to shape national drug policy within the conventions' parameters.
- 6.19 The following section of this chapter summarises the main obligations that New Zealand must discharge, focusing on those that are relevant to our review.

### Coverage and control

- 6.20 The conventions establish a system of controls over the narcotic drugs, psychotropic substances and precursor substances listed in their Schedules and Tables.<sup>390</sup> The controls vary depending on the categorisation of the drug or substance.

#### 1961 Convention – narcotic drugs

- 6.21 The 1961 Convention covers over 100 drugs<sup>391</sup> categorised into four overlapping Schedules.<sup>392</sup>
- 6.22 The key features and requirements of the Convention shaped the regulatory framework for drugs in New Zealand that is contained in the Misuse of Drugs Act 1975 and related legislation, such as the Medicines Act 1981. With the exception of a short list of “preparations” in Schedule III (which are only subject to rather loose regulatory requirements), these requirements include the following:
- manufacture, trade, import, export, distribution, possession, and use must be limited to medical and scientific purposes;<sup>393</sup>
  - manufacture, trade, import, and export can only be conducted by government organisations or under licence;<sup>394</sup>
  - supply to individuals requires a medical prescription (for drugs other than those in Schedule II);<sup>395</sup> and
  - possession is not permitted except under lawful authority.<sup>396</sup>

#### 1971 Convention – psychotropic substances

- 6.23 As with the 1961 Convention, the 1971 Convention has four Schedules of controlled substances, subject to different levels of restriction. While the 1971 Convention covers a different group of drugs from that covered by the 1961 Convention, it imposes very similar requirements in relation to these drugs to those imposed by the earlier Convention. The manufacture, trade, import,

390 See 1961 Convention, above n 360, art 2; 1971 Convention, above n 1, art 2; 1988 Convention, above n 376, art 12.

391 Drugs commonly used in industry for other than medical or scientific purposes are exempt from the provisions of the Convention provided that the drugs are rendered safe for use – 1961 Convention, above n 360, art 2(9).

392 Ibid, art 3 describes the criteria for additions and amendments to the Schedules.

393 Ibid, art 4.

394 Ibid, arts 29–31. Licensees and senior persons in government organisations must be adequately qualified to carry out duties in accordance with the law – article 34(2).

395 Ibid, art 30(2)(b(i)).

396 Ibid, art 33.

export, distribution, possession and use of these substances must be limited to medical and scientific purposes.<sup>397</sup> It is “desirable” that parties not permit possession of such substances except under legal authority.<sup>398</sup>

- 6.24 Together with the requirements imposed by the 1961 Convention, these key elements of the 1971 Convention are reflected in New Zealand’s legal framework, including the Misuse of Drugs Act.

### *1988 Convention – precursors and materials*

- 6.25 The 1988 Convention focuses on precursor substances commonly used for the purpose of illicit manufacture of controlled drugs.<sup>399</sup> These substances are listed in two Tables to the Convention. Parties must take “appropriate” measures to prevent controlled precursors being diverted into illicit traffic and co-operate accordingly.<sup>400</sup> Parties must also take “appropriate” measures to monitor the manufacture and distribution of precursors within their own territory.<sup>401</sup> In particular, they must maintain systems for monitoring international trade; identifying and reporting suspicious transactions; documenting and labeling imports and exports; and seizing precursors used in illicit manufacture.
- 6.26 In addition to the regulation of precursors, the Convention also requires parties to take “appropriate” measures to prevent trade in and diversion of materials and equipment used to produce controlled drugs.<sup>402</sup>
- 6.27 The 1988 Convention also aims to reinforce controls already established by the 1961 and 1971 Conventions,<sup>403</sup> particularly those concerned with illicit cultivation. Parties must adopt appropriate measures to prevent illicit cultivation of and eradicate plants containing narcotic drugs and psychotropic substances.<sup>404</sup> Such measures must respect fundamental human rights and traditional licit uses, as well as protect the environment.<sup>405</sup> However, these measures must not be less stringent than the controls on cultivation required by the 1961 and 1971 Conventions.<sup>406</sup>
- 6.28 Alongside the many supply control measures in the three conventions, the 1988 Convention introduces a general obligation to adopt appropriate measures aimed at reducing illicit demand for controlled drugs, “with a view to reducing human

397 1971 Convention, above n 360, arts 2(7)(a), 5(2) and 7.

398 Ibid, art 5(3). This is a weaker requirement than the 1961 Convention’s plain statement (article 33) that parties “shall not permit” possession of narcotic drugs except by legal authority

399 1988 Convention, above n 376, art 12.

400 Ibid, art 12(1).

401 Ibid, art 12(8)(a). Subparagraph (b) suggests, but does not require, regulation by way of licensing.

402 Ibid, art 13.

403 See also *ibid*, art 16, which reinforces the export documentation requirements established by the earlier Conventions.

404 Ibid, art 14(2).

405 Ibid.

406 Ibid, art 14(1).

suffering and eliminating incentives for illicit traffic”.<sup>407</sup> No specific measures are mandated, however, and none are indicated in the official United Nations Commentary on the 1988 Convention.<sup>408</sup>

### Criminal law measures

- 6.29 The system of controls established by the three conventions is reinforced by requirements to establish and use a range of criminal law measures. In the 1961 and 1971 Conventions, the measures are concerned primarily with offences and punishment. As outlined earlier, the 1988 Convention is concerned specifically with illicit traffic and seeks to tackle it with a comprehensive law enforcement response at the national and international level.

### Criminal offences

- 6.30 Each of the conventions requires parties to criminalise specified conduct.
- 6.31 The 1961 and the 1971 Conventions require parties, subject to their constitutional limitations, to treat as “punishable offences” certain conduct that is committed intentionally.
- 6.32 In the 1961 Convention, a wide range of prohibited conduct is specified:<sup>409</sup>
- [C]ultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention.
- 6.33 In the 1971 Convention, the definition of prescribed conduct is less clear:<sup>410</sup>
- [A]ny action contrary to a law or regulation adopted in pursuance of [a party's] obligations under this Convention.
- 6.34 Both Conventions provide that the offences are to include all forms of secondary participation (for example, aiding, inciting, counselling), conspiracies, attempts, and preparatory acts.<sup>411</sup> Countries have wide discretion to formulate such provisions according to their domestic criminal law principles.<sup>412</sup>
- 6.35 The 1988 Convention is much more extensive in its coverage. It requires “criminal offences” to be established to cover two categories of proscribed conduct.

407 Ibid, art 14(4)

408 United Nations *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1998).

409 1961 Convention, above n 360, art 36(1)(a).

410 1971 Convention, above n 360, art 22(1)(a).

411 1961 Convention, above n 360, art 36(2)(a)(ii); 1971 Convention, above n 360, art 22(2)(a)(ii).

412 The obligation is “subject to the constitutional limitations of a Party, its legal system and domestic law.” See 1961 Convention, above n 360, art 36(2); 1971 Convention, above n 360, art 22(2).

6.36 Paragraph 1 offences<sup>413</sup> cover the following matters:

- Production and distribution:
  - (a) the production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation or exportation of any controlled drug contrary to the provisions of the 1961 and 1971 Conventions;<sup>414</sup>
  - (b) the possession or purchase of any controlled drug for the purpose of any of the activities in (a);<sup>415</sup>
- Cultivation:
  - (c) cultivating the opium poppy, coca bush or cannabis plant contrary to the 1961 Convention;<sup>416</sup>
- Precursors, equipment and materials:
  - (d) the manufacture, transport or distribution of equipment, materials or listed precursor substances, knowing they are to be used for the illicit cultivation, production or manufacture of controlled drugs;<sup>417</sup>
  - (e) possession of equipment, materials or listed precursor substances, knowing they are to be used for the illicit cultivation, production or manufacture of controlled drugs;<sup>418</sup>
- Organisation and financing;
  - (f) the organisation, management or financing of any of the activities in (a)–(d);<sup>419</sup>
- Money laundering:<sup>420</sup>
  - (g) knowing that property is derived from any offence in respect of the activities in (a)–(d) and (f):
    - (i) converting or transferring the property for the purpose of hiding or disguising its illicit origin or helping anyone involved in the offence to evade justice;<sup>421</sup>
    - (ii) hiding or disguising the true nature, source, location, disposition, movement, rights with respect to, or ownership of the property;<sup>422</sup>
    - (iii) acquiring, possessing or using the property.<sup>423</sup>

413 1988 Convention, above n 376, art 3(1)(a)–(c).

414 Ibid, art 3(1)(a)(i).

415 Ibid, art 3(1)(a)(iii).

416 Ibid, art 3(1)(a)(ii).

417 Ibid, art 3(1)(a)(iv).

418 Ibid, art 3(1)(c)(ii).

419 Ibid, art 3(1)(a)(v).

420 Ibid, arts 3(1)(b)(i)–(ii) and (c)(i).

421 Ibid, art 3(1)(b)(i).

422 Ibid, art 3(1)(b)(ii).

423 Ibid, art 3(1)(c)(i).

- 6.37 Paragraph 1 also requires that offences fully cover all acts of participation, attempt and conspiracy, as well as “public” incitement or inducement to commit any of the prescribed offences.<sup>424</sup> These requirements and the offences in (e) and (g)(iii) above are subject to a party’s “constitutional principles and the basic concepts of its legal system”.
- 6.38 Paragraph 2 is concerned just with the establishment of “personal use” offences in respect of:<sup>425</sup>
- [T]he possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention.
- 6.39 The requirement to establish these “personal use” offences is also subject to a party’s “constitutional principles and the basic concepts of its legal system”.<sup>426</sup>
- 6.40 Additional provisions are included to bolster and support the prosecution of offences. These include, for example, the requirement that parties shall, where appropriate, establish a long limitation period for the prosecution of paragraph 1 offences and an even longer period for those who have evaded justice.<sup>427</sup>

### *Sentencing and punishment*

- 6.41 Alongside the description of required offences, the three conventions give considerable attention to the punishment and treatment of offenders.
- 6.42 The 1961 and 1971 Conventions strike a balance between punishment and rehabilitation. “Serious” offences are to be “adequately” punished, particularly by imprisonment or other loss of liberty.<sup>428</sup> However, for offences by drug users, rehabilitative measures (for example, treatment, education, after-care or social reintegration) may be considered as an alternative or in addition to conviction or punishment.<sup>429</sup>
- 6.43 In the 1988 Convention, rehabilitative measures as an alternative to conviction or punishment are confined to the paragraph 2 personal use offences and “appropriate cases of a minor nature” involving paragraph 1 offences.<sup>430</sup> In all other paragraph 1 cases, rehabilitative measures are permissible only in addition to conviction or punishment.<sup>431</sup> Use of such measures may, however, be considered in respect of all offenders, not just drug users.
- 6.44 The 1988 Convention therefore places a strong emphasis on punishment in relation to paragraph 1 offences. First, there is a general statement that sanctions are to correspond to the “grave nature” of paragraph 1 offences, in particular through use of imprisonment and other deprivations of liberty, pecuniary

424 Ibid, arts 3(1)(c)(iii) and (iv).

425 Ibid, art 3(2).

426 Ibid.

427 Ibid, art 3(8).

428 1961 Convention, above n 360, art 36(1)(a); 1971 Convention, above n 360, art 22(1)(a).

429 1961 Convention, above n 360, art 36(1)(b); 1971 Convention, above n 360, art 22(1)(b).

430 1988 Convention, above n 376, arts 3(4)(c) and (d).

431 Ibid, art 3(4)(b).



sanctions, and confiscation.<sup>432</sup> This is reinforced by a requirement that courts and other competent authorities take into account aggravating factors that render some paragraph 1 offences “particularly serious”.<sup>433</sup> These factors are:

- involvement in the offence of an organised crime group to which the offender belongs;
- the offender’s involvement in other organised crime activities;
- the offender’s involvement in other illegal activities facilitated by the drug offending;
- use of violence or arms;
- the offence being connected to a public office held by the offender;
- victimisation or use of minors;
- commission of the offence in or near a prison, educational establishment or social service facility or in other places used by school children and students for sport, leisure or education;
- prior convictions, whether foreign or domestic, to the extent permitted by domestic law.<sup>434</sup>

6.45 Finally, authorities responsible for releasing offenders from penal custody are also to “bear in mind” the serious nature of paragraph 1 offences and the presence of the specified aggravating factors when considering parole or early release.<sup>435</sup>

### *Other criminal law measures*

6.46 The conventions contain a number of provisions which encourage effective international co-operation to aid the enforcement of the criminal law requirements in the conventions. These include:

- issues of jurisdiction and a general strengthening of requirements relating to extradition;<sup>436</sup>
- endorsement of the technique of “controlled delivery” (the incorporation of this technique into the Misuse of Drugs Amendment Act 1978 is discussed in further detail in chapter 14);<sup>437</sup>
- mutual legal assistance in the investigation, prosecution, and adjudication of offences;<sup>438</sup>
- transfer of proceedings between parties where this is in the interests of the “proper administration of justice”.<sup>439</sup>

432 Ibid, art 3(4)(a).

433 Ibid, art 3(5)(a)–(h).

434 Subject to similar qualifications, the 1961 and 1971 Conventions also provide for foreign convictions to be taken into account for the purpose of establishing recidivism. See 1961 Convention, above n 360, art 36(2)(a)(iii); 1971 Convention, above n 360, art 22(2)(a)(iii).

435 1988 Convention, above n 376, art 3(7).

436 1961 Convention, above n 360, art 36; 1971 Convention, above n 360, art 22; 1988 Convention, above n 376, arts 4 and 6.

437 1988 Convention, above n 376, art 11.

438 Ibid, art 7.

439 Ibid, art 8.

### Problem limitation

- 6.47 The conventions also include stand-alone provisions with a “problem limitation” or “harm reduction”<sup>440</sup> character. They are not prominent but they do constitute clear obligations that need to be read together with the controls and criminal law measures outlined above.
- 6.48 The 1961 Convention requires parties to “take all practicable measures for the prevention of the abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration” of drug users.<sup>441</sup> The 1971 Convention extends this obligation to the abuse of psychotropic substances.<sup>442</sup>
- 6.49 As highlighted earlier, rehabilitation may also be used in the enforcement of the criminal law.

### Other obligations under the conventions

- 6.50 The conventions also require parties to take other miscellaneous measures to support the system of international drug control, including requirements to:
- report on implementation of and compliance with the conventions, and on developments in drug use and drug crime;<sup>443</sup>
  - co-operate with other parties in preventing and repressing illicit traffic in drugs;<sup>444</sup>
  - maintain a “special administration” for the purpose of applying the provisions of the conventions;<sup>445</sup>
  - ensure that controlled drugs and equipment used in the commission of offences are liable to seizure and confiscation<sup>446</sup> and adopt measures to enable confiscation of not only controlled drugs but also the proceeds and instruments of paragraph 1 offences.<sup>447</sup>
- 6.51 There are also provisions to deal with identification, tracing, freezing and seizure of proceeds and instruments liable to confiscation, and mutual assistance in the execution of the confiscation process.<sup>448</sup>

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440 These concepts are not separately defined in any of the Conventions.

441 1961 Convention, above n 360, art 38(1).

442 1971 Convention, above n 360, art 20(1).

443 1961 Convention, above n 360, arts 3 and 18; 1971 Convention, above n 360, arts 2, 3 and 16; 1988 Convention, above n 376, arts 5, 12 and 20.

444 1961 Convention, above n 360, art 35; 1971 Convention, above n 360, art 21; 1988 Convention, above n 376, arts 10, 15 and 17–19.

445 1961 Convention, above n 360, art 17; 1971 Convention, above n 360, art 6.

446 1961 Convention, above n 360, art 37; 1971 Convention, above n 360, art 22(3).

447 1988 Convention, above n 376, art 5(1).

448 *Ibid*, art 5.

6.52 This section considers the application of the penal provisions to activities involving personal use of controlled drugs.

### Personal use

6.53 The overarching obligation in the 1961 and 1971 Conventions is to limit the use of drugs to medical and scientific purposes. Parties may rely on a range of legislative and administrative measures to achieve this end, including criminalisation of conduct related to personal use (such as possession, purchase, or cultivation). However, there is no requirement in the conventions to criminalise the use of drugs per se.<sup>449</sup> “Use” is not mentioned in either article 36 of the 1961 Convention or in article 3 of the 1988 Convention.

### Possession for personal use

#### *Commentaries on the Conventions*

6.54 The official UN Commentary on the 1961 Convention<sup>450</sup> acknowledges that governments take different views about whether simple possession must be criminalised and does not attempt to resolve the difference. The Commentary does, however, make it plain that parties must nevertheless take such measures as are necessary to limit the use of drugs to medical or scientific purposes, in accordance with their fundamental obligations under article 4, and cannot therefore legally authorise possession and use for other purposes.

6.55 The Commentary on article 4 of the Convention, which requires that possession be limited to medical or scientific purposes, includes the following passages:

18. Article 4, paragraph (c), undoubtedly refers to both kinds of possession; but whether that provision must be implemented by imposing penal sanctions on possession for personal consumption is a question which may be answered differently in different countries. Some Governments seem to hold that they are not bound to punish addicts who illegally possess drugs for their personal use...

19. Parties ... which hold that possession of drugs for personal consumption must be punished under article 36, paragraph 1, may undoubtedly choose not to provide for imprisonment of persons found in such possession, but to impose only minor penalties such as fines or even censure...

21. It has ... been pointed out ... that the penalisation of all unauthorised possession of drugs, including that for personal use, facilitates the prosecution and conviction of traffickers, since it is very difficult to prove the intention for which the drugs are held...It may also be remarked that constitutional limitations, which can free a Party from all obligation to punish an action mentioned in article 36, paragraph 1, will generally not prevent the penalisation of the unauthorised possession of drugs.

22. It may finally be mentioned that Parties must prevent the possession of drugs for other than medical and scientific purposes by all the administrative measures which they are bound to adopt under the terms of the Single Convention, whatever may be

<sup>449</sup> Use of controlled drugs is, however, currently an offence under New Zealand law by virtue of section 7(1)(a) of the Misuse of Drugs Act 1975.

<sup>450</sup> United Nations *Commentary on the Single Convention on Narcotic Drugs* (1962).

their view on their obligation to resort to penal sanctions or on the kind of punishment which they should impose.

23. What has been said in regard to the need for penal sanctions for limiting the possession of controlled drugs exclusively to medical and scientific purposes pursuant to article 4, paragraph (c), also applies to the obligation of Parties under article 33 not to permit the possession of drugs except under legal authority.

- 6.56 It might be thought that article 3, paragraph 2 of the 1988 Convention resolved the doubt by expressly requiring the establishment of offences for “possession, purchase or cultivation of narcotic drugs and psychotropic substances for personal consumption.”
- 6.57 The official Commentary, published 10 years after the 1988 Convention was adopted, did not dwell long on the topic.<sup>451</sup> After noting the Commentary on the 1961 Convention, and uncertainty about the treatment of possession under the 1971 Convention, the authors of the 1998 Commentary said that the text of the 1988 Convention reflected several compromises:
- inclusion of the “safeguard” clause referring to constitutional principles and the basic concepts of a party’s legal system;
  - the statement that the conduct must be contrary to the provisions of the earlier conventions;
  - the separation of possession offences from the production and trafficking offences in paragraph 1.
- 6.58 In summing up the position, however, the 1988 Commentary appears to be unequivocal:

It will be noted that, as with the 1961 and 1971 Conventions, paragraph 2 does not require drug consumption as such to be established as a punishable offence. Rather, it approaches the issue of non-medical consumption indirectly by referring to the intentional possession, purchase or cultivation of controlled substances for personal consumption. In contrast to the position under the 1961 and 1971 Conventions, however, paragraph 2 clearly requires parties to criminalise such acts unless it would be contrary to the constitutional principles and the basic concepts of their legal systems to do so.

- 6.59 In 2009, the INCB indicated that in its opinion:<sup>452</sup>

[T]he 1988 Convention requires that illicit possession of controlled substances must be prohibited, but it does not require criminal prosecution for small quantities. At times, drug possession can serve as a pretext to detain an otherwise dangerous or suspect individual, but otherwise, the law must allow for non-custodial alternatives when a police officer stumbles upon small amounts of drugs. It is important that the incident be documented and the opportunity availed to direct the user to treatment if required, but it is rarely beneficial to expend limited prison space on such offenders.

451 *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, above n 408.

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

### *Latitude for interpretation*

- 6.60 Despite the apparently plain words of article 3, paragraph 2 of the 1988 Convention, there is considerable variation in national responses, particularly in Europe. In the European Union, for example, possession of drugs for personal use is unlawful in all member countries, but the use of the criminal law and penal sanctions is far from uniform.<sup>453</sup>
- 6.61 Alternative approaches adopted for possession of small quantities of controlled drugs include possession being:
- tolerated under official “non-prosecution” policies;
  - made a criminal offence but attracting only administrative sanctions;
  - treated as an administrative infringement only.
- 6.62 Krajewski notes that the conventions are formulated in very broad, sometimes vague, language that reflects political compromises as well as accommodating national legal differences.<sup>454</sup> This allows for considerable latitude in interpretation, identified by him as including the following:
- Criminalising small-scale demand side activity is such an exception to the conventions’ focus on illicit trafficking that different, less restrictive approaches should be adopted in respect of the article 3, paragraph 2 requirements.
  - Countries can interpret the requirements in light of the constitutional and political principles particular to their own legal system.
  - As personal use is not itself required to be criminalised by the conventions, provisions on possession for personal use can be interpreted consistently, particularly if a country’s domestic law does not criminalise drug use per se.
  - Approved “medical” and “scientific” uses are not defined.
  - “Depenalisation”, which retains the essence of criminality while allowing alternatives to criminal sanctions, is not only consistent with article 3, paragraph 2 but can also be supported by other articles.<sup>455</sup>

### *“Contrary to the provisions” of the conventions*

- 6.63 An important point that is often overlooked is that the 1988 Convention does not create a new prohibition in respect of possession for personal use. It requires offences to be created in respect of such conduct where the conduct is prohibited by the 1961 and 1971 Conventions. One must turn to those conventions to ascertain if possession for personal use is contrary to their provisions. This is not straightforward because of the generality of many provisions.

453 On variations in legislation amongst European countries see N Dorn and A Jamieson *Room for Manoeuvre – Overview of Comparative Legal Research into National Drug Laws of France, Italy, Spain, the Netherlands and Sweden and their Relation to Three International Drug Conventions* (DrugScope, London, 2000); European Monitoring Centre for Drugs and Drug Addiction *Illicit Drug Use in the EU: Legislative Approaches* (European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2005).

454 K Krajewski “How Flexible are the United Nations Drug Conventions?” (1999) 10 *International Journal of Drug Policy* 329.

455 For example, 1961 Convention, above n 360, art 36(1)(b); 1971 Convention, above n 360, art 22(1)(b); 1988 Convention, above n 376, art 3(4)(d).

*"Possession" under the 1961 Convention*

- 6.64 Article 4 of the 1961 Convention requires parties, subject to the exceptions expressly permitted by the 1961 Convention, to limit the possession of drugs exclusively to medical and scientific purposes. Parties may not therefore authorise the possession of drugs for other purposes.
- 6.65 Article 4 also has to be read in connection with both articles 33 and 36 of the 1961 Convention.
- 6.66 Article 33 provides that the parties shall not permit the possession of drugs except under legal authority. However, article 33 does not itself require that possession of drugs be made unlawful. It simply states that where possession is unlawful it shall not be "permitted". Further, article 33 does not specify either the mode of legal authorisation or the means by which a party might discharge its obligations not to permit unauthorised possession.
- 6.67 The Commentary on article 33 acknowledged that the obligations must be met but that methods other than criminalising possession are available:
- Whatever the position the Parties may take on [the] question of penal sanctions, it does not affect their obligation under article 33 not to permit the unauthorised possession of drugs for personal consumption, like any other possession of drugs without legal authority. If they choose not to impose penalties on the unauthorised possession for personal use, they still must use their best endeavours to prevent this possession by all those administrative controls of production, manufacture, trade and distribution which are required by the Single Convention, and whose basic objective is the prevention of the abuse of drugs and therefore also to prevent the unauthorised possession by addicts.
- 6.68 The penal provision in the 1961 Convention is article 36 which, as noted in paragraph 6.32 above, requires parties to treat as punishable offences a wide range of specific forms of conduct, including possession.
- 6.69 Against this background, it would seem there are two possible approaches.
- 6.70 In a plain sense, one might say that the purpose and intent of articles 4 and 36 of the 1961 Convention, when read together, are clear. Possession of drugs in whatever quantity, if not for medical or scientific purposes or otherwise excepted under the Convention, must be contrary to the Convention and therefore must be criminalised. It might be further argued that the 1961 Convention needs to be read together with, and in light of, the 1988 Convention. Despite the non-derogation provision<sup>456</sup> in the 1988 Convention, a supporter of this view might argue that the general obligations expressed in article 4 of the 1961 Convention should take into account the marked emphasis on criminal law measures in the 1988 agreement. This allowance, coupled with the express terms of article 3, paragraph 2, would support a requirement to criminalise possession for personal use.

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<sup>456</sup> 1988 Convention, above n 376, art 25. This article provides that the 1988 Convention does not derogate from the rights and obligations imposed under the 1961 and 1971 Conventions.



- 6.71 However, a number of factors point in the opposite direction. Article 4 is a very high-level statement of general obligations.<sup>457</sup> It expressly contemplates that each party will assess what legislative and administrative measures may be necessary to discharge these high level obligations. The activities of production, manufacture, trade, distribution, import and export, all mentioned in article 4, are supported by other articles creating specific obligations to prohibit, restrict and regulate such activities. In contrast, there are no similar substantive articles restricting simple possession of drugs.
- 6.72 To require the establishment of criminal offences for possession on the basis of article 4 itself would therefore necessitate “reading down” the article to such an extent that parties were deprived of its intended flexibility.
- 6.73 That leaves article 36, the penal provision. This article must be understood in the context of its location. The preceding article requires parties to take co-operative action against illicit traffic. “Illicit traffic” is defined as “cultivation or trafficking”<sup>458</sup> contrary to the provisions of the Convention. Given the minimal attention given to possession elsewhere in the Convention, it can therefore be argued that possession in article 36 is, in context, a reference to possession for the purposes of trafficking.
- 6.74 In their treatment of possession, there is no material difference in the character of the 1961 and 1971 Conventions. The preferred conclusion on this topic should apply equally to obligations arising from both Conventions.

### *Conclusion*

- 6.75 In summary, there is no international consensus about whether the conventions require possession of illicit drugs for personal use to be established as a criminal offence.
- 6.76 Full legalisation of possession “for other than medical or scientific uses” is not permissible on either view of the penal provisions because of the requirements of articles 4 and 33 of the 1961 Convention.
- 6.77 However, a legal argument can be made that, despite possession for personal use apparently being marked out for criminalisation in article 3 of the 1988 Convention, the terms of the earlier conventions are neither clear nor specific enough about such conduct to indicate that it must be treated as a criminal offence requiring criminal sanctions.
- 6.78 A more conservative view, supported by the official Commentary on the 1988 Convention, is that possession for personal use must be criminalised “subject to [a party’s] constitutional principles and the basic concepts of its legal system”.

<sup>457</sup> 1971 Convention, above n 360, art 5 is of a similar character.

<sup>458</sup> 1961 Convention, above n 360, art 1.

It is accepted that there are no constitutional principles or basic concepts of the New Zealand system on which New Zealand could rely to justify not criminalising possession for personal use if that was a preferred policy choice.<sup>459</sup>

- 6.79 If possession remains a criminal offence, there is considerable scope to look at alternatives to prosecution, alternatives to conviction, the use of non-custodial criminal sanctions,<sup>460</sup> and the use of alternative civil or administrative sanctions.

### Purchase for personal use

- 6.80 Following the less conservative view of the conventions discussed above in relation to possession, it might be argued that because purchase is not specifically regulated by the conventions, it should not be treated as “contrary to the provisions” of the 1961 and 1971 Conventions and therefore something more is required to bring the conduct within the framework of the penal provisions.
- 6.81 The argument in favour of criminalisation is much stronger in relation to conduct that constitutes participation in trafficking. Taking into account that one of the fundamental aims of all three conventions is to combat illicit traffic in drugs, a “good faith” interpretation of the above articles supports the conclusion that they necessarily prohibit the purchasing as well as the supply side of such transactions.
- 6.82 On a more conservative interpretation of the conventions, the purchase of drugs for personal consumption is “contrary to the provisions” of the 1961 and 1971 Conventions when such conduct falls outside the schemes for trade in drugs and distribution of drugs required by article 30 of the 1961 Convention and articles 8 and 9 of the 1971 Convention. As these articles focus on regulation of supply side activities, this argument relies on its being implicit that unlawful purchase of drugs inherently contravenes the schemes.
- 6.83 This argument can also be extended to small-scale purchase for personal consumption, although it is not as compelling, despite the language of article 3, paragraph 2 of the 1988 Convention.
- 6.84 In summary, the legal position is unclear and the official Commentaries provide no real assistance on the point. However, in view of the aims of the three conventions, the better view may be that offences are required for any purchase of drugs outside the conventions’ required framework for trade and distribution.

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459 It is conceivable that “constitutional” arguments might be made in a New Zealand court about punishment of personal drug use. However, there are not in New Zealand’s statute laws or jurisprudence any established constitutional notions about the regulation of conduct primarily involving self-harm or perceived self-harm.

460 The 1988 Convention does not require imprisonment for “personal use” offences in contrast to the very strong requirements to punish “trafficking” offences with substantial terms of imprisonment.

## Cultivation for personal use

- 6.85 There is a stronger argument that the conventions do not require an offence of cultivating drugs for personal use.
- 6.86 Article 22 of the 1961 Convention requires parties to prohibit cultivation of the opium poppy, the coca bush and the cannabis plant if they judge that the prevailing conditions in their country render a ban on cultivation the most suitable measure for protecting public health and preventing the diversion of drugs into illicit traffic. There is a corresponding duty to seize any plants unlawfully cultivated.
- 6.87 The critical question for each country is whether a ban on cultivation is “the most suitable measure”. The official Commentary on article 22 allows that prohibition may not be required if the overall risks to public health or of diversion are relatively small.
- 6.88 While the article does not differentiate between cultivation for trade and cultivation for personal use, it could be read as allowing parties to prohibit cultivation for some purposes but not others, depending on their assessment of the necessity of prohibition for those discrete purposes. In other words, a country might consider that prohibiting cultivation of small amounts for personal use was not the best way to protect the public health or was not necessary to prevent those drugs being diverted into illicit traffic.
- 6.89 Such an interpretation would seem consistent with the underlying purpose of article 22, although no support one way or the other can be found in the Commentary.

## TRAFFICKING AND SUPPLY

- 6.90 In contrast to the position with personal use of controlled drugs, the conventions afford very little scope for adopting wholly alternative approaches to the serious “trafficking” offences covered by article 3, paragraph 1 of the 1988 Convention. The Convention is clear that these offences are to be regarded as grave and should be met with the full force of penal and confiscation laws.<sup>461</sup> Moreover, the main requirements<sup>462</sup> for international criminal law co-operation are mandatory.
- 6.91 However, there are two areas where there may be more latitude in formulating national drug policy: social sharing (for example, sharing between friends or acquaintances for no profit); and the use of alternatives to imprisonment.

## Social sharing

- 6.92 It is not certain whether social sharing must be established as a criminal offence.
- 6.93 Commercial supply of controlled drugs is clearly contrary to the 1961 and 1971 Conventions,<sup>463</sup> is required to be criminalised under those conventions,<sup>464</sup> and falls squarely within the paragraph 1 offences in the 1988 Convention.<sup>465</sup>

461 See 1988 Convention, above n 376, art 3(4)–(6).

462 1988 Convention, above n 376, arts 4–7.

463 1961 Convention, above n 360, art 30 and 1971 Convention, above n 360, art 8 both require strict controls on trade.

464 1961 Convention, above n 360, art 36(1)(a); 1971 Convention, above n 360, art 22(1)(a).

465 1988 Convention, above n 376, art 3(1)(a)(i).

- 6.94 However, the position with sharing on a social scale is less certain. There are no specific provisions in the 1961 and 1971 Conventions regulating distribution at a personal level. Further, although the penal provisions in the 1961 and 1988 Conventions use broad terms such as “offering”, “distribution”, “delivery on any terms whatsoever”, these terms appear in provisions aimed squarely at commercial supply and trafficking.
- 6.95 The paragraph 1 offences generally attract punitive sanctions and must be the subject of special measures such as extraterritorial jurisdiction, extradition, and mutual legal assistance. It is difficult to conclude that the 1988 Convention intended social sharing, which is associated with personal use rather than illicit traffic, to be treated in that manner.
- 6.96 A better view may be that the international obligations to criminalise and punish social sharing extend no further than they do in respect of possession for personal use. If the less conservative interpretation of the conventions is preferred and they do not require criminal offences and penalties for possession for personal use, analogous reasoning supports a similar conclusion in respect of social sharing.

### Alternatives to imprisonment

- 6.97 There remains some flexibility for responses other than imprisonment.
- 6.98 The requirement to imprison paragraph 1 offenders is very strong but not absolute. The 1988 Convention also recognises that rehabilitative measures remain an option for responding to paragraph 1 offences, though primarily in addition to formal punishment unless the offence is minor, when rehabilitation can be considered as an alternative to conviction or punishment.<sup>466</sup>
- 6.99 The INCB has itself endorsed the consideration of alternative approaches to minor offending:<sup>467</sup>

There is a range of alternatives to conviction for relatively minor offences, including discontinuation of criminal proceedings, conditional discontinuance and admonishment or cautioning, as well as a range of alternatives to custody, including fines and suspended sentences, parole, probation, community service, corrective labour, treatment and supervision. It should, however, be clearly understood that the Board, in supporting appropriate recourse to treatment and non-custodial measures for minor offences, is in no way suggesting that drug-related offences should be decriminalised or that the implementation of the international drug control treaties should at all be weakened.

<sup>466</sup> See *ibid*, art 3(4).

<sup>467</sup> International Narcotics Control Board “Report of the International Narcotics Control Board for 1996” (1996) E/INCB/1996/1, ch 1, para 26.

- 6.100 In 2007, the INCB devoted the first part of its Annual Report to “The principle of proportionality and drug-related offences”.<sup>468</sup> One of its recommendations was:<sup>469</sup>

*Alternative sentencing.* Governments should consider widening the range of custodial and noncustodial options for drug-related offences by illicit drug users so that authorities can respond proportionately to the circumstances of each case. In some cases drug courts focusing on persons who frequently relapse into high-risk lifestyles and mandatory treatment programmes can offer drug abusing offenders effective alternatives to imprisonment.

- 6.101 It is for each party to determine, as a matter of prosecution policy or law, what kind of conduct might fairly be regarded as “relatively minor”. Depending on the circumstances, examples might include small-scale:

- non-commercial supply (if social sharing is criminalised);
- cultivation for the purpose of social sharing;
- one-off incidents of commercial supply;
- importing or exporting for personal use.

## PROBLEM LIMITATION

- 6.102 As outlined earlier, parties have a duty to take “all practicable measures” to prevent the abuse of drugs and minimise the harmful impact on drug abusers through treatment, education, care, and rehabilitation.<sup>470</sup> Implementation of such measures must take account of the fundamental obligation in the 1961 and 1971 Conventions to limit the use of narcotic drugs and psychotropic substances to medical and scientific purposes.

- 6.103 Some problem limitation programmes permit drug use on specified conditions or under controlled circumstances. This tests the balance between the above obligations. To what extent is it permissible under the conventions to implement programmes whose primary objective is to reduce the harm to drug users by facilitating safe drug use without necessarily preventing it?

## Official statements

- 6.104 The INCB sees problem limitation as an important strategy provided it is undertaken for demand reduction purposes – that is, to reduce the demand for drugs by drug users. In its 2000 Annual Report, the INCB acknowledged that some countries had begun placing more emphasis on problem limitation measures:<sup>471</sup>

The Board would like to reiterate that harm reduction programmes can play a part in a comprehensive drug demand reduction strategy but such programmes should not be carried out at the expense of other important activities to reduce the demand for illicit drugs, for example drug abuse prevention activities.

<sup>468</sup> International Narcotics Control Board “Report of the International Narcotics Control Board for 2007” (5 March 2007) E/INCB/2007/1, ch 1.

<sup>469</sup> Ibid, paragraph 60(c).

<sup>470</sup> 1961 Convention, above n 360, art 38(1); 1971 Convention, above n 360, art 20(1).

<sup>471</sup> International Narcotics Control Board “Report of the International Narcotics Control Board for 2000” (2000) E/INCB/2000/1, paras 445 and 446.

...The Board regrets that the discussion on drug injection rooms and some other harm reduction measures has diverted the attention (and, in some cases, funds) of Governments from important demand reduction activities such as primary prevention or abstinence-oriented treatment.

- 6.105 The INCB has since indicated that it does not support “drug consumption rooms” that allow the illicit possession and consumption of controlled drugs.<sup>472</sup>

### Permissible measures

- 6.106 In 2002, the INCB requested the UN Drug Control Programme (UNDCP) to develop a legal position on the flexibility of the conventions in respect of problem limitation measures. The UNDCP examined five types of programme:<sup>473</sup>
- (a) drug substitution treatment (prescription of controlled doses of one drug by way of treatment for addiction to another drug);
  - (b) drug maintenance treatment (treatment of drug addiction by administering controlled doses of the drug in question);
  - (c) needle and syringe exchange (provision of sterile needles and syringes in exchange for used equipment);
  - (d) drug injection rooms (provision of facilities for safe injection by intravenous drug users);
  - (e) drug quality control (provision of facilities for drug users to test the quality or otherwise of their drugs, for example, ecstasy pill testing).
- 6.107 A further and more extensive opinion on the same topic was prepared by the British Institute of International and Comparative Law the following year.<sup>474</sup>
- 6.108 That opinion concluded that there was a strong case for arguing that, with the possible exception of drug quality testing, these programmes were permissible under the conventions.
- 6.109 In essence, the opinion considered that programmes may be compatible with the conventions’ allowance for medical use of controlled drugs<sup>475</sup> and the requirements to promote treatment and rehabilitation<sup>476</sup> if they were undertaken for legitimate health-related purposes. Much depends on the specific details of each programme. Compliance is much less likely to be achieved if the overall effect of the programme is to increase or encourage drug use and is more likely to be achieved if the programme is conducive to treatment and the reduction of drug dependence.

472 International Narcotics Control Board “Report of the International Narcotics Control Board for 2008” (19 February 2008) E/INCB/2008/1, para 29.

473 United Nations Drug Control Programme Legal Affairs Section “Flexibility of Treaty Provisions as Regards Harm Reduction Approaches” (30 September 2002) E/INCB/2002/W.13/SS.5.

474 British Institute of International and Comparative Law “Opinion on the Legality of Health Promotion Measures in Light of the United Nations Drug Conventions Regime” (Senlis Lisbon International Symposium on Global Drug Policy. Lisbon, 23 to 26 October 2003).

475 1961 Convention, above n 360, art 4(c); 1971 Convention, above n 360, art 5(1).

476 1961 Convention, above n 360, art 38; 1971 Convention, above n 360, art 20.



- 6.110 It is also important to have a sound evidence base for the health-related benefits claimed for the programme. The opinion was doubtful about the legitimacy of pill testing because it was still relatively new and there was not yet strong evidence that pill testing actually minimised risky behaviour.
- 6.111 The UNDCP opinion was more cautious. It identified some of the legal arguments without expressing a conclusive view. To the extent that its opinion offered support for programmes to be considered compatible with the conventions, it emphasised a treatment-related context aimed at reducing drug dependence.
- 6.112 Little guidance as to the acceptability of problem limitation measures can be obtained from the text of the conventions. Neither “medical purposes” nor “treatment” are defined and the articles that provide support for problem limitation measures are couched in general terms.<sup>477</sup> Notwithstanding reservations held by the INCB, it would seem that parties have considerable flexibility to implement practical measures to reduce the harmful consequences of drug use, taking into account the considerations mentioned above about the aims and effects of particular programmes.

## CONCLUSION

- 6.113 Two key points emerge from examination of the international drug conventions. First, the conventions require New Zealand to maintain a system of prohibition for the drugs that they cover. Second, although the 1988 Convention places considerable reliance on the criminal law, there is significant room for movement in the treatment of personal drug use and lower order offending in general. The main conclusions relevant to the development of national drug policy follow.
- 6.114 The conventions require parties to maintain a system of controls over the drugs included in the conventions. Those controls must limit the production, manufacture, import, export, trade, distribution, possession and use of convention drugs to legitimate medical and scientific purposes. Specific controls include:
- manufacture and distribution only under licence or other approval;
  - strict limits on cultivation;
  - import and export restricted and only under authorisation;
  - detailed record-keeping of permitted activities and transactions;
  - regular reporting to UN drug bodies.
- 6.115 Parties must also monitor and regulate the precursor substances listed in the 1988 Convention.
- 6.116 Trafficking in convention drugs (that is, production, distribution, import and export of drugs, and related conduct including money laundering) must be criminalised. Generally, trafficking is to be punished severely with imprisonment the norm. Punishment of trafficking must include the ability to confiscate the proceeds and instruments of offending. For minor trafficking offences, however, non-custodial and non-criminal sanctions can be considered and rehabilitative measures are permissible in addition to or as an alternative to punishment.

<sup>477</sup> Ibid.

- 6.117 Parties must co-operate with each other to combat illicit traffic in all convention drugs and prevent the diversion of precursors into illicit traffic. Parties must enable cross-border law enforcement by ensuring trafficking offences are subject to extraterritorial jurisdiction, extradition, and mutual legal assistance, including cross-border enforcement of confiscation.
- 6.118 The conventions do not allow full legalisation of convention drugs. Possession and use of convention drugs for other than medical or scientific purposes must continue to be restricted and unlawful. There is significant uncertainty about the approach that must be taken in relation to possession and cultivation of drugs for personal use, and social sharing at a personal level. It may be open to parties to interpret the conventions as not requiring the establishment of criminal offences for these activities. There is no requirement to establish criminal offences in respect of the use of drugs per se, although it is arguable that offences may be required in relation to obtaining drugs for personal use.
- 6.119 Where offences are maintained for conduct related to personal use, the permissible alternatives include:
- non-prosecution policy and discretion;
  - diversion;
  - treatment and rehabilitation as an alternative to prosecution;
  - civil or administrative sanctions;
  - treatment and rehabilitation as an alternative to punishment;
  - use of non-custodial sentences.
- 6.120 Parties must take practicable measures to prevent the abuse of drugs and address the treatment and rehabilitation of drug users. For these purposes, it is permissible to consider programmes that allow the use of drugs in controlled circumstances, such as drug maintenance and drug substitution treatment, needle exchange schemes, and drug injection rooms.

# Chapter 7

## Models of drug regulation

### SUMMARY

This chapter identifies and discusses the reasons why regulation of drug use may be justified. It concludes that, with some limited exceptions in respect of the young and those whose mental faculties are impaired, regulation of drug use is generally only justified to the extent necessary to prevent harm to others. The benefits arising from that reduction in harm must also outweigh the costs arising from regulation itself. With this justification in mind, the chapter then goes on to consider the ways in which drug use may be regulated (the “models of drug regulation”).

### WHY REGULATE DRUGS?

- 7.1 At the outset of this paper, we noted the view, at one end of the spectrum, that taking mind-altering substances which affect judgement and the functioning of the mind for recreational purposes robs an individual of free will and essential humanity. That view is based on the premise that use of drugs is a moral issue,<sup>478</sup> and that the justification for their prohibition or other regulation rests in part on their immorality.<sup>479</sup>
- 7.2 We accept that the law has a vital role in reflecting, enforcing, and sometimes shaping moral values. As Neil MacCormick has argued, “the question cannot be whether the criminal law should be morally loaded, but, rather, what moral load it should bear.”<sup>480</sup> However, there are at least two reasons why it is difficult to justify the use of law to enforce moral values relating to drug use.
- 7.3 First, there is no clear community view that use of mind-altering substances is immoral. As we noted in chapter 1, few see all use of mind-altering substances as contrary to core moral values. Many of us will have drunk alcohol in the recent past, itself a mind-altering substance, without feeling morally compromised. Most of us also recognise, again perhaps with alcohol mainly in mind, that using

478 See, for example, James Q Wilson “Against the Legalisation of Drugs” (1990) 89 Commentary 21, 26.

479 Douglas N Husak “Recreational Drugs and Paternalism” (1989) 8 Law and Philosophy 353, 359.

480 Neil MacCormick *Institutions of State: An Essay in Legal Theory* (Oxford University Press, Oxford, 2007) 216.

these substances can bring benefits. In the main, these benefits relate to the short-term and immediate effects of use, such as increased sociability and relaxation. Many drugs also have recognised therapeutic uses.

- 7.4 Social attitudes to mind-altering substances are therefore deeply ambivalent, contradictory, and divisive. Distinctions in how communities and groups view particular substances are more an accident of history and circumstance than the product of rational policy or a firmly-grounded moral view.<sup>481</sup> We see no basis for using the law to perpetuate those distinctions on moral grounds alone.
- 7.5 Secondly, it is arguable that the values that preclude the use of mind-altering substances (or at least some of these substances) are not integral to social solidarity, and regulation is not justified to maintain them. In fact, it is equally arguable that drug regulation in itself undermines other values that are at least, if not more, important to our social fabric. These include, for example, the ability for individuals to exercise freedom of choice and personal autonomy. By preventing a drug user from engaging in an activity in which he or she would otherwise choose to engage, regulation itself is impinging on a value that most if not all of us would see as integral to how society functions.
- 7.6 In chapter 2, we outlined the variety of harms associated with cannabis and methamphetamine use. Methamphetamine users, for example, are at increased risk of a range of physical and mental health problems, from minor ailments like skin irritations and blurred vision to very serious conditions like heart disease and psychosis. If the enforcement of morality is not a justification for drug regulation, what about the prevention of these harms to users themselves?
- 7.7 We accept that regulation is justified to prevent individuals from acting contrary to their best interests when they substantially lack the capacity or information to prevent harm to themselves. Our statute book has many examples of regulation being used for this purpose. Legislation to protect the personal and property rights of people who no longer have the capacity to look after their own affairs is one example,<sup>482</sup> as is the raft of legislation that prevents children and young people from engaging in certain activities before they reach a certain age.<sup>483</sup>
- 7.8 This paternalistic approach arguably has particular applicability to drug use. For example, individuals do not have the ability (due to a lack of information, time, or otherwise) to assess the safety of every drug they use. For this reason, it is appropriate that regulation is in place to ensure that this assessment is made on

481 For example, Ethan Nadelman “Drug Prohibition in the United States: Costs, Consequences, and Alternatives” (1989) *Science* 939 argues:

Only the Mormon and a few other like-minded sects, who regard as immoral any intake of substances to alter one’s state of consciousness or otherwise cause pleasure, are consistent in this respect; they eschew not just the illicit drugs but also alcohol, tobacco, caffeinated coffee and tea, and even chocolate. “Moral” condemnation by the majority of Americans of some substances and not others is little more than a transient prejudice in favour of some drugs and not others.

482 Protection of Personal and Property Rights Act 1988.

483 For example, young people under the age of 15 are prohibited from driving, young people under the age of 18 are prohibited from placing a bet at the TAB, buying tobacco, or buying alcohol on or from any licensed premises. See Ministry of Youth Development *Does Your Policy Need an Age Limit?* (Ministry of Youth Development, 2005) 6.

behalf of us all. There is also likely to be little disagreement that young people and those whose mental faculties are impaired should be protected from the harms of drug use.<sup>484</sup>

- 7.9 However, we do not support more general use of the law for paternalistic reasons. Fundamentally, using the law in this way is at odds with the value society places on an individual's ability to make his or her own choices and decide what is in his or her own best interests. If someone, fully aware of the risks involved, chooses to participate in an activity that risks causing harm only to themselves, most of us would respect the right to make that choice, even if we consider the choice to be wrong or misguided. Not doing so also seems counter-productive because the law would be preventing one harm by creating another (that is, the harm of restricting an individual's ability to act as he or she chooses).
- 7.10 This is not to say that drug regulation is never justified. In particular, an individual should not be able to engage in drug use that harms other people, because this compromises others' ability to live life as they choose.<sup>485</sup> As outlined in chapter 2, these harms range from the impact of drug use on a user's family, friends and workplace to the costs to the health budget from treating drug-related conditions.
- 7.11 However, in deciding whether regulation is the best way to prevent this harm, it is also necessary to consider and weigh up the harm that regulation itself causes. Heavy-handed regulation to prevent a very small harm is not justified as a matter of principle and risks being counter-productive.
- 7.12 It is also important to note that, while the distinction between regulation to prevent harm to users themselves and regulation for other reasons is an important distinction in conceptual terms, it is somewhat artificial in reality. For example, the distinction between the protection of values and the prevention of harm is in many respects a false dichotomy. The values that underpin our social structure forge social consensus and maintain social harmony; and the undermining or disintegration of those values ultimately runs the risk of destroying social solidarity, reducing the effective functioning of society and harming the quality of life of us all.
- 7.13 Even more fundamentally, few activities only cause harm to the individual who engages in them. The old adage "no man is an island" applies. Any activity that causes significant harm to the individual is likely to also cause harm to others. For example, the requirement to wear a seatbelt is as much due to the likely health care and other social costs of being in a car accident while not wearing a seatbelt, as it is due to the increased harm that we may cause to ourselves.

<sup>484</sup> Although note that there is some controversy about the view that regulation is justified because the effects of drug intoxication or addiction impair users' ability to make rational decisions that are in their best interests. While some commentators accept that the effects of intoxication or addiction can impair a user's judgment in this way, others are less convinced. See Robert MacCoun and Peter Reuter *Drug War Heresies: Learning from Other Vices, Times and Places* (Cambridge University Press, New York, 2001) 64 and Husak, above n 479, 377–378.

<sup>485</sup> See discussion in MacCoun and Reuter, *ibid.*, 60–61.

- 7.14 Bearing these matters in mind, our view is that regulation of drug use is generally only justified to the extent necessary to prevent harm to others. Regulation is also justified in limited circumstances to protect the young and those whose mental faculties are impaired. The benefits arising from the reduction in harm must outweigh the costs arising from regulation itself. This is, in essence, the approach taken in our issues paper on the regulation of alcohol.<sup>486</sup> We see no reason to take a different view in this context.

## HOW SHOULD DRUGS BE REGULATED?

### Introduction

- 7.15 As with decisions about *whether* to regulate, decisions about *how* to regulate can also be presented as a choice between two extremes. At one extreme is complete prohibition. At the other extreme is legalisation, in which a drug is freely and legally available, with its use subject to few, if any, controls. In reality, however, models of drug regulation are more varied and nuanced than that kind of formulation would suggest. We now go on to consider what these models might be. In doing so, we focus our attention on the regulation of drugs for non-medicinal (“recreational”) purposes. The way in which drugs should be made available to facilitate their medicinal and scientific use is considered in chapter 13.

### Full prohibition

#### Description

- 7.16 Under a full prohibition model, all activities in relation to drugs (for example, use, possession, production/manufacture, import/export, sale, and supply) are illegal and subject to criminal offences and criminal penalties.

#### Rationale

- 7.17 The basis of prohibition is the view that drugs pose such an unacceptable threat to human health that their production, trade, and use should be regulated for most purposes,<sup>487</sup> and prohibited altogether for recreational purposes. Prohibition, accompanied by strong enforcement and clear messages about the dangers of drug use,<sup>488</sup> should deter people from using and selling drugs, restrict the availability of drugs, and increase their price. By doing so, prohibition should reduce, if not eliminate altogether, recreational drug use.
- 7.18 In theory prohibition enables an approach to drug control that balances strategies of supply control, problem limitation, and demand reduction. However, in practice, the substantial law enforcement effort that prohibition requires means that supply control tends to become the dominant approach to drug control in comparison to other strategies.

486 See New Zealand Law Commission *Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws* (NZLC IP15, Wellington, 2009) [*Alcohol in Our Lives*].

487 Commission on Narcotic Drugs “Making Drug Control ‘Fit for Purpose’: Building on the UNGASS Decade” (7 May 2008) E/CN.7/2008/CRP.17, 10.

488 International Drug Policy Consortium *The 2006 World Drug Report: Winning the War on Drugs?* (International Drug Policy Consortium, London, 2006) 2.



## Examples of the model in practice

- 7.19 Prohibition is the dominant global approach taken to controlling the use of illegal drugs for recreational purposes. This is primarily a result of the international drug conventions which, as discussed in chapter 6, aim to maintain a system of global prohibition of narcotic drugs, psychotropic substances, and precursor substances. Prohibition is the predominant regulatory model reflected in New Zealand's Misuse of Drugs Act 1975.

## Costs and benefits

- 7.20 It is difficult to identify the impact of prohibition on recreational drug use and the recreational drug market – that is, whether the “war on drugs” is being won. The extent to which people would have used drugs in the absence of prohibition is unknown. The United Nations Office on Drugs and Crime (UNODC) considers that global prohibition has at least led to drug use being contained. Around 5 % of the adult population worldwide (or between 140–250 million people) report using illegal drugs at least once in the past year. These proportions, which have remained relatively stable over recent years, are substantially smaller than for legal psychoactive substances such as tobacco and alcohol.<sup>489</sup>
- 7.21 However, trends over recent years need to be considered in the context of over 40 years of global drug control. Even if some kind of plateau in levels of drug use has now been reached, the International Drug Policy Consortium argues that there has been a “massive increase in the scale and diversity of international markets for illegal drugs, and increasing rates of drug use in almost every country” over this time.<sup>490</sup> The United Nations itself has said that the drug “problem” may get worse before it gets better.<sup>491</sup>
- 7.22 New Zealand's experience provides some support for this view. For example, methamphetamine, a drug of particular community concern, is a relatively new drug on the illegal drugs market, only coming to prominence in New Zealand in the late 1990s.<sup>492</sup>

489 United Nations Office of Drugs and Crime (UNODC) *World Drug Report 2009* (United Nations Office of Drugs and Crime, New York, 2009) 169. The World Health Organisation estimates that in 2000, there were 185 million users of illegal drugs worldwide, compared to 2 billion alcohol users and 1.3 billion tobacco smokers – see Marcus Roberts, David Bewley-Taylor and Mike Trace *Facing the Future: The Challenge for National Drug Policy* (R6, The Beckley Foundation Drug Policy Programme, 2005) 5.

490 International Drug Policy Consortium, above n 488, 2.

491 Commission on Narcotic Drugs, above n 487, 10.

492 See chapter 1, paragraphs 1.16–1.17.

- 7.23 The scale of the global drugs market remains immense. The wholesale international illegal drugs market was valued at US\$94 billion in 2003 (compared to \$17.4 billion for wine, \$6.7 billion for beer, and less than \$6 billion for coffee) and the retail international illegal drugs market at \$322 billion.<sup>493</sup> It is claimed that the illegal drugs market is the third most profitable market in the world, behind the markets in oil and arms.<sup>494</sup> In New Zealand, the cannabis market was estimated to have a wholesale value in 2005 of between \$74 million and \$95 million, and a retail value of between \$183 million and \$235 million.<sup>495</sup> Some of the value of the illegal drugs market will reflect the illegality of the substances involved and the risk in making them available. Nevertheless, figures such as these may be one reason why UNODC now considers the reduction or elimination of drug use to be an “aspirational goal akin to the elimination of war and poverty”.<sup>496</sup>
- 7.24 It is far from clear that drug prohibition itself is responsible for any stabilisation in drug use. In particular, the extent to which prohibition does and should deter drug use is debatable and uncertain. As applied to drug use, deterrence theory requires drug users to make rational decisions about whether to use drugs, by weighing up the costs and benefits of doing so.<sup>497</sup> The illegality of drug use, and the fear of the legal consequences that flow from that illegality, should mean that the costs to the user of engaging in drug use, regardless of the pleasure to be derived from it, are simply not worth it. The greatest deterrent effect should occur when the user perceives the legal consequences or punishment to be both certain (that is, there is a high likelihood of being caught) and severe.
- 7.25 For some new or potential users, fear of being caught, or of the legal consequences if caught, may be sufficient to deter experimentation with drugs. However, the same is unlikely to be true of dependent users. Drug dependence does not lend itself to a rational calculation of the costs and benefits of engaging in drug use.<sup>498</sup> Therefore, current users who are drug dependent are unlikely to be deterred by the legal framework in place at the time.
- 7.26 Research has demonstrated that the certainty of punishment has a much greater deterrent impact than its severity.<sup>499</sup> However, in relation to the most widely used illegal drug in New Zealand, cannabis, we estimate that less than 1 % of all

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493 UNODC, above n 489, 127–128.

494 Roberts, Bewley-Taylor and Trace, above n 489, 1.

495 New Zealand National Drug Intelligence Bureau “*New Cannabis: The Cornerstone of Illicit Drug Harm in New Zealand, 2007 Strategic Assessment* (New Zealand Police, Wellington, November, 2007) 53.

496 UNODC, above n 489, 163. For critique of this comparison, see International Drug Policy Consortium *The 2009 World Drug Report: A Response From the International Drug Policy Consortium* (International Drug Policy Consortium, London, 2009) 10.

497 MacCoun and Reuter, above n 484, 78.

498 Ibid, 86.

499 Andrew von Hirsch and others *Criminal Deterrence and Sentence Severity: an Analysis of Recent Research* (Hart Publishing, University of Cambridge Institute of Criminology, 1999) 5; Andrew Ashworth *Sentencing and Criminal Justice* (Cambridge University Press, 2005) 79.

users in New Zealand in 2006 were prosecuted for their cannabis use.<sup>500</sup> New Zealand research has also found that most cannabis users are not prosecuted or convicted for cannabis-related offences.<sup>501</sup>

- 7.27 In other jurisdictions, research has estimated that cannabis users have an average annual risk of arrest of about 3 % and cocaine users an average annual risk of arrest of about 6 %.<sup>502</sup> The risk per transaction for both drug users and drug dealers has been estimated at being even lower – at around one in 3000.<sup>503</sup> Therefore, the vast majority of users and their associates will be able to use drugs with little, if any, legal consequence. New Zealand research reinforces that current drug laws are not seen as a deterrent to personal use, either by the general public or by current users.<sup>504</sup>
- 7.28 This is supported by research suggesting that factors other than the certainty and severity of punishment have a greater influence on whether an individual uses, or continues to use, drugs<sup>505</sup> and that fear of punishment or the drug's illegal status is not a major driver in a decision to stop using drugs.<sup>506</sup> This decision is instead driven by the impact of drug use on a user's family relationships, home and work life, and physical health.<sup>507</sup> Similarly, Australian research of cannabis users in Western Australia and South Australia indicates that being apprehended for cannabis use did not stop them from using drugs.<sup>508</sup>

500 The national household survey on drug use amongst those aged 15–45 found that 18 % of respondents reported using cannabis in the last 12 months – see chapter 1, para 1.22. This equates to 306,977 users based on the 2006 census figures for usual resident population aged 15–45 (n = 1,705,431) – see Statistics New Zealand Table Builder [wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx](http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx) (accessed 7 October 2009). 1438 people were prosecuted for using cannabis in 2006 (see 2006 conviction statistics on Statistics New Zealand Table Builder [wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx](http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx) (accessed 7 October 2009)). The prosecution figures are not limited to the 15–45 age group so some over-counting is likely. We have not been able to make a similar estimate for the number of cannabis users arrested for cannabis use. 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) 102. New Zealand Police apprehension statistics indicate that approximately 2 % of users are apprehended for a possession or use offence (Statistics New Zealand Table Builder <http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx> (accessed 23 December 2009)). 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.

501 D M Fergusson, NR Swain-Campbell and L J Horwood “Arrests and Convictions for Cannabis-Related Offences in a New Zealand Birth Cohort” (2003) 70 *Drug and Alcohol Dependence* 53.

502 MacCoun and Reuter, above n 484, 82.

503 Ibid.

504 Acqumen Quality Solutions and UMR Research *Research into Knowledge and Attitudes to Illegal Drugs – A Survey among the General Public and People with Experience of Drug Use* (Ministry of Health, Wellington, 2009) 31 and 88; 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* 545; Fergusson, Swain-Campbell and Horwood, above n 501, 53–63.

505 David Ryder, Noni Walker and Alison Salmon *Drug Use and Drug-Related Harm: A Delicate Balance* (2 ed, IP Communications, Melbourne, 2006) 124; Robin Room and others *The Global Cannabis Commission Report – Cannabis Policy: Moving Beyond Stalemate* (The Beckley Foundation Global Cannabis Commission, September 2008) 148 [*Global Cannabis Commission Report*].

506 Dave Bewley-Taylor, Mike Trace and Alex Stevens *Incarceration of Drug Offenders: Costs and Impacts* (Briefing Paper 7, the Beckley Foundation Drug Policy Programme, 2005) 6.

507 Ibid.

508 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 Series No 36, National Drug Strategy, 1998) 25.

- 7.29 People also obey the law because they believe it is morally appropriate to do so, either because they agree with the content of the law itself or, even if they do not, because they agree that the law was legitimately made.<sup>509</sup> Social and cultural attitudes towards the activity and law in question are therefore crucial.
- 7.30 Changes in patterns of drug use are, in part, simply a reflection of wider social and cultural changes. For example, we noted in chapter 4 the association between experimentation with cannabis and hallucinogens and the development of the psychedelic “hippie” counterculture in the 1960s and 1970s. More recently, the use of ecstasy and party pills has been associated with the emergence of New Zealand’s dance scene.
- 7.31 There is little recent New Zealand research on the public’s attitudes towards our current drug laws.<sup>510</sup> However, perhaps not surprisingly, Australian research of cannabis users in Western Australia and South Australia indicates that most people that were apprehended for cannabis use did not support its continued prohibition.<sup>511</sup>
- 7.32 Irrespective of their illegality, some drugs in New Zealand appear to be readily available, particularly drugs that are locally manufactured or cultivated. For example, when asked about search time for purchasing illegal drugs, 45 % of frequent drug users in New Zealand who had purchased cannabis in the last six months said that it took less than 20 minutes; 65 % of those who had purchased methamphetamine and 51 % of those who had purchased amphetamine were able to do so in one hour or less. In contrast, 43 % of those who had purchased ecstasy and 35 % of those who had purchased LSD said the purchase took days or weeks.<sup>512</sup>
- 7.33 The effectiveness of prohibition in restricting the availability of illegal drugs therefore differs from drug to drug. It seems clear that prohibition is more effective for some drugs than for others. In particular, the way in which a drug is produced, distributed, and consumed may have as great an impact on a drug’s availability as its illegal status. For example, it is likely to be more difficult to restrict the availability of a drug like cannabis that can be easily grown, and tends to be consumed, in a private residence; that has relatively high rates of use; and that many consider to be less harmful than legal drugs like tobacco and alcohol.

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509 von Hirsch and others, above n 499, 3.

510 Some research has been undertaken on attitudes towards enforcement of drug prohibition, as opposed to prohibition. In relation to cannabis, those surveyed tended to the view that enforcement of cannabis possession laws was “too heavy” while enforcement of cannabis sale laws was “too light”. In relation to other drugs, those surveyed considered that the enforcement of laws against both possession and sale was too light. See Chris Wilkins and others *Drug Use in New Zealand: National Surveys Comparison 1998 & 2001* (Alcohol and Public Health Research Unit, University of Auckland, 2002) 51.

511 Lenton and others, above n 508, 15.

512 C Wilkins, M Girling and P Sweetsur *Recent Trends in Illegal Drug Use in New Zealand, 2005–2007 – Findings from the 2005, 2006, and 2007 Illicit Drug Monitoring System* (Centre for Social and Health Outcomes Research and Evaluation, Massey University, Auckland, 2009) 24. At page 34 a frequent drug user was defined as being someone who used methamphetamine or ecstasy at least monthly or who injected a drug intravenously at least monthly. The respondents to the survey are not a random sample of frequent drug users, but were instead recruited through promotional campaigns and “snowballing”.

In contrast, it is likely to be easier to restrict the availability of a drug like cocaine or heroin that cannot be manufactured or produced locally; that is not widely used; and that many consider to cause an unacceptable amount of harm.<sup>513</sup>

- 7.34 There is some evidence that prohibition impacts on price. For example, it has been estimated that a milligram of morphine sulphate that costs 6 cents in New Zealand's medical system sells for \$1 in the black market.<sup>514</sup> In the United States, it has been estimated that a pound of cannabis which costs \$US3000 on the black market could be produced for as little as \$US1.07 in the legal market.<sup>515</sup> Other analysis indicates that the mark-ups for heroin and cocaine, from the farm gate to the consumer, are about 16,800 % and 15,800 % respectively.<sup>516</sup> The sheer fact of a drug's illegal status increases its price by, for example, increasing the level of risk to the dealer at each point of the supply chain.<sup>517</sup>
- 7.35 However, price is also a function of supply and, therefore, also depends on the availability of the drug concerned. In relation to cannabis, for example, while its price may be significantly higher than it would be if it could be legally produced, it remains "readily available in many Western societies at a cost that allows [it] to compete with alcohol as a source of intoxication."<sup>518</sup> In New Zealand, a tinnie of cannabis, which is enough for two to three joints, is available from around \$14 to \$30,<sup>519</sup> comparable to a bottle of wine or spirits, or a dozen beer.
- 7.36 The benefits of prohibition must also be weighed against its costs. These costs were discussed in chapter 2 in relation to cannabis and methamphetamine, and include law enforcement costs as well as costs for individual users. Costs such as these have led some to argue that the harm caused by prohibition outweighs the harms caused by drug use itself.<sup>520</sup>
- 7.37 For example, prohibition may inhibit users from accessing treatment for addiction or dependence due to fear of arrest or prosecution.<sup>521</sup> Prohibition can also make public education about safe use of drugs difficult, not only because this seems inconsistent with the overall aims of prohibition, but also because prohibition makes it more difficult to identify and access target groups.

513 Robert MacCoun, Peter Reuter and Thomas Schelling "Assessing Alternative Drug Control Regimes" (1996) 15 *Journal of Policy Analysis and Management* 330, 346.

514 Chris Wilkins *A Framework for Assessing Alternative Drug Control Regimes* (Centre for Social and Health Outcomes Research and Evaluation, Massey University, Auckland, 2008) 27.

515 Ibid.

516 Laura Wilson and Alex Stevens *Understanding Drug Markets and How to Influence Them* (R 14, the Beckley Foundation Drug Policy Programme) 2.

517 See discussion in *ibid.*

518 *Global Cannabis Commission Report*, above n 505, 75.

519 New Zealand National Drug Intelligence Bureau, above n 495, 52.

520 Ryder, Walker and Salmon, above n 505, 201.

521 See, for example, Wilkins, Girling and Sweetsur, above n 512, 162. 23 % of frequent drug users cited "fear of police" as a reason for not seeking drug treatment.



Prohibition also means that there are no controls on the ingredients contained in a substance or the production process. As a consequence, harm arising from drug use may not be reduced, and may even be increased.<sup>522</sup>

- 7.38 In addition, that so many individuals engage in recreational drug use at some point in their lives suggests that there is some benefit to be derived from it.<sup>523</sup> In the main, these benefits will relate to the short-term and immediate effects of drug use, such as euphoria, increased energy, or relaxation. Many prohibited drugs also have recognised therapeutic uses.<sup>524</sup> Depriving people of these benefits as a result of drug prohibition is itself harmful, particularly if one drug cannot be substituted for another.
- 7.39 Harm also results from a user's interaction with crime and the criminal justice system as a result of a drug's illegality. Drug prohibition means that an offence is committed with every instance of use<sup>525</sup> and usually requires a user to have direct contact with criminal elements (if only to obtain a drug supply). Those instances of use that are detected may lead to the user having direct involvement in the criminal justice system.<sup>526</sup> Further difficulties may arise from a drug conviction including, for example, difficulties in obtaining employment.
- 7.40 The UNODC has itself identified five unintended consequences of prohibition.<sup>527</sup> These are:
- (a) A huge criminal black market "that now thrives in order to get prohibited substances from producers to consumers... There is no shortage of criminals competing to claw out a share of a market in which hundred fold increases in price from production to retail are not uncommon." UNODC considers the violence and corruption associated with the black market to provide the "strongest case" against the global drug control system.<sup>528</sup>
  - (b) Policy displacement, in which available funds have been drawn into public security and law enforcement and away from public health interventions.
  - (c) Geographical displacement, in which tightening controls in one country or geographical area inevitably produces an increase in drug production or supply in another country or geographical area. For example, as cocaine supply reduced in Peru and Bolivia in the second half of the 1990s, it increased in Colombia.<sup>529</sup>

522 See, for example, Commonwealth of Australia *Legislative Options for Cannabis Use in Australia* (Monograph Number 26, 1994) 51 which notes that the illegality of water pipes for cannabis use mean more people consume cannabis in cigarette papers, which is the form of consumption most damaging to lungs.

523 See, for example, discussion in 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) 64–65 and Husak, above n 479, 365. This argument may not apply to users who are addicted.

524 See MacCoun, Reuter and Schelling, above n 513, 341.

525 See MacCoun and Reuter, above n 484, 110 who argue that this is itself harmful, even if the particular instance goes undetected and unpunished.

526 37% of frequent drug users questioned as part of New Zealand's 2007 Illicit Drug Monitoring System reported legal or police problems that were related to their drug use. See Wilkins, Girling and Sweetsur, above n 512, 160.

527 Commission on Narcotic Drugs, above n 487, 10.

528 UNODC, above n 489, 163.

529 Commission on Narcotic Drugs, above n 487, 11.



- (d) Substance displacement so that suppliers and users move on to other drugs with similar psychoactive effects when their current drug-of-choice is controlled. Most recently, for example, UNODC has noted that while the markets for cannabis, cocaine, and opiates appear to be shrinking, the market for synthetic stimulants appears to be increasing and the problem caused by these stimulants is worsening.<sup>530</sup>
- (e) The way that we perceive and deal with drug users. As noted by the UNODC, “a system appears to have been created in which those who fall into the web of addiction find themselves excluded and marginalised from the social mainstream, tainted with a moral stigma, and often unable to find treatment even when they may be motivated to want it.”<sup>531</sup>

7.41 These harms and unintended consequences of drug prohibition have led some jurisdictions, as well as the United Nations itself,<sup>532</sup> to consider less restrictive approaches to prohibition. These approaches continue broadly with prohibition but, at least in relation to personal use offences, place greater emphasis on limiting prohibition’s harms and give more attention to strategies of demand reduction and problem limitation.

## Prohibition models that encompass diversionary approaches

### *Description*

7.42 Under this model, the use, possession, cultivation, importation, exportation, sale and distribution of a drug for recreational purposes remain prohibited and subject to criminal offences and penalties. However, informal or intermediate measures are available to divert some drug offenders from the formal criminal justice system when an offence is detected or prosecuted. These measures may be used at various stages, including pre-sentence and post-conviction, but are most commonly used at the pre-arrest and pre-trial stages.

### *Rationale*

7.43 This model reflects a view that some drug offences do not warrant the full intervention of the criminal justice system, and that a less formal response may be equally if not more effective in preventing re-offending and further drug use. It aims to reduce the negative and punitive effects of the criminal justice system on drug offenders, and to reduce the costs to the State. A less formal response to the offending may also be more proportionate to the offender’s culpability and the harm the offending caused. Many approaches based on this model include a rehabilitative or educative focus, to reduce drug use and limit the problems it causes.

<sup>530</sup> UNODC, above n 489, 9.

<sup>531</sup> Commission on Narcotic Drugs, above n 487, 10–11.

<sup>532</sup> UNODC, above n 489, 166.

*Examples of the model in practice*

- 7.44 Approaches based on this model are not new, either in New Zealand or elsewhere. In New Zealand, there is a Police Adult Diversion Scheme that, in broad terms, 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 generally not available for Class A and B drug offences,<sup>533</sup> 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.<sup>534</sup>
- 7.45 The Scheme requires that a prosecution commence and an acknowledgement of guilt 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 diversion (for example, by fulfilling the diversion conditions), the charge will be withdrawn. If not, the prosecution of the offender continues. There is no statutory basis for the Scheme, and its implementation is a matter of police discretion with the assistance of police guidelines.
- 7.46 All Australian states and territories have some form of cautioning schemes specifically for minor drug offences such as personal possession and use. These schemes operate in broadly similar ways – that is, offenders who are apprehended for minor drug offences are able to receive a caution for that offending rather than being prosecuted in court. There are, however, some important differences. These include the type of drugs and other activities that are covered,<sup>535</sup> the amounts of drugs involved,<sup>536</sup> the age-range of eligible offenders,<sup>537</sup> the emphasis

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

534 Police Diversion policy as at 22 September 2009, 11 [www.police.govt.nz/sites/default/files/services/diversion/Policy%20-%20Adult%20diversion%20scheme%20-%20updated%2022Sep09.pdf](http://www.police.govt.nz/sites/default/files/services/diversion/Policy%20-%20Adult%20diversion%20scheme%20-%20updated%2022Sep09.pdf) (accessed 19 October 2009).

535 The schemes in New South Wales and Queensland are limited to cannabis. South Australia has separate diversion schemes for cannabis, other illegal drugs, and prescription drugs, all of which operate in slightly different ways. Tasmania and Victoria also treat cautions for cannabis and for other drugs differently. The Northern Territory and Western Australia have caution schemes for drugs other than cannabis; these supplement infringement-offence systems for cannabis offending. The Australian Capital Territory's scheme applies to all illegal drugs in the same way. The schemes in New South Wales, Western Australia and Queensland extend to implement offences. See Jason Payne, Max Kwiatkowski and Joy Wundersitz *Police Drug Diversion: A Study of Criminal Offending Outcomes* (Australian Institute of Criminology, Canberra, 2008) 77–80.

536 For example, New South Wales' cannabis scheme appears the most restrictive, being limited to possession of not more than 15g of cannabis. Most other states appear to allow up to 50g of cannabis to be possessed. See Joanne Baker and Derek Goh *The Cannabis Cautioning Scheme Three Years On: An Implementation and Outcome Evaluation* (NSW Bureau of Crime Statistics and Research, Sydney, 2004) 2.

537 South Australia's schemes apply to those aged between 10 and 17. The New South Wales and Western Australia schemes apply to those aged 18 or over. The schemes in Tasmania, Australian Capital Territory, Queensland, and the Northern Territory apply from age 10. Victoria's cannabis scheme applies from age 17, while its scheme for non-cannabis applies from age 10. Payne, Kwiatkowski and Wundersitz, above n 535, 77–80.

placed on education and treatment,<sup>538</sup> how many times an individual may be cautioned before he or she becomes ineligible for a caution,<sup>539</sup> and whether the scheme is mandated by legislation.<sup>540</sup>

- 7.47 The New South Wales (NSW) Cannabis Cautioning Scheme commenced on 3 April 2000. Adults who are found using or possessing less than 15 grams of (dried) cannabis and/or equipment for using cannabis may receive a formal police caution. The cannabis must be possessed for personal use and sufficient evidence to prosecute the offender for the offence must exist. The offender must admit the offence, must not be involved in any other criminal offence at the time, and must have no prior convictions for drug, violent or sexual offences. Police are required to seize and secure the cannabis and/or equipment.
- 7.48 A caution can only be issued on two occasions. The notice issued with the first caution includes information on the health and legal consequences of cannabis use, and provides information about treatment and support services. Those who receive a second caution must participate in a mandatory education session over the telephone on cannabis use. As with New Zealand's Diversion Scheme, there is no statutory basis for the NSW Scheme; instead, there are a set of guidelines that guide the exercise of police discretion.
- 7.49 There are also opportunities at later stages in New Zealand's criminal justice system for 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.<sup>541</sup> The offender's participation in that programme may then be taken into account in an offender's sentence. This option is available to any offender, and is not limited to drug offenders.
- 7.50 Similar opportunities exist in all Australian jurisdictions. However, these court-based diversion programmes tend to operate on a more formalised and systematic basis than in New Zealand and specifically target drug users or offenders whose offending appears to be related to their drug use. Successful completion of a programme, including participation in a drug treatment programme, may result in charges being withdrawn or that completion being taken into account in the offender's final sentence.<sup>542</sup>

538 Most schemes provide offenders with information about the legal or health consequences of drug use. Some provide the offender with contact details for health providers, with attendance voluntary (for example, Victoria, New South Wales). Some also require participation in a mandatory education session (for example, Queensland for any caution; New South Wales and Tasmania upon receiving a second caution; Northern Territory, Victoria, and Western Australia for any caution received for non-cannabis). Ibid.

539 There is no limit on the number of cautions in South Australia and Northern Territory; in New South Wales, Victoria, Queensland, and the Australian Capital Territory, a person can only be cautioned twice; in Western Australia a person can only be cautioned once. Ibid.

540 Queensland and South Australia are the only States with legislation.

541 Sentencing Act 2002, s 25.

542 Joy Wundersitz *Criminal Justice Responses to Drug and Drug-Related Offending: Are They Working?* (Australian Institute of Criminology, Canberra, 2007) 12.

*Costs and benefits*

- 7.51 It is important to note that, under this model, drug offenders remain subject to the criminal law, even if the response from the criminal justice system is sometimes less formal in nature. Most jurisdictions target their diversionary response to particular offenders or offending. Offenders and offending that fall outside those limits can still be prosecuted and convicted.
- 7.52 Most diversion or cautioning schemes at the pre-trial or pre-arrest stage aim to avoid prosecution and formal court proceedings for minor offenders, and are successful in this regard. A 2004 evaluation of the first three years of the NSW Cautioning Scheme found that the number of charges laid and dealt with by the courts, and the number of convictions, decreased over that time.<sup>543</sup> However, the decrease in charges that the courts dealt with was not of the same magnitude as the number of cautions issued.<sup>544</sup> This raises the issue of “net-widening” – that is, that some individuals who received a caution may have previously had no action taken against them, or been issued with an informal warning.<sup>545</sup>
- 7.53 The NSW evaluation also found that the Scheme resulted in savings in police and court time of approximately \$AUS1.4 million over the first three years. The net saving, once running and implementation costs were taken into account, was approximately \$AUS300,000.<sup>546</sup>
- 7.54 The impact cautioning schemes have on rates of drug use is unclear. As discussed above, the range of factors that may influence an individual’s decision to use drugs means that it is difficult to isolate the specific impact of a particular regulatory approach. However, the 2007 national household survey of drug use in Australia found that past-year cannabis use in NSW was the lowest of all Australian states and territories.<sup>547</sup>
- 7.55 A useful component of most cautioning schemes is the opportunity to educate users about the risks of drug use, and to divert users into drug treatment if required. In this regard, the education and treatment component of the NSW Scheme did not appear to be particularly effective. Few offenders sought

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543 Baker and Goh, above n 536, 35. There were 2658 fewer people convicted per year.

544 Ibid, 26–29. Over 9000 cautions were issued in the first three years of the Scheme. The number of charges laid has decreased by less than 7000, the number of charges dealt with by the courts has decreased by less than 6000 and the number of people convicted has decreased by less than 3000.

545 Ibid, 32. The fact that caution notices tended to be issued for possession of very small amounts of cannabis suggested that net-widening had been a consequence of the New South Wales Scheme. 96 % of the 9235 cautions issued were for possession offences rather than equipment offences. Over 75 % of the possession offences for which a caution was issued involved 5 grams of cannabis or less.

546 Ibid, 37. The running costs were approximately \$AUS1.1 million over evaluation period.

547 In New South Wales, 8 % of the population aged 14 years or over used cannabis in the past 12 months, compared to Victoria: 8.8 %; Queensland: 9.5 %; Western Australia: 10.8 %; South Australia: 10.2 %; Tasmania: 10.8 %; Australian Capital Territory: 9.1 %; Northern Territory: 13.8 %, and Australia overall: 9.1 %. See Australian Institute of Health and Welfare 2007 *National Drug Strategy Household Survey: State and Territory Supplement* (AIHW, Canberra, 2008) 8.

assistance or treatment as a result of their cannabis use, and less than half of those offenders who were correctly issued with a second caution notice attended their mandatory education session.<sup>548</sup>

- 7.56 In NSW, there is no follow-up to ensure the offender completes his or her caution requirements. Other jurisdictions, such as Queensland and Tasmania, have made participation in education or treatment an enforceable requirement of a caution that may lead to charges being laid for the original offending (or for the failure to comply with the caution notice) in the event of non-compliance. While this may provide a necessary enforcement mechanism, it also lessens the scheme's diversionary nature. This is because the potential for escalation through the criminal justice process remains.<sup>549</sup> It also increases a scheme's cost.
- 7.57 Jurisdictions that implement cautioning or diversion schemes for personal use offences also tend not to address the issue of supply. Consequently, a black market in the prohibited drug remains and, unless they make or produce their own supply, users must access illegal markets to obtain drugs.
- 7.58 Particularly where there is no mandating legislation, whether or not an individual is offered a caution or diversion depends in large measure on the exercise of police discretion, and the response of individual police officers when an offence is detected. In NSW, the use of cautions varied across the state. A key reason for the regional variation appeared to be the extent to which the Scheme was supported in the local area.<sup>550</sup> While some variation in response to local conditions is appropriate and should be expected, it also raises the prospect of selective or inequitable use of police discretion.
- 7.59 It is also necessary to ensure that any education or treatment that is part of a cautioning or diversion scheme is appropriate and provided only to those who are likely to benefit from it. Otherwise, significant costs may be incurred for little advantage. There may be little to be gained, for example, in requiring users who will not use again or who may use only infrequently, or who experience no particular problems from their drug use, to participate in education or treatment.

## Prohibition models that preclude the possibility of criminal conviction

### *Description*

- 7.60 Under this model, the use, possession, cultivation, importation, exportation, sale, and distribution of a drug for recreational purposes remain prohibited and illegal. However, it is not possible for an individual to be convicted of an offence in relation to minor instances of some of those activities, and the offence is not dealt with through the usual criminal justice process. This can be achieved in one of two ways. First, the possibility of conviction can simply be removed, even though the offences remain criminal offences subject to criminal penalties.

<sup>548</sup> The approach to second cautions was amended in 2001. There appeared to be a lack of training and communication to police about how the second cautions were to work, meaning that only 25 % of second caution notices were assessed as being issued correctly. But this only affected a small number of people, as only 187 people were cautioned on two occasions. Baker and Goh, above n 536, 22–24.

<sup>549</sup> This appears to be the reason why New South Wales did not take this approach – see *ibid*, 5.

<sup>550</sup> *Ibid*, 19.



This is the approach taken in New Zealand to the vast majority of infringement offences. Alternatively, criminal offences and penalties can be removed altogether and be replaced with civil ones.<sup>551</sup>

- 7.61 The term “decriminalisation” is often used to describe both types of approaches. Technically, however, that term is only correct in relation to the latter approach – that is, where the status of the offences changes from criminal offences to civil offences, and where civil, rather than criminal, penalties apply.

### *Rationale*

- 7.62 This model shares many of the goals of a diversionary model. It aims to reduce the punitive impact and costs of the criminal law, while still maintaining the illegality of the prohibited conduct. This maintains the normative message that drug use is “wrong” or harmful. However, by precluding the possibility of formal criminal proceedings and the possibility of conviction, it aims to reduce the harms and costs of prohibition to both the individual and the State.

### *Examples of the model in practice*

- 7.63 There are two types of approaches operating in other jurisdictions. The first is essentially an infringement offence system, which requires the payment of a monetary fee or completion of some other fixed penalty when an infringement offence notice is issued for a minor drug offence. Some Australian States, and the United Kingdom, operate this type of approach in relation to cannabis offences. The second approach applies purely administrative or civil sanctions, including referral to or participation in an education or treatment session. This type of approach is more likely to be found in European jurisdictions.

### *Infringement offence systems*

- 7.64 Infringement offence systems are intended to deal with high-volume and/or minor offences that are considered not to require the full intervention of the criminal law or the full extent of due process, or that would otherwise clog the court system. Most cases are resolved between the defendant and the prosecuting authority without court involvement. The court process is only used when the defendant denies the charge or wishes to make submissions as to penalty, or when the infringement fee is not paid on time (or another form of penalty is not complied with).<sup>552</sup>
- 7.65 Infringement offences are an established part of New Zealand’s justice system. Twenty different infringement offence regimes are currently in force, ranging from minor traffic offences, dog control, litter, and liquor licensing to resource management, biosecurity, civil aviation, and occupational health and safety. There is no infringement offence regime in New Zealand for drug offences.

551 Note that there are very few civil infringement offence regimes in New Zealand. The only regime that we are aware of is in Part 4A of the Telecommunications Act 2001 which enables a civil infringement notice to be issued in relation to a variety of statutory and regulatory breaches under the Act.

552 See New Zealand Law Commission *The Infringement System: A Framework for Reform* (NZLC SP16, Wellington, 2005) 2.



- 7.66 In Australia, infringement offence regimes for minor cannabis offences are in place in South Australia, the Northern Territory, Australian Capital Territory, and Western Australia.<sup>553</sup> The longest-running scheme is the South Australian Cannabis Expiation Notice Scheme which was introduced in 1987. An adult who commits a minor possession,<sup>554</sup> use,<sup>555</sup> or cultivation<sup>556</sup> offence must be issued with an expiation notice, rather than be prosecuted. There are prescribed infringement fees depending on the activity detected and the amount of cannabis involved. A maximum fee of \$300 applies when the offence involves cultivation, or when the offence involves possession of between 25 grams and 100 grams of cannabis or between five grams and 20 grams of cannabis resin.<sup>557</sup>
- 7.67 Since January 2009, when cannabis was reclassified from a Class C to a Class B drug, the United Kingdom has included cannabis possession in its Penalty Notice Disorder (PND) Scheme. An adult found in possession of a small amount of cannabis or cannabis derivatives that the police consider to be for personal use may be issued with a PND, which requires the payment of an £80 fine. A PND can only be issued once, and will not be issued when the cannabis is being used in a public place, when there is a related local policing problem,<sup>558</sup> or when the possession of cannabis is creating a particular risk to young people (for example, because it is possessed in premises that young people use such as schools or youth clubs).<sup>559</sup>

#### Approaches that apply civil or administrative penalties

- 7.68 In some European States, individuals who are apprehended for minor drug offences are referred to administrative authorities for consideration of their education and treatment needs (with the drugs usually confiscated). In Portugal, this approach applies to the purchase, possession, and consumption of all drugs for personal use, all of which are civil offences. Other drug offences, in particular, production/manufacture, import/export, and supply remain criminal offences subject to criminal penalties.
- 7.69 A key component of Portugal's approach was the establishment of Commissions for Dissuasion of Drug Addiction. The commissions are locally-based panels that decide how individuals ("consumers") who are apprehended by the police for personal use offences should be dealt with. Consumers must appear in front of a commission

553 A Bill to replace the Western Australian scheme, the Cannabis Law Reform Bill 2009, was introduced into Western Australia's Legislative Assembly on 14 October 2009. That Bill replaces the infringement notice regime with a Cannabis Intervention Requirement Scheme, which requires those in possession of less than 10 gms of cannabis to participate in an education session.

554 Controlled Substances Act 1984 (SA), s 33L(2)(a) – Possession. This applies to a person in possession of 100gms of cannabis, 20 gms cannabis resin, or 0 ml of cannabis oil. Controlled Substances (General) Regulations 2000 (SA), reg 9B(2).

555 Controlled Substances Act 1984 (SA), s 33L(2)(b) – Use. This does not apply where the offending occurs in a public place or a prescribed place.

556 Controlled Substances (General) Regulations 2000 (SA), reg 9B(1) – Cultivation. This applies to a person who has cultivated one plant. This does not apply to hydroponic cannabis (Controlled Substances Act 1984 (SA), s 45A).

557 Controlled Substances (General) Regulations 2000 (SA), Schedule 5.

558 For example, "fear of antisocial behaviour associated with the use of cannabis". Association of Chief Police Officers *ACPO Guidance on Cannabis Possession for Personal Use: Revised Intervention Framework* (ACPO, London, 2009) 5.

559 Ibid.

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, a prohibition on being in a certain place, associating with certain people, or working in a particular occupation or profession.<sup>560</sup> The commission can suspend the imposition of sanctions on the condition that the consumer seeks treatment.

- 7.70 Most cases dealt with by the commissions involve cannabis,<sup>561</sup> are committed by young people,<sup>562</sup> and result in proceedings being suspended while drug treatment is undertaken (83 % of cases in 2005). In those cases where sanctions are imposed (15 % of cases in 2005), the most common is the imposition of reporting requirements. The remaining cases result in “absolution”.<sup>563</sup>

### *Costs and benefits*

- 7.71 These types of approaches tend to be implemented as part of an overall strategy to achieve a greater legal and practical distinction between drug users and suppliers, and to redirect law enforcement resources towards the latter.<sup>564</sup> For example, introduction of South Australia’s Expiation Notice Scheme was accompanied by increased penalties for more serious cannabis offences such as commercial sale and supply. In Portugal, in the four years after the introduction of its Scheme, there was an 11 % increase in individuals charged with trafficking offences, as compared to the four years prior.
- 7.72 The impact of these types of approaches on rates of drug use remains contentious. An early study of the South Australian Scheme concluded that an increase in self-reported lifetime cannabis use among South Australians aged 14 years and older between 1985 and 1995 was unlikely to be a result of the Scheme, because a similar increase had been reported in other areas of Australia.<sup>565</sup> Similar conclusions have been drawn about the impact of the Australian Capital Territory and Western Australian schemes.<sup>566</sup>

560 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.

561 65 % cannabis, 15 % heroin, 6 % cocaine in 2005. The proportion of cases involving cannabis has increased since 2001 (from 47 % in 2001 to 65 % in 2005) and the proportion of cases involving heroin has decreased (from 33 % in 2001 to 15 % in 2005). Caitlin Hughes and Alex Stevens *The Effects of Decriminalisation of Drug Use in Portugal* (Briefing Paper 14, the Beckley Foundation Drug Policy Programme, 2007) 3.

562 Ibid, 2.

563 Absolution presumably means no action being taken. These proportions have remained roughly the same since the law’s enactment – Glenn Greenwald *Drug Decriminalisation in Portugal: Lessons for Creating Fair and Successful Drug Policies* (Cato Institute, Washington, 2009) 6.

564 Alisen Brooks and others *Costs Associated with the Operation of the Cannabis Expiation Notice Scheme in South Australia* (Drug and Alcohol Services Council, South Australia, 1999) 8; Hughes and Stevens, above n 561, 2.

565 *Global Cannabis Commission Report*, above n 505, 131.

566 Ibid, 132.

- 7.73 More recently, the 2007 national household survey of drug use in Australia found that levels of cannabis use in those Australian jurisdictions with infringement offence regimes are the same as or higher than the other states and territories and the overall national level.<sup>567</sup> Use in all Australian jurisdictions has been decreasing since at least 1998, with the greatest reductions occurring in jurisdictions with infringement offence regimes: Northern Territory, Western Australia, and the ACT. The Northern Territory, which implemented its infringement offence regime in 1996, has seen the annual prevalence of cannabis use drop from 36.5 % to 13.8 % between 1998 and 2007.<sup>568</sup>
- 7.74 It appears that drug use has increased overall in Portugal since 2001. However, there is evidence of a similar increase in neighbouring countries, Spain and Italy.<sup>569</sup> 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.<sup>570</sup> While there has been an increase in cannabis use, particularly amongst young people aged 16–18,<sup>571</sup> there has been a decrease in heroin use in that same age bracket.
- 7.75 The harm caused by heroin use was a particular public and political concern prior to the Portuguese reforms.<sup>572</sup> The decrease in heroin use and related harm is seen as a particular success of the reforms.
- 7.76 The number of users seeking treatment for drug abuse and addiction has also increased in Portugal. This includes a 147 % increase in the number of people in substitution treatment.<sup>573</sup> There has also been an increase in the nature and number of drug treatment programmes, and drug-related deaths<sup>574</sup> and disease<sup>575</sup> have declined.
- 7.77 The infringement offence regimes tend not to have a significant emphasis on drug education or treatment. In Western Australia, those issued with an infringement notice may attend a 1.5 hour education session on drug use rather than pay a monetary fee, and those issued with a notice on two separate occasions in the past three years must attend that session. A three-year review of the Western Australian Scheme completed in 2007 found that most participants

567 Australian Institute of Health and Welfare, above n 547, 8.

568 Ibid, 8; Drug and Alcohol Office *Statutory Review: Cannabis Control Act 2003: Report to the Minister of Health* (Drug and Alcohol Office, Perth, 2007), 81.

569 Hughes and Stevens, above n 561, 5.

570 Greenwald, above n 563, 14.

571 Lifetime prevalence of cannabis use among students aged 16–18 increased from 9.4 % in 1999 to 15.1 % in 2003. Hughes and Stevens, above n 561, 3.

572 The United Nations reports a stable or declining trend in opiate use in Western Europe, and an increasing trend in Eastern Europe. UNODC, above n 489, 54.

573 From 6040 people in 1999 to 14,877 people in 2003. Hughes and Stevens, above n 561, 2.

574 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, 3.

575 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 (*Global Cannabis Commission Report*, above n 505, 3). Since 2000, a mild reduction in the rates of new hepatitis B and C infections was also reported (Greenwald, above n 563, 16).

found the session to be somewhat to very useful, with the majority of participants considering that the session had increased their knowledge about the health, social, and legal issues associated with cannabis, and treatment options.<sup>576</sup>

- 7.78 The South Australian Scheme appears to have resulted in some savings in enforcement and justice costs.<sup>577</sup> The impact on the criminal justice system in Portugal has also been significant. In 2000, 7592 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.
- 7.79 In addition, a study comparing the social impact of receiving an infringement notice in South Australia versus the social impact of receiving a conviction in Western Australia prior to the introduction of its infringement offence regime concluded that the South Australian Scheme was effective in preventing the range of negative social outcomes that follow a conviction. These included the impact on employment opportunities and relationships, the ability to find accommodation, and consequences for travel.<sup>578</sup>
- 7.80 These regimes all contain an inherent trade-off between providing a simple, speedy, and inexpensive response to wrongdoing and reducing the due process protections that would be available to an individual as part of a conventional criminal justice response. For example, an offence must only be alleged (and not proved) for an infringement notice to be issued, although the individual is still given the opportunity to contest it.
- 7.81 As with cautioning schemes, the ease with which infringement notices or citations can be issued also means that there is likely to be some “net-widening”. This has particular implications in those jurisdictions, such as South Australia, where non-payment of an infringement fee can lead to conviction for the original offence.
- 7.82 If the only penalty available is payment of a fixed monetary fee, this can create particular hardship for the financially or socially disadvantaged. Australian states tend to have an initial compliance rate before enforcement action is taken of around 50 %. Most jurisdictions have mechanisms in place that attempt to address this issue, such as the ability for a monetary penalty to be reviewed or paid in instalments. Non-monetary penalties (for example, attendance at an

576 Drug and Alcohol Office, above n 568, 148.

577 One study estimated that the cost of issuing expiation notices was \$AUS1.24 million in 1995/96, compared to a cost of \$AUS2.01 million to deal with those offences through standard criminal justice processes. Revenue generated through the payment of infringement fees and fines was also greater than what would have been generated through the payment of fines for those offences in the criminal justice system. Broadly, the cost of the expiation notice scheme was estimated by calculating the unit cost per infringement notice that was then aggregated to a total. This cost did not include infrastructure or detection costs. This was based on the 1995/96 expiation rate of 44 %. Brooks and others, above n 564, iv–v.

578 Lenton and others, above n 508. The impact of a conviction in Western Australia compared as follows with a South Australian expiation notice: self reports of adverse employment consequences were 32 % in Western Australia compared with 2 % in South Australia; further contact with the criminal justice sector was 32 % in Western Australia compared with 0 % in South Australia; relationship problems were 20 % in Western Australia compared with 5 % in South Australia; accommodation difficulties were 16 % in Western Australia compared with 0 % in South Australia.

education session as in Western Australia<sup>579</sup>) are also possible. In New Zealand, it has been estimated that only 39 % of infringement fees by value are paid to the prosecuting authority without enforcement action being taken.<sup>580</sup>

## De facto partial prohibition

### Description

- 7.83 Under a model of *de facto* partial prohibition, the use, possession, manufacture, import, export, and other distribution of a drug remains illegal in law, but that law is not actively enforced and may even be openly tolerated at an official level.

### Rationale

- 7.84 *De facto* partial prohibition shares many of the goals and aims of the other less punitive approaches to prohibition. These include a desire to reduce the social and economic costs of prohibition, and to separate minor drug activities and users from more serious drug activities and users. It also aims to achieve a more balanced approach to strategies of supply control, problem limitation, and demand reduction.

### Examples of the model in practice

- 7.85 The exercise of police discretion means that in practice most jurisdictions, including New Zealand, operate some form of *de facto* partial prohibition in relation to many instances of offending. Minor or trivial offending, in particular, may often result in the police taking no action, or issuing an informal (usually oral) warning or caution, rather than taking any formal action. The appropriate action to be taken is a decision for individual officers, guided by any internal policy or guidelines.<sup>581</sup> In addition, the emphasis the police give to enforcing particular offences or activities depends on relative priorities and resources, and can be expected to change over time. This is partly reflected in police apprehensions statistics: police apprehensions for possession and use of drugs, for example, have decreased from 13,577 in 1999 to 9708 in 2008.<sup>582</sup>

579 13 % of all those issued with an infringement notice chose to attend the education session rather than pay the monetary fee – Drug and Alcohol Office, above n 568, 38.

580 Ministry of Justice and New Zealand Law Commission *Review of the Infringement System: Options for Reform* (Wellington, 2004) 39. In 2008/09, 47 % of infringement notices issued by the New Zealand Police were paid on time (figures supplied by the Ministry of Justice, December 2009).

581 See New Zealand Police *Illicit Drug Strategy to 2010* (New Zealand Police, Wellington 2008) 7, for example, which prioritises activities in relation to methamphetamine and cannabis. It sets out three key focus areas: methamphetamine, cannabis, and groups at risk.

582 Statistics New Zealand Table Builder <http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx> (accessed 4 November 2009).



- 7.86 In the drugs context, the most well-known example of *de facto* partial prohibition is the approach taken in the Netherlands since 1976 to cannabis offences.<sup>583</sup> Cannabis remains a prohibited drug but there is a formal policy of not prosecuting offences that involve a small amount of cannabis (five grams or less) for personal use.<sup>584</sup> Instead, personal use and possession of cannabis is “actively tolerated”<sup>585</sup> in the home and in licensed coffee shops, where small amounts of cannabis can also be purchased.<sup>586</sup> Coffee shops are officially sanctioned and regulated, with national guidelines about how they are to be run and where they are to be located. These guidelines include limits on advertising and the amount of cannabis that can be sold,<sup>587</sup> and a ban on sale to minors or the sale or use of other illegal drugs.<sup>588</sup> More recently, the Dutch Government has required that coffee shops not be located within a certain distance of schools.<sup>589</sup> Official action, including prosecution, will only be taken against individuals (and coffee shops) who do not comply with the guidelines.
- 7.87 The Netherlands also applies partial prohibition 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.<sup>590</sup>
- 7.88 For about five years in the United Kingdom, from 2004 to 2009, police guidelines included a general presumption against arrest for cannabis possession. This occurred as part of a reclassification of cannabis from Class B to Class C, and despite accompanying statutory changes that introduced a power to arrest in relation to Class C drugs. Police were required to confiscate any cannabis found, but otherwise no further action was to be taken.<sup>591</sup>

583 There are also relevant police guidelines in the Netherlands in relation to other offences – for example, the guidelines give low priority to the investigation and prosecution of heroin possession <http://eldd.emcdda.europa.eu/html.cfm/index5174EN.html#> (accessed 14 August 2009).

584 Wilkins, above n 514, 29.

585 *Global Cannabis Commission Report*, above n 505, 113.

586 *Ibid.*

587 Ryder, Walker and Salmon, above n 505, 122.

588 *Global Cannabis Commission Report*, above n 505, 114.

589 See [www.dutchamsterdam.nl/548-amsterdam-closing-coffeeshops](http://www.dutchamsterdam.nl/548-amsterdam-closing-coffeeshops) (accessed 19 October 2009).

590 List 1 includes, for example, heroin, cocaine, methamphetamine, morphine, opium. See Netherlands Country Report, European Legal Database on Drugs <http://eldd.emcdda.europa.eu> (accessed 5 August 2009).

591 Mike Trace, Axel Klein and Marcus Roberts *Reclassification of Cannabis in the United Kingdom* (Drugscope Briefing Paper, No 1, Beckley Foundation Drug Policy Programme, 2004) 3. See also, L H Leigh “The Seamless Web? Diversion from the Criminal Process and Judicial Review” (2007) 70 MLR 654.



## Costs and benefits

- 7.89 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,<sup>592</sup> although there remains a question about its impact on rates of use among young people.<sup>593</sup> The approach does appear to have been particularly successful in separating the market for, and users of, cannabis from those of other substances.<sup>594</sup>
- 7.90 Partial prohibition is 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. 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".<sup>595</sup> This pressure has led to the Netherlands progressively tightening its approach.<sup>596</sup> As a result, the number of coffee shops has decreased from approximately 1500 in the mid-1990s to just over 700 in 2004.<sup>597</sup>
- 7.91 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.

## Legalisation with regulatory restrictions

### Description

- 7.92 Under this model, specified drug-related activities would be legal, but subject to governmental regulation and control. Activities that occur outside those bounds would be illegal and subject to civil or criminal sanctions.

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592 *Global Cannabis Commission Report*, above n 505, 143.

593 *Ibid*, 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 caution conclusion is warranted, pending further research.

594 *Ibid*, 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".

595 *Ibid*, 114.

596 See *ibid*, 114 and Dirk Korf "An Open Front Door: The Coffee Shop Phenomenon in the Netherlands" in Sharon Rodner Sznitman, Borje Olsson, Robin Room *A Cannabis Reader: Global Issues and Local Experiences* (European Monitoring Centre for Drugs and Drug Addiction, Lisbon, 2008). 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.

597 Korf, above n 596, 142.

*Rationale*

- 7.93 Some view legalisation with regulatory restrictions as a pragmatic approach to the reality that prohibition is either unachievable or infeasible.<sup>598</sup> The focus therefore is to ensure that drug use takes place in as safe an environment as possible. For this reason, this model has been described as a model of “grudging tolerance”. Drug use and related activities are tolerated, but are not positively endorsed and may even be actively discouraged.<sup>599</sup> This model also aims to address some of the harms of prohibition, including the existence of a criminal black market in an illegal substance. Recent proposals in the United States of America to legalise and regulate cannabis (see paragraph 7.95 below) have also been supported as a way to generate tax revenue from cannabis sales.
- 7.94 More fundamentally, legalisation with regulatory restrictions can be justified on a more principled basis; that is, in a free and democratic society, the decision to completely prohibit a drug should be a last resort when lesser regulatory options have proven ineffective in preventing the harm that use of that drug causes. In this sense, this model is an intermediate position between full legalisation (see below) and prohibition.

*Examples of the model in practice*

- 7.95 No jurisdiction has moved to regulate currently illegal drugs, although some proposals have been made.<sup>600</sup> For example, in the United States of America, there are legislative proposals to legalise and regulate the cultivation, use, possession, and sale of cannabis in front of California’s State Assembly<sup>601</sup> and Massachusetts’ Senate and House Assembly.<sup>602</sup> In Australia, the Premier’s Drug Advisory Council recommended to the Victorian Government in 1996 that use and possession of less than 25 grams of cannabis and cultivation of up to five cannabis plants should no longer be offences. The Advisory Council noted that cannabis use was widespread and considered that:<sup>603</sup>

[S]trategies to reduce use and misuse are most likely to be effective if use of cannabis is no longer a criminal offence but is regulated in a number of important respects. Education and treatment will be facilitated by this change and respect for the law may also increase.

- 7.96 The recommendation was not adopted by the Victorian Government, which has since implemented a cannabis cautioning scheme.

598 MacCoun, Reuter and Schelling, above n 513, 336.

599 See discussion in Mark A R Kleiman “Neither Prohibition Nor Legalisation: Grudging Toleration in Drug Control Policy” (1992) 121 *Daedalus*, 53.

600 *Global Cannabis Commission Report*, above n 505, 122. See also: Senate Special Committee on Illegal Drugs “Cannabis: Our Position for a Canadian Public Policy” (September 2002); Alex Wodak and Annie Cooney “Should Cannabis be Taxed and Regulated?” (2004) 23 *Drug and Alcohol Review* 139.

601 California – Marijuana Control, Regulation and Education Act AB 390.

602 Massachusetts – Cannabis Regulation and Taxation Act.

603 Premier’s Drug Advisory Council *Drugs and our Community: Report of the Premier’s Drug Advisory Council* (Victorian Government, Melbourne, 1996) 129.

- 7.97 There are a number of regulatory regimes in New Zealand that potentially apply to psychoactive substances. These include the restricted substances regime under the Misuse of Drugs Amendment Act 2005 (which regulates psychoactive substances that are not so harmful that they should be prohibited under the Misuse of Drugs Act) and the regulatory regime under the Hazardous Substances and New Organisms Act 1996. The details of these and other relevant regimes are discussed in detail in chapter 5.
- 7.98 Legalisation with regulatory restrictions is also the model applied in New Zealand and elsewhere to the control of alcohol and tobacco.

### *Costs and benefits*

- 7.99 A key advantage of this model is that it enables regulatory decisions (including a decision about whether to regulate at all and, if so, how) to be informed by the purpose of an activity and the harms it causes. The vast majority of activities are regulated in this way. Restrictions by way of regulation are only imposed when that is considered necessary to prevent harm, and the benefits of those restrictions outweigh their costs. This is consistent with the needs of a free and democratic society.
- 7.100 A regulatory model enables restrictions to be tailored to the harm that they aim to prevent. Chapter 5 outlined the variety of ways in which restricted and hazardous substances may be regulated under their applicable regimes. The regulation of alcohol provides another example. That approach regulates:<sup>604</sup>
- who may purchase, possess, or consume alcohol – there is a minimum age of 18 years to purchase alcohol on or from any licensed premise;<sup>605</sup>
  - when alcohol may be sold or served – for example, licensees and managers of licensed premises must not serve minors or intoxicated persons,<sup>606</sup> and there are restrictions on the sale of alcohol on Good Friday, Easter Sunday, Christmas Day or until 1pm on Anzac Day;<sup>607</sup>
  - where the possession, consumption, or sale of alcohol is permitted or prohibited – for example, supermarkets and grocery stores cannot sell spirits or spirits-based drinks;<sup>608</sup> most local authorities have liquor bans that prohibit the consumption of alcohol in specified public places;<sup>609</sup>
  - what activities may or may not be associated with consumption of alcohol – for example, there are limits on the amount of alcohol that may be consumed before driving;<sup>610</sup>
  - labelling – alcoholic beverage containers must list the alcohol content and the number of standard drinks in the container;<sup>611</sup>

604 Based on the framework in MacCoun, Reuter and Schelling, above n 513, 336–337.

605 Sale of Liquor Act 1989, s 162(5).

606 Sale of Liquor Act 1989, ss 155(1) and 166(1).

607 Sale of Liquor Act 1989, ss 14 and 37.

608 Sale of Liquor Act 1989, s 37(3).

609 Research for the Law Commission's Review of the Sale of Liquor Act shows that 93 % of territorial authorities have at least one liquor ban – *Alcohol in Our Lives*, above n 486, 196.

610 Land Transport Act 1989, s 11.

611 Australia New Zealand Food Standards Code, standard 2.7.1.

- (f) advertising – the Advertising Standards Authority has produced a Code for Advertising Liquor, which includes restrictions on the time at which alcohol can be advertised on television and the nature of advertisements that may be produced;<sup>612</sup>
  - (g) taxation – the manufacture of alcohol is subject to an excise tax, which varies according to the type of product produced and its alcohol content;<sup>613</sup>
  - (h) access – those who wish to sell liquor must have a licence, which will have a range of mandatory and discretionary conditions attached.<sup>614</sup>
- 7.101 The benefits and costs of New Zealand’s current approach to alcohol regulation are discussed in depth in our recent issues paper on the reform of New Zealand’s liquor laws. Since the enactment of the Sale of Liquor Act 1989, a highly competitive industry has developed offering consumers unprecedented choice and access to alcohol. The alcohol industry is a multi-billion dollar sector, with our wine industry alone estimated to have contributed \$1.5 billion to New Zealand’s gross domestic product in 2008.<sup>615</sup> However, it has proven difficult to control or address the misuse of alcohol, which is a contributory factor to a range of social harms. For example, about 1000 deaths a year are directly attributable to alcohol,<sup>616</sup> and a significant proportion of crimes recorded by police are committed by people who had consumed alcohol prior to committing the offence.<sup>617</sup>
- 7.102 The regulation of any other psychoactive substance, whether it is currently illegal or not, will not prompt the scale of the market and the extent of use that is apparent in relation to alcohol. Alcohol use is deeply embedded in New Zealand’s culture, in a way that is not comparable to the use of any other drug.<sup>618</sup> Nevertheless, the experience with alcohol does highlight some possible consequences of applying a regulatory model to other psychoactive substances. For example, it may be difficult to control misuse of a particular drug and the harm that then arises. In addition, there are likely to be significant costs associated with administering any new regime and enforcing the restrictions it imposes. This latter concern was one reason why the Expert Advisory Committee on Drugs recommended that BZP be reclassified from a restricted substance to a Class C drug.<sup>619</sup>

612 Code reproduced in *Alcohol in Our Lives*, above n 486, 178.

613 Reproduced in *ibid*, 165.

614 For full discussion, see *ibid*, 9.

615 *Ibid*, 19.

616 *Ibid*, 72.

617 *Ibid*, 59.

618 For example, it is estimated that over 80% of the adult population drink occasionally (*Ibid*, 30). The 2006 National Household Survey of Legal Party Pill Use found that one in seven (15.3%) of the sample had used legal party pills in the preceding 12 months – see C Wilkins and others *Legal Party Pill Use in New Zealand: Prevalence of Use, Availability, Health Harms and “Gateway Effects” of Benzylpiperazine (BZP) and Trifluoromethylphenylpiperazine (TFMPP)* (Massey University Centre for Social and Health Outcomes Research and Evaluation, Auckland, 2006) 5 [*Legal Party Pill Use in New Zealand*].

619 Expert Advisory Committee on Drugs (EACD), to the Associate Minister of Health “Further EACD advice on Benzylpiperazine (BZP) and related substances” (4 December 2006) Letter, 5. The EACD was concerned about the significant enforcement and administrative capacity that would be required to control the availability, advertising, and supply of BZP if it were to remain a restricted substance, as was already in place for pharmaceuticals, tobacco, and alcohol.

- 7.103 Legalisation of a drug is also likely to increase its use. Unless carefully controlled, a commercial industry is likely to develop with a vested interest in increasing a regulated drug's availability and use.<sup>620</sup> Legalisation may also be perceived as a signal of society's approval of the drug or as a message that a drug is safe to use.<sup>621</sup>
- 7.104 Some have argued that the extent of any increase will depend more on the extent of commercial promotion of the drug, than on its legal status.<sup>622</sup> The link between commercial promotion and consumption of a substance is complex.<sup>623</sup> The extent to which there is an increase in use as a result of commercial promotion will depend on the form and level of regulation used. As with alcohol, it would be possible to impose controls on the circumstances under which a regulated drug was sold, and on advertising and promotion. Alternatively, a government monopoly on production and supply could be established.
- 7.105 In addition, an increase in use does not necessarily mean an increase in drug-related harm. This is particularly so if users shift to using less harmful but more available regulated substances in preference to more harmful but less available prohibited substances. For example, there is some evidence to suggest that, prior to its reclassification, people used BZP in preference to more harmful illegal drugs.<sup>624</sup>
- 7.106 An important consequence of shifting from a prohibition model to a regulatory model is the removal of most activities relating to a regulated drug from the scope of the criminal justice system. Contravention of the regulatory regime may still result in a criminal prosecution. However, it would not be an offence to use a regulated drug. In addition, there is unlikely to be any impetus for the development of a black market in the drug (unless prices were unreasonably high and/or availability of the drug was severely restricted). As a result, many of the harms that arise from drug prohibition would be addressed.
- 7.107 This model does not comply with the requirements of the international drug conventions. A State could therefore not apply this model to drugs covered by the conventions and uphold its international obligations.

620 The "active marketing" of BZP was noted in the EACD's advice to the Government in relation to BZP reclassification – see *ibid*, 3.

621 See discussion in United States General Accounting Office *Confronting the Drug Problem: Debate Persists on Enforcement and Alternative Approaches* (DIANE Publishing Company, Darby (PA), 1993) 42–44. In New Zealand, there was a public perception of the safety of BZP based on its legal status – see *ibid*, 4.

622 See MacCoun and Reuter, above n 484, 77.

623 See discussion in *Alcohol in Our Lives*, above n 486, 179.

624 *Legal Party Pill Use in New Zealand*, above n 618, 43. Note, however, that the relationship between legal BZP and illegal substances is not particularly clear – 45 % of BZP users sampled reported that they used BZP so they did not have to use illegal drugs. 28 % reported that they used BZP when they could not get hold of illegal drugs, and 27 % reported that they used BZP with illegal drugs to enhance their effects or duration of their effects.



## Legalisation without regulatory restrictions

### *Description*

- 7.108 Under this model,<sup>625</sup> some or all of the use, possession, manufacture, importation, exportation, sale, and other distribution of a drug would be legal and subject to no regulatory restrictions.

### *Rationale*

- 7.109 This model rejects any role for the State in regulating drug use, either because the autonomy of the individual is considered paramount regardless of any harm his or her drug use may cause, or because a particular drug is not so harmful that restrictions on its use can be justified.

### *Examples of the model in practice*

- 7.110 In reality, there are few substances (psychoactive or not) that can be bought and sold to which pure legalisation applies. All psychoactive substances that come onto the New Zealand market are, technically at least, subject to some form of regulation.<sup>626</sup>

- 7.111 Full legalisation also receives little support in the literature:<sup>627</sup>

With the exception of some libertarians...no one seriously advocates relaxing the drug laws so that the currently illicit substances would be as freely available as butter or gasoline, regulated only for purity, quality, or safety. Everyone seems to agree that children, at least, should not be able to buy cocaine at the local candy store. Thus "legalisation", taken literally, is not under discussion. Indeed even for the presently legal drugs, except for caffeine (with high dependency potential but very modest stimulant effect and negligible health consequences), there is some age restriction.

### *Costs and benefits*

- 7.112 The removal of criminal sanctions for drug use would eliminate many of the prohibition-related harms to the user. These include the exposure to legal risk and the social costs and consequences of receiving a conviction. Legalisation would also lower prices and eliminate the black market. However, the wide availability of drugs that is likely to follow legalisation is also likely to increase the frequency and duration of drug use.
- 7.113 Legalisation without regulatory restrictions may also be a derogation of the State's responsibility to mitigate the harm to society that arises from drug use. Nor would it comply with the international drug conventions. Many activities that were previously unregulated are now subject to some form of regulation on this basis. This has led one report to conclude that full legalisation is "not a viable contemporary option".<sup>628</sup>

625 This is also referred to as *de jure* partial prohibition in the literature.

626 See discussion in chapter 5.

627 MacCoun, Reuter and Schelling, above n 513, 332. Note other regulations apply to caffeine – for example, labelling requirements.

628 Commonwealth of Australia, above n 522, 8.



## CONCLUSION

- 7.114 We have argued in this chapter that, with some limited exceptions in respect of the young and those whose mental faculties are impaired, regulation of drug use is only justified to the extent necessary to prevent harm to others, and where the benefits arising from that reduction in harm outweigh the costs arising from regulation itself. This justification provides an important foundation for the remainder of this paper, because it also guides decisions about the choice of model once a decision to regulate has been made.
- 7.115 The harm arising from prohibition has led many jurisdictions to apply less punitive models to personal use offences. The primary aim of these models is to reduce the costs to the individual and the State of prohibition and, by doing so, to reduce drug-related harm. Many jurisdictions have also taken a less punitive approach as part of an overall strategy to strengthen the distinction between users and suppliers by diverting users from the criminal justice system but coming down harder on commercial suppliers. There is clear evidence that they are successful in achieving these objectives.<sup>629</sup> We consider the applicability of these types of approaches to New Zealand in chapter 11.

<sup>629</sup> *Global Cannabis Commission Report*, above n 505, 148.



# Part 2

## PROPOSALS FOR REFORM



# Chapter 8

## Our proposed approach to drug regulation

### SUMMARY

This chapter considers the factors that are relevant to the choice of regulatory model for the non-therapeutic use of drugs and suggests a possible approach to drug regulation for New Zealand. It considers also the approach that should be taken as an alternative to prohibition for new recreational psychoactive substances that are not covered by the international drug conventions and identifies the core features that this type of regulatory regime should have. It invites feedback on these issues and on whether regulation under the Hazardous Substances and New Organisms Act 1996 (HSNO) or under a separate regime designed specifically for new recreational psychoactive substances would be the better approach.

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**INTRODUCTION** 8.1 In chapter 7, we identified and assessed the possible models of regulation for the non-therapeutic use of drugs. In this chapter we consider the factors that are relevant to the choice of model and suggest a possible approach for New Zealand.

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**THE CHOICE OF REGULATORY MODEL** 8.2 There are a number of factors to consider when choosing the best regulatory model.

### Effectiveness

8.3 In chapter 7, we suggested that the primary justification for regulating drugs is to minimise the harm drugs cause to persons other than the drug user and to society as a whole. It follows that the key question for our review is which regulatory approach will most effectively minimise drug-related harm.

- 8.4 The answer to this question is far from straightforward. MacCoun and Reuter suggest there are four steps involved in the assessment of alternative drug control regimes:<sup>630</sup>
- (i) identifying all the relevant consequences under the current control regime;
  - (ii) measuring the magnitude of those consequences;
  - (iii) quantifying their dollar value (to facilitate comparison with alternative approaches); and
  - (iv) quantifying the dollar value of changes in drug-related consequences brought about by a change to an alternative drug control regime.
- 8.5 However, there are significant gaps in the evidence, so that this kind of assessment may not be possible. We pointed out some of the challenges in measuring drug harms in chapter 2. These include a lack of robust evidence about the full range of drug-related harms, their uneven distribution, and their differential impact on groups such as users, families, employers and taxpayers. When considering the consequences of the existing regime it is also necessary to take into account the effects of the regime itself. For example, the consequences of the current regime include not only the benefits of any reduction in the consumption or abuse of drugs that flows from prohibition, but also the costs that directly flow from prohibition: the growth of black markets and associated crime; the marginalisation of drug users; and limitations on the ability to promote public health messages about illegal drugs. All of this makes it enormously difficult to identify the effects of, let alone quantify the cost of, the current regime.
- 8.6 Moreover, even if more robust evidence was available, there are significant elements of judgement involved. Many drug harms are intangible and cannot readily be quantified in monetary terms. What value is attached to these harms is inherently subjective. There are also subjective trade-offs to be made between the priority and weight to be given to the various harms suffered by different persons and groups.
- 8.7 So far as possible, drug policy should be evidence-based. But when it comes to determining the appropriate regulatory approach, it is important to recognise the significant limitations of the evidence and also the extent to which the choice of regulatory model necessarily involves making value judgements.
- 8.8 Even if all of the benefits and costs of the current regime could be quantified, there is no evidence about the effects of alternative regulatory approaches. While some commentators<sup>631</sup> have attempted to draw conclusions by extrapolating from the experience with substances like alcohol, tobacco and regulated activities such

630 Robert J MacCoun and Peter Reuter *Drug War Heresies: Learning from Other Vices, Times and Places* (Cambridge University Press, Cambridge, 2001).

631 See *ibid*, chs 7 and 8.



as gambling and prostitution, there are limits to this type of analysis because of their different social and historical contexts. Reuter and MacCoun describe the problem as follows:<sup>632</sup>

[T]he harms are highly variegated and that variety is part of the policy problem, since it prevents effective aggregation and thus straightforward comparison of different regimes. For many reasons, there are not even approximate numbers on most of the harms under the current regime, let alone for any hypothetical regime that is substantially different.

- 8.9 Finally, we note that the choice of regulatory regime needs to be made on a substance by substance basis. Though drug policy debates tend to focus on illegal drugs as a whole and question whether prohibition or regulation is the better approach, there are significant differences between drugs that need to be taken into account in determining the appropriate policy response. There are potentially a wide range of regulatory options that can be applied to different substances depending on the purpose for which they are used and the nature and magnitude of risks they pose.

### Convention drugs

- 8.10 We outlined in chapter 6 New Zealand's international obligations. The three United Nations drug conventions require states to prohibit dealings with the substances listed in the schedules to the conventions except for medical and scientific purposes. There are over 100 narcotic drugs and psychotropic substances listed in the conventions. These substances have historically been the most widely used psychoactive substances for medicinal, scientific and recreational purposes.
- 8.11 There is a significant debate internationally about the effectiveness of the prohibitory approach required by the drug conventions. It is argued that prohibition has not deterred drug use and itself causes very substantial harm. Whatever the merits of that debate, states that have ratified the conventions are bound under international law to comply with the obligations the conventions impose. The only alternative is for a state to denounce one or more of the conventions,<sup>633</sup> an action no state has ever taken.<sup>634</sup>
- 8.12 Compliance with the conventions is consistent with New Zealand's role as a member of the international community. A very high proportion of countries are signatories to the conventions and, despite the increasing disquiet over the effectiveness of prohibition, there still remains a high level of international

632 Ibid, 101.

633 See Single Convention on Narcotic Drugs 1961, as amended by the 1972 Protocol (the 1961 Convention), art 46. A State Party cannot denounce part of the Convention. Any denunciation must be of the whole Convention.

634 However, it should be noted here that a few countries declared reservations when ratifying the 1961 Convention and do not consider themselves to be bound by those reserved provisions. Saudi Arabia, Bahrain, Andorra and Vietnam for example have declared upon ratification that they will not be bound by article 48, paragraph 2 (which provides for mandatory referral to the International Court of Justice of any dispute which cannot be resolved under paragraph 1 of that article).

consensus on the broad parameters of drug policy.<sup>635</sup> Moreover, it is not feasible for one party to the conventions to legislate in this area in isolation from others. To do so risks compromising the effectiveness of international efforts towards drug control. There are also likely to be significant adverse consequences for that state, as experience in the Netherlands illustrates. There, the policy of tolerating the sale of cannabis in coffee shops resulted in an influx of tourists taking advantage of the ready availability of cannabis, creating a significant public nuisance.<sup>636</sup> There is of course scope within the prohibitory framework of the conventions for different approaches to be taken to the possession and use of drugs. We discuss these and other options for minimising drug-related harm within the convention framework in chapters 6, 7 and 11.

## Non-convention drugs

- 8.13 There is not a similar international obligation to prohibit psychoactive substances that are not covered by the conventions. Regulatory approaches alternative to prohibition can therefore be considered for new synthetic drugs as they emerge and other organic substances not covered by the conventions. As we noted in chapters 4 and 5, various psychoactive substances, some in the form of party pills, have emerged over recent years. Benzylpiperazine (BZP), trifluoromethylphenylpiperazine (TFMPP) and more recently preparations containing 1,3 dimethylamylamine (DMAA) are all examples of psychoactive substances that have been incorporated into party pills and other products. It is also likely that new psychoactive substances will continue to be developed.
- 8.14 We suggest that a model of legalisation with regulatory restrictions should be the starting point for regulating drugs not covered by the conventions. Any such restrictions that are imposed should also normally be the minimum necessary to prevent or reduce that harm and obviously must not cause more harm than they alleviate. In a free and democratic society full prohibition should be a last resort option when lesser regulatory restrictions have proved ineffective.
- 8.15 As a general rule, the level or degree of regulation should increase with the level of risk, with restrictions imposed reflecting the purpose for which things are used and the nature of the risks they pose. This is the approach taken to the regulation of medicines, food, hazardous substances and a few recreational drugs (notably alcohol and tobacco).
- 8.16 In all these existing regulatory schemes the decision to prohibit goods, services or activities altogether is the last resort and is generally only justified if it can be shown to be the only effective way to prevent the harm. This occurs where the harm is so significant that there is virtually no way to safely undertake the activity or use the goods, or where the less restrictive alternative regulatory option is not an efficient model because the costs of regulating exceed the benefits of not prohibiting.

635 Over 95 % of United Nations members are parties to the 1961 Convention covering 99 % of the world's population; see International Narcotics Control Board *Report of the International Narcotics Control Board for 2008* (United Nations, New York, 2009) 3.

636 MacCoun and Reuter, above n 630, 247–248.

- 8.17 In our view there is no reason to take a different approach in relation to psychoactive substances that are used recreationally and are not covered by the conventions. The starting presumption in a free and democratic society should, where possible, be that use should be regulated rather than prohibited. Psychoactive substances should only be prohibited if that is shown to be the only efficient and effective way to prevent the harm associated with their use. If it is possible to effectively regulate their use, that option must be preferred.
- 8.18 There are some risks inherent in this approach. Arguably, if the supply and use of some psychoactive substances is legal, that might lead to an increase in the prevalence of their use as recreational drugs. For example, alcohol and tobacco are both legally available and are the first and second most widely used drugs in New Zealand. Before BZP was prohibited it was legally available and was reported to be the fourth most widely used drug in New Zealand (although it was not as widely used as cannabis, which is of course not legally available).
- 8.19 But it is important to recognise that an increase in prevalence of use across the population does not necessarily mean an increase in drug-related harm. Some prevalent drugs, like alcohol, are used by many people in moderation with limited adverse consequences. More serious drug-related harm tends to be experienced by the subset of people who use harmful drugs (including alcohol) regularly or excessively. Moreover, there could potentially be a reduction in drug-related harm if the differential application of regulatory controls encourages a shift away from more to less harmful drugs and to safer modes of administration. One study on the prevalence of BZP use, which was undertaken before BZP was reclassified as a Class C controlled drug in 2008, found that 44 % of respondents who used BZP had been mostly using illegal drugs but had substituted BZP for their illegal drug use.<sup>637</sup> Another study that surveyed users of BZP found that just under half who indicated they were otherwise likely to use BZP in the future would be more likely as a result of the ban on BZP to use ecstasy instead.<sup>638</sup> On that basis, arguably, the legal availability of BZP may have prevented at least some people from using other more harmful drugs.
- 8.20 Where regulation rather than prohibition of a drug will not have the effect of encouraging a shift from more to less harmful drugs, the option of prohibition would remain. Prohibition might be appropriate, for example, if a new psychoactive substance is found to be more harmful than a convention drug and might be more widely used because of its legal status. In other words, one of the factors that will need to be considered when determining how a new drug should be regulated is the impact this decision could have on the decisions people might make about substituting one drug for another.
- 8.21 If the approach we recommend is taken, it will be important that the regulatory regime that applies to new regulated psychoactive substances is carefully monitored and evaluated. This will allow for early intervention if the controls on a substance prove to be ineffective. It will also provide important information that could assist

637 C Wilkins and others *Legal Party Pill Use in New Zealand: Prevalence of Use, Availability, Health Harms and "Gateway Effects" of Benzylpiperazine (BZP) and Trifluoromethylphenylpiperazine (TFMPP)* (Centre for Social and Health Outcomes Research (SHORE) & Te Ropu Whariki, Massey University, 2006) 43.

638 James A Green "Partying on? Life After BZP-based Party Pills" (2008) 121 NZMJ 4.

in assessing the effectiveness of alternative regulatory approaches. In the longer term, information of this kind could usefully inform the international debate about the effectiveness of alternative drug control regimes.

**Q1** Do you agree that the model for regulating drugs other than convention drugs should generally be regulation with restrictions, rather than prohibition, but with prohibition available as a last resort where regulation has proved ineffective?

## A NEW FRAMEWORK FOR REGULATION

- 8.22 We turn to consider what regulatory restrictions should be imposed as an alternative to prohibition for new recreational psychoactive substances that are not covered by the conventions. We identify the core features that this type of regulatory regime should have and then consider whether a separate regime or regulation under the Hazardous Substances and New Organisms Act 1996 (HSNO) would be the better approach. If a separate regime is considered the better approach, it should be included in the new legislative framework we are proposing in this paper to replace the Misuse of Drugs Act.

### Recap of the current position

- 8.23 As we outlined in chapter 5, an amendment to the Misuse of Drugs Act in 2005 introduced the restricted substances regime. This was intended to provide a regime for regulating new recreational psychoactive substances that were not harmful enough to justify prohibition.
- 8.24 Chapter 5 discussed a definitional problem with the restricted substances regime. “Hazardous substances”, “foods”, “medicines” and “controlled drugs” are all excluded from the restricted substances regime. However, the definition of “hazardous substances” currently includes substances that are toxic. By their nature recreational psychoactive substances temporarily change the physiological functioning of the brain and are therefore toxic and excluded from the restricted substances regime. If a psychoactive substantive is not a “food”, a “medicine”, or a “controlled drug”, it must be a “hazardous substance”. Since all of these are excluded from the restricted substances regime, there appear to be no substances that can come within the regime. We understand that an amendment to the Act is being considered by the Government to address this particular problem.
- 8.25 The current position therefore is that technically all new recreational psychoactive substances other than those classified as food or medicines fall under the regime in HSNO. The Ministry of Health is an enforcement agency under that Act. However, in practice the HSNO regime has never been used to deal with recreational psychoactive substances. As a result, party pills containing BZP appeared on the market without any regulatory controls.
- 8.26 The question arises whether new drugs should be dealt with by HSNO (which would require operational but not necessarily legislative change) or whether they are better regulated under a regime (like the current restricted substances regime) which is separate from HSNO and designed specifically for new recreational psychoactive substances.

- 8.27 In order to resolve that question, we need to determine what the core features of a regulatory regime for new recreational psychoactive substances should be.

### Approval of new substances

- 8.28 A key difference between the restricted substances regime and HSNO is that the restricted substances regime proceeds on the assumption that there are no legal restrictions on the manufacture, supply and use of new psychoactive substances before they are brought under the regime. These activities are all left unregulated until a substance is made a restricted substance. Section 32 of the Misuse of Drugs Amendment Act 2005 gives the Expert Advisory Committee on Drugs (EACD) the function of carrying out evaluations of substances to assess whether or not a recreational psychoactive substance should be restricted and, if so, the type of restrictions that are appropriate. However, in practice an evaluation is not normally undertaken by the EACD until a substance comes to its attention because it is perceived to be causing harm. In the case of BZP, this occurred only after products containing BZP had been on the market for some time. By that stage, there were already a number of manufacturers, importers and suppliers engaged in the distribution and promotion of these products.
- 8.29 In contrast, the hazardous substances regime automatically covers all substances that meet the definition of hazardous and requires that they be approved by the Environmental Risk Management Agency (ERMA) before being manufactured or imported.<sup>639</sup> This ensures that appropriate regulatory controls to promote the safe use of the substance can be imposed before the substance can be legally manufactured or imported. It also places on the manufacturer or importer the responsibility of showing that a substance can be managed with appropriate controls.
- 8.30 In our view, any regulatory regime for new recreational psychoactive substances should follow the approach in HSNO. New recreational psychoactive substances should require an approval before they can be manufactured, imported or distributed in New Zealand. We think that it is better for all new psychoactive substances, other than food and medicine, to automatically fall within a regulatory regime of this sort. This would ensure that the risks associated with the recreational use of a substance are assessed by a regulatory body, and appropriate controls are put in place, before it becomes available for sale.
- 8.31 We also suggest that, as part of the approval process, the importer or manufacturer of such a substance should be required to provide to the regulatory body all available information about the composition of the substance and its known health effects, in order to assist in the determination of what regulatory controls are appropriate.
- 8.32 If a substance is assessed and not approved, because it appears from the available evidence (such as, for example, the experience with it in other jurisdictions) that it has such significant adverse effects that these cannot be adequately managed with conditions, the regulatory body should refer the substance to the agency responsible for prohibited drugs so that the substance can be brought under the prohibited drugs regime.

<sup>639</sup> Where there is uncertainty as to whether a substance is hazardous or not an application can be made for a determination under section 26 of the Act. This process is discussed in chapter 5.



- 8.33 We think that other products that contain psychoactive substances but are primarily manufactured, imported and distributed for other purposes – such as solvents, butane, petrol and various other domestic and industrial products – should continue to be regulated under HSNO for their dominant use and not as recreational psychoactive substances. However, we suggest that when ERMA is assessing these substances and determining appropriate controls under that regime, greater consideration should be given to the potential for these products to be misused for their psychoactive effects. Where there is evidence that substances are being used in this way, the restrictions, particularly on retail sales, should reflect the harm such misuse may cause.

Q2 Do you agree that a psychoactive substance falling within the ambit of the proposed regime should require an approval from the regulatory body before it can be manufactured or imported?

Q3 Do you agree that all new psychoactive substances that are manufactured or imported for recreational use should be covered by the proposed new regulatory regime?

### Generic or specific regulatory controls

- 8.34 Under HSNO, the controls that apply to the manufacture, import and distribution of any hazardous substance normally depend upon the conditions attached by ERMA to the substance's approval. In other words controls are tailored to reflect the type of substance for which approval is sought. This is generally required because of the extensive and diverse range of substances that fall within the hazardous substances regime.
- 8.35 Regulations may be made under HSNO to prescribe generic default controls which then apply to all hazardous substances falling within a specific hazard classification (for example, explosives, flammable gases).<sup>640</sup> ERMA may also issue a common set of conditions (called a "group standard") that applies instead of an individual approval to all substances that fall within the criteria set for that group.<sup>641</sup> The objective is to cover existing and new products that have similar profiles and uses and cause similar toxic effects. ERMA may issue, amend or revoke a group standard on its own initiative or on application by any person.<sup>642</sup> In practice, the conditions in group standards tend to be in broadly similar areas, including information requirements and restrictions relating to site and storage, transportation and disposal. Group standards are really designed for products that are at the lower end of the hazard spectrum. ERMA must be satisfied that issuing a group standard is a more efficient and effective way of managing the risks of all the hazardous substances in the identified group than the ordinary approval process.<sup>643</sup>

<sup>640</sup> Hazardous Substances and New Organisms Act 1996, ss 75 and 140.

<sup>641</sup> Hazardous Substances and New Organisms Act 1996, s 96A.

<sup>642</sup> Hazardous Substances and New Organisms Act 1996, s 96B(3).

<sup>643</sup> Hazardous Substances and New Organisms Act 1996, s 96C(1)(a)–(c).



8.36 In contrast, there are a number of regulatory controls in the restricted substances regime that are generic. We described these in chapter 5, although it is useful to briefly recap. The restricted substances regime prohibits:

- the sale or supply of a restricted substance to any person under the age of 18 years;<sup>644</sup>
- any person under the age of 18 years from selling any restricted substance;<sup>645</sup>
- any manufacturer, distributor, importer or retailer of a restricted substance from distributing or supplying it free of charge or from offering a range of incentives, such as promotional gifts, to encourage purchase;<sup>646</sup>
- the advertising of a restricted substance on television or radio or in a newspaper or other periodical such as a magazine, or in any other medium specified by regulation.<sup>647</sup>

8.37 There are also broad powers to make regulations relating to:<sup>648</sup>

- (i) the places at which restricted substances can be sold or supplied;
- (ii) additional advertising restrictions and requirements;
- (iii) labelling restrictions and requirements;
- (iv) packaging and storage restrictions and requirements;
- (v) health warning requirements;
- (vi) signage and display requirements;
- (vii) quantity, dosage, form and serving requirements;
- (viii) record-keeping requirements.

To date, one set of generic regulations that apply to all restricted substances has been made. The Misuse of Drugs (Restricted Substances) Regulations 2008 impose generic restrictions on the place of sale or supply, advertising, labelling, packaging, storage, and signage and display for all restricted substances.

8.38 Regulations can be made that generally apply to all restricted substances or to any particular type of restricted substances, or even one particular substance. There is scope, therefore, to tailor regulations so as to impose appropriate conditions, although it could become quite cumbersome and complex if there were separate sets of regulations for each different substance.

8.39 In addition, the Director-General of Health may issue codes of manufacturing practice.<sup>649</sup> Where a code is in place, only those substances that comply fully with the code may be manufactured or imported.

644 Misuse of Drugs Amendment Act 2005, ss 36 and 39: section 39(1)(b) also prohibits supply to any other person with the intention that it be supplied to a person under 18 years.

645 Misuse of Drugs Amendment Act 2005, s 38.

646 Misuse of Drugs Amendment Act 2005, s 42.

647 Misuse of Drugs Amendment Act 2005, s 43.

648 Misuse of Drugs Amendment Act 2005, s 62.

649 Misuse of Drugs Amendment Act 2005, s 63.

## Minimum regulatory controls

- 8.40 There are significant differences between psychoactive substances which might require different controls. For example, it is difficult to see how a generic regulation relating to dosages could ever be made to work because different dosages will be appropriate for different substances.
- 8.41 However, we suggest also that there are some regulatory requirements that should apply to all recreational psychoactive substances, if they are approved. These generic conditions should be included in primary legislation.

## Age restrictions

- 8.42 Age restrictions should probably apply to the sale and supply of all recreational psychoactive substances.
- 8.43 As has been noted, legislation currently prohibits the sale or supply of a restricted substance to, or by, a person under 18. This restriction is consistent with current age restrictions on the sale of alcohol under the Sale of Liquor Act 1989 and tobacco under the Smoke-free Environments Act 1990. These all set a minimum age at which psychoactive substances can be purchased by young people or supplied to them. Age restrictions of this type are used across the world to limit the access young people have to legally available psychoactive substances. In the case of alcohol a legal purchase age is recognised internationally as being a highly effective and inexpensive supply control mechanism.<sup>650</sup> We suggest it might have a similar effect for other psychoactive substances.
- 8.44 Alcohol and other psychoactive drugs have the potential to affect neurological development in adolescents. Age restrictions might therefore be justified from a harm reduction perspective, because there is evidence that such substances do pose a greater risk of harm to young people. In chapter 2 we noted, for example, the increasing evidence of a causal relationship between cannabis use in early teens and some mental health disorders, and the greater impact of cannabis on the perceptions, short-term memory, attention, and motor skills of young people. In chapter 4 of the Law Commission's Issues Paper *Alcohol in Our Lives*, we also note that new research has found that young people experience more harm per standard drink than other drinkers.<sup>651</sup>
- 8.45 Whether the recreational psychoactive substances that would be regulated under the type of regime proposed here would affect young people and their development more adversely than others is difficult to assess. This is partly because we do not at present know what those substances are. Based on experience with other psychoactive substances, it is reasonable to assume that some might, while others might not. But even if new psychoactive substances that are developed in the future do not affect young people more adversely than other people, it can be assumed that they will have the potential to cause a range of physical and psychological harms,

<sup>650</sup> See the discussion on this point in New Zealand Law Commission *Alcohol in Our Lives: an Issues Paper on the Reform of New Zealand's Liquor Laws* (NZLC IP 15, Wellington, 2009) 151.

<sup>651</sup> See the discussion on this point and the harm alcohol causes youth in *ibid*, 47.

particularly if used repeatedly or excessively.<sup>652</sup> Again we think this is a reasonable assumption to make based on experience to date with the new synthetic drugs that have emerged over recent decades, including party pills.

- 8.46 Given the risk of harm, there is a strong argument for the state to take a paternalistic approach and to impose age restrictions aimed at preventing access to these potentially harmful substances until young people are sufficiently mature to assess the risks for themselves. As discussed in chapter 7, in the area of drug use, a paternalistic approach in respect of children and young people is necessary.
- 8.47 The difficulty comes with determining the appropriate age at which such restrictions are no longer justified. In the case of alcohol and tobacco this has been quite contentious. The legal purchase age for alcohol has been under discussion for a number of years. An important consideration in that debate has been concern over the extent to which a lower age limit may increase the level of access those younger than the set age will have in practice. While there may be some important differences between the risks of harm associated with alcohol and those associated with the types of psychoactive substances that may ultimately be regulated under the regime proposed here, there are similar considerations around a young person's maturity to make decisions on substance use, for example, in relation to likely addiction, impact on schooling and social development. There are also similar issues around the impact of age restrictions on the access of those younger than the set age. There is therefore good reason for applying the same age limit that applies to alcohol to new psychoactive substances.
- 8.48 Another argument for aligning the purchase age for psychoactive substances with the purchase age for alcohol is that it would avoid the possibility of young people shifting their use from alcohol to other psychoactive substances. Against that, evidence suggests that alcohol is at least as harmful as, if not more harmful than, many other psychoactive substances.<sup>653</sup>
- 8.49 On that basis we suggest that 18 should be the statutory minimum age for the supply of any psychoactive substance. This is consistent with the current approach to alcohol and tobacco. We note the Government intends to introduce new legislation regulating alcohol later this year. The legal purchase age for alcohol will be reconsidered in that context. If the age at which alcohol can be purchased is increased, consideration may need to be given to increasing the age at which new psychoactive substances can be purchased to align it with the age that applies to the purchase of alcohol. An intermediate option would be a statutory minimum age of 18, with the regulatory agency having power to increase the purchase age to 20 if that was appropriate having regard to the particular nature of the substance.

652 In one study undertaken on the use by young people of legally available party pills containing BZP, a range of negative emotional or psychological effects were identified as occurring during the "comedown" period. These included feeling depressed or down, tense and edgy, angry or annoyed, socially withdrawn, or anxious or paranoid. Other negative impacts relating to the "comedown" period included lack of sleep/ inability to sleep, loss of appetite, lethargy, headache, nausea, aching and tense body, impaired work or study performance (including absences) and dehydration. See Janie Sheridan and Rachael Butler *Legal Party Pills and their Use by Young People in New Zealand: A Qualitative Study Final Report of Findings* (University of Auckland, Auckland, 2007) vii.

653 See for example David Nutt and others "Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse" (2007) 369 *Lancet* 1047.

- 8.50 The restricted substances regime prohibits the advertising of restricted substances in the mainstream media. Restricted substances cannot be advertised on television or radio or in a newspaper or other periodical such as a magazine. Regulations can also be made specifying other media in which advertising is prohibited. There is also a prohibition on other promotions of restricted substances such as the distribution or supply of a restricted substance free of charge or the offering of incentives such as promotional gifts to encourage purchase. Regulations made under the Act provide that advertising for a restricted substance may appear only on premises where a restricted substance is sold or supplied. Such advertising must be confined to the inside of the premises and must not be easily visible or audible from outside the premises. However, the regulation expressly excludes advertising on the Internet from these restrictions.
- 8.51 Even broader advertising restrictions apply to the advertising of tobacco products in New Zealand. Section 22 of the Smoke-free Environments Act prohibits the publication of, or the making of arrangements to publish, any tobacco product advertisement. The term “tobacco product advertisement” is broadly defined in section 2 of the Act. It means “any words, whether written, printed or spoken including on film, video recording or other medium, broadcast or telecast and any pictorial representation or device used to encourage the use or notify the availability or promote the sale of any tobacco product or promote smoking behaviour” and includes:
- (a) any trade circular, any label and any advertisement in any trade journal; and
  - (b) any depiction in a film, video recording, telecast or other visual medium, of a tobacco product or tobacco product trade mark where in return for that depiction any money is paid or any valuable thing is given whether to the maker or producer of that film, video recording, telecast or visual medium or to any other person; and
  - (c) the use in any advertisement or promotion to the public of a tobacco product manufacturer’s name where that name or any part of that name is used or is included in a tobacco product trade mark.

This definition would appear to include advertising on the Internet.

- 8.52 In contrast, far less restriction is currently placed on the advertising and promotion of alcohol. The model here is one of industry self-regulation. Advertisements for alcohol that comply with the Code of Practice for Advertising Liquor can be run in all mainstream media. The Code requires that all advertising of alcohol must adhere to certain principles. There are also guidelines issued to help advertisers interpret and apply the principles in the Code. In 2009, a separate Alcohol Promotions Code was established to cover promotion. The alcohol industry in New Zealand spends millions of dollars annually on alcohol advertising through print, broadcast, news media and sponsorship.<sup>654</sup>

<sup>654</sup> See Report of the Steering Group for the Review of the Regulation of Alcohol Advertising (2007) 33 <http://www.ndp.govt.nz> (accessed 16 November 2009).

- 8.53 The Advertising Standards Authority (ASA) oversees the Code. Complaints can be made to the ASA about any advertisement in any media that any person considers breaches the Code. The ASA funds a separate self-regulatory body called the Advertising Standards Complaints Board that adjudicates on complaints received about advertisements that may breach a code of advertising practice. Where a complaint is upheld, advertisers are required to voluntarily withdraw the advertisement.
- 8.54 In addition, section 154A of the Sale of Liquor Act deals with some forms of promotion. It is an offence for a licensee or manager of licensed premises to do anything in the promotion of the business (or any event or activity held on the premises) that is intended or likely to encourage people on the licensed premises to consume alcohol excessively.
- 8.55 The different models for tobacco and alcohol represent the two ends of the spectrum of approaches that might be taken to regulating the advertising and promoting of other recreational psychoactive substances.
- 8.56 If new recreational psychoactive substances are to be legal and regulated rather than prohibited, it will be important to prevent the kind of commercialisation that surrounds alcohol and tobacco. Some commentators suggest that the harm associated with products such as alcohol and tobacco stem as much from the commercialisation of these products as from their mere availability. MacCoun and Reuter, for example, drew on evidence from gambling, tobacco, alcohol and Dutch cannabis coffee shops to argue that commercial promotion may matter as much as or more than the mere availability of a substance.<sup>655</sup>
- 8.57 The experience with alcohol advertising suggests that self-regulation is not an effective regulatory model. The submissions on the Commission's Issues Paper *Alcohol in Our Lives* strongly supported much more stringent regulation of alcohol advertising and promotion.<sup>656</sup> Moreover, although there are now extensive restrictions applying to the advertising and promotion of tobacco in New Zealand, historically that has not been the case. The earlier experience with tobacco is often used by commentators to illustrate the risks around commercialisation. One way of preventing commercialisation is by imposing and enforcing broad restrictions on advertising and promotion.
- 8.58 We therefore strongly favour the type of restrictions found in the Smoke-free Environments Act. The restrictions should include a prohibition on advertising on the Internet.
- 8.59 We acknowledge that restrictions on advertising raise issues of consistency with the right to freedom of expression in section 14 of the New Zealand Bill of Rights Act 1990. Section 14 protects the right to freedom of expression, including the freedom to seek, receive and impart opinions of any kind and in any form. The right to freedom of expression has been interpreted to extend to all forms of communication which attempt to express an idea or meaning, including commercial speech such as advertising.<sup>657</sup>

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655 MacCoun and Reuter, above n 630, 77.

656 New Zealand Law Commission, above n 650.

657 *Irwin Toy Ltd v Attorney-General (Quebec)* [1989] 1 SCR 927 (SCC).



- 8.60 However, courts in other jurisdictions have generally been willing to limit commercial expression more readily than other forms of speech. For example, in *Markt Intern and Beerman v Germany*,<sup>658</sup> the European Court of Human Rights held that member states have a wider margin of appreciation when it comes to imposing limitations on freedom of expression that impinge on commercial expression than they do with other forms like artistic or academic expression.
- 8.61 Nevertheless, in both the United States and Canada the courts have struck down blanket bans on advertising. In the United States, the Supreme Court struck down a blanket ban on advertising the price of prescription drugs.<sup>659</sup> In Canada, the Supreme Court held that a blanket advertising ban on cigarette advertising infringed the Canadian Charter of Rights and Freedoms because it did not limit the right to freedom of expression as little as reasonably possible in the circumstances. The Court accepted that a more targeted tobacco advertising ban could be justified.<sup>660</sup>
- 8.62 These cases concerned advertising products that were already legal. We consider that broad restrictions on the advertising of new recreational psychoactive substances similar to those in the Smoke-free Environments Act are at least arguably a justified limitation on the right in section 14 under the Bill of Rights Act for a number of reasons. These include that:
- (i) research suggests there is a need to prevent commercialisation of new recreational psychoactive substances to ensure they do not become as prevalent as alcohol and tobacco and to minimise the harm they might otherwise cause;
  - (ii) if advertising restrictions are not imposed, it may be necessary to prohibit the manufacture or import of these substances altogether which would entail a greater restriction on individual freedom (although not a right protected by the Bill of Rights Act);
  - (iii) as these are new products, those who choose to enter the market will do so knowing of the restrictions that are imposed;
  - (iv) it is consistent with the approach taken to the advertising of tobacco products.
- 8.63 In any event, any uncertainty over whether advertising restrictions of this nature might be considered inconsistent with the Bill of Rights Act would be less important if Parliament enacted the restrictions in primary legislation rather than leaving them to regulations which could be vulnerable to challenge.
- 8.64 We also favour a prohibition on the promotion of recreational psychoactive substances similar to that currently applying to restricted substances.

658 *Markt Intern and Beerman v Germany* (1989) 12 EHHR 61 (ECHR).

659 *Virginia State Board of Pharmacy v Virginia Citizens Consumer Council Inc* 425 US 748 (1976).

660 *RJR McDonald Ltd v Canada* [1995] 3 SCR 199.



*Places of sale restrictions*

- 8.65 As outlined earlier, the restricted substances regime provides for regulations to be made limiting places from which restricted substances can be sold or supplied. Regulations currently prohibit the sale or supply of restricted substances from:
- (i) places where alcohol is sold;
  - (ii) petrol stations;
  - (iii) non-fixed premises such as vehicles, tents and mobile street cars;
  - (iv) places where children gather (schools, recreational facilities and sports facilities).
- 8.66 By way of contrast, the Sale of Liquor Act requires premises at which alcohol is sold to be licensed.
- 8.67 We doubt that there would be a sufficient number of new recreational psychoactive substances to warrant the introduction of a full licensing system like that applying to alcohol. However, we suggest that the restrictions currently in the Misuse of Drugs (Restricted Substances) Regulations should be included in legislation setting minimum requirements applying to the sale of all recreational psychoactive substances.
- 8.68 It is desirable to keep the sale of alcohol and other psychoactive substances separate, since the combination of alcohol and some other psychoactive substances is more harmful than either substance individually. It would send the wrong message if they were able to be sold together. We note that the harms associated with all new psychoactive substances may not necessarily be increased by alcohol, but there is evidence that when some drugs (for example, BZP, ecstasy, fantasy) are combined with alcohol the toxicological effects are much harder to predict.
- 8.69 Similarly, driving while under the influence of alcohol or other drugs is inherently undesirable. For this reason, the Sale of Liquor Act prohibits the sale of alcohol at petrol stations.<sup>661</sup> The same principle should apply to other legally available psychoactive substances. Their sale should be separated from activities related to driving. We would also add pharmacies to the list of places prohibited from selling or supplying psychoactive substances. The substances we are concerned with here are not therapeutic products and there should be no room for misunderstanding about that. As well as these statutory restrictions, the regulatory body should have the power to impose additional restrictions on the place of sale, if appropriate, having regard to the nature of the substance.

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661 Section 36(3)(a) of the Sale of Liquor Act prohibits an off-licence from being granted to sell alcohol from any service station or other premises in which the principal business is the sale of petrol or other automotive fuels.

### *Restrictions on who can supply recreational psychoactive substances*

- 8.70 The restricted substances regime imposes no restrictions on who can sell or supply restricted substances other than a restriction on sale or supply by persons under 18. However, the court can prohibit a person from selling or manufacturing a restricted substance if that person is convicted of an offence relating to a restricted substance within two years of being sentenced on another such offence. When imposing the sentence for the second (or subsequent) offence, the court may make an order to this effect.<sup>662</sup>
- 8.71 In our view, there need to be further protections. In a market where some recreational psychoactive substances are legal and others are not, it is important that the legal market is kept separate from the black market. On that basis, we suggest that there should be a prohibition on the manufacture and sale of legal substances by any person who has been convicted within the previous five years of a dealing offence under the Misuse of Drugs Act or a serious offence under the Crimes Act 1961 with a maximum penalty of seven years. We think the court should also have the power, when sentencing a person convicted of an offence related to a legally available psychoactive substance, to prohibit that person from manufacturing or selling substances under the regime. Unlike the restricted substances regime, do not think that two convictions should be needed to trigger this power, as there may be cases where there is such a blatant disregard for the regulatory requirements that immediate action is appropriate.

### *Other restrictions*

- 8.72 Two other restrictions, currently in the Misuse of Drugs (Restricted Substances) Regulations, would also be useful for inclusion as minimum requirements. These are a requirement for these substances to be stored in child-proof and tamper-proof containers and a requirement that the label contain the phone number and address of the National Poisons Centre. Both requirements are obviously useful safety precautions. They also make it abundantly clear to potential purchasers or users of these substances that they are potentially harmful and, as such, send a useful health message.

<sup>662</sup> Misuse of Drugs Amendment Act 2005, s 54.

- Q4 Do you agree that the following should be standard minimum requirements:
- (a) restrictions on the sale or supply of recreational psychoactive substances to persons under 18 (if so, should the age be changed in the event of a change to the purchase age for alcohol?);
  - (b) advertising restrictions along the lines of the restrictions on advertising tobacco products under the Smoke-free Environments Act;
  - (c) a prohibition on the promotion of these substances similar to that currently applying to restricted substances;
  - (d) a prohibition on the sale of these substances at:
    - (i) places where alcohol is sold;
    - (ii) petrol stations;
    - (iii) non-fixed premises such as vehicles, tents, and mobile street cars;
    - (iv) places where children gather;
    - (v) pharmacies;
  - (e) a prohibition on the manufacture, importation and sale of these substances by any person:
    - (i) under the age of 18 years; or
    - (ii) who has been convicted within the previous five years of a dealing offence under the Misuse of Drugs Act or an offence under the Crimes Act punishable by seven years imprisonment; or
    - (iii) who has been convicted of an offence under the regime applying to these substances and has been prohibited by the court from undertaking any of these activities;
  - (f) a requirement that these substances be stored in child-proof and tamper-proof containers; and
  - (g) a requirement that the labels should contain the contact details of the National Poisons Centre?

- Q5 Are there other matters that should become minimum standard requirements?

### Conditions of approval

- 8.73 We suggested earlier that, as well as the statutory minimum requirements, more tailored conditions are required. Therefore, legislation should also specify a range of matters where the regulatory body has power to impose additional tailored conditions as part of an approval to manufacture or import a recreational psychoactive substance. Additional conditions could relate to any or all of the following:
- (i) additional place of sale restrictions;
  - (ii) labelling restrictions and requirements;
  - (iii) packaging restrictions and requirements;

- (iv) health warning requirements;
- (v) signage requirements;
- (vi) quantity, dosage, form and serving requirements;
- (vii) storage and display restrictions;
- (viii) record-keeping requirements;
- (ix) any other requirements considered necessary or desirable to minimise the harm that might occur as a result of use of the substance.

- 8.74 The legislation would require any person selling or supplying a psychoactive substance, as well as the manufacturer or importer, to comply with any specific conditions relating to these matters that have been specified in the manufacturing or importing approval for a substance.
- 8.75 Provisions are also needed to enable the regulatory body to amend the conditions of an approval or revoke it if it becomes evident that the risks associated with a particular substance are more or less significant than was assessed based on the information available at the time the approval was given. Appeal and review mechanisms will also be needed.
- 8.76 The legislation should also empower the regulatory body to issue codes of manufacturing practice. These would bind manufacturers and importers of different substances.

**Q6** Do you agree that the regulating body should have power to impose additional conditions on an approval for a new recreational psychoactive substance? If so, should the conditions cover:

- (i) additional place of sale restrictions;
- (ii) labelling restrictions and requirements;
- (iii) packaging restrictions and requirements;
- (iv) health warning requirements;
- (v) signage requirements;
- (vi) quantity, dosage, form and serving requirements;
- (vii) storage and display restrictions;
- (viii) record-keeping requirements;
- (ix) any other requirements considered necessary or desirable to minimise harm that might occur as a result of use of these products?

**Q7** Should the regulatory body have the power to issue manufacturing codes of practice?

### Powers to recall products

- 8.77 Under the restricted substances regime, the Minister has power to recall a restricted substance if the Minister considers the substance is:
- (a) unsound or unfit for human consumption;
  - (b) damaged, deteriorated or perished;
  - (c) contaminated with any poisonous, deleterious or injurious substance.

- 8.78 We consider a power of this kind is necessary and should rest with the regulatory body, rather than with the Minister. This would ensure that a recall can occur as soon as a problem becomes apparent.

Q8 Do you agree that there should be a power of recall? If so, in whom should that power vest?

### Offences

- 8.79 The regulatory requirements will need to be supported by offence provisions that apply to any person who manufactures, imports, exports, sells or supplies any new recreational psychoactive substance without an approval, or in breach of the minimum statutory conditions or any additional conditions that were imposed at the time of approval.
- 8.80 Offences under the restricted substances regime are punishable by fines not exceeding \$5000 in the case of an individual and \$10,000 in the case of a body corporate. In addition, as we have already noted, the court may prohibit a person from selling or manufacturing a restricted substance if that person is convicted of an offence relating to a restricted substance within two years of being sentenced on another such offence. In contrast, the penalties for contraventions of the HSNO regime attract penalties of up to three months imprisonment and fines of up to \$500,000.
- 8.81 If new recreational psychoactive substances remain within HSNO, that offence regime will apply. That regime covers a broad range of hazardous substances as well as new organisms, some of which can create significant environmental or public health risks. Very few of the types of offences that might be committed with new recreational psychoactive substances will involve this type of risk.
- 8.82 Alternatively, if there is a separate regime specifically for new recreational psychoactive substances, penalty levels might instead be set at levels that are comparable with those imposed for breaches of the equivalent regulatory controls on alcohol and tobacco. Comparable offences involving a breach of the restrictions on tobacco (including advertising and display restrictions) are punishable by fines of up to \$50,000. The level of fine varies depending on whether an offence is committed by an individual or a body corporate and whether the person is a manufacturer, distributor or retailer. There are some comparable offences under the Sale of Liquor Act attracting a maximum fine of \$40,000 and up to three months imprisonment.

Q9 Should penalty levels for offences be set at the levels currently provided for in HSNO or should they be set at similar levels to penalties in regimes regulating drugs like alcohol and tobacco?

### Enforcement powers

- 8.83 We discuss enforcement powers in chapter 14. In particular, we suggest that a power of entry and inspection for regulatory purposes is required. We note in passing here that currently under HSNO, where new psychoactive substances are

imported without an approval, they become prohibited imports under section 54 of the Customs and Excise Act 1996 so that section 209 of that Act applies.<sup>663</sup> Consequently section 122 of HSNO provides a power for customs officers to direct that hazardous substances imported in breach of HSNO remain on the ship or vessel by which they were brought to New Zealand or to require that they be removed from New Zealand at the importer's expense. In addition, prohibited imports are forfeited to the Crown<sup>664</sup> and can be seized.<sup>665</sup> These would seem useful provisions to include in any new regime for recreational psychoactive substances.

- 8.84 Finally, we note that whatever regime is to deal with new recreational psychoactive substances, it is essential that the requirements are actively enforced. One of the main reasons for the EACD recommendation to reclassify BZP as a Class C controlled drug was the “absence of a significant administration and enforcement capacity such as exists for pharmaceuticals and for legal drugs, tobacco and alcohol.”<sup>666</sup> In our view the administrative and enforcement capacity to regulate these substances should be made available. There is certainly reason to believe that appropriately regulating these substances may be more effective at minimising drug-related harm than prohibiting them altogether and there is the opportunity to test this in a closely monitored and controlled environment. The restricted substances regime in New Zealand has been the subject of significant international interest for this reason. It would be unfortunate if the failure to provide adequate resources for administration and enforcement means that this opportunity is wasted.

### HSNO or a separate regime

- 8.85 As we have already said, technically new recreational psychoactive substances that are not foods or medicines are hazardous substances and can be regulated by HSNO. The issue is whether they should be dealt with under that Act or under a new separate regime that replaces the restricted substances regime. If they remain within HSNO, any new psychoactive substance that is not approved because it has significant adverse effects that cannot be adequately managed by the imposition of conditions, would need to be referred by ERMA to the agency responsible for prohibited drugs so the substance could be brought under the prohibited drugs regime.
- 8.86 The advantages of regulating these substances under HSNO are:
- the mechanisms are already in place for approving the import and manufacture of hazardous substances and appeals against approval decisions;
  - there may be an insufficient number of new recreational psychoactive substances to justify the expense of a separate system;
  - it avoids the need for a separate definition of new recreational psychoactive substances and the attendant difficulties at the margins of determining which regime should regulate a particular substance;
  - with one agency assessing and approving all harmful substances, there may be more consistency over the level of hazard tolerated and less need for coordination between different agencies.

<sup>663</sup> Under section 209 of the Customs and Excise Act 1996 it is an offence to import a prohibited import.

<sup>664</sup> Customs and Excise Act 1996, s 225.

<sup>665</sup> Customs and Excise Act 1996, s 226.

<sup>666</sup> Meeting Minutes, Expert Advisory Committee on Drugs (29 November 2006).



- 8.87 However, there are also disadvantages with use of the HSNO system and advantages in having a separate regime. Firstly, we have suggested that there are some regulatory requirements that should form a set of statutory minimum controls applying to all recreational psychoactive substances. If the substances were to be regulated under HSNO, some changes would need to be made to that regime to place such minimum controls in statute.
- 8.88 Secondly, substances have not historically been regulated under the predecessor statutes to HSNO. As a result ERMA does not necessarily have the specific expertise required to deal with this particular type of substance. Moreover, the large number of substances that fall to be regulated under HSNO creates a risk that these new substances may not receive as much attention as they would under a separate regime. As we said earlier, if new recreational psychoactive substances are to be regulated rather than prohibited, it is important that there be careful monitoring and evaluation of the effectiveness of the regulatory regime. This is more likely to occur under a separate regime.
- 8.89 Thirdly, the criteria in HSNO are not entirely appropriate for psychoactive substances. When considering an application for an approval for a hazardous substance, ERMA must take into account:
- any controls that may be imposed on the substance;
  - all effects of the substance during the lifecycle of that substance;
  - the likely effect of the substance being unavailable.
- 8.90 If the positive effects of the substance outweigh the adverse effects, the application can be approved, but otherwise it must be declined. An application can also be declined if the applicant fails to provide sufficient information for the assessment.
- 8.91 The positive effects of a psychoactive substance that is for recreational use are much less tangible than for substances typically evaluated by ERMA. Without more specific guidance it may be difficult to weigh the intangible recreational benefits people may enjoy against a substance's more tangible adverse effects. The matters ERMA considers do not expressly include the likely consequences of any proposed regulatory model or the possible displacement effects that may result from the way other substances are regulated. This suggests that criteria tailored specifically for assessing psychoactive substances may be preferable.
- 8.92 On balance, therefore, we are inclined to the view that a new separate regime is preferable to regulation through HSNO.
- 8.93 For such a regime, tailored criteria would need to be devised for deciding whether a substance should be regulated and an approval issued. Relevant criteria seem to be:
- (i) the nature of the harm caused by the substance and any benefits associated with its use;
  - (ii) whether that harm can be effectively managed by the imposition of regulatory controls (including considering any research into the impact of different regulatory controls on minimising harm generally and also specifically (if available) for that substance);

- (iii) the likely consequences of any proposed regulatory controls or prohibiting the substance (including the cost of different regulatory options); and
  - (iv) any possible displacement effects that might occur because of the way other substances are regulated. (While this is an aspect of the previous criterion, it is important enough to be expressly included.)
- 8.94 In looking at issues of effectiveness under the second criterion, it would be important to consider the prevalence of use of a substance. If a substance is widely available and widely used, some types of regulatory restriction or prohibition might be less effective than they may be with a less prevalent substance.
- 8.95 Under the third criterion, the relevant consequences of all alternative drug control options for the substance would be assessed. This would involve identifying the consequences, measuring the magnitude of those consequences, and, to the extent it is possible, quantifying them to facilitate comparison with the consequences of other options for control (that is, prohibition).
- 8.96 The fourth criterion expressly requires consideration of the risk that full prohibition of a substance might encourage the use of more harmful substances. It also takes into account the possibility that the use of more harmful prohibited drugs may be discouraged by the availability of less harmful alternatives.
- 8.97 As we discussed at the beginning of this chapter, there are significant gaps in the available evidence concerning the effectiveness of different regulatory approaches. There are also important elements of subjective value judgement involved in weighing up the evidence and the tangible and intangible costs and benefits. While it is important to acknowledge these limitations, the regulatory authority should consider what evidence is available and base its judgements on the available evidence. This will require a common sense judgement about matters such as the experience of the substance in other jurisdictions and its similarity to other substances and their known effect.
- 8.98 If a separate regime for recreational psychoactive substances is established, there are good reasons for the regulatory and enforcement authority to be the same as that responsible for regulating prohibited drugs. If an approval to manufacture or import a substance is declined, the substance should normally be brought under the control regime that applies to prohibited drugs. This suggests that either the Minister or the Director-General of Health, rather than ERMA, should be the regulatory authority, and that the Ministry of Health should administer and enforce the regime.
- 8.99 We note that there are some possible disadvantages in giving either the Minister or the Director-General the function of issuing manufacturing and importation approvals for these substances. An approval from either the Minister or the Director-General may be seen as sanctioning such substances for use. It may therefore send quite the wrong message over their use. The counter-argument is that the purpose of the regulatory controls is to minimise the harm associated with recreational psychoactive substances and the involvement of the Minister or the Director-General in harm minimisation is appropriate, particularly if such decisions are informed by expert evidence and evaluation.

- 8.100 We think that decisions on whether approvals are issued or not should be made by the Minister of Health. The choice between the Minister and the Director-General concerns the appropriate level within the executive at which these types of decisions need to be made. The Legislation Advisory Committee Guidelines advise that the broader the policy element the more appropriate it may be for the matter to be settled by Ministers who are responsible to Parliament, and ultimately to the electorate. We suggest that the Minister of Health should probably therefore hold the decision-making power under the regime because of the important elements of subjective value judgement involved in decisions on approvals.
- 8.101 Whether the decision-maker is the Minister or the Director-General, it will be essential to have the involvement of a committee with appropriate expertise to review and evaluate the evidence and make recommendations to the decision-maker. The committee's expertise will be particularly important in identifying the nature of the harm that may be caused by any substance. We will discuss the functions of the committee in these areas in more detail in chapter 9.
- 8.102 We suggest also that there needs to be a clear link between decisions to approve or not approve a substance, and a subsequent decision to bring an unapproved substance within the prohibited drugs regime. It seems logical that, where an approval is declined because legalisation with restrictions is not appropriate, the Minister considers initiating steps to prohibit the substance. However, there may be some situations where this would not necessarily be appropriate. For example, an application might be declined because there is insufficient information on which to adequately assess the risks associated with the substance. In such circumstances it might be premature to make a decision on whether the substance should be prohibited.
- 8.103 There will also be situations where a new psychoactive substance, which has not been approved, comes to the attention of the Ministry of Health or another enforcement authority. Although such a substance would not be legally available in New Zealand, it would not be subject to the enforcement and sanction regime for prohibited drugs. We suggest that the regulatory body should be able to initiate an assessment of such a substance in advance of any application to manufacture or import it, and refer it to the expert committee for evaluation and advice.

Q10 Do you agree that new recreational psychoactive substances should be regulated by a separate regime designed specifically for new recreational psychoactive substances rather than HSNO?

Q11 Under the proposed separate regime, do you agree that the Minister of Health rather than the Director-General should issue approvals?

## Coordination between regulatory bodies

- 8.104 If recreational psychoactive substances are to be dealt with under a new separate regime as we have suggested, careful consideration needs to be given to how the substances that fall within the regime are defined. It will, for example, be necessary to specifically exclude the substances from HSNO to avoid the problem that has arisen with the restricted substances regime. In addition, the new regime should probably be restricted to those substances that are manufactured for the primary purpose of being administered, ingested, inhaled, or injected in order to induce a psychoactive response. This is the position under the restricted substances regime. Otherwise the regime would capture substances like paint, glue and other solvents which, though capable of being used recreationally, are primarily used for other purposes. In our view these substances are better dealt with under HSNO. Substances that are medicines and foods will similarly also need to be excluded.
- 8.105 In chapter 5, we noted that some difficulties have occurred at the margins over the coverage of the different regulatory regimes for foods, medicines, hazardous substances and restricted substances. One example we discussed is when psychoactive substances are incorporated into drinks or tablets that are marketed as stimulants and energy enhancers. Recently new “energy shots” have emerged in a liquid form containing high levels of caffeine. These products are consumed orally; they contain some psychoactive ingredients but also other ingredients and nutrients that are commonly used in food. We suggested in chapter 5 that there can be a degree of uncertainty over which regime applies to such products.
- 8.106 Issues over the application of the different regulatory regimes need to be addressed. One option would be a requirement for regular consultation between the relevant regulatory bodies. The aim would be to ensure that potentially harmful products do not fall between the cracks of the various regulatory regimes. It would also be possible to establish a panel comprising representatives of the various regulatory bodies that could make determinations about which regulatory regime applies where there is doubt. Any person intending to import or manufacture a substance which falls at the margins of the various regimes could then seek a determination from the panel about which regime applies. This would protect importers/manufacturers from possible prosecution for failing to obtain the appropriate approvals.

Q12 Is any formal mechanism required to ensure effective coordination between the various regulatory bodies responsible for foods, medicines, hazardous substances and new psychoactive substances?

# Chapter 9

## Drug classification system

### SUMMARY

This chapter examines the ABC drug classification system and considers criticisms and issues that have arisen over the classification criteria and process. It then examines the options for reform in this area.

**INTRODUCTION** 9.1 The ABC classification scheme for drugs has been controversial during recent years in the United Kingdom. Although there has been much less discussion about the classification system within New Zealand, there has been some criticism of the process by which drugs are classified. In this chapter we consider the evolution of New Zealand's three-tiered system of classification, and consider in some detail the criticisms that have been levelled at the similar system in the United Kingdom and their applicability to New Zealand. We then examine the options for reform.

**ADOPTION AND DEVELOPMENT OF THE CLASSIFICATION SYSTEM** 9.2 The ABC classification system has its origins in the 1973 report of the Blake-Palmer Committee.<sup>667</sup> 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".<sup>668</sup> The report recommended making a formal distinction between controlled drugs with different potential for harm, especially between cannabis plant and the opiates, seeing this as having "important symbolic significance."<sup>669</sup> It suggested 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.<sup>670</sup> 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.<sup>671</sup>

<sup>667</sup> 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.

<sup>668</sup> 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) 42.

<sup>669</sup> *Ibid.*, 48.

<sup>670</sup> *Ibid.*

<sup>671</sup> *Ibid.*



9.3 Accordingly the report recommended, among other things, that:<sup>672</sup>

- controlled drugs should be placed in several separate schedules (or parts of schedules) which broadly indicate their relative potential for harm and 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

9.4 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. 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. The system is modelled on the Misuse of Drugs Act 1971 (UK).

9.5 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.<sup>673</sup>

### Subsequent amendments to New Zealand's classification system

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

9.7 An amendment in 1998 added a fourth schedule to the Misuse of Drugs Act listing precursor substances. We discuss the issues relating to precursor substances in chapter 12.

<sup>672</sup> For a full list of recommendations see *ibid*, 100.

<sup>673</sup> See the transcript of the second reading debate (18 July 1975) 399 NZPD 3142-3157; the role of officials and experts is discussed on page 3146.



- 9.8 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 and accordingly:<sup>674</sup>
- (a) drugs that pose a very high risk of harm are classified as Class A drugs; and
  - (b) drugs that pose a high risk of harm are classified as Class B drugs; and
  - (c) drugs that pose a moderate risk of harm are classified as Class C drugs.
- 9.9 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 listed in the first and second Schedules,<sup>675</sup> but could add, omit or rename any substance listed in the third Schedule. Other amendments to drug classifications had to be made by Act of Parliament.
- 9.10 Fuller powers to classify drugs by Order in Council were restored in 2000, subject to a new affirmative resolution procedure provided for in the standing orders. An Order in Council cannot be brought into force until a resolution is made by Parliament approving it through that procedure.<sup>676</sup>
- 9.11 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.<sup>677</sup> 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.
- 9.12 As outlined earlier in chapter 4, the classification system was amended again in 2005 with the introduction of the new restricted substances category. Substances included in that category are regulated rather than prohibited. Restricted substances can be added or removed by Order in Council subject to the affirmative resolution procedure.<sup>678</sup>
- 9.13 The 2005 amendment also introduced some new restrictions on the use of the Order in Council procedure. 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 or changed to a restricted substance without recourse to the full legislative process.<sup>679</sup>
- 9.14 We return to the issues around the Order in Council process later in the chapter.

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674 See Misuse of Drugs Act 1975, s 3A.

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

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

677 See Misuse of Drugs Act 1975, s 4B.

678 See Misuse of Drugs Amendment Act 2005, s 34.

679 See Misuse of Drugs Act 1975, s 4.

## United Kingdom

- 9.15 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

- 9.16 In Canada, the Controlled Drugs and Substances Act 1996 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 schedules of precursor substances. The Canadian 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

- 9.17 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 nor Victoria classify 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.

## Europe

- 9.18 According to the Police Foundation Inquiry report (discussed more fully below), in most European jurisdictions drugs are not classified for penalty purposes. 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).

- 9.19 There has been very little discussion or debate about the ABC classification system in New Zealand, although there has been some criticism of the classification process. 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. We review the relevant reports below.

### The Independent Inquiry into the Misuse of Drugs Act 1971 (the “Police Foundation Inquiry”)<sup>680</sup>

- 9.20 In 1997, a Committee chaired by Viscountess Runciman was established to inquire into the effectiveness of drug laws in the United Kingdom. Amongst other matters, the Committee considered whether it remained appropriate to classify drugs using the three-tier ABC classification system based on comparative harm.
- 9.21 The Committee noted that the United Kingdom was alone among European countries in using such a system. It considered whether to do away with classes of drug altogether. 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.
- 9.22 As an alternative, the Committee considered whether the number of classes should be reduced to two. The Committee noted that this would enable a clear division to be opened up between seriously harmful and less harmful drugs. But, while commending the two-tier system in the Netherlands for its attempt to draw a clear and meaningful distinction between harmful and less harmful drugs, it doubted whether this accurately reflects the complexity of the situation. In the Committee’s view, 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. Ultimately the Committee recommended no change to the three-tier system. However, it suggested there should be a much more systematic approach to the assessment of harm.
- 9.23 In reaching this conclusion, the Committee argued that the major justification for controlling drugs lies in the harm that the use of drugs causes to users, people affected by users and the community at large. Accordingly, it thought that it was appropriate to consider the relative harms of different drugs on these groups. The Committee noted that the relative harmfulness of drugs is determined by a number of factors, some applying to the individual and some to society. Having regard to the various harms involved, the Committee suggested the following criteria for assessing the harmfulness of drugs for classification purposes:<sup>681</sup>
- 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.
- 9.24 Applying those criteria, the Committee suggested a number of changes to the existing classifications. These recommendations were not accepted by the Government.

680 The Police Foundation *Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971* (Police Foundation, London, 1999).

681 *Ibid*, chapter 3, paragraph 38.

## The report of the Science and Technology Committee<sup>682</sup>

- 9.25 In 2006, the United Kingdom House of Commons Science and Technology Committee presented a detailed critique of the scientific anomalies within the classification system. It concluded that the three-tier classification system in the United Kingdom was not “fit for purpose”<sup>683</sup> and should be abandoned. The Committee suggested the ranking of drugs based on harm needed to be “decoupled”<sup>684</sup> from penalties for drug offences.
- 9.26 The Committee considered that this “decoupling” is necessary because knowledge of drug harms is constantly evolving, thus requiring constant revision of the classification system. The law cannot keep up. Also, there is very little scientific knowledge of the harms associated with some drugs. 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.
- 9.27 The Committee declined to say 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”.<sup>685</sup>
- 9.28 A number of the criticisms of the classification system in the report relate specifically to the performance of the ACMD and are therefore of limited relevance in the New Zealand context. However, the following criticisms are relevant:
- 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;
  - there is an insufficient evidence base for many 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.
- 9.29 The United Kingdom Government rejected the Committee’s finding that the classification system is not “fit for purpose”, arguing that the three-tier system discharges its functions fully and has withstood the test of time. In the

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

683 Ibid, 3.

684 Ibid.

685 Ibid, 46.

Government's view, 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".<sup>686</sup>

### Matrix of harm: Nutt/Blackmore hierarchy of harms

- 9.30 In the wake of the Police Foundation Inquiry, the ABC classification system was considered against a matrix of drug-related harm developed by Professors David Nutt, William Blakemore, William Salisbury and Leslie King.<sup>687</sup> The matrix uses nine criteria for determining harmfulness 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.
- 9.31 Two groups of experts were asked to score each substance for each of the nine parameters. The first group was a group of consultant psychiatrists who were on the register of the Royal College of Psychiatrists as specialists in addiction. The second group comprised other scientists and experts in psychoactive drugs.<sup>688</sup> 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.
- 9.32 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.<sup>689</sup> Social harm here 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.

686 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) 3.

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

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

689 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 *Lancet* 1857.



- 9.33 A table setting out the results of the assessment is provided below. It indicates that there was a significant correlation between the scores of the two groups of experts. Another point of particular interest is the high harm scores of alcohol and tobacco relative to a number of illegal drugs.

TABLE ONE

Matrix of harm: Nutt/Blackmore 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.<sup>690</sup>

690 Nutt and others, above n 687, 1051.

- 9.34 The authors of the study concluded that the results of the study do not provide justification for the sharp A, B or C classifications in the Misuse of Drugs Act (UK).<sup>691</sup> 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 was to remain, 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.
- 9.35 Some criticisms have been made of the matrix of harm. 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.<sup>692</sup>
- 9.36 The matrix has also been criticised for being too subjective. The United Kingdom's Academy of Medical Sciences, for example, considered that the reliance of the matrix on the subjective assessment of experts means it made 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.<sup>693</sup>

#### The report of the Royal Society for the Encouragement of Arts, Manufacture and Commerce (RSA) Commission<sup>694</sup>

- 9.37 The 2007 report of the RSA Commission on Illegal Drugs, Communities and Public Policy (an independent Commission established by the RSA) also recommended the abandonment of United Kingdom's ABC classification system.
- 9.38 The report made similar criticisms of the three-tier system to those made in the Science and Technology Committee's report. The Commission was particularly concerned about the way the system was used by the Government to convey messages about drug use. It suggested that where the classification system is used in this way, it either fails to transmit the desired message at all or else sends signals that are garbled. The Commission also considered that the "opacity" of the classification system and the "oversimplifications built into its workings"

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691 Ibid.

692 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 *Lancet* 1857.

693 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).

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

reduce its value as a sentencing tool and undermine it as a prevention strategy, since prevention depends on the accuracy and plausibility of official information about drugs.<sup>695</sup>

- 9.39 The 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.
- 9.40 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 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.
- 9.41 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.<sup>696</sup> 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 effect consequential changes in the penalties attached to offences involving the substances in the index. The 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)<sup>697</sup> reviews.

<sup>695</sup> Ibid, 287.

<sup>696</sup> Ibid, 319.

<sup>697</sup> Ibid, 320. The report records that Professor Nutt suggested five yearly reviews in an evidence session with the Science and Technology Committee as part of its follow up on its report.

The report of the Academy of Medical Sciences<sup>698</sup>

- 9.42 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<sup>699</sup> 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.
- 9.43 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. In this respect, the AMS report noted that drug laws are controversial and public consultation is essential if changes to legislation are to be implemented effectively.
- 9.44 Most participants in the public engagement activities considered the United Kingdom's drug classification to be "confused, inconsistent and arbitrary".<sup>700</sup> The AMS suggested, therefore, that the classification system needed to be revised to reflect more accurately the harms associated with each drug.
- 9.45 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.<sup>701</sup>
- 9.46 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.

## SHOULD THE CLASSIFICATION SYSTEM BE REFORMED?

- 9.47 The New Zealand classification system is more developed than its counterpart in the United Kingdom. The 2000 amendments set out the basis for making drug classifications, with Class A being drugs posing a very high risk of harm, Class B posing a high risk of harm and Class C posing a moderate risk of harm. In addition, the Act is more explicit about the classification process and the factors that are to be taken into account in drug classification decisions. However, 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.
- 9.48 Despite these differences, many of the criticisms of the classification system in the reports reviewed above are relevant in the New Zealand context. We examine those criticisms below.

698 The Academy of Medical Sciences, above n 693.

699 Foresight *Drugs Futures 2025?* (Office of Science and Technology, London, 2005).

700 The Academy of Medical Sciences, above n 693, 74.

701 Ibid, 73.

## Criticisms of the present classification system

- 9.49 The first criticism is that there is no evidence that the classification system itself or changes in individual drug classifications have a deterrent effect. However, deterrence is only one of the purposes of sentencing. It is not the only or even the predominant purpose. Sentencing should reflect the culpability of the offender. If the reason for controlling drugs is that they cause harm, there is a coherent argument that the more harmful the drug, the more culpable it is to deal with it, and the greater the penalty should be. 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.
- 9.50 The second criticism is that there is uncertainty about the definition of harm which creates confusion for classification decisions. 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 of the definition. In chapter 2, we discussed the difficulties surrounding the measurement of drug harm and expressed some scepticism about the value of attempts to describe and quantify the costs of all drug use. But these difficulties do not necessarily make it wrong to group drugs into broad harm categories for the purpose of fixing maximum penalties for drug offences.
- 9.51 Inevitably with any classification system there will be issues about where the boundaries for 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 we noted above, there was a significant correlation between the scores of the two groups of experts that independently assessed drug harms for the Nutt/Blakemore matrix.
- 9.52 The third criticism is that the classification system is vulnerable to political and media pressure, resulting in classification 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 has been sacked because of his public comments about anomalous drug classifications. In New Zealand, the recommendations of the EACD have never been ignored,<sup>702</sup> although there have been occasions, such as the recent 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.
- 9.53 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,

702 Although it should perhaps be noted that the EACD has never recommended a downward reclassification of any drug.



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 committee in the classification process at least ensures that evidence relating to drug harms is considered when penalty levels are set.

- 9.54 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. However, if a three-tier classification system were to be retained, this issue could be addressed by a statutory provision that put in place a system for regular review of classification decisions.
- 9.55 The final criticism is that the 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. However, in our view, this does not mean 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.

#### OPTIONS FOR REFORM OF THE CLASSIFICATION SYSTEM

#### Reform of the current classification system

- 9.56 There is a range of options for reforming the current classification system.

##### *Option 1: A single maximum penalty for all drugs*

- 9.57 Under this option, the ABC classification would be dispensed with. Substances would be classified as controlled drugs but not broken into classes in legislation. 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). Some of these are discussed in chapter 10.)
- 9.58 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 were 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. But a major difficulty would be that there would be no systematic way of informing the judiciary about the different harms associated with different drugs.
- 9.59 The main advantage of this option 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 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). It seems desirable that Parliament give greater guidance than this as to the maximum penalties that should apply to drug offences that involve widely varying degrees of harm.

- 9.60 A variant on this option 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 real 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.

### *Option 2: A two-tier classification system*

- 9.61 Under this option, there would be one tier of the classification system for seriously harmful drugs and one tier for less harmful drugs.
- 9.62 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 views 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”.

### *Option 3: Retain the current three-tier classification system*

- 9.63 The advantage of this option is that it may discriminate more accurately than a two-tier system between the different levels of harm posed by different drugs. It gives a clearer signal about the level of penalty Parliament intends for certain types of offending involving particular drug types. Against that, the current difficulties with classifying drugs would remain, although at least some of these could be avoided by a provision for regular review of classification decisions. Provision for regular review would ensure that such decisions were kept up-to-date with developing scientific knowledge and relevant changes in the drug landscape.
- 9.64 If this system is retained, it will be important that there is a full scale review to assess the appropriate drug classification of current drugs before any new legislation is passed. It is clear that some of the current classifications are inconsistent with what is now known about drug harms. For example, if we generally accept the Nutt/Blakemore scheme for assessing harm, it would seem to follow that 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, it would also be desirable that there is continual and regular monitoring and evaluation of the effects of classification decisions and of any changes that are made to them.

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

- 9.65 Under this option, further tiers could 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.
- 9.66 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. However, this option also has real difficulties. The problems surrounding the accurate measurement of drug harms discussed earlier would be exacerbated under this option. The more tiers in the system, the harder it would become 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.

**Q13** Do you favour:

- (a) no classes and a single maximum penalty for all drugs;
- (b) a two-tier classification system;
- (c) retention of the current three-tier system based on an improved assessment of risk and regular reviews;
- (d) a more nuanced classification system (four-tier plus) based on a scientifically based drug harm matrix;
- (e) some other approach? (please specify)

### Defining harm

- 9.67 If a classification system is retained, as it would be under options 2 to 4, there needs to be criteria to determine the classification to be applied to each substance.
- 9.68 Section 4B of the Misuse of Drugs 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 are intended to 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.

- 9.69 In our view, there are problems with the approach to these criteria. The current classification system is 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 factors are therefore taken into account in deciding whether or not a drug should be prohibited as are taken into account in deciding maximum penalties for drug offences. But these are very different decisions which depend upon quite different considerations.
- 9.70 As we outlined in chapter 8, except where there are international obligations, decisions about whether and how to regulate drugs should be based on which regulatory approach will most effectively minimise drug-related harm. Decisions about maximum penalties for drug offences depend on an assessment of how culpable it is to deal with the substance. The level of culpability depends in turn on how much harm is caused to others by the particular conduct involving the drug.
- 9.71 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 is relevant to the way it is regulated, including the possibility of making it available on prescription. However, once it has been decided to prohibit a substance (whether it is available on prescription or not), it is difficult to see the relevance of a substance's therapeutic value to penalty levels for its misuse. In our view, the list of factors that determine a drug's classification for penalty purposes needs to be different from the list of factors that determine the way it is regulated.
- 9.72 The most important consideration for determining maximum penalties for drug offences is how much harm is caused to others by any particular substance. 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. This kind of assessment is also necessary to inform decisions about drug regulation.
- 9.73 We have already outlined the 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 used in the Nutt/Blakemore scheme (set out in paragraph 9.30 above) should be taken into account.<sup>703</sup>
- 9.74 More controversial is the relevance of prevalence. Section 4B(2)(a) of the Misuse of Drugs Act 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. However, in our view, prevalence is not a relevant factor 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

<sup>703</sup> Dr Doug Sellman and others in New Zealand have begun some work on developing a scale for assessing the risks different drugs pose to public health.

causes, not for harm that is done by others. In any event, there is no evidence that giving drug offences higher maximum penalties does act as a deterrent, as the United Kingdom reports make clear.

- 9.75 Another factor seen 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 different classification systems are used in different countries and not all systems are evidence-based. Instead, there should be a requirement to consider assessments of drug harms undertaken both in New Zealand and in other jurisdictions. There is increasing interest internationally in the development of scientifically based indices of drug harms. The AMS report also suggests ways in which drug harms can be measured in a more objective way. It is appropriate that developments in this area are taken into account when making assessments of drug harms.
- 9.76 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.
- 9.77 The next issue is how harm is to be assessed. The Nutt/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 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. Implicit in this is the suggestion that objective criteria should replace subjective assessment.
- 9.78 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 can be given to the different types of drug harms (that is, physical harms, likelihood of dependence and social harms) as the Nutt/Blakemore scheme contemplates. The judgements are more nuanced than that. There are also significant gaps in the evidence. Notwithstanding these difficulties, we suggest, expert advice on drug harms can and should inform decisions about drug regulation and the penalties for drug offences. Without this, it is doubtful whether good policy outcomes can ever be achieved because of the controversial and emotive nature of drug issues. We discuss the possible composition of an expert advisory committee next.



Q14 Do you agree that there should be separate criteria for the decision to regulate a drug and the decision to classify a drug in order to determine penalty? Is it appropriate to classify drugs on the basis of their risk of harm? If so, should harm include physical harms, dependence potential and social harms? Is prevalence a relevant factor in defining drug harm? Are any other factors relevant?

## The role of an expert advisory committee

9.79 Section 5 of the Misuse of Drugs Act 1975 authorises the Minister of Health to establish advisory and technical committees. As we have noted, legislative amendments in 2000 required the Minister to establish an Expert Advisory Committee on Drugs (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.

9.80 We note that the ACMD in the United Kingdom has a much broader role than the EACD in New Zealand. This includes, for example, a role in advising on matters such as drug education and treatment.

9.81 In our view there is a need for a statutory committee (or sub-committee) of experts to advise the Government on the nature and severity of drug harms to inform decisions about how drugs should be regulated and the penalties for drug offences. The existence of a statutory committee will ensure that expert evidence about the nature and severity of drug harms is at least considered when making these decisions.

- 9.82 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.
- 9.83 Four issues with an expert committee arise:
- whether the committee should be independent;
  - whether the expert committee should retain consumer representation;
  - whether the current composition of the committee has the necessary expertise to advise Government on drug regulation and classification; and
  - the size of the committee.

#### *Independence of the committee*

- 9.84 There are arguments both for and against government representation on the committee. The arguments for including government representation is that this 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 might 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.
- 9.85 However, there are also strong 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.
- 9.86 On balance, we consider that an independent committee is the better option. At the very least the chair 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.

### Consumer representation

- 9.87 The reason for having an expert committee is to ensure that decisions on drug policy are evidence-based. There may therefore be an argument that consumers lack the necessary expertise to advise on the nature and severity of drug harm. Against that, consumers may be able to provide some insight into the likely impact of alternative regulatory approaches, this being an area where the evidence is currently lacking. At least until some experience has been gained with alternative regulatory approaches, this may be some of the best evidence available.

### Committee expertise

- 9.88 We consider that expertise in pharmacology, toxicology, drug and alcohol and drug treatment and community medicine is important and should remain. We would, however, add to that list neuroscience, emergency medicine, psychiatry and expertise in drug policy, research and evaluation. What we have in mind for the latter is a person who is able to contribute up-to-date information on developments in other jurisdictions, including information about alternative regulatory approaches and the evidence of their effectiveness.

### Committee size

- 9.89 The optimal size for a committee of this type would be about eight people. This should be sufficient to cover the needed areas of expertise without becoming unduly large and cumbersome. We propose a committee of eight people who between them have appropriate expertise in one or more of the following: pharmacology, toxicology, drug and alcohol treatment, psychology, community medicine, neuroscience, emergency medicine, psychiatry and expertise in drug policy, research and evaluation.

**Q15** Do you agree that there is a need for an expert committee to advise on drug regulation and drug classification (if a classification system is retained)? Should the committee be independent? Should it have consumer representation? What expertise is required? What is the committee's optimal size?

### Controlled drug analogues

- 9.90 The current classification system makes explicit provision for controlled drug analogues. A controlled drug analogue is a substance that has a structure substantially similar to that of a controlled drug unless that substance is itself listed as a controlled drug or is a pharmacy-only medicine, a prescription medicine or a restricted medicine regulated under the Medicines Act 1981.<sup>704</sup> Whenever a substance is classified as a controlled drug, all of its analogues, unless they are themselves already classified as controlled drugs or medicines, are Class C drugs by default.<sup>705</sup>

<sup>704</sup> Misuse of Drugs Act 1975, s 2(1).

<sup>705</sup> *Ibid.*

- 9.91 The analogue provision has proved reasonably effective in recent years at catching emerging new substances that are structurally similar to controlled drugs, but that are not prohibited under the Act. This has meant that these substances are automatically prohibited. However, providing a default classification is something of a compromise because it involves trying to anticipate the development of new drugs that might become a problem in the future. We understand that an analogue does not necessarily have a similar risk of harm as its parent drug; it may be more or less potent or harmful, or its potency or risk of harm may be unknown.
- 9.92 Currently, an assessment of the evidence of harm associated with an analogue is not required, so that these substances are not normally assessed by the EACD. Also, even if an analogue is assessed by the EACD against the criteria in the Act and is found to have a lower than moderate risk of harm, it cannot have its classification as a Class C drug removed, because the Act does not allow for this. (Analogues that have therapeutic purposes and are classified as medicines are excluded from Class C, but analogues that do not have therapeutic purposes (even if they have a low or no risk of harm) will always remain Class C drugs simply because they are analogues.)
- 9.93 We suggest that some changes are needed here. Assuming that the current classification system largely remains intact, the default classification as Class C should be retained. However, this should be an interim measure that applies only until the drug analogue has been assessed against the criteria in the Act and classified. If it would not qualify, based on its own harm profile, for inclusion in Class C, it should be removed.

Q16 Do you agree that controlled drug analogues should by default be included as Class C drugs, but only on an interim basis so that they can be evaluated and appropriately classified?

#### THE CLASSIFICATION PROCESS

- 9.94 As we outlined earlier, an amendment in 2000 provided for drug classification decisions to be made by Order in Council subject to an affirmative resolution procedure. The ability to classify through primary legislation remains as occurred with BZP. Primary legislation is also required, as noted earlier, to reduce the classification of any drug.
- 9.95 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.<sup>706</sup>

<sup>706</sup> See Misuse of Drugs Act 1975, s 4A.

- 9.96 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”.<sup>707</sup> 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 ability to respond quickly to the creation of new synthetic or designer drugs.<sup>708</sup> The affirmative resolution procedure was intended to provide a check on Executive power.
- 9.97 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.<sup>709</sup>
- 9.98 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 to reduce them. George Tanner, then Chief Parliamentary Counsel, in a 2004 submission to the Regulations Review Committee described the problem as follows:<sup>710</sup>
- 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.
- 9.99 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”.<sup>711</sup> In addition, Orders in Council are delegated legislative instruments and are therefore vulnerable to challenge on the ground of *ultra vires*.<sup>712</sup> 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.
- 9.100 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.

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

708 Hon Georgina Te Heuheu (Associate Minister of Health) (5 October 1999) 580 NZPD 19707-19708.

709 George Tanner “Submission by Chief Parliamentary Counsel to Regulations Review Committee – Inquiry into Affirmative Resolution Procedure”.

710 Ibid.

711 Ibid, 12.

712 *Ultra vires* is a Latin phrase that literally means “beyond the powers”.



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 10 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 outlined in chapter 5, technically the 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<sup>713</sup> rests on a misunderstanding of the current law.

- 9.101 In our view the Order in Council procedure is not justified and brings with it an unacceptable risk of challenge. Drug classification decisions require full parliamentary scrutiny.
- 9.102 However, the Order in Council procedure does have one significant strength. As we outlined earlier, 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. As we have noted earlier, we consider that drug classification decisions are informed by expert evidence if good outcomes are to be achieved, given the controversial and polarising nature of drug issues and emotional reactions to them.
- 9.103 Therefore, if the procedure is abolished, we suggest there should be a requirement that the Minister present to the House a report from the expert committee at the time legislation is introduced, or as soon as reasonably practicable thereafter in the case of a Member's Bill. The report should spell out the nature and extent of the harm associated with the substance being classified, the available evidence about what regulatory approach would best minimise that harm, and which broad harm category the substance fits into. This would ensure Parliament's decisions and public debate are fully informed by independent and expert advice. We note that the Act has in the past given the Minister a function of providing and publishing reports, information, and advice concerning the misuse of drugs.<sup>714</sup>
- 9.104 If the Order in Council process is retained, it is more logical that the procedure should also be available for downward classifications and removing substances. It is anomalous that the Order in Council 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).

713 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.

714 Section 4A as inserted by section 2 of the Misuse of Drugs Amendment Act 1978 provided that "the functions of the Minister, on behalf of the Crown, shall include the provision and publication of reports, information and advice concerning the misuse of drugs and the treatment and rehabilitation of persons suffering from the misuse of drugs". This section was repealed in 2000 when the EACD was established.

Q17 Do you agree that drug classifications should be made by primary legislation rather than by Order in Council? If so, should there be a requirement for the Minister to table an expert report on drug harms when legislation is introduced?

Q18 If the Order in Council process is retained, should it be available for reducing classifications as well as increasing them?

# Chapter 10

## Dealing

### SUMMARY

This chapter considers the offences for dealing in controlled drugs contained in the Misuse of Drugs Act 1975 and considers options to deal with problems arising from these offences.

**INTRODUCTION** 10.1 The Misuse of Drugs Act 1975 creates offences for dealing in controlled drugs. This includes sale and supply, possession for sale or supply, importation, exportation, manufacture, production and cultivation. As currently drafted, these offences are potentially problematic because of the broad range of activities that they cover. The offence of possession for supply and the presumption of supply, which reverses the onus of proof, is also controversial. This chapter will consider the structure of the dealing offences in detail.

### CURRENT OFFENCES

- 10.2 Section 6(1) of the Misuse of Drugs Act 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).
- 10.3 Under section 7(1)(b), it is 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”.
- 10.4 It is also an offence under section 9 of the Act to cultivate prohibited plants.

## Should sale and supply be treated differently?

- 10.5 Under the Misuse of Drugs Act, supply is defined to cover distributing, giving or selling.<sup>715</sup> It therefore covers gratuitous supply.
- 10.6 In contrast, sale requires some form of consideration or value. The Act distinguishes sale from supply according to the class of the drug in question.
- 10.7 It is an offence under section 6 to supply Class A and B drugs, whether the supply is for consideration or not. But, under section 6, it is only an offence to supply Class C drugs to a person under 18 or to sell them to a person of or over 18 years of age. Supply of Class C drugs to adults is dealt with in section 7 and is treated as having a lower level of criminality – that is, the same criminality as a possession or use offence.
- 10.8 The harm caused by drugs is the primary rationale for the criminalisation of dealing. However, the distinction between sale and supply in relation to Class C drugs reflects a view that the culpability of an offender is greatest when supply is coupled with a profit. It is difficult to see why a profit motive would aggravate a Class C drug offence but not an offence involving Class A or B drugs. In any event, we are not convinced that this view is correct. The supply of a large quantity of drugs will always cause significant harm, whether or not any money changes hands. It does not seem right that an offender who supplies these drugs without consideration should invariably be considered to be less culpable than an offender who makes a profit, no matter how small. While the profit motive aggravates culpability and is therefore relevant to sentence, it is not so central to the legislative objective to the extent that it justifies a separate offence. 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 will the fact that a commercial dealer supplies a large quantity of drugs to a vulnerable young person for free for the purposes of developing a future market.
- 10.9 In our view, therefore, the scale of the transaction is more important to an assessment of culpability than whether it can be proved that money changed hands. The degree of profit involved will remain relevant to this assessment; a very small quantity will suggest non-commercial offending, while a very large quantity will suggest offending motivated by profit. However, a focus on scale recognises that other factors are equally as relevant, particularly the amount of drugs involved in the transaction and the overall size of the offender's dealing operation.
- 10.10 For these reasons, we consider that the scale of offending rather than proof of sale is a more accurate measure of the culpability of the offender. Distinguishing offences of supply in this way removes the need to distinguish sale from supply.

<sup>715</sup> Misuse of Drugs Act 1975, s 2.

Q19 Should the scale of supply rather than whether or not the supply was for profit be the focus of the supply offence?

### Scale of supply

- 10.11 If it is accepted that supply should be distinguished according to the scale of the offending rather than whether a sale has taken place, it is necessary to consider how this should be done. There appear to be two options:
- (a) include scale as an element of the substantive offence; or
  - (b) treat scale as a sentencing matter.

### *Should scale be part of the offence?*

- 10.12 The first option is to incorporate scale in the definition of the offence. This approach has been adopted in a number of Australian jurisdictions. In those jurisdictions, offences are framed in terms of the quantity of drugs rather than the class of drug involved (as is the case in New Zealand).
- 10.13 An example of this approach is that taken to drug trafficking in Australia's Federal Criminal Code. There are three graded offences:
- base level trafficking, which covers sales or other prohibited conduct involving any quantity of a controlled drug;
  - trafficking in "marketable quantities" (a "marketable quantity" is defined, for example, as 25,000 grams or more of cannabis and 250 grams or more of methamphetamine);
  - trafficking in "commercial quantities" (a "commercial quantity" is defined, for example, as 125,000 grams or more of cannabis and 750 grams or more of methamphetamine).
- 10.14 A legal presumption also operates in relation to all three offences. Where the amount of the drug involved is a "trafficable quantity", it is presumed that the defendant intended to sell the substance or believed that another person intended to sell the substance.<sup>716</sup> A "trafficable quantity" is set, by way of example, at 250 grams or more of cannabis and at 2 grams or more of methamphetamine.<sup>717</sup> The defendant has the burden of proving that he or she did not have the requisite intention.

<sup>716</sup> Criminal Code 1995 (Cth), 302.5. See also commercial cultivation of controlled plants (ss 303.4–303.7), commercial manufacture of controlled drugs (ss 305.3–305.6), and pre-trafficking controlled precursors (ss 306.2–306.5) which follow a similar pattern to trafficking. Importing and exporting follow a different pattern. The offences are based on the quantities as above. There are two offences relating to importing or exporting any quantity, one with a defence if the person proves he or she did not intend to sell or did not believe that another person intended to sell the substance (s 307.3) and one without such a defence and a correspondingly lower penalty (section 307.4).

<sup>717</sup> As the trafficable quantities are lower than commercial and marketable quantities, the presumption will always operate where a person is charged with trafficking in commercial or marketable quantities.



- 10.15 If offences were to be defined according to the scale of the offending, some distinctions on the basis of quantity along the Australian lines would need to be made. The Australian Model Criminal Code Officers Committee, on which the Federal Criminal Code is based, considered that “[q]uantity provides the most realistic measure of the commercial magnitude of the unlawful enterprise”.<sup>718</sup>
- 10.16 However, quantity often presents an incomplete picture of the scale of the offending. To get a full picture of scale it may be necessary to take into account other circumstances. For example, in *R v Fatu*, the Court of Appeal 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)”.<sup>719</sup> Despite expressing concern about basing sentencing on activity that the Crown has not directly proved, the Court noted that it needed to take a realistic view and that the “practical potential of the operation” must be relevant to an offender’s sentence.<sup>720</sup>
- 10.17 We agree. The quantity of drugs actually seized, or otherwise proved to have been supplied, is only one measure of scale.
- 10.18 However, considerations beyond quantity are too diverse to be readily incorporated into an offence definition in the substantive offence. Moreover, an offence structure that focuses 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.

### *Should scale be a sentencing matter?*

- 10.19 The second option, that scale be reflected in the sentence an offender receives, is the current position in New Zealand. This allows more flexibility as to the factors that can be taken into account when determining the seriousness of supply. In addition to quantity, such factors include:
- the value of drugs involved;
  - any evidence of supply taking place (tick lists, payment records, cash reserves, asset accumulation);
  - the offender’s role (unexplained income, the identity of the customers, how sale was initiated).
- 10.20 We favour this option. Judges have shown an ability to effectively consider these factors when assessing the scale of offending. From time to time the Court of Appeal has also issued guideline judgments that have created bands of seriousness,

<sup>718</sup> Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General *Model Criminal Code: Chapter 6: Serious Drug Offences: Report* (1998) 67.

<sup>719</sup> *R v Fatu* [2006] 2 NZLR 72, para 37.

<sup>720</sup> *Ibid*, para 40.

with accompanying sentence ranges, for different scales of offending.<sup>721</sup> Guideline judgments provide a mechanism to ensure a consistent approach is taken to assessments of scale.

Q20 Do you agree that the scale of offending should be treated as a sentencing matter rather than be reflected in the offence?

### Social supply

- 10.21 Although scale should generally be treated simply as a sentencing matter, there is a class of supply that we consider should be carved out for separate treatment. This class of supply is “social supply”, where supply is of a very low level, among friends or acquaintances, without profit or with a very small profit, and with no significant element of commerciality.
- 10.22 The reasons for distinguishing this type of offending are that:
- the absence of any significant commerciality makes its criminality more analogous to possession;
  - 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.
- 10.23 Treatment can be incorporated into the court process in a variety of ways, through intermediate court-based diversion programmes through to full drug courts, and from pre-charge through to post-sentence. We discuss the need for greater use of drug treatment in the court system more fully in chapter 15.
- 10.24 The offence in section 7(1)(b) (supply of a Class C drug to adults) is effectively a social supply offence. It treats the 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.<sup>722</sup>
- 10.25 However, the offence is currently limited in scope. It only applies to Class C drugs, and focuses solely on whether money has changed hands. As noted above, we have reservations about this latter approach, particularly its failure to have regard to equally important factors such as the amount of drugs involved. We think a new, broader approach is required.
- 10.26 It is necessary to consider how that approach might be implemented. The first option is to create a separate offence. However, it would be difficult to frame such an offence and to provide a precise statutory definition of what constitutes social supply. Although social supply would always involve small amounts of the drug in question, there would be a number of other relevant factors to consider, such

721 See for example, *R v Fatu*, above n 719, for supply of methamphetamine; *R v Ulrich* [1981] 1 NZLR 310 for dealing in class A drugs; *R v Wallace* [1999] 3 NZLR 159 the guideline judgment for dealing in Class B drugs; *R v Terewi* [1999] 3 NZLR 62 for cannabis cultivation and dealing; and *R v Xie* [2007] 2 NZLR 240 for importation of pseudoephedrine.

722 In these debates, one MP, Dr Wall referred to this type of behaviour as “a social ‘shout’” (18 July 1975) 399 NZPD 3148.

as whether the offender was using the drugs, whether the supply was among friends and acquaintances and whether any profit or commerciality was involved. These factors could not be accurately incorporated into a statutory definition.

- 10.27 Nor would it be workable to establish an offence of social supply based solely on the amount of drug supplied. The relevant amount would vary from drug to drug and would need to be set on a drug by drug basis much like the presumption for supply. This would be difficult to implement, and require significant work to establish and keep up-to-date. It would also entail arbitrary thresholds.
- 10.28 These difficulties have led us to the view that social supply should be distinguished at a sentencing level. Doing so would ensure there are appropriate penalties and therapeutic options available to people who engage in social supply.
- 10.29 There is some evidence that this would be largely in line with public opinion on the seriousness of such conduct and the way in which it should be responded to. As part of the Law Commission's current review of maximum penalties across all major offences, it commissioned Colmar Brunton in 2009 to undertake public consultation on how criminal offences should be ranked in terms of seriousness. Eight focus groups in Auckland, Wellington, New Plymouth, Christchurch and Ashburton were given 28 selected crime scenarios and asked to rank them. They then discussed the reasons for their respective rankings and were asked to re-rank the scenarios following the discussion. One of the scenarios was possession for social supply. Prior to the discussion it was ranked 28, the least serious offence (below minor theft) and after the discussion it was ranked 26.<sup>723</sup>
- 10.30 One option for dealing with social supply is to introduce a presumption against imprisonment. Such a presumption exists currently for supply of a Class C drug to an adult under section 7(1)(b).
- 10.31 We suggest that the presumption could apply where the judge was satisfied that the following circumstances indicating social supply existed:
- the supply was in small quantities;
  - the offender was also using the drugs;
  - the supply was to friends or acquaintances;
  - the offending was not motivated by profit.
- 10.32 Unlike the provision in section 7, this would apply regardless of the class of the drug.

Q21 Should social supply be treated differently from other types of supply for all classes of drugs? Should the factors that indicate social supply be broadened as set out in paragraph 10.31?

Q22 If so, do you agree that social supply should be dealt with as a sentencing matter rather than through the creation of a separate offence?

<sup>723</sup> Colmar Brunton *Review of Maximum Penalties: Consultation to Understand Public Reasoning for Ranking Crime* (Wellington, 2009).

Q23 Should there be a presumption against imprisonment in cases of social supply?

### Maximum penalties

- 10.33 Currently the maximum penalties for supply offences depend on the class of drug in question. The question of how to set maximum penalties in a new legislative regime will depend, in part, upon the decisions made in relation to the classification system. This includes whether New Zealand continues to have different classes of drugs and, if so, how many classes there are.
- 10.34 Offences under section 6 carry a maximum penalty of imprisonment for life in relation to a Class A drug, 14 years imprisonment in relation to a Class B drug and eight years imprisonment in any other case.<sup>724</sup> 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.
- 10.35 The maximum penalty for cultivation under section 9 is seven years imprisonment.<sup>725</sup> The maximum penalty for supply of a Class C drug under section 7(1)(b) is three months imprisonment and/or a \$500 fine.
- 10.36 The penalties in place in other jurisdictions tend to depend on the offence structure and whether the jurisdiction in question has a classification system in place. Penalties in other jurisdictions tend to be set having regard to the following factors:
- the quantity of the drug in question;<sup>726</sup>
  - a drug's classification;<sup>727</sup>
  - a drug's quantity and classification; or
  - a high maximum penalty for all offending.<sup>728</sup>
- 10.37 While it is difficult to draw direct comparisons given the different approaches, looking at the sentences for the most serious offending in each jurisdiction is nevertheless instructive. Table Two below sets out the maximum penalties for the most serious level of supply or trafficking in New Zealand, Australian jurisdictions, Canada, and the United Kingdom.

724 Misuse of Drugs Act 1975, s 6(2). Where a person is summarily convicted in relation to a Class C drug the maximum penalty is one year imprisonment or \$1000 fine (Misuse of Drugs Act, 1975, s 6(3)). As part of the Criminal Procedure (Simplification) Project, it is proposed to remove those maximum penalties that apply upon summary conviction.

725 The maximum penalty is 2 years imprisonment or \$2000 when tried summarily.

726 Criminal Code (Cth); Criminal Code 2002 (ACT); Drug Misuse and Trafficking Act 1985 (NSW); Controlled Substances Act 1984 (SA); Drugs, Poisons and Controlled Substances Act 1981 (Vic).

727 Controlled Drugs and Substances Act SC 1996 c 19 (Canada); Misuse of Drugs Act 1971 (UK).

728 Misuse of Drugs Act (NT); Drugs Misuse Act 1986 (Qld).

TABLE TWO:

Comparison of maximum penalties across jurisdictions

Jurisdiction	Offence	Penalty
<b>Misuse of Drugs Act 1975 (NZ)</b>	Supply of Class A drugs (section 6)	Life
<b>Criminal Code (Cth)</b>	Trafficking in commercial quantities	Life or 7500 penalty units or both
<b>Criminal Code 2002 (ACT)</b>	Trafficking in large commercial quantities	Life
<b>Drug Misuse and Trafficking Act 1985 (NSW)</b>	Supply in large commercial quantities (section 25)	Life or 5000 penalty units
<b>Misuse of Drugs Act (NT)</b>	Supply of commercial quantities of a Schedule 1 drug to an adult (section 5)	25 years
<b>Drugs Misuse Act 1986 (Qld)</b>	Trafficking Schedule 1 drug (section 5)	25 years
	Supplying Schedule 1 drug (section 6)	20 years
<b>Controlled Substances Act 1984 (SA)</b>	Trafficking in large commercial quantity	Life or \$500,000 or both
<b>Misuse of Drugs Act 2001 (Tas)</b>	Trafficking (section 12)	21 years
<b>Drugs, Poisons and Controlled Substances Act 1981 (Vic)</b>	Trafficking in large commercial quantities	Level 1 imprisonment (life) and 5000 penalty units
<b>Misuse of Drugs Act 1981 (WA)</b>	Supplies (section 6(1))	25 years or \$100,000 or both
<b>Controlled Drugs and Substances Act SC 1996 c 19 (Canada)</b>	Trafficking in Schedule 1 or 2 drug (section 5)	Life
<b>Misuse of Drugs Act 1971 (UK)</b>	Supply of Class A drug	Life

- 10.38 As shown, the maximum penalties for the most serious offending are broadly similar across jurisdictions, ranging from 20 years to life imprisonment. In a number of the Australian jurisdictions, much higher penalties are available for dealing in large quantities of drugs classified as Class B or C in New Zealand. Conversely, much lower penalties are available for dealing in small quantities of drugs classified as Class A here. However, this is a consequence of the different offence structures in these jurisdictions. In practice it is of little significance, as the nature of the drugs involved will be taken into account by the judge in determining a sentence within the maximum penalty prescribed in Australian jurisdictions.
- 10.39 Under section 6, the maximum penalty for supply of a Class C drug to a person under 18, or for sale of a Class C drug to a person of or over 18, is eight years imprisonment. In contrast, under section 7 the maximum penalty for supplying a Class C drug to a person over 18 is three months imprisonment. We propose that these offences be combined into a single offence (see above, paragraphs

10.5–10.10 and below paragraph 10.52). It is therefore necessary to consider what the maximum penalty for the worst class of such an offence should be (presumably large-scale commercial supply to minors).

- 10.40 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. Moreover, Class C drug dealing is the only offence in the statute book with a maximum penalty of eight years, thus making it out of step with the framework of maximum penalties. We therefore propose that the maximum penalty for the new combined offence be seven years.
- 10.41 We do not anticipate that this would necessarily result in a reduction in actual sentence levels. We note that in 2004 to 2006 90 % of sentences were at or below two and a half years imprisonment and the highest sentence was six years two months.
- 10.42 A maximum penalty of seven years would be the same as the penalty that currently attaches to cultivation under section 9. This would make it consistent with the approach taken to Class A and B drugs, where supply has the same maximum penalty as manufacture.

Q24 Should the current maximum penalties for the supply of Class A (imprisonment for life) and Class B (14 years imprisonment) drugs be maintained?

Q25 Do you agree that seven years imprisonment is an appropriate maximum penalty for the supply of Class C drugs?

### Presumptions for and against imprisonment

- 10.43 Section 6 contains a presumption of imprisonment in relation to dealing in Class A drugs.<sup>729</sup> As noted above, section 7 contains a presumption against imprisonment for supply of Class C drugs to adults.
- 10.44 Presumptions for and against imprisonment are a form of statutory guidance about the type of sentence that should be given. Apart from those in the Misuse of Drugs Act, the only statutory presumptions in existence are for murder and sexual violation.<sup>730</sup>

<sup>729</sup> 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).

<sup>730</sup> Sentencing Act 2002, s 102; Crimes Act 1961, s 128B.



- 10.45 We have earlier proposed that there be a statutory presumption against imprisonment in relation to social supply. This will replace the presumption against imprisonment in section 7.
- 10.46 We think that a statutory presumption of imprisonment may still be appropriate in relation to the most serious dealing offences – for example, large-scale commercial dealing of Class A drugs. Offending of this magnitude is of the highest culpability and is likely to cause significant harm to the community. Imprisonment in all but the most exceptional cases therefore seems appropriate. However, the current presumption will need to be modified to exclude social supply.
- 10.47 We doubt whether this presumption should extend to large-scale dealing of Class B and C drugs. The current presumption in favour of imprisonment does not do so. The allocation of drugs to these classes indicates that they are inherently less harmful than Class A drugs. While current tariffs do prescribe imprisonment, particularly for substantial dealing, a statutory presumption in favour of imprisonment for all dealing other than social supply is arguably unnecessary.

Q26 Should there be a presumption in favour of imprisonment for Class A drugs in cases of large-scale commercial offending?

Q27 Do you agree that the presumption of imprisonment should not extend to Class B and C drugs?

### Should supply to under 18 year olds be treated separately?

- 10.48 As noted above, the Act makes a distinction between the supply of Class C drugs to adults (the offence in section 7(1)(b)) and the supply of Class C drugs to young people (the offence in section 6(1)(d)). This distinction is based on a view that there is greater harm involved in the supply of drugs to young people. It is currently necessary to single this conduct out in relation to Class C drugs, as supply of Class C drugs to persons over 18 years of age under section 7(1)(b) is treated as a less serious offence. The current section 6(1)(d) does not sit well with our proposed removal of the distinction between sale and supply.
- 10.49 There may still be justification for having an offence of supply to those aged under 18, with a higher maximum penalty than general supply.<sup>731</sup> The rationale for this offence would be to protect young people on the basis of evidence showing that drug use is more harmful to young people than to adults and in light of the particular vulnerability of children and young people. The latest New Zealand research suggests that drug use before the age of 15 increases the risk of a range of poor outcomes, including involvement in crime and early pregnancy.<sup>732</sup>

<sup>731</sup> This could not of course apply to supply of Class A drugs as the penalty is life.

<sup>732</sup> See Candice L Odgers and others “Is it Important to Prevent Early Exposure to Drugs and Alcohol among Adolescents” (2008) 19 Psychological Science 10.

- 10.50 In the Australian Federal Criminal Code, there are a number of distinct offences relating to the supply of drugs to children, including supply for the purposes of trafficking, and the use of children in trafficking activities.<sup>733</sup>
- 10.51 In the Law Commission's recent review of crimes against the person, it recommended that certain victim-specific offences (assault on a child and male assaults female) be repealed.<sup>734</sup> This was on the basis that victim-specific offences:<sup>735</sup>
- may lead to inconsistent charging practice as the victim-specific offence will inevitably overlap with the generally applicable offence and police have discretion at the charging stage to select the offence under which the offender will be charged;
  - create an arbitrary disparity from singling 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.
- 10.52 For these reasons, we do not believe that a specific offence of supply to those aged under 18 is justified. The maximum penalty for the generic offence instead needs to be 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.<sup>736</sup>

**Q28** Do you agree that, in relation to Class C drugs, supply to those under 18 years of age should be an aggravating factor on sentence rather than a separate and more serious offence?

**Q29** Are any other offences in this area required?

## POSSESSION FOR SUPPLY

### Nature of the offence

- 10.53 The offence of possession for supply in section 6(1)(f) of the Misuse of Drugs Act differentiates possession for the purposes of supply to others from possession of a small quantity of drugs for personal use.
- 10.54 The Act treats possession for supply as similar to the offence of supply.

<sup>733</sup> Criminal Code (Cth), s 309.

<sup>734</sup> New Zealand Law Commission *Review of Part 8 of the Crimes Act 1961: Crimes Against the Person* (NZLC R 111, Wellington, 2009) paras 3.21–3.22, 3.29.

<sup>735</sup> *Ibid*, para 3.4.

<sup>736</sup> See Sentencing Act 2002, s 9(1)(g).

## Presumption of supply

- 10.55 The key legal issue arising in relation to the offence of possession for supply is the matter of proof of the defendant's intention to supply the drugs. Under the Misuse of Drugs Act, this is 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)).

- 10.56 This presumption reverses the onus of proof so that, to avoid a conviction, a defendant who is in possession of the requisite quantity of the drug in question must prove on the balance of probabilities that he or she was not in possession of the drug for supply.

- 10.57 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:<sup>737</sup>

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.

- 10.58 There are a number of arguments for having such a presumption. If there was no presumption, it would sometimes be difficult for the prosecution to prove that the accused was in fact in possession of 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 purpose. In that event, 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 jury that the accused 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 are said to justify the reversal of the onus of proof.

- 10.59 A related argument put forward in support of placing the onus of proof on the defendant is that the defendant must give evidence about his or her own usage, something that he or she is uniquely placed to prove. However, this argument 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 profits 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.

<sup>737</sup> United Nations *Commentary on the Single Convention on Narcotic Drugs 1961* (United Nations) article 4, para 21.

- 10.60 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.
- 10.61 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.<sup>738</sup>
- 10.62 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 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.
- 10.63 Given the Supreme Court's conclusion in relation to the presumption in section 6(6), the question arises as to how to best address the problems of proof that the presumption seeks to remedy, while respecting the fundamental protection conferred by section 25(c). We consider that there are four options:
- (a) to remove the presumption;
  - (b) to repeal the offence of possession for supply;
  - (c) to establish an evidential onus;
  - (d) to retain the presumption, but in a form that can be justified under section 5 of the Bill of Rights Act.

#### *Option (a) – No presumption*

- 10.64 The first option is to have the offence of possession for supply without any presumption. This is the situation in Canada, where there is an offence of possession for the purpose of trafficking but no presumption in the legislation.<sup>739</sup> This would be consistent with the Bill of Rights Act. However, its practical effect would be likely to be increases in cost and time due to the prosecution having to call expert witnesses to make out the case. It would be likely to make it significantly more difficult to prove that a person intended to supply the drugs in his or her possession.
- 10.65 This approach also overlooks the fact that a presumption is likely to facilitate consistency in charging practice. In the absence of such a presumption, individual police officers will have to determine whether a quantity is sufficient to charge as possession for supply or not. These decisions are likely to vary from one police district and one police officer to another. The potential for such inconsistency was recognised recently in the United Kingdom, after a proposal to introduce an

<sup>738</sup> *R v Hansen* [2007] 3 NZLR 1 Tipping, Anderson and McGrath JJ. Elias CJ did not think that section 5 should be considered and Blanchard J considered that the limitation was justified under section 5.

<sup>739</sup> Controlled Drugs and Substances Act SC 1996 c 19, s 5(2).

evidential burden based on the quantity of the drug possessed was abandoned in 2006. Caroline Flint MP (a member of the relevant House of Commons Standing Committee) commented on the dangers of adopting *de facto* thresholds:<sup>740</sup>

I understand that in parts of the country the CPS and the police often look at the amount of possession informally. While that is not enshrined in guidance, they use it as a guide for whether they can take a case to court or not. That has not had the rigour of consultation and could lead to inconsistencies in different parts of the country.

- 10.66 This concern has also been recognised in New Zealand. In an affidavit prepared for the purposes of the *Hansen* case (but which the Supreme Court declined to admit), a specialist adviser in drug policy for the New Zealand Police deposed that without a legislative presumption of supply set at a particular quantitative threshold, there would be the potential for significant inconsistencies in charging practice.<sup>741</sup>

#### *Option (b) – No offence of possession for supply*

- 10.67 The second option is to repeal the offence of possession for supply and simply have an offence of possession. This could be done in two ways:
- (a) by dividing possession into two categories depending on quantity, with the offence relating to the higher quantity having a higher maximum penalty; or
  - (b) by having one possession offence which has a high maximum penalty and relying upon judicial sentencing guidance as to different scales of offending.
- 10.68 These approaches would both comply with the Bill of Rights Act. They would also avoid the necessity of having to call expert witnesses to prove that the amount was above levels ordinarily possessed for personal use.
- 10.69 An example of approach (a) can be seen in Queensland where there is no offence of possession for supply but the penalties for possession depend on the amount of drug involved. The worst offending, involving large quantities of a Schedule 1 drug, has a maximum penalty of 25 years, the same as the maximum penalty for supply of Schedule 1 drugs.<sup>742</sup>
- 10.70 Approach (a) runs the risk that those dealing in drugs would simply modify their behaviour by moving and possessing drugs in smaller quantities in order to avoid the risk of 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.

740 Charlotte Walsh “On the Threshold: How Relevant Should Quantity be in Determining Intent to Supply?” (2008) 19 International Journal of Drug Policy 479, 482.

741 Affidavit of Michael Webb sworn on 9 February 2006 for the purposes of *R v Hansen*, above n 738, para 14.

742 Drugs Misuse Act 1986 (Qld), s 9.



- 10.71 If approach (a) was taken it would be necessary to determine the quantity of drugs at which the higher penalty level applied. This would need to be set at a level that is likely to be inconsistent with personal use. The expert advisory committee proposed in chapter 9 could be asked to advise government on the quantity of drugs that would attract the aggravated penalty level.
- 10.72 A person charged with possession under the single offence in approach (b) would be liable to a single maximum penalty, and an intent to supply would be treated as an aggravating factor that would need to be proved by the prosecution beyond reasonable doubt under section 24(2)(c) of the Sentencing Act 2002. That would in effect be no different from leaving the possession for supply offence intact but removing the presumption.
- 10.73 In contrast, the twin offences in approach (a) would arguably have a different result. Since the aggravated possession offence would be indicative of supply, the fact that possession was for personal use 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.

#### *Option (c) – Evidential onus*

- 10.74 The third option would be to adopt an evidential onus. This would operate so that, in the absence of any evidence to the contrary, it would be presumed that the drugs were intended to be supplied, with the defendant bearing the burden of raising that evidence. However, the legal burden would not shift and once the defendant had displaced the presumption by raising sufficient evidence of the issue, the prosecution would have to prove guilt beyond reasonable doubt, including disproving the defendant's contention that he or she did not intend to supply. This type of presumption is more likely to be seen as consistent with the Bill of Rights Act.<sup>743</sup>
- 10.75 The Misuse of Drugs Act 1971 (UK) has an evidential presumption in subsections 5(4A) and (4B), which were inserted in 2005. Subsection (4A) provides that in proceedings for possession for supply, under section 5(3), a defendant who possesses over the prescribed amount of the substance is presumed to possess it for supply. However, subsection (4B) provides that subsection (4A) does not apply "if evidence is adduced which is sufficient to raise an issue that the accused may not have had the drug in his possession with intent". This change was introduced after the House of Lords decision in *R v Lambert*, which read down the previous legal presumption as an evidential presumption in order to be consistent with the Human Rights Act 1998 (UK).<sup>744</sup>

<sup>743</sup> See discussion in *R v Hansen*, above n 738. See also *R v Lambert* [2002] 2 AC 545, where the House of Lords read down a presumption in the United Kingdom's Misuse of Drugs Act 1971 to be an evidential burden. Notwithstanding the approach of the House of Lords in *Lambert*, the Parliamentary Joint Committee on Human Rights, in considering a proposed evidential presumption to be contained in the Misuse of Drugs Act 1971, concluded that it was unable to reach a definitive view on the compatibility of the proposed evidential burden in these sections due to the fact that the prescribed amounts that would lead to the burden being imposed were not found within the legislation itself.

<sup>744</sup> *R v Lambert*, above n 743.



10.76 A disadvantage of an evidential presumption is that the distinction between this and no presumption is a subtle one that is likely to be difficult for juries to understand. More importantly, it is unlikely to adequately address the problems caused by not having any presumption. 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 must prove that the defendant possessed for the purposes of supply. Therefore, in a practical sense there is very little difference between an evidential presumption and no presumption. As Blanchard J said in *Hansen*:<sup>745</sup>

[In] the vast majority of cases, a requirement for an evidential burden to be surmounted, dischargeable by adducing or pointing to some evidence which, if believed, could support the defence, would in practical (as opposed to theoretical) terms be no different from a requirement that the Crown discharge the onus of proving the requisite purpose of the accused beyond reasonable doubt.

10.77 However, other judges in *Hansen* did not share Blanchard J's view. One of the reasons for considering that the presumption was not justified under section 5 of the Bill of Rights Act was the fact that an evidential onus could have been adopted. Both Tipping and McGrath JJ considered that the impairment of the right was more than reasonably necessary because of the possibility of an evidential onus. As Tipping J said:<sup>746</sup>

It seems to me that a presumption rebuttable in terms of an evidential onus does put the Crown in a materially better position than if there was no presumption at all... I have not been persuaded that the level of forensic advantage likely to be derived by the Crown from this more easily rebutted presumption would fail to sufficiently serve the overall objective.

10.78 Tipping J also considered that the limit of the presumption was not proportionate to the objective and considered that "an evidential onus would sufficiently serve the purpose but without the same risk of convicting innocent persons".<sup>747</sup>

10.79 We share Blanchard J's assessment that the evidential onus cannot work effectively to address the difficulties of proof in a possession for supply case.

#### *Option (d) – Retain the reverse onus*

10.80 The final option is to retain the reverse onus. Two main concerns about section 6(6) emerge from the judgments in *Hansen*. The first is that the presumption in section 6(6) does not minimally impair the right as an evidential onus could be adopted (see our discussion of this option above).<sup>748</sup>

10.81 The majority also expressed concern as to the lack of clarity about the basis on which the amount of the drug was set, and whether this created a risk of wrongful conviction. This led to a view that the limit on the right was not proportionate.<sup>749</sup> Elias CJ doubted whether a reverse onus provision could ever

<sup>745</sup> *R v Hansen*, above n 738, para 79.

<sup>746</sup> *Ibid*, para 128.

<sup>747</sup> *Ibid*, para 135.

<sup>748</sup> *Ibid*, paras 128, 135 and 224.

<sup>749</sup> *Ibid*, Tipping J para 135, McGrath J para 214, Anderson J paras 276–280.

be justified.<sup>750</sup> However, there were suggestions in some other judgments that a reverse onus might be considered justified under section 5 if it were set at a high enough level to reduce or avoid the possibility of wrongful convictions resulting from operation of the presumption.

10.82 McGrath J referred to the 1975 Parliamentary debates on the enactment of the Misuse of Drugs Act, which shows that the rule of thumb for presumption levels was one month's supply for a moderate user.<sup>751</sup> He considered that where the person is in possession of an amount close to the margins, it may not satisfy the rational connection test and may lead to wrongful convictions.<sup>752</sup> However, his Honour declined to discuss whether the new process adopted in 2000 for setting the levels provided a more rational connection.<sup>753</sup>

10.83 Arguably Tipping J went further when he expressed concern about whether the presumption level in relation to cannabis plant "suggests that a supply purpose is probable, or highly probable or indeed exists beyond reasonable doubt".<sup>754</sup> In his view:<sup>755</sup>

If the level were set for each drug on the basis that possession at that level could of itself reasonably support a conclusion of possession for supply beyond reasonable doubt, there could be little objection to some form of presumption arising at that level. If the selected level was designed to show that supply was highly probable, there might be room for some concern but not much. If the level is designed to suggest only the probability of supply, by which I mean a bare balance of probabilities conclusion, then the risk of wrongly convicting people must be significant.

10.84 His Honour took the view that:<sup>756</sup>

...the Expert Committee and the Minister should be given clearer and firmer parliamentary direction on this crucial topic. Rather than having the limit influenced by the concept of a reasonable amount for personal use, I consider that to achieve compliance with s 5 Parliament should require the Minister to be satisfied that possession of the trigger amount gives rise to a high probability that such possession is for supply. Likewise any non-exhaustive indicators suggestive of a supply purpose should be consistent with that high probability.

10.85 In cases of large-scale commercial supply, it will make no difference where the burden of proof lies; the amounts will lead to a natural inference of supply, and any defence claim to the contrary will be rejected as implausible. However, there are a substantial group of cases in the middle where the absence of a reverse burden would significantly affect the prosecution's ability to secure a conviction for any offence other than possession. In such cases, while the volume of drugs might generally indicate possession for supply, it will nevertheless be impossible for the prosecution to preclude possession for personal use beyond reasonable doubt.

750 Ibid, para 41

751 Hon T M McGuigan 399 NZPD (18 July 1975) 3143 cited in *ibid*, para 210.

752 *R v Hansen*, above n 738, para 214.

753 Ibid, para 216.

754 Ibid, para 138.

755 Ibid.

756 Ibid, para 147.

- 10.86 The difficulty with Tipping J's suggestion that the presumption be set at a very high level is that it takes insufficient account of this substantial group of cases in the middle. A presumption set at this level is likely to apply to only a small number of cases. The practical effect of such a change may not be very different from removing the presumption altogether.
- 10.87 In our view, if the reverse onus is retained it must be set at a level that achieves the original Parliamentary objective of addressing the problems of proof arising in this area. Blanchard J also took the view in *Hansen* that any remedy to address the problem of proof must be effective, which is why he was persuaded that the reverse onus was necessary.<sup>757</sup>
- 10.88 This would suggest that the presumption should be required to be set at a level where the amount is unlikely to be for personal use. However, while clarifying that the presumption amounts are to be set on this basis might go some way towards achieving Bill of Rights Act consistency, there remains a significant risk that a court would find this threshold too low.
- 10.89 If the legal presumption currently contained in section 6(6) is retained, how should the threshold for the presumption in favour of possession for the purpose of supply be set? Since 2000, the Misuse of Drugs Act has contained a prescribed process by which the presumption is set. The Act establishes an Expert Committee to advise the Minister, among other things, on "the level at and over which controlled drugs to which clause 2 of Schedule 5 applies are presumed to be for supply".<sup>758</sup> The Governor-General by Order in Council may, on the recommendation of the Minister, set the amount at which a drug is presumed to be for supply.<sup>759</sup> Before making such a recommendation the Minister must consult with the Expert Advisory Committee on the amount and have regard to:<sup>760</sup>
- (a) the amount of the drug that could reasonably be possessed for personal use, including, without limitation, levels of consumption, the ability of the drug to create physical or psychological dependence, and the specific effects of the drug; and
  - (b) the amount, level, or quantity at and over which the drug is presumed to be for supply in other jurisdictions; and
  - (c) any other matters that the Minister considers relevant.
- 10.90 Regarding this process, Blanchard J said in *Hansen* that "it can be inferred that the current legislative scheme ensures that each trigger level is fixed at a quantity most unlikely to be in someone's possession except for the purpose of supply".<sup>761</sup>

Assuming that the Expert Committee follows the statutorily mandated process, it is most unlikely that a person acquiring a drug for consumption only could inadvertently take himself or herself over a trigger level set by the Expert Committee. It is important to emphasise that the Court does not have before it any evidence that any trigger levels have been inappropriately set.

<sup>757</sup> Ibid.

<sup>758</sup> Misuse of Drugs Act 1975, s 5AA(1)(b)(iii).

<sup>759</sup> Misuse of Drugs Act 1975, s 4(1B).

<sup>760</sup> Misuse of Drugs Act 1975, s 4B(3) and (4).

<sup>761</sup> *R v Hansen*, above n 738, para 78.

- 10.91 However, while there is a process for setting levels now in place, there is no requirement for the levels to be regularly reviewed or for them to be amended as evidence of changes in drug use and supply patterns come to light. As a result, none of the levels have in fact been reviewed since the process was put in place. This was no doubt a substantial factor in the concerns held by the majority in *Hansen* with respect to the presumption level for cannabis, given that this level has not been changed since 1965 when the presumption was first enacted in New Zealand.
- 10.92 There also seem to be problems in the consistency of the presumption level across different types of drugs, especially regarding Class A drugs. For example, the level at which the presumption of possession for supply operates is 5 grams of methamphetamine but only 0.5 grams of heroin or cocaine. Evidence suggests that all these drugs are dealt with in similar quantities.
- 10.93 Accordingly, if the presumption were to be retained, the current presumption levels would have to be reviewed to ensure that they are not out of date. Furthermore, we consider that it would be necessary for the legislation not only to prescribe a robust process for setting the levels, but also to require that the levels be kept under regular review so that there is less danger of the amounts becoming out of date.
- 10.94 On balance we consider the difficulties associated with any attempt to achieve a reverse onus provision that is consistent with the Bill of Rights Act outweigh its possible advantages. Given the differing approaches of the judges in *Hansen*, it would be impossible to predict with any certainty that the presumption would be found by a court to be consistent with the Bill of Rights Act unless it was set at a level which is unlikely to be effective.
- 10.95 Accordingly, our tentative view is that the best option is to create an aggravated possession offence based on the possession of a quantity of drugs that is generally inconsistent with personal use (option (b)). The Expert Advisory Committee on Drugs should be asked to advise government on the quantity of drugs that would attract the aggravated offence.

Q30 Do you agree that the offence of possession for supply should be repealed and replaced with two possession offences: simple possession and aggravated possession (the latter involving a quantity that is indicative of supply)?

Q31 If not, which of the following options do you favour:

- (a) remove the presumption;
- (b) establish an evidential presumption;
- (c) retain the presumption at its current levels; or
- (d) retain the presumption, but set at levels that are more likely to be found justified under the Bill of Rights Act?

## Structure of the offence of possession for supply

- 10.96 If an offence of possession for supply is retained, the next question is how to structure such an offence. The offence currently covers possession for the purposes of sale or supply under section 6(1)(c), (d) and (e). If the distinction between sale and supply were removed, this would have a flow-on effect for the offence.
- 10.97 As discussed above in relation to supply, the scale of offending should not dictate the substantive offence but should instead be dealt with as a sentencing matter.
- 10.98 As with supply, possession for supply can be committed where no commercial activity is involved and the drugs are intended to be shared socially among friends. We consider that the possession of drugs for the purposes of social supply should be treated in the same way as social supply and there should be a presumption against imprisonment.
- 10.99 This presumption should apply where the following circumstances indicate possession for social supply:
- the supply was in small quantities;
  - the offender was also using the drugs;
  - the supply was to friends or acquaintances;
  - the offending was not motivated by profit.

**Q32** If the offence of possession for supply is retained, do you agree that there should be a single offence and a presumption against imprisonment where the possession is for the purpose of social supply?

## Maximum penalties

- 10.100 The penalties for this type of offending in other jurisdictions vary depending upon the offence structure in that jurisdiction and how the issue of possession for supply is treated. Some jurisdictions define trafficking to cover what is considered to be possession for supply in New Zealand.<sup>762</sup> Others have a separate offence as in New Zealand.<sup>763</sup> Others have no such offence and it is dealt with under possession.<sup>764</sup> However, despite these differences in approach, the maximum penalties for the worst offending across all jurisdictions considered are the same as for supply (see Table Two).
- 10.101 However, it is open to question whether the penalty for possession for supply should be the same as for supply itself. Possession for supply is an inchoate offence. Arguably, it should be treated as more like an attempt and therefore attract a lesser penalty.

**Q33** What should the maximum penalties for possession for supply be?

<sup>762</sup> See, for example, Criminal Code (Cth) and Criminal Code 2002 (ACT).

<sup>763</sup> See, for example, Misuse of Drugs Act 1971 (UK), s 5(3); Controlled Drugs and Substances Act SC 1996 c 19 (Canada), s 5(2).

<sup>764</sup> See, for example, Drugs Misuse Act 1986 (Qld), s 9 and Misuse of Drugs Act (NT), s 9.

IMPORT,  
EXPORT,  
PRODUCTION,  
MANUFACTURE  
AND  
CULTIVATION

### Structure of the offences

- 10.102 The other dealing activities covered by the Misuse of Drugs Act are importation, exportation, production, manufacture and cultivation. There is a question about whether there is any reason for treating these offences any differently than supply.
- 10.103 On the one hand, these offences involve making a substance available to members of society, through importation or creation, which would not otherwise be available. Such offences are therefore analogous to offences of supply or possession for supply; both sustain the drugs market.
- 10.104 On the other hand, there is an argument in favour of different and more serious treatment due to the dangers involved in some manufacturing processes. For example, the manufacture of methamphetamine, cannabis oil or home bake all involve dangerous chemicals. This may justify treating manufacture as more serious than other dealing offences due to the added potential harm arising.
- 10.105 However, we do not regard this harm as such a significantly aggravating factor that it warrants a separate offence and enhanced maximum penalty that would apply to almost all drugs. While some harm may arise through the manufacturing process, this is no more significant than many other aggravating factors (for example, supply to children) and it can be adequately addressed in sentencing. The main drug with which additional harm from the manufacturing process is associated (methamphetamine) already carries a maximum penalty of life imprisonment and no enhancement would be possible.
- 10.106 We favour treating all the dealing offences in the same way.

Q34 Do you agree that:

- (a) there should be a single offence, with scale of offending dealt with as a sentencing matter; and
- (b) importation, exportation, production, manufacture and cultivation should have the same maximum penalty as supply?

### Own use or offending for social supply

- 10.107 Importation, exportation, production, manufacture and cultivation can all be done for social supply or for a person's own use. That type of dealing activity can be distinguished from the seriousness of commercial dealing.
- 10.108 At a minimum, we think that, where circumstances suggest that the drugs are for the offender's own use or for sharing socially, the offending should be treated in the same way as social supply and a presumption against imprisonment should apply. These circumstances are likely to be:
- dealing in small quantities;
  - evidence that the drug was for the offender's own use and possibly also for supply to friends or acquaintances;
  - the absence of a profit motive.



- 10.109 In chapter 11, we discuss whether to go further so that any new approach that is taken to personal use offences should also apply to cultivation of small amounts of a prohibited plant (particularly cannabis) and, perhaps, to other dealing activities for personal use.

Q35 Do you agree that importation, exportation, production, manufacture and cultivation for personal use or for social supply should be distinguished from other forms of dealing?

Q36 If so, is a presumption against imprisonment the most appropriate way to make this distinction?

## Maximum penalties

- 10.110 As with supply, the maximum penalty for importing, exporting and manufacture of Class A drugs is life imprisonment. This is similar to maximum penalties for the most serious level of these types of offending in comparable jurisdictions, where the maximum penalties range from 20 years to life imprisonment.
- 10.111 However, there is a considerable difference between the maximum penalty for cultivation in New Zealand and the penalties in other jurisdictions. In New Zealand, the maximum penalty for cultivation is seven years imprisonment. This penalty applies regardless of the class of drug in question. In contrast, the maximum penalties in other jurisdictions are consistently much higher. For example, in a number of jurisdictions, where very large quantities of plant are cultivated commercially, the penalty is life<sup>765</sup> or 25 years.<sup>766</sup> In other jurisdictions cultivation is defined to fall within the manufacturing or producing offence and accordingly has high maximum penalties. For example, in Queensland, the penalty is 25 years for producing a Schedule 1 drug in large quantities.<sup>767</sup> Like New Zealand, Tasmania has one maximum penalty (21 years imprisonment) for cultivation, which applies regardless of the drug or the amount.<sup>768</sup>
- 10.112 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

765 See Criminal Code (Cth), Criminal Code (ACT), Drugs Misuse and Trafficking Act 1985 (NSW); Controlled Substances Act 1984 (SA); Drugs Poisons and Controlled Substances Act 1981 (Vic).

766 Misuse of Drugs Act (NT).

767 Drugs Misuse Act 1986 (Qld), s 8. See also Controlled Drugs and Substances Act SC 1996 c 19 (Canada), s 7 where the penalty is life for Schedule 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.

768 Misuse of Drugs Act 2001 (Tas), s 7; See also Misuse of Drugs Act 1981 (WA) where the penalty for cultivation with an intention to sell is 25 years.

in respect of cultivation, specify different penalties for cannabis outside the normal classification system. These are seven years in Canada<sup>769</sup> and 14 years on indictment and 12 months on summary conviction in the United Kingdom.<sup>770</sup>

- 10.113 Currently the presumption in favour of imprisonment applies to importation, exportation, production, manufacture and cultivation of Class A drugs even where these activities are undertaken for personal use or for sharing with friends. Consistent with our view in paragraph 10.108 above, we think that personal use and social supply should be excluded from that presumption.

Q37 Do the maximum penalties for these offences need to be revised?

Q38 Do you agree that the presumption of imprisonment for importation, exportation, production, manufacture and cultivation of Class A drugs should be excluded where the offending is for the purposes of personal use or social supply?

ADMINISTERING 10.114 Sections 6(1)(c) and (d) and 7(1)(b) refer to the offence of administering. This offence 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 could not be convicted of supply.<sup>771</sup> New Zealand commentaries have suggested that this case offers an example of when a charge of administering rather than supply is appropriate.<sup>772</sup>

- 10.115 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 offence of injury by an unlawful act and culpable homicide would not be available, if injury or death materialised.

- 10.116 Such an offence is qualitatively different from supply or other dealing offences and should not be lumped together with them. In our view, it should be a separate offence with its own maximum penalty. 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 term of imprisonment for two years for endangerment offences where injury or death does not result.<sup>773</sup> We suggest this would be an appropriate maximum penalty for administering drugs, whatever their class.

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

770 Misuse of Drugs Act 1971 (UK), s 6(2) and Schedule 4.

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

772 Don Mathias *Brookers Misuse of Drugs* (Loose leaf, Brookers, Wellington, 1998) para 1702 (last updated 30 November 2007) para 406; Bruce Robertson (ed) *Adams on Criminal Law* (Loose leaf, Brookers, Wellington, 1992) para CP 3.02 (last updated 19 January 2010) para MD6.17.

773 New Zealand Law Commission, above n 734.

Q39 Do you agree that “administering” should be made a separate offence rather than continuing to be grouped with supply?

Q40 If the former, do you agree that the maximum penalty should be two years imprisonment? If not, what should it be?

# Chapter 11

## Personal use

### SUMMARY

This chapter proposes that a new approach be taken to drug possession, drug use, and other offences related to personal use, and outlines what some of the options for that approach might be.

**INTRODUCTION** 11.1 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.<sup>774</sup> Many jurisdictions, including all Australian states and territories, the United Kingdom, and various European states, have gone further. This chapter considers whether anything more is required in this country.

### OUR INTERNATIONAL OBLIGATIONS IN RELATION TO PERSONAL USE OFFENCES

- 11.2 We have earlier noted our view that the approach that New Zealand takes to drug regulation must comply with its obligations under the 1961, 1971, and 1988 international conventions. Those obligations in relation to personal use activities were discussed in chapters 6 and 8. In summary:
- possession and use of convention drugs for other than medical or scientific purposes must continue to be restricted and unlawful;
  - there is no requirement to establish criminal offences in respect of the use of drugs per se, although it is arguable that offences may be required in relation to obtaining drugs for personal use;
  - it may be open to parties to interpret the conventions as not requiring the establishment of criminal offences for possession and cultivation of convention drugs for personal use;
  - where criminal offences are in place for conduct related to personal use, there are a number of permissible responses under the conventions when those offences are detected, ranging from the application of a non-prosecution policy to the use of non-custodial sentences if a prosecution is taken.

<sup>774</sup> 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.

- 11.3 Most recently, the United Nations Office on Drugs and Crime has stated that drug possession cases are a “non-priority” and that arrest is only appropriate in a small proportion of those cases. The Office has 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.<sup>775</sup> 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.<sup>776</sup>

- 11.4 The remainder of this chapter is written with these obligations and views in mind. There are, of course, no similar obligations in relation to drugs not included in the conventions.

## CURRENT OFFENCES

### Drug possession and use

- 11.5 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.<sup>777</sup> This offence carries a maximum penalty of six months imprisonment and/or a \$1000 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.<sup>778</sup> There is a statutory presumption against the use of imprisonment in relation to a Class C drug.<sup>779</sup>
- 11.6 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.
- 11.7 We are uncertain whether a separate criminal offence for drug use remains necessary in this country. Although our international obligations 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.

<sup>775</sup> United Nations Office of Drugs and Crime *World Drug Report 2009* (United Nations Office of Drugs and Crime, New York, 2009) 167.

<sup>776</sup> *Ibid.*, 2.

<sup>777</sup> Misuse of Drugs Act 1975, s 7(1)(a).

<sup>778</sup> Misuse of Drugs Act 1975, s 7(2)(b).

<sup>779</sup> *Ibid.*, which 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.

- 11.8 The use offence has not itself caused any difficulty, and its retention would not cause any harm. In addition, removing the offence may provide a signal that drug use itself is acceptable. That is undesirable and would not assist the overall goal of reducing drug-related harm. However, because anyone caught using drugs can also be charged with possession,<sup>780</sup> there is arguably little to be gained by both activities being offences.
- 11.9 New Zealand statistics indicate that there are very few instances where the police take action against an individual for use instead of possession. In relation to offences recorded by the police in 2008, for example, 93 % of cannabis possession and use offences, and 97 % of non-cannabis possession and use offences, related to possession.<sup>781</sup>
- 11.10 Some use arguably involves greater culpability and criminality than simple possession. This includes, for example, use in public that is likely to cause offence (such as “shooting up” in a public street) or use that occurs in front of children. It may be appropriate that use in those circumstances remains a criminal offence.<sup>782</sup> Alternatively, use in these circumstances could have the effect of aggravating the offence of possession (for example, so that it would not fall within the ambit of any new approach taken to personal use offences – see paragraphs 11.70–11.71).

Q41 Should there continue to be a criminal offence for drug use?

Q42 If so, should that offence encompass all drug use or only use in specified circumstances?

Q43 What circumstances, other than those identified in paragraph 11.10, could be considered an “aggravated” form of use?

780 Note that an individual caught using drugs could not be charged with separate offences of possession and use.

781 Possession includes procurement. However, we assume most if not all “possession” offences relate to possession itself. Table Builder (<http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx>, accessed 3 November 2009).

782 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 \$1000 to behave in an offensive manner in or within view of any public place. However, explicitly criminalising use in public, rather than relying on it being caught by section 4, would provide extra clarity and transparency. Use in front of children may not fall within the scope of section 4, for example, if it occurred in a private residence.



## Possession of utensils

11.11 Under section 13, it is an offence to:

- (a) Possess any pipe or other utensil (other than a needle or syringe) for the purpose of committing an offence against the Act.<sup>783</sup> The maximum penalty is 12 months imprisonment and/or a fine not exceeding \$500.<sup>784</sup>
- (b) Possess 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.<sup>785</sup> The maximum penalty is 12 months imprisonment and/or a fine not exceeding \$500.<sup>786</sup>

11.12 Both offences are most commonly, if not exclusively, prosecuted in relation to the possession of utensils for the purpose of using drugs. In relation to that purpose, the offence has at least two related rationales. The first is that prohibiting possession of the utensils in which drugs are used prevents drug use by making it more difficult. The second is that these utensils are inherently harmful (because they facilitate drug use) and, on that basis, their possession should be prohibited.

11.13 A prohibition on utensils will obviously be more effective for some drugs than for others. For example, cigarette paper to roll a cannabis cigarette is legally available, and drugs in tablet form can be taken without the aid of any utensils. Allowing users to possess utensils may also encourage safer drug use. Smoking cannabis via a bong or pipe is a less harmful way of using cannabis than smoking a cannabis joint.<sup>787</sup> A similar rationale lies behind the Health (Needles and Syringes) Regulations 1998, which enable intravenous drug users to buy new needles and syringes and return used ones without committing an offence.<sup>788</sup>

11.14 It is not often that police only charge a person with a utensils offence.<sup>789</sup> In addition, many people found in possession of utensils for personal use will also have some drugs in their possession. In that sense, the utensils offence does not reflect any additional criminality on their part. Taking action against an individual in relation

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

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

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

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

787 See, for example, Commonwealth of Australia *Legislative Options for Cannabis Use in Australia* (Monograph Number 26, 1994) 51, which notes that the illegality of water pipes for cannabis use means more people consume cannabis in cigarette papers, which is the form of consumption most damaging to lungs.

788 From a registered pharmacy, an approved medical practitioner, or an authorised representative.

789 The Ministry of Justice has provided us with figures which indicate that where a prosecution for this offence was taken in 2008, it was the only offence prosecuted in 16 % of cases and was prosecuted with an offence of possession/use in 52 % of cases. These proportions are comparable to the previous four years.

to possession should usually provide a more than adequate response to the user's behaviour. The only circumstance in which it may not is when use occurred in the past, and no drugs are currently in the individual's possession.<sup>790</sup>

- 11.15 We therefore think an argument can be made for the abolition of this offence. There is no specific obligation in the international conventions to prohibit the use of utensils. It is instead one way in which parties comply with their general obligations under the conventions to limit the use of prohibited drugs.<sup>791</sup>
- 11.16 However, if pipes and utensils were no longer prohibited, there would be no justification for enabling their forfeiture. If forfeiture was considered desirable (for example, on the basis that pipes and utensils are harmful items in themselves), their continued prohibition would be required.
- 11.17 Finally, we note that it is currently possible for a more severe sentence to be imposed for possessing a utensil to use a Class B or C drug than for possessing or using the drug itself.<sup>792</sup> Therefore, if this offence does remain, its maximum penalty should be revised to ensure it has appropriate relativity with the possession/use offence.
- 11.18 It is also an offence to import or supply utensils for using cannabis or methamphetamine.<sup>793</sup> We consider this offence further in chapter 12.

**Q44** Should the possession of utensils for the purpose of using drugs remain a criminal offence?

#### A NEW APPROACH TO PERSONAL USE OFFENCES

- 11.19 Chapter 7 outlined the arguments for and against drug prohibition and reviewed the development of less punitive approaches in other jurisdictions to personal use. These approaches aim to provide a more proportionate response to the harm that personal use causes, and to address or mitigate some of the harms that inevitably result from prohibition. All Australian states and territories, the United Kingdom, and many European countries have adopted variants of these approaches. We are of the view that a less punitive approach is also appropriate for New Zealand.

<sup>790</sup> Note there is conflicting authority about whether, in order for an offence to be committed, the purpose for which a utensil is possessed must relate to a future purpose to commit an offence against the Act or a purpose in the past (i.e. past use). The Court of Appeal has recently held the latter – see *R v Jones* [2007] NZCA 187, 59.

<sup>791</sup> For example, as required by article 4(c) of the Single Convention on Narcotic Drugs 1961.

<sup>792</sup> But see *Mackay v Police* (19 March 1993) HC TM AP 27/93 where a sentence for possessing a pipe to smoke cannabis was reduced for this reason. It is likely that judges would take this approach in practice.

<sup>793</sup> Misuse of Drugs (Prohibition of Cannabis Utensils and Methamphetamine Utensils) Notice 2003 made under regulation 22(1A) of the Misuse of Drugs Act 1975.

- 11.20 A significant amount of effort in our criminal justice system appears to focus on the enforcement of personal use offences. Possession and use offences comprised 46 % of the approximately 20,000 drug offences recorded by police in 2008.<sup>794</sup> Police detection of these offences is, in many cases, likely to be incidental to the detection of other offences.<sup>795</sup> However, a possession or use offence was the most serious offence in 36 % of the approximately 8000 drug cases prosecuted in 2007.<sup>796</sup> Approximately two-thirds of these cases resulted in a conviction.<sup>797</sup>
- 11.21 In addition to the effect on individual users, particularly those users who would otherwise not come to police attention, it is questionable whether this is the best use of a limited resource. In our view, it is more productive to focus enforcement resources and activity on more harmful drug-related offending, particularly commercial dealing. This is where most drug-related harm occurs.
- 11.22 A less punitive approach may also mitigate the likelihood of inequitable enforcement of drug prohibition on users. Despite the significant proportion of criminal justice resource spent enforcing possession and use offences, most users do not come to police attention.<sup>798</sup> New Zealand research has found that those most likely to be arrested or convicted for cannabis-related offences are male, Māori, have a previous arrest record for non-cannabis related offences and report involvement in violent or property offending.<sup>799</sup>
- 11.23 The criminal justice system can play a key role in identifying individuals whose drug use is causing harm to themselves or to others and diverting them into drug education, assessment, and treatment. For some people, being apprehended may be a crisis point that encourages them to address their drug use. In this sense, simply punishing a drug user, without taking steps to address their drug use, is a wasted opportunity.

794 20,732 drug offences were recorded. 8903 offences were recorded in relation to possession for purposes other than supply and 592 offences were recorded in relation to use. The same offences comprised 52 % of all prosecuted drug cases in 1999. Table Builder (<http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx>, accessed July 2009).

795 These offences may be more serious or less serious than the possession or use offence.

796 There were 7972 prosecuted drug cases in total. In 2400 cases, cannabis possession or use was the lead offence. In 501 cases, possession or use of other drugs was the lead offence. Of the remainder, 34 % of prosecuted cases related to dealing and 30 % related to other drug offences. The number of drug cases prosecuted for possession and use represents a decrease from a high of 44 % in 1998–2000. Table Builder (<http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx>, accessed 18 March 2009).

797 There were 1614 convicted cases for cannabis, and 316 convicted cases for other drugs. Table Builder (<http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx>, accessed 18 March 2009).

798 For example, we estimate that less than 1 % of all cannabis users in 2006 were prosecuted in relation to their cannabis use – see chapter 7.

799 D M Fergusson, NR Swain-Campbell and L J Horwood “Arrests and Convictions for Cannabis-related Offences in a New Zealand Birth Cohort” (2003) 70 *Drug and Alcohol Dependence* 53.

- 11.24 Concern that a less restrictive approach to prohibition will increase drug use, by increasing both the number of users and the frequency of their use, has been the critical issue in law reform debates in this area. This includes concern that any relaxation in drug prohibition would signal society's increased tolerance of drug use and would make illegal drugs more available.
- 11.25 The effect of strict prohibition and less punitive approaches on rates of use is discussed in more detail in chapter 7. In other jurisdictions, the impact of less punitive approaches on levels of use remains a controversial issue. However, most studies in this area have concluded that changes in use levels are independent of the regulatory approach in place. While less punitive approaches do not reduce drug use, neither do they increase it.<sup>800</sup> This conclusion is supported by comparisons of actual use levels and rates of increase in jurisdictions with different regulatory approaches.<sup>801</sup>
- 11.26 A reduction in drug use is not usually an explicit objective of less restrictive approaches. They instead aim to reduce drug-related harm. Reducing drug use is one way of reducing drug-related harm, but it is not the only way and may not be the most effective way. For example, drug-related harm may decrease despite an increase in use of a particular drug if that drug is being used in lower doses or at a lower strength, or if it is being used as a substitute for another more harmful drug.
- 11.27 In summary, therefore, we consider that a less restrictive approach to personal use 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.
- 11.28 In proposing a new approach to personal use offences, we do not intend to downplay the significant harm that drug use, either on its own or in combination with other factors, can cause to the user, his or her family, and the wider community. Our aim is to find the most effective way to address this harm. In our view, the current approach is not that way.

800 Robin Room and others *The Global Cannabis Commission Report – Cannabis Policy: Moving Beyond Stalemate* (The Beckley Foundation Global Cannabis Commission, September 2008) 148 [*Global Cannabis Commission Report*].

801 See chapter 7 for a discussion about the available evidence relating to the impact of different regulatory approaches on levels of use.

## Introduction

- 11.29 Table Three identifies the range of options that we consider are available at the time police apprehend an individual for a personal use offence. These options draw on the discussion in chapter 7 about models of prohibition, particularly those models that include diversionary approaches or that preclude the possibility of criminal conviction. These are the models that appear permissible under our international obligations.

TABLE THREE: Possible approaches when a personal use offence is detected		
Option	Description	Overseas examples
Formal non-arrest/ non-prosecution policy	Introduce formal police policy which states that police will not take any action in relation to personal use offences, although drugs/utensils could be confiscated.	The Netherlands [all illegal drugs], United Kingdom (2004–2009) [cannabis only]
Confiscation only	Confiscation of drugs or utensils, with no other action taken.	–
Confiscation and referral to community panel	Refer users to a community panel that imposes an appropriate sanction in light of the user's level of drug use and treatment needs. May include referral to drug treatment.	Portugal [all drugs]
Confiscation and monetary penalty	Personal use offences become infringement offences with a fixed infringement fee attached. Non-monetary penalties may also be possible.	Some Australian states and territories – ACT, Northern Territory, South Australia, Western Australia [cannabis only]
Formal cautioning scheme in lieu of arrest and prosecution	Formal caution issued when personal use offence detected. May also include referral to health services or provision of information on harm from drug use. Graduated approach possible, so that intensity of response increases the more times an individual is caught.	All Australian states and territories <sup>802</sup>
Greater use of Police Adult Diversion Scheme	Extension of Scheme to wider range of drug offences, for example, possession of Class A and B drugs.	–

- 11.30 If criminal prosecution for a personal use offence remains possible, there is also a range of options for what may happen at later stages of the criminal process including, for example, diversion into treatment or rehabilitation programmes prior to conviction or sentence. We consider those options later in the chapter.
- 11.31 Much is made in the literature about the legal status of relevant offences and penalties – that is, whether the offences are criminal offences or civil offences. Arguably, however, this legal distinction makes little difference in practice.

<sup>802</sup> Those jurisdictions that have an infringement offence regime for cannabis (Australian Capital Territory, Northern Territory, South Australia and Western Australia) apply their cautioning scheme to other illegal drugs. The cautioning schemes in New South Wales and Queensland apply to cannabis only. The cautioning schemes in Victoria and Tasmania apply to all illegal drugs.



For example, if an infringement offence regime is adopted, a conviction for a personal use offence would not be possible even though the offence remained a criminal offence. Nor is the distinction between civil offences and criminal offences a distinction that is well understood by members of the community. Those individuals who incur a parking fine or a speeding ticket would not consider themselves to be criminals for doing so. Technically, however, they have committed a criminal offence. In our view, the focus should be on finding the most effective way of responding to a personal use offence when it is detected. The legal status of that offence, while important, is a secondary consideration.

- 11.32 The debate in New Zealand tends to focus on law reform in relation to cannabis. The arguments for a different approach to personal use may apply more strongly to a drug like cannabis because it is the most widely used illegal drug (indicating that prohibition has not been particularly effective in deterring its use or restricting its availability) and is also perceived to be the least harmful of all illegal drugs (indicating that the harms caused by the current approach may not be proportionate to the harm caused by cannabis use itself). In addition, applying a less restrictive approach only to a less harmful drug like cannabis may also provide an incentive to use that drug as a substitute for more harmful drugs.
- 11.33 However, our discussion in this chapter is not limited in this way. In our view, the main arguments for a different approach apply regardless of the nature of the drug involved. In addition, the reality of drug use is that most drug users do not specialise in any one drug, but use a range of substances.<sup>803</sup> That is why many jurisdictions have not limited any new approach to cannabis, but have put in place a new approach to personal use of all illegal drugs. In Australia, for example, New South Wales and Queensland are the only two states that apply their less restrictive approach only to cannabis.
- 11.34 This is not to say that a drug-specific approach is also not required. However, the characteristics of particular drugs and the nature of their use are more relevant to determining which approach is preferable, and how that approach might work, rather than to deciding whether a new approach is required at all.

### Preferred options

- 11.35 In our view, any new approach to personal use must be provided in legislation. A legislative scheme provides certainty and transparency, both for the police who will be primarily responsible for its implementation and for drug users. In addition, the approach to be taken to personal use is a matter of significant public and political interest. Implementing that approach via legislation will give elected politicians and the public the opportunity to have input into the approach through the parliamentary process.

803 See, for example, Joseph M Boden, David M Fergusson and L John Horwood "Illicit Drug Use and Dependence in a New Zealand Birth Cohort" (2006) 40 *Australian and New Zealand Journal of Psychiatry* 156, which found evidence of substantial poly-drug use amongst the Christchurch Longitudinal Study cohort; and C Wilkins, M Girling and P Sweetsur *Recent Trends in Illegal Drug Use in New Zealand, 2005-2007 – Findings from the 2005, 2006, and 2007 Illicit Drug Monitoring System* (Massey University Centre for Social and Health Outcomes Research and Evaluation (Massey University SHORE), Auckland, 2008) 51, which found that frequent drug users had tried an average of 14 drug types in their lifetimes and an average of seven drug types in the past six months.



- 11.36 We do not support the introduction of 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.<sup>804</sup> In addition, this option risks creating an uneasy distinction between law and practice and confusion in the public's mind about what the law actually is.
- 11.37 For many of the same reasons, we have reservations about simply making greater use of the Police Adult Diversion Scheme. There are some positive aspects of the Scheme in the drugs context, including the ability for drug users to be put in touch with treatment services. However, there is no statutory basis for the Scheme, and its substantive content and implementation is a matter for the police. It is also limited to first offenders and, generally, to minor Class C drug offences. In the context of other projects, the Law Commission has queried key aspects of the Scheme, particularly the requirement that a prosecution commence before diversion is offered.<sup>805</sup> In the context of this discussion, we prefer an approach that limits users' contact with the criminal justice system, including their exposure to prosecution, as much as possible, and that places the criminal justice response to users on a more systematic and transparent footing.
- 11.38 We do not support an option based solely on confiscation. This option would maintain the illegality of personal use activities for the sole purpose of complying with the international conventions. It reflects an assumption that these activities are so minor and cause so little harm that no action other than confiscation is justified (if even that can be justified). We do not believe this can be said of all drug use. Nor do we believe it is appropriate to put in place an approach that effectively pays only lip-service to the requirements of the international conventions. Public and political pressure also means such an approach is unlikely to be durable over the longer term.
- 11.39 We have also considered but discarded an option based on the Portuguese approach. Although this approach appears to have been effective in Portugal,<sup>806</sup> we believe its infrastructure of Commissions of Dissuasion is too resource-intensive for New Zealand. In addition, we have concerns about some aspects of the approach including the level of coercion that is potentially applied through what is essentially a civil process. We believe that the outcomes of the Portuguese approach can be achieved in a less costly and less intrusive way.
- 11.40 It is important to note that none of the options presented below are without their difficulties. We have therefore identified below the options that we believe are worth further consideration and consultation, without indicating a preference for any particular one.

804 We are aware that the New Zealand Police is developing some new initiatives in this area, which would apply to all offending. This includes, for example, a more formal approach to issuing warnings for minor offences that is being piloted in Auckland.

805 New Zealand Law Commission *Criminal Pre-Trial Processes: Justice Through Efficiency* (NZLC R89, Wellington, 2005) 27–29.

806 Caitlin Hughes and Alex Stevens *The Effects of Decriminalisation of Drug Use in Portugal* (The Beckley Foundation Drug Policy Programme, Briefing Paper 14, 2007); Glenn Greenwald *Drug Decriminalisation in Portugal: Lessons for Creating Fair and Successful Drug Policies* (Cato Institute, Washington, 2009).

- 11.41 There are two particular difficulties that are common to more than one option. First, whichever option is implemented, it is likely that some individuals who previously would have received an informal warning or had no action taken against them will instead be subject to some more formal police action (“net-widening”). This is the case even though it would remain possible for the police to issue an informal warning or take no action under any new approach that is adopted. The experience of other jurisdictions in implementing similar options indicates that some net-widening is unavoidable.
- 11.42 Secondly, two of the options (options one and three) depend on the availability of appropriate treatment services. As we discuss further in chapter 15, there is already concern that current treatment services available to the justice system are insufficient to meet demand. This is a critical issue that would need to be addressed before either of those options could be implemented.

*Option 1: Formal cautioning scheme for all drugs*

- 11.43 This option is based on the cautioning schemes implemented in most Australian jurisdictions. Its key components are that:
- Police would be able to issue a caution notice when a personal use offence was detected.
  - The drugs and any utensils in the user’s possession would be confiscated whenever a caution notice was issued.
  - 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.
  - The first and second caution notices would be accompanied by information on the legal and health consequences of drug use, and the contact details of treatment providers. No other enforcement action would be taken.
  - The third caution notice would require the user to attend a brief intervention session and be assessed to identify whether he or she was in need of specialist drug treatment. There would be no requirement as part of the caution conditions for the user to attend any specialist drug treatment that was identified as needed as a result of the brief intervention session.
  - If the police considered that a user who came to police attention for the first or second time was in immediate need of a drug assessment, the user could be escalated to the level of a third caution and be required to attend a brief intervention.
  - A user who came to police attention for a personal use offence for a fourth time would be prosecuted.
- 11.44 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 use offence. Because it is unlikely that all of those apprehended will be in need of drug treatment, access to treatment is limited to those users who come to police attention for a personal use offence on more than two occasions. However, it would be possible to “leapfrog” the first two levels of cautions in other cases if that was considered necessary or desirable.

- 11.45 There would be little consequence for a user who police apprehended once or twice for a personal use offence, other than the confiscation of any drugs/utensils. The main consequence is that he or she would move closer to a mandatory brief intervention session (and prosecution) in the event of another apprehension for a personal use offence. A user apprehended for a third time would be required to attend the brief intervention session or face prosecution.
- 11.46 We think our proposed approach to a cautioning scheme strikes an appropriate balance between the needs of users who may require drug assessment and treatment, and other users. However, there is no consensus in the overseas approaches about the critical components of an effective cautioning scheme. For example, there is significant variation between the Australian cautioning schemes in how many cautions can be issued, if and when users are required to attend a brief intervention or similar session, and how many sessions they must attend.<sup>807</sup>
- 11.47 This option would not remove the possibility of prosecution for a personal use offence altogether. In particular, a prosecution would commence if a user who came to police attention had exhausted all of his or her caution options. Prosecution may also be appropriate in other circumstances – for example, if a user was being charged with other more serious offences or had a criminal history of serious drug offending.<sup>808</sup> These users may be less likely to benefit from a diversionary response. In addition, in both situations, there is likely to be a greater public interest in prosecution with any diversionary approach more appropriately subject to court oversight. This is the approach taken in most Australian cautioning schemes.
- 11.48 Brief interventions are discussed in more depth in chapter 15. For the purposes of this option, we envisage that they would provide a mechanism to identify those users who are experiencing problem drug use,<sup>809</sup> and to refer them to specialist drug treatment services. Further consideration would be required about how and by whom brief interventions would be provided and the likely cost.
- 11.49 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. A user who disputes that an offence

807 In South Australia (non-cannabis only) and the Northern Territory (all drugs), there are no limits on the number of cautions that may be issued. In Queensland (all drugs), only one caution can be issued. In the Australian Capital Territory (non-cannabis only), New South Wales (cannabis), and Victoria (all drugs), two cautions can be issued. In Tasmania, referral for a brief intervention occurs after one caution is issued. In Victoria, referral for a brief intervention occurs at the first caution. In Western Australia's scheme for drugs other than cannabis, the individual must attend three treatment and counselling sessions within 30 days. In Victoria's drug diversion programmes for drugs other than cannabis, the individual must attend two sessions within ten days. Jason Payne, Max Kwiatkowski and Joy Wundersitz *Police Drug Diversion: A Study of Criminal Offending Outcomes*. (Australian Institute of Criminology, Canberra, 2008) 77–80.

808 Note that we would not want to exclude offenders with a criminal history for any offending, because this would severely limit the application of the programme – see Chris Wilkins, Paul Sweetsur and Richard Griffiths *Conviction and Sentencing for Cannabis Use Offences in New Zealand, 1990-2008* (Massey University SHORE, Auckland, 2009) 18, which found that of 1044 people convicted for the use of cannabis in 2008, 89.4% had previous convictions for drug or other offending.

809 The nature of problematic drug use is discussed more fully in chapter 15. In terms of the continuum presented in that chapter, we are using the term “problem drug use” to including anything from hazardous use to dependence.

occurred should be able to require the case against him or her to be proved in court. The need for consent may also 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. However, we still consider that consent should always be obtained for the reasons explained above.)

- 11.50 The possibility of prosecution in the event that a user does not comply with caution conditions, or does not consent to a caution being issued, 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 and a prosecution is justified in the public interest). This may also limit the extent of net-widening that may otherwise occur.

### *Option 2: Infringement offence regime for less harmful drugs*

- 11.51 This option is based on the current approach taken to the personal use of cannabis in Western Australia and other Australian jurisdictions.<sup>810</sup> The key components of this option are that:

- An infringement notice would be issued when police detected a personal use offence.
- The infringement notice would be accompanied by information on the legal and health consequences of drug use, and the contact details of treatment providers.
- The infringement penalty would include confiscation of the drugs/utensils in the user's possession, as well as payment of a fixed fee.
- An alternative non-monetary option of participation in a drug education session could also be available – for example, for users who could not afford to pay a monetary penalty.
- Criminal prosecution and conviction would not be possible; police could only impose an infringement notice or take a lesser response (for example, informal warning).
- The user would not be required to consent to an infringement notice being issued or be required to acknowledge responsibility for the offence.
- If the user disputed responsibility for the offence, he or she would be required to challenge the notice in court. If the challenge was unsuccessful, the user would be required to pay or complete the original infringement penalty.
- Standard enforcement procedures would apply if the penalty was not completed. As with all infringement offence regimes, the unpaid infringement fee would be enforced as a court fine.

- 11.52 The primary aim of this option is to keep drug users out of the criminal justice system, and provide a low-key response that is more commensurate with the seriousness of, and harm caused by, personal use offences. There is no possibility

<sup>810</sup> A bill to replace the Western Australian scheme, the Cannabis Law Reform Bill 2009, was introduced into Western Australia's Legislative Assembly on 14 October 2009. That Bill replaces the infringement notice regime with a Cannabis Intervention Requirement Scheme, which requires those in possession of less than 10 grams of cannabis to participate in an education session.

of users being prosecuted or convicted, and no limit on the number of notices that could be issued. Unless they have also committed other offending, users' contact with the criminal justice system would be very limited.

- 11.53 Because users would not be required to consent to the imposition of an infringement notice or acknowledge responsibility for the offence, this option lacks a safeguard that option one includes. However, this is how all infringement offence regimes operate. The trade-off is that a user could never be convicted for a personal use offence. Moreover, they would still have the opportunity to contest responsibility for the offence in court.
- 11.54 Unlike a cautioning scheme, there would also be no scope for the circumstances of individual users to be considered, including any treatment needs they may have. The only opportunity to address the health consequences of drug use would be through the provision of information with the infringement notice and the proposed education session, the attendance at which would be a decision for the user. Imposition of an infringement notice would be the standard response when police detect a personal use offence.
- 11.55 The prospect of persistent users continually being issued with infringement notices does risk the regime as a whole being brought into disrepute, on the grounds that an infringement notice is a meaningless sanction. However, the same could be said of any other infringement notice regime.
- 11.56 We are not aware of any evidence suggesting that this has become an issue in the Australian infringement offence schemes. However, partly as a way to address this concern, Western Australia's scheme requires a user to attend an education session if he or she has been issued with two or more notices on separate days in the past three years. We do not support this approach. It is unlikely to be cost-effective to require users who are resistant to receiving education and who may therefore derive little benefit from it to attend a mandatory session.
- 11.57 Our proposed education session would be aimed at achieving two complementary goals. First, it would provide an opportunity to educate users about the health and social consequences of drug use, the treatment of drug-related harm, and the laws relating to personal use. Secondly, it may provide a useful alternative for users facing financial hardship who could not afford an infringement fee and would otherwise be dealt with through the fines enforcement system.<sup>811</sup> There is, however, a trade-off for the State between avoiding the costs of the fines enforcement system and the costs of providing education to those who may not otherwise benefit from it.
- 11.58 In our view, option 2 is only appropriate for drugs that cause a lower level of harm and/or that generally only cause harm to the user. Cannabis may be one example. For those drugs that cause a higher level of harm, like methamphetamine or the opiates, we consider that a more rehabilitative response is required which aims to address the needs of these users, perhaps along the lines of option one above.

<sup>811</sup> These are the broad purposes of Western Australia's Cannabis Education Session – see Cannabis Control Act 2003 (WA), s 17(1).



- 11.59 This option aims to reduce the costs to the State of enforcing prohibition of minor drug offences. However, costs may not be minimised if enforcement action is required to recover the infringement fee – the Australian schemes tend to have an initial compliance rate before enforcement action is taken of around 50 %.<sup>812</sup> Because there would be no limit on the number of infringement notices that could be issued, there is also the potential for some users to accumulate large amounts of unpaid drug infringement fines. If this occurs, the integrity of the scheme as an effective enforcement approach to personal drug use would be compromised. There would also be costs associated with establishing the required infrastructure for the proposed education sessions (including the need for a provider approval and monitoring process).
- 11.60 Introduction of an infringement offence regime also has implications for the enforcement powers discussed in chapter 14. A search warrant cannot be obtained for an infringement offence.<sup>813</sup> The use of the coercive powers that currently exist for drug offences, including warrantless searches when a person is suspected of possessing a controlled drug<sup>814</sup> or an internal search of a person under arrest,<sup>815</sup> could therefore not be justified. Nor would there be a power of arrest.

### *Option 3: A menu of options*

- 11.61 The final option is effectively a combination of the above two options, with the approach taken when an offence is detected tailored to the individual case. The key components of this option are that:
- There would be a number of responses open to police depending on the circumstances of the offence and the offender. These responses would range from the issuing of a caution or infringement notice, to referral to drug assessment with a view to treatment, to prosecution.
  - The user would be prosecuted if he or she denied the offence or refused to attend a drug assessment session as required.
- 11.62 This option has parallels with the approach taken to cannabis possession in the United Kingdom, although that approach requires a more structured escalation through the “menu” than what we are envisaging here. In the United Kingdom, the police can issue either a cannabis warning or an infringement notice, or arrest the user with a view to prosecution.<sup>816</sup>
- 11.63 The primary advantage of this option is that it enables the police response to individual users to be targeted to the circumstances of that use. This recognises that not all drugs and not all users can be dealt with in the same way; the problems posed by an addicted methamphetamine user, for example, are quite different from

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

813 Summary Proceedings Act 1957, s 198(1) carried over into the Search and Surveillance Bill 45-1 (2009), cl 6, which limits the availability of search warrants to imprisonable offences and the ability to apply for them to constables.

814 Misuse of Drugs Act 1975, s 18(3) carried over into the Search and Surveillance Bill 45-1 (2009), cl 19.

815 Misuse of Drugs Act 1975, s 18A(2) carried over into the Search and Surveillance Bill 45-1 (2009), cl 22.

816 See Drug Laws and Licensing – Cannabis Reclassification [www.drugs.homeoffice.gov.uk/drugs-laws/](http://www.drugs.homeoffice.gov.uk/drugs-laws/) (accessed 7 October 2009).



those posed by a first-time ecstasy or BZP user. For example, if the drug use was considered to be an isolated incident or otherwise unproblematic, an infringement notice would be the most likely response. If the drug use was considered to be problematic (for example, because the user was drug-dependent), the police could refer the individual to a drug assessment.

11.64 This option also enables the police to avoid some of the difficulties that may occur if a cautioning approach or infringement offence regime was implemented on its own. In relation to the latter, this includes the prospect of continually issuing infringement notices to a persistent user knowing that the fee is unlikely to be paid and that use will continue.

11.65 However, the corollary is that the decision about the appropriate option in an individual case would be left to police discretion, guided by any internal policy or guidelines that are developed. There is at least some prospect, therefore, of decisions in individual cases being based on criteria that are unrelated to the regime's overall objectives, as well as some inconsistency developing in the treatment of like cases.

Q45 Do you agree that a new enforcement approach should be taken to personal use offences?

Q46 If so, should there be a cautioning regime (option 1), an infringement regime (option 2) or an approach based on a menu of options (option 3)? Why?

Q47 Would you change any of the proposed key components of options 1 to 3?

Q48 Should any other options be considered (including any from Table Three that we propose not be progressed)?

## Application of the regime to personal use offences

### *Possession*

11.66 There are three potential approaches to determining eligibility for any new regime with reference to the offence of possession. The simplest approach is to apply the new regime to every possession offence. However, this assumes that everyone charged with a possession offence will only possess that drug for the purposes of personal use. This will not always be the case. In addition, if, as is one of the options discussed in chapter 10, the offence of possession for supply were abolished in favour of one broad possession offence, a way to isolate cases of possession for personal use would be required.

- 11.67 Most jurisdictions determine eligibility for their regime by identifying a specified amount of each drug that is deemed to be possessed only for personal use. This is the approach taken in some Australian regimes (which specify the applicable amount by numbers of grams or tablets), and in Portugal (which applies its regime to the average amount consumed by an individual over 10 days).
- 11.68 While this may be the clearest and most transparent approach, it also creates some difficulties. This includes, for example, the prospect of commercial suppliers tailoring the amount possessed to come within the scheme.<sup>817</sup> Whatever numerical amount is adopted will also lead to some arbitrariness on the boundary – for example, the difference between x grams and x.1 grams or y tablets and y.5 tablets might be small in practical terms but have quite different legal consequences for the user. In this respect, there seems no consistency in the amounts specified in other jurisdictions.<sup>818</sup> Finally, unless there was a residual discretion to exclude individuals from the regime, it would mean that an individual in possession of the applicable amount of drugs would come within any new regime even if the drug was possessed for the purposes of supply.
- 11.69 The final approach is not to identify a quantifiable limit, but to require the police to make an assessment in each case of whether the drugs are possessed for personal use. This approach is taken in the United Kingdom and in some Australian regimes.<sup>819</sup> It deals with the difficulties identified above, but makes the decision about whether a person is eligible for the new regime more complex and may lead to some inconsistency in how the regime is applied.

Q49 How should any new approach taken to personal use offences apply to the offence of possession?

### Use

- 11.70 When discussing whether drug use itself should remain a criminal offence (see paragraphs 11.5–11.10 above), we argued that some use (for example, use that occurs in front of children) encompasses greater culpability and criminality than simple possession. If use remains a criminal offence, “aggravated” use could be excluded from any new approach taken to personal use offences.
- 11.71 For example, in the United Kingdom, cannabis use that occurs in a public place or view is an aggravating factor that makes prosecution for cannabis possession, rather than the issuing of a penalty notice for disorder, more likely.<sup>820</sup> Similarly,

817 This seems more likely under an infringement regime given the relative lack of consequences an infringement notice carries compared to a cautioning scheme, and the unlimited number of times an infringement notice could be imposed.

818 Australia cannabis regimes range from 15 grams (New South Wales) to 100 grams (South Australia). Western Australia’s drug diversion scheme applies to the possession of no more than two tablets or, if the drug is “ambiguous” (for example, mushrooms), the amount that would give rise to a simple offence or, in other cases, a quarter of the amount in the Misuse of Drugs Act 1981 (WA) that would raise the sale/supply presumption.

819 For example, Tasmania’s diversion programmes and the South Australian diversion programme for drugs other than cannabis.

820 Association of Chief Police Officers *ACPO Guidance on Cannabis Possession for Personal Use: Revised Intervention Framework* (ACPO, London, 2009) para 2.2.1.

South Australia excludes from its infringement offence regime cannabis use that occurs in a public place, including in a motor vehicle, train, tram or any other vehicle while it is in public.<sup>821</sup>

Q50 If use remains a criminal offence, should “agravated” use be excluded from any new approach taken to personal use offences?

### *Possession of utensils*

- 11.72 We have argued above that there may be no purpose in retaining the prohibition on the possession of pipes and utensils for the purposes of using drugs. However, if that prohibition remains, we consider that the relevant offence should be included in the new approach. It seems illogical to apply any new approach to a substance without also applying it to the vessel or device in which the substance was used.

Q51 Should the possession of utensils for the purpose of using drugs, if it remains a criminal offence, be included in any new approach taken to personal use offences?

### *Cultivation of a prohibited plant*

- 11.73 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 10 in the context of dealing and proposed that, at a minimum, a presumption against imprisonment should apply where cultivation is for personal use.
- 11.74 Discussion of the approach that should be taken to personal use offences often includes a discussion about whether the same approach should be taken to cultivation, particularly cannabis cultivation. This is to ensure that users who grow their own supply are not subject to greater penalties than those who obtain their supply from others, and that users have less need to mix with criminal drug sellers to obtain their supply.
- 11.75 All Australian infringement offence regimes include limited cannabis cultivation for personal use within their approach to personal cannabis use. The amount of plants able to be cultivated is no more than two, and tends to be limited to plants that are not hydroponically 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.

821 Controlled Substances Act 1984 (SA), s 45A and Controlled Substances (General) Regulations 2000 (SA), r 9B.

- 11.76 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,<sup>822</sup> that supply still represents the end of a criminal supply chain. Enabling users to “grow their own” therefore weakens the cannabis black market.
- 11.77 Including some cultivation in a new regime with reference to the number of plants that may be grown 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 than from a fully-matured plant.
- 11.78 In addition, depending on the maximum number of plants that are subject to any new regime, there is some risk that they 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,<sup>823</sup> and is one reason why the maximum number of cultivated plants subject to the Scheme has progressively reduced from 10 to one since the Scheme started.<sup>824</sup> Western Australia 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.<sup>825</sup> A 2007 statutory review recommended that cannabis cultivation be removed from the Western Australian scheme.<sup>826</sup>
- 11.79 There seems a stronger argument for including cultivation in an infringement offence regime than 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.
- 11.80 As a matter of principle, the approach that is taken to cannabis cultivation should also be taken to the cultivation of any other prohibited plant. However, given that few, if any, other prohibited plants are cultivated in New Zealand, it may make little practical difference to the overall scope of the regime.

822 Chris Wilkins and others “Estimating the Dollar Value of the Illicit Market for Cannabis in New Zealand” (2005) 24 Drug and Alcohol Review 227, 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, 1998) 29.

823 A Sutton and E McMillian “Criminal Justice Perspectives on South Australia’s Cannabis Expiation Notice Procedures” (2000) 19 Drug and Alcohol Review 281.

824 The original ten plant limit was reduced to three plants in 1999, one plant in 2000, and then one non-hydroponic plant in 2001. *Global Cannabis Commission Report*, above n 800, 111.

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

826 Drug and Alcohol Office *Statutory Review: Cannabis Control Act 2003 Executive Summary Report to the Minister of Health* (Drug and Alcohol Office, Perth, 2007) 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.

Q52 Should cultivation of a prohibited plant for personal use be included within any new approach taken to personal use offences?

### *Other “dealing” activities*

- 11.81 In theory, the import, export, production, or manufacture of drugs can be committed in a personal use context. If cannabis cultivation is included in any new approach, it seems inconsistent not to make similar provision for these other “dealing” activities.
- 11.82 In chapter 10, we proposed that, at the least, the import, export, production, and manufacture of drugs for the defendant’s own use should be treated in the same way as proposed for social supply, so that a presumption against imprisonment should apply.
- 11.83 We do not propose to go further and apply any new approach taken to personal use offences to these offences as well. For convention drugs, there appears to be little, if any, scope to take such an approach anyway. Regardless of convention requirements, however, the potential harms inherent in the manufacturing process mean a less restrictive approach to those activities is not appropriate. Although the same harms do not apply to import/export, 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 also compromise the integrity of our borders and international efforts towards drug control.

Q53 Do you agree that the manufacture, production, and import or export of drugs for personal use should not be included in any regime that is applied to other personal use offences?

### **Approach to drug use by youth**

- 11.84 If a new approach is taken to personal 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.
- 11.85 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.<sup>827</sup> The latest New Zealand research suggests that drug use before the age of 15 increases the risk of a range of poor outcomes, including involvement in crime and early pregnancy.<sup>828</sup> The law in relation to personal use should reflect this evidence and, to the extent possible, protect young people from the harm of drug use.

<sup>827</sup> See, for example, paragraphs 2.28 – 2.33 of chapter 2.

<sup>828</sup> See Candice L Odgers and others “Is it Important to Prevent Early Exposure to Drugs and Alcohol among Adolescents” (2008) 19 *Psychological Science* 10.



- 11.86 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 % of young people in their studies had at least tried cannabis.<sup>829</sup> By age 21, approximately 9 % of these users were cannabis dependent.<sup>830</sup>
- 11.87 As with any offending committed by children and young people, personal 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.<sup>831</sup> Youth offenders over 15 years may also be transferred from the Youth Court to the District Court for sentencing.<sup>832</sup>
- 11.88 In 2008, there were 1545 police apprehensions in New Zealand of children and young people aged 16 and under for illegal drug offences.<sup>833</sup> The majority of apprehensions were for possession and use offences (68 %), involved cannabis (95 %), and were committed by 14–16 year olds (88 %). Most apprehensions resulted in a warning or caution (42 %) or referral to Police Youth Aid (38 %). Only a small proportion resulted in prosecution (16 %).<sup>834</sup> The vast majority of personal use offences committed by children and young people are therefore dealt with outside any formal court process.
- 11.89 Our preliminary view is that any new regime that is applied to personal use by adults should not apply to young people. There is already significant scope within the youth justice system to identify and deal with any drug treatment or other rehabilitative needs a young person may have. It would be counter-productive to remove the ability to access those responses in appropriate cases. For example, mechanically applying an infringement offence to young people, without any opportunity for diversion into drug assessment or treatment and with the potential to accumulate large amounts of unpaid fines, is not appropriate.
- 11.90 There is a stronger argument for applying option one (a cautioning scheme) to youth if that option was adopted for adults. 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, whereas the approach taken in individual

829 David M Fergusson and L John Horwood “Cannabis Use and Dependence in a New Zealand Birth Cohort” (2000) 113 *New Zealand Medical Journal* 156, 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, 545.

830 Fergusson and Horwood, above n 829, 157; Poulton and others, above n 829, 545.

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

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

833 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.

834 Table Builder (<http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx>, accessed 8 October 2009).



cases in the youth justice system is a matter for police discretion. If greater legislative guidance was considered desirable for the police response to youth in these cases, option two could be considered further.

**Q54** Do you agree that the approach that is taken to personal use offences committed by adults should not be extended to personal use offences committed by youth?

## Review and evaluation

11.91 If a new approach is taken to personal use offences, it will be necessary to review the impact of that approach after it has been in force for a sufficient period. The review should be aimed at assessing the effectiveness of the approach in meeting its objectives, and identifying any changes to it that are required. The review should also report on any changes in levels of drug use that are apparent over the period for which the approach has been in place.

**Q55** Should any new approach taken to personal use offences be reviewed after a specified period?

## OPTIONS FOR REFORM – THE COURT SYSTEM

### Introduction

11.92 The focus of this chapter has been on the regulatory approach that should apply at the time a personal use offence is detected. However, prosecution for a personal use offence will remain possible under at least two of the proposed options.<sup>835</sup> In addition, if none of the three options are progressed, there may still be scope to do more once a personal use offence reaches court.

11.93 Those who are prosecuted will benefit from the existing regulatory approach which enables a less severe approach to be taken to these offences than to other drug offences. This includes the possibility of Police Adult Diversion, and the prospect of sentencing being adjourned to enable an offender who has been convicted of a personal use offence to undertake a treatment programme prior to sentencing.<sup>836</sup> 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.

11.94 Unlike the earlier discussion about options for reform at the point an offence is detected, this discussion is limited to options for dealing with adults in the criminal justice system. The youth justice system remains an appropriate option for dealing with any offending by young people that falls outside any new approach that may be applied as a result of the discussion in paragraphs 11.84–11.90.

<sup>835</sup> Under option one (a cautioning scheme) and option three (a menu of options), it will remain possible for an individual to be prosecuted for a personal use offence. In addition, under all options, prosecution may also be possible for some aggravated instances of use (for example, use that occurs in front of children).

<sup>836</sup> Sentencing Act 2002, s 25.

11.95 Potential options to be applied in the court system include:

TABLE FOUR: Possible approaches to personal use offences at later stages of the criminal process		
Option	Description	Overseas examples
Greater use of Police Adult Diversion Scheme	Extension of Scheme to wider range of drug offences, for example, possession of Class A and B drugs.	–
Less severe penalties	Presumption against imprisonment could apply, or offences could become non-imprisonable.	Some Australian jurisdictions <sup>837</sup>
More formal opportunities for court-based diversion into assessment and treatment	Diversion of offenders into treatment-based services pre-conviction or sentence.	Australian jurisdictions, United Kingdom, United States [all drugs]

### Option 1: Greater use of Police Adult Diversion Scheme

- 11.96 It may be appropriate to extend the application of the Police Adult Diversion Scheme beyond its current focus on Class C drugs. If a less restrictive approach was taken to all drugs at earlier stages in the criminal process, there is no reason in principle to restrict the Scheme's application at this later stage in the process to a particular drug class.
- 11.97 There is a question about the overlap of the Scheme with any cautioning scheme that applies at the point an offence is detected. In particular, there seems little to be gained in requiring an offender who has exhausted all of his or her caution options (including attendance at a brief intervention session with a view to accessing voluntary treatment) to then be required to participate in drug assessment or treatment as part of the diversion conditions. 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.
- 11.98 As noted in chapter 7, there is no statutory basis for the Scheme. Any extension of the Scheme would therefore be a matter for the police, and its implementation would be guided by internal police policy.

<sup>837</sup> Primarily in relation to minor cannabis possession and related offences – see, for example, section 33K and section 33L of the Controlled Substances Act 1984 (SA), and section 171 of the Drugs of Dependence Act 1989 (ACT).

## Option 2: Less severe penalties

- 11.99 Another option would be to lessen the severity of the penalties that currently apply to possession and use offences. This could be achieved by extending the statutory presumption against imprisonment to all personal use offences (including Classes A and B), or by making these offences non-imprisonable.<sup>838</sup>
- 11.100 In chapter 10, we proposed that there be a presumption against imprisonment in cases involving social supply of any drug. This is on the basis that social supply is a less serious offence than any other form of supply, and is of a similar criminality to possession. It therefore makes sense that there is also a presumption against imprisonment for personal use offences.
- 11.101 However, this presumption, or a reduction in the maximum penalty itself, may have little impact on sentence levels in practice. For example, although the percentages differ between drugs,<sup>839</sup> most convicted cases of possession and use already result in a sentence of less than imprisonment.<sup>840</sup>

## Option 3: Court-based diversion into assessment and treatment

- 11.102 In chapter 15, we discuss making greater use of the court system to provide the defendant with assessment and treatment where alcohol or drug abuse and dependence are identified.<sup>841</sup> There is no reason why any new approach that is adopted as a result of that discussion should not also apply to personal use offences.

**Q56** Where prosecutions are initiated for personal use should any of the following options apply:

- (a) greater use of Police Adult Diversion Scheme;
- (b) less severe penalties;
- (c) court-based diversion into assessment and treatment?

Why?

**Q57** Should any other options be considered?

<sup>838</sup> If these offences were made non-imprisonable, the most severe sentences that could be imposed in terms of the current hierarchy of sentences would be a sentence of community detention or intensive supervision. Home detention would not be available, due to the statutory requirement that a judge cannot impose that sentence unless he or she would otherwise impose imprisonment (Sentencing Act 2002, s 15A).

<sup>839</sup> For example, while 1 % of convicted cases involving cannabis possession resulted in imprisonment in 2007, 10 % of convicted case involving possession of other drugs resulted in imprisonment. Table Builder (<http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx>, accessed 18 March 2009).

<sup>840</sup> In 2007, approximately 3 % of convicted cases resulted in imprisonment. 62 % of convicted cases resulted in a monetary penalty, 19 % resulted in a community-based sentence, and 13 % were ordered to come up if called upon or received a conviction and discharge. Table Builder (<http://wdmzpub01.stats.govt.nz/wds/TableViewer/tableView.aspx>, accessed 18 March 2009).

<sup>841</sup> See paragraphs 15.50–15.66 of chapter 15.

# Chapter 12

## Other offences and penalties, and procedural provisions

### SUMMARY

This chapter reviews those offences in the Misuse of Drugs Act 1975 that are not covered in other chapters, particularly chapter 10 (dealing) and chapter 11 (possession and use). It also considers those 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 drugs offence and matters of forfeiture.

**INTRODUCTION** 12.1 In addition to those offences already covered in earlier chapters, particularly chapters 10 and 11, the Misuse of Drugs Act 1975 contains a range of offences targeting other drug-related activities. This chapter reviews those offences and considers whether any changes to them are required. It also reviews those procedural and other provisions in the Act that apply, broadly, when a charge is being contemplated or laid.

**PRECURSOR SUBSTANCES** 12.2 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.

12.3 Under the Act, it is an offence to:

- (a) 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<sup>842</sup> (maximum penalty of five years imprisonment);<sup>843</sup>

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

843 Misuse of Drugs Act 1975, s 12A(3)(b). A lesser penalty applies upon summary conviction (s 12A(4)). As part of the Criminal Procedure (Simplification) Project (a joint project between the Law Commission and the Ministry of Justice to reform and simplify criminal procedure), it is proposed to remove those maximum penalties that apply upon summary conviction.

- (b) 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<sup>844</sup> (maximum penalty of seven years imprisonment);<sup>845</sup>
- (c) import or export any precursor substance knowing that it will be used to produce or manufacture any controlled drug<sup>846</sup> (maximum penalty of seven years imprisonment);<sup>847</sup>
- (d) import or export any precursor substance without a reasonable excuse<sup>848</sup> (maximum penalty of 12 months imprisonment and/or a \$1000 fine).<sup>849</sup>

12.4 Precursor substances are defined by their inclusion in Schedule 4 of the Act.<sup>850</sup> Most precursor substances also have legitimate industrial or medical uses, which often constitute their 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, there is some overlap in the regulation of precursor substances between the Misuse of Drugs Act, the Hazardous Substances and New Organisms Act 1996, and the Medicines Act 1981. It also means that 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 a precursor substance, unless it is possessed with the intention of producing, manufacturing or cultivating a controlled drug.

### Classification as precursor substances and controlled drugs

12.5 Some precursor substances are 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 scheduled as Class C drugs (although the Government has announced its intention to reclassify both as Class B2 drugs)<sup>851</sup> and precursor substances.

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

845 Misuse of Drugs Act 1975, s 12A(3)(a). A lesser penalty applies upon summary conviction (s 12A(4)(a)); see above n 843.

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

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

848 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)).

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

850 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 Schedule 4 is limited to ephedrine and pseudoephedrine, and was created in 2005 so that enforcement powers enabling warrantless search powers under section 18(2) of the Misuse of Drugs Act could apply.

851 Department of the Prime Minister and Cabinet *Tackling Methamphetamine: an Action Plan* (DPMC, Wellington, 2009) 31.

- 12.6 All three substances were reclassified as controlled drugs after their inclusion in Schedule 4.<sup>852</sup> We have been unable to ascertain the reason or impetus for reclassifying lysergic acid as a Class A drug. Pseudoephedrine and ephedrine were reclassified in response to increasing concern about the use of methamphetamine.
- 12.7 Broadly, reclassification as a controlled drug should enable greater controls to be placed over 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,<sup>853</sup> whereas many precursor substances can be.<sup>854</sup> However, there is a statutory exemption for some preparations of pseudoephedrine that enables it to be sold by pharmacists, and be bought by any person.<sup>855</sup> An amendment to the Misuse of Drugs Act in 2005 also extended enforcement powers to search, detain and seize certain controlled drugs without warrant to pseudoephedrine and ephedrine.<sup>856</sup> As a consequence, there are greater controls on these two controlled drugs than some Class B drugs and any other Class C drug.<sup>857</sup>
- 12.8 We are unsure why, after reclassification, these three substances remained listed in Schedule 4. Regardless, the treatment 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, and importation of a Class B drug carries a maximum penalty of 14 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 only seven years imprisonment.
- 12.9 Offences committed in relation to pseudoephedrine and ephedrine will almost always be in the context of their use as precursors in manufacturing methamphetamine. However, it seems unlikely that a precursor offence will be charged in these situations, in light of the higher maximum penalties that apply to offences involving controlled drugs.
- 12.10 We believe that it is preferable for substances to be scheduled as either precursor substances or controlled drugs, but not both. If a precursor substance is being used largely or solely for illegitimate purposes, it seems appropriate that it be reclassified as a controlled drug and that the offences and penalties in relation to controlled drugs apply.

852 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.

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

854 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.

855 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.

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

857 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.



- 12.11 The Expert Advisory Committee on Drugs has also raised with us a concern that the Act does not contemplate that the indirect harm caused by precursor substances can be used as a determinant in their classification. We are unsure why the Committee takes the view that the legislation precludes consideration of indirect harms. However, it may be helpful to clarify the appropriate approach, and make more explicit provision for the classification of precursor substances.

Q58 Do you agree that precursor substances should not be able to be classified as both precursor substances and controlled drugs?

Q59 Should precursor substances always be classified as controlled drugs in themselves when they are largely or solely used for illegitimate purposes? Is there a need to clarify that the indirect harms they cause should be taken into account in determining their appropriate classification level?

### Other issues

- 12.12 There is one precursor substance, norephedrine, which is included as a precursor substance in the 1988 Convention but not listed in Schedule 4. Norephedrine is a similar substance to ephedrine and pseudoephedrine. In 2008, the EACD agreed to recommend to the Minister of Health that norephedrine be classified as a Class B2 controlled drug and as a precursor substance.<sup>858</sup> We understand that this recommendation has been accepted and that the reclassification of norephedrine is pending.<sup>859</sup>
- 12.13 There are also a number of common chemicals used in the manufacture of illegal drugs, particularly methamphetamine, that are not subject to any controls under the Misuse of Drugs Act. These substances may instead be the subject of voluntary controls by the relevant industries.
- 12.14 As part of its action plan against methamphetamine, the Government has announced the establishment of a working group to investigate the imposition of stronger controls on other precursor substances and products used in methamphetamine manufacture.<sup>860</sup> The working group is to be established by 1 March 2010, with the first report-back to Ministers due by 31 May 2010.
- 12.15 That work aims to control and reduce methamphetamine manufacture by restricting access to the required precursor substances and other chemicals.<sup>861</sup> However, as the recent debate on the reclassification of pseudoephedrine has demonstrated, the imposition of stronger controls is likely to restrict a substance's legitimate use and availability. It will therefore be necessary to consider, as part of that work, whether the proposed controls are justified in light of the costs they will impose.

858 Expert Advisory Committee on Drugs (13 November 2008) meeting minutes [www.ndp.govt.nz/moh.nsf/pagescm/565/\\$File/eacd-minutes-13nov09.pdf](http://www.ndp.govt.nz/moh.nsf/pagescm/565/$File/eacd-minutes-13nov09.pdf) (accessed 22 October 2009).

859 Advice from the Ministry of Health (18 December 2009).

860 Department of the Prime Minister and Cabinet, above n 851, 29.

861 Ibid.

- 12.16 In the light of the establishment of that working group, we have not looked any further at issues related to the control of precursor substances as part of our review.

Q60 Are there any matters relating to precursor substances that could be usefully addressed as part of the Law Commission's review, rather than by the working group established under the Government's methamphetamine action plan?

OFFENCES  
COMMITTED  
FOR THE  
PURPOSE OF  
COMMITTING  
OTHER DRUGS  
OFFENCES

- 12.17 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*

- 12.18 As discussed in chapter 11, it is an offence under section 13 to possess a utensil, such as a pipe, bong or needle, for the purpose of committing an offence against the Act.<sup>862</sup> Regardless of the class of drug involved, this offence carries a maximum penalty of 12 months imprisonment and/or a \$500 fine.<sup>863</sup>
- 12.19 In chapter 11, we queried whether the offence remains appropriate in relation to its primary purpose, to prohibit the possession of utensils for the purpose of using drugs. If it is not, we do not think this offence is required at all. Since 1998, the possession of equipment (including utensils) to produce, manufacture, or cultivate drugs has been covered by a separate offence (see paragraph 12.25(c)). We are not aware of any recent cases of individuals being charged with the possession of utensils for the purpose of committing any other offence against the Act (for example, sale or supply).<sup>864</sup>

*Import and supply of pipes and utensils*

- 12.20 There is currently a notice, made under the Minister of Health's regulation-making powers in section 22(1A), prohibiting the import and supply of utensils for using cannabis or methamphetamine.<sup>865</sup> Contravention of this notice is an offence carrying a maximum penalty of three months imprisonment and/or a \$1000 fine for an individual, or a \$5000 fine for a body corporate.

862 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).

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

864 The only case we could find is *R v Tunui* (1992) 8 CRNZ 294 (HC) Anderson J, 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 12.25(c) of this paper.

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

- 12.21 If the possession of utensils for the purpose of using drugs does not remain an offence, there is a question about whether the import or supply of utensils for that purpose should remain so. Arguably, it is inconsistent to legalise the possession of these utensils, but to require users to access criminal markets to obtain them.
- 12.22 However, retaining an offence seems consistent with our overall approach to direct enforcement away from users and towards suppliers. Removing an offence relating to the possession of utensils is not intended to signal that these utensils are desirable items to have but, rather, to recognise that the relevant offence serves no useful purpose.
- 12.23 If the import and supply of utensils was no longer a criminal offence, some regulatory controls might still be required to restrict the way in which these utensils can be sold and supplied. For example, as part of its infringement notice regime for minor cannabis offences,<sup>866</sup> Western Australia has introduced legislative controls on the sale and supply of utensils used to smoke cannabis.<sup>867</sup> Sellers of utensils must display a warning notice on the adverse consequences of cannabis use,<sup>868</sup> and make available prescribed cannabis education material to anyone who buys utensils.<sup>869</sup> Non-compliance with these requirements is an offence punishable by a fine.<sup>870</sup> It is also an offence to sell utensils to a person under 18 years, which is also punishable by a fine.<sup>871</sup>
- 12.24 If the import and supply of utensils remained a criminal offence, we consider that the relevant offence should be contained in primary legislation and not in a regulation-making power. As discussed later in chapter 13, section 22 is essentially a reserve power that is available to deal with unanticipated and urgent safety issues. We have reservations about its use to deal with less urgent matters. There also seems no reason to limit the prohibition specifically to cannabis and methamphetamine utensils.

Q61 Is an offence prohibiting the supply and import of utensils still required?

Q62 If an offence of prohibiting the supply and import of utensils is required:

- (a) Do you agree that it should be in primary legislation, rather than be established via a regulation-making power?
- (b) Should the offence be broadened to cover utensils for using other drugs as well as cannabis and methamphetamine?

<sup>866</sup> Regime to be repealed by Cannabis Law Reform Bill 2009 (WA), introduced 14 October 2009.

<sup>867</sup> The provision applies to any cannabis smoking “paraphernalia” which include anything made or modified to be used in smoking cannabis, or any other thing prescribed by regulation to be cannabis smoking paraphernalia (Cannabis Control Act 2003 (WA), s 21). No regulation for this purpose has been made.

<sup>868</sup> Cannabis Control Act 2003 (WA), s 22.

<sup>869</sup> Cannabis Control Act 2003 (WA), s 23.

<sup>870</sup> \$1000 fine for an individual, \$5000 fine for a body corporate – see Cannabis Control Act 2003 (WA), ss 22–23.

<sup>871</sup> \$5000 fine for an individual, \$25,000 for a body corporate – see Cannabis Control Act 2003 (WA), s 24.

Q63 If an offence is not required, should the supply and import of utensils be regulated? If so, what regulatory controls are required?

### Other offences

12.25 It is also 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.<sup>872</sup> The maximum penalty depends on the class of drug in relation to which the offence was committed.<sup>873</sup>
- (b) Supply, produce or manufacture 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, knowing that the equipment or material is to be used for that purpose.<sup>874</sup> The maximum penalty is seven years imprisonment.<sup>875</sup>
- (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.<sup>876</sup> The maximum penalty is five years imprisonment.<sup>877</sup>

12.26 Arguably, the offence in (a) is no longer necessary. This is because an individual who committed this offence could also be held liable as a party to the principal offence. However, a separate offence may be more transparent. In addition, if the offence was repealed in favour of parties' liability, the applicable maximum penalty would increase substantially. For example, a party to dealing in a Class A drug is subject to a maximum penalty of life imprisonment, while an individual convicted under this provision for the same conduct is subject to a maximum penalty of ten years imprisonment. In both instances, the extent of the party's participation in the offence would be reflected in the sentence imposed.

12.27 A review of relevant authorities indicates that there are no particular difficulties with the offences in (b) or (c) that require legislative amendment. However, we are unsure why, unlike (a) above, their maximum penalties are not linked more directly to the seriousness of the offence that may have otherwise been committed. For example, it is arguably more serious to commit either offence in relation to a Class A drug than a Class C drug. Currently, however, this only becomes relevant at sentencing.<sup>878</sup>

<sup>872</sup> Misuse of Drugs Act 1975, s 12(1).

<sup>873</sup> Misuse of Drugs Act 1975, s 12(2). The maximum penalty is 10 years for a Class A drug, seven years for a Class B drug, and three years in any other case. Lesser penalties apply upon summary conviction (s 12(3)).

<sup>874</sup> Misuse of Drugs Act 1975, s 12A(1)(a).

<sup>875</sup> Misuse of Drugs Act 1975, s 12A(3)(a). A lesser penalty applies upon summary conviction (s 12A(4)(a)); see above n 843.

<sup>876</sup> Misuse of Drugs Act 1975, s 12A(2)(a).

<sup>877</sup> Misuse of Drugs Act 1975, s 12A(3)(b). A lesser penalty applies upon summary conviction (s 12A(4)(a)); see above n 843.

<sup>878</sup> See, *R v McLean* (18 August 2005) CA 102/05, para 18 William Young J for the Court.

12.28 In addition, the relativities between some of the maximum penalties are questionable. For example, it is debatable whether the maximum penalty for supplying, producing or manufacturing equipment to cultivate a prohibited plant should be the same as that for cultivating the plant itself. Some revision of the maximum penalties therefore appears required.

Q64 Should the offence in section 12(1) of the Misuse of Drugs Act of knowingly permitting any premises, vessel etc to be used for the purpose of committing an offence be retained?

Q65 Are any amendments required to the offences in paragraphs 12.25 (b) and (c) (sections 12A(1)(a) and 12A(2)(a))?

Q66 Should the maximum penalties for the offences referred to in Q64 and 65 be revised? If so, what should they be?

## OFFENCES COMMITTED OUTSIDE NEW ZEALAND

12.29 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);
- (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

12.30 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 12.29. The maximum penalty for the offence is the same as it would be if the offence was committed in New Zealand.<sup>879</sup>

12.31 A person cannot be charged under section 12C unless he or she is a New Zealand citizen<sup>880</sup> and is present in New Zealand,<sup>881</sup> and the Attorney-General has given consent to a charge being laid.<sup>882</sup> 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,

<sup>879</sup> Misuse of Drugs Act 1975, s 12C(3).

<sup>880</sup> Misuse of Drugs Act 1975, s 12C(2)(a).

<sup>881</sup> Misuse of Drugs Act 1975, s 12C(2)(b).

<sup>882</sup> Misuse of Drugs Act 1975, s 28A(1).

and he or she may be remanded in custody or on bail.<sup>883</sup> The Attorney-General may make such inquiries as he or she thinks fit when deciding whether or not to give consent.<sup>884</sup>

- 12.32 The act or omission must be an offence under the law of the place where the act was done or omitted.<sup>885</sup> 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.<sup>886</sup> We discuss evidential onuses such as these later in the chapter.
- 12.33 This offence was introduced as part of New Zealand's obligations under the 1988 Convention. It has some notable features, including its extra-territorial effect and requirement for the Attorney-General to give consent to a charge being laid. We do not consider these features to be problematic. Extra-territorial jurisdiction has become a standard feature of many international agreements in criminal law,<sup>887</sup> and is reflected in other provisions in the Crimes Act 1961.<sup>888</sup> The provisions relating to the Attorney-General's consent are also consistent with the Crimes Act provisions.<sup>889</sup>
- 12.34 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. However, it differs from extra-territorial provisions in the Crimes Act, which extend jurisdiction to a person ordinarily resident in New Zealand.<sup>890</sup> Under that formulation, jurisdiction extends to people who are not in New Zealand at the time the offence is committed but who effectively make their home here.<sup>891</sup>

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883 Misuse of Drugs Act 1975, s 28A(2).

884 Misuse of Drugs Act 1975, s 28A(3).

885 Misuse of Drugs Act 1975, s 12C(4).

886 Misuse of Drugs Act 1975, s 12C(5).

887 See, for example, the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment 1984, which is reflected in the extra-territorial offences in the Crimes of Torture Act 1989. See also the Convention on Combating Bribery of Foreign Public Officials in International Business Transactions 1997, which is reflected in the extra-territorial offence of the Crimes Act 1961, s 105D.

888 Crimes Act 1961, s 7A.

889 Crimes Act 1961, s 7B.

890 See Crimes Act 1961, ss 7A and 105D (bribery of foreign officials).

891 Under section 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.



- 12.35 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. As a matter of policy, we are unsure why section 12C should differ from other Crimes Act provisions in this respect. We also consider it desirable that all extra-territorial provisions are drafted in as similar a manner as possible.

Q67 Do you agree that extra-territorial jurisdiction under section 12C should extend to those “ordinarily resident” in New Zealand?

Q68 Are any other changes to section 12C required?

### Offence committed while in New Zealand

- 12.36 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 12.29 above,<sup>892</sup> or
  - (b) would, if done or omitted in New Zealand, constitute one of the offences identified in paragraph 12.29,<sup>893</sup> and is an offence in the country where it occurred.<sup>894</sup>
- 12.37 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). The drafting of the provision therefore needs to be simplified and clarified.
- 12.38 The maximum penalty if the act or omission constitutes an offence of dealing is 14 years imprisonment.<sup>895</sup> Otherwise, the maximum penalty is seven years imprisonment.<sup>896</sup>
- 12.39 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.<sup>897</sup> There are similar, although less stark, examples for other offences.<sup>898</sup>

<sup>892</sup> Misuse of Drugs Act 1975, s 10(1)(a).

<sup>893</sup> Misuse of Drugs Act 1975, s 10(1)(b).

<sup>894</sup> Misuse of Drugs Act 1975, s 10(4).

<sup>895</sup> Misuse of Drugs Act 1975, s 10(2)(a). A lesser penalty applies upon summary conviction (s 10(3)); see above n 843.

<sup>896</sup> Misuse of Drugs Act 1975, s 10(2)(b). A lesser penalty applies upon summary conviction (s 10(3)); see above n 843.

<sup>897</sup> The maximum penalty for dealing in a Class C drug is eight years (Misuse of Drugs Act 1975, s 6(2)(c)).

<sup>898</sup> For example, the maximum penalty for dealing in Class B drugs is 14 years imprisonment (Misuse of Drugs Act 1975, s 6(2)(b)) and the maximum penalty for obtaining or possessing the proceeds of drug offending with the intention of money laundering is five years (Misuse of Drugs Act 1975, s 12B(3)).

- 12.40 We propose to review the maximum penalties for this offence. One possible approach is to set its maximum penalties so that they are in line with offences where the equivalent act or omission is committed in this country.

Q69 Should the maximum penalties for section 10 be reviewed, to ensure appropriate relativities with acts or omissions committed in New Zealand?

Q70 Are any other changes to section 10 required?

#### LAUNDERING PROCEEDS OF DRUG OFFENCES

- 12.41 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);
  - (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).<sup>899</sup>
- 12.42 A maximum penalty of seven years imprisonment applies if the money laundering transaction was actually engaged in,<sup>900</sup> with a maximum penalty of five years imprisonment if property was possessed or obtained with the intention of doing so.<sup>901</sup>
- 12.43 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.<sup>902</sup> 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.<sup>903</sup>
- 12.44 These offences were introduced in 1998 to meet New Zealand's obligations under the 1988 Convention. Except for the specific reference to those offences identified in paragraph 12.41 above, section 12B is identical in terms to the money laundering provisions in the Crimes Act that prohibit laundering the proceeds of serious offences.<sup>904</sup> The offences identified in paragraph 12.41 also fall within the application of the Crimes Act provisions (where serious

899 Misuse of Drugs Act 1975, s 12AB(2) and (3).

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

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

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

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

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

offence is defined as meaning an offence punishable by imprisonment for a term of imprisonment of five years or more,<sup>905</sup> which is currently the case for all of the offences in paragraph 12.41).<sup>906</sup>

- 12.45 However, despite these similarities, a specific money laundering offence was included in the Misuse of Drugs Act to facilitate the application of special rules relating to extra-territoriality and extradition that were required by the 1988 Convention.<sup>907</sup> The existence of a specific offence 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. We support its inclusion as a separate offence on this basis.

Q71 Are any changes to section 12B required?

## MISCELLANEOUS OFFENCES **Theft of controlled drugs**

- 12.46 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;
  - (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.
- 12.47 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.<sup>908</sup>
- 12.48 We are not aware of any difficulties with this offence that require legislative amendment. However, we are not sure that this offence is strictly necessary, given the general dishonesty offences provided in the Crimes Act. Those offences appear to cover the same ground.<sup>909</sup>

905 Crimes Act 1961, s 243(1).

906 If the maximum penalties for those offences were to change as a result of this review, a specific money laundering offence for drugs may be required.

907 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.

908 See Crimes Act 1961, ss 223 and 247.

909 See Crimes Act 1961, ss 219 (theft), 240 (obtaining by deception) and 246 (receiving).

- 12.49 One argument in favour of its retention is that the maximum penalties for the relevant dishonesty offences are linked to the amount stolen or received.<sup>910</sup> A separate maximum penalty would therefore be required for dishonesty offences involving a controlled drug.

Q72 Should section 11 be retained?

### Possession of seed or fruit of prohibited plant

- 12.50 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<sup>911</sup> or as may be provided by regulations.<sup>912</sup> The maximum penalty is 12 months imprisonment and/or a fine not exceeding \$500.<sup>913</sup>
- 12.51 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.<sup>914</sup> We discuss legal onuses such as these later in the chapter.
- 12.52 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. We therefore support its retention on that basis.

Q73 Should section 13(1)(b) be retained?

Q74 Are any changes to section 13(1)(b) required?

### False statements

- 12.53 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 \$1000.

910 See Crimes Act 1961, ss 223 (punishment of theft), 241 (obtaining by deception) and 247 (punishment of receiving).

911 Under a licence to cultivate prohibited plants issued under section 14 of the Misuse of Drugs Act 1975.

912 For example, Misuse of Drugs (Industrial Hemp) Regulations 2006.

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

914 Misuse of Drugs Act 1975, ss 9(4), 13(2).

- 12.54 To commit the offence, it is not necessary for a person to actually obtain a licence or some other benefit as a consequence of the false statement or document. All that is necessary is that the statement be made or the document be used for that purpose. In addition, the offence's application to "any other purpose" under the Act significantly broadens its scope. For example, it would appear to apply to a patient who falsely represented symptoms to a medical practitioner to obtain a prescription for a controlled drug.<sup>915</sup>
- 12.55 We think that an offence of making false statements for the purposes of obtaining a licence should be retained. The licensing authority ought to have the power to prosecute a person who knowingly provides false information for that purpose.
- 12.56 However, we are less certain about whether making false statements in other situations ought to be an offence. As we have noted, the scope of this offence is unclear. We do not think it is appropriate to have a broad offence that covers false statements made in other unspecified circumstances. Instead, the circumstances in which it is an offence to make a false statement or use a document that is not genuine should be expressly provided for in the provision.

Q75 Should it continue to be an offence for a person to make a false statement for the purposes of obtaining a licence under the Act (section 15)?

Q76 In what other circumstances under the Act should it be an offence for a person to make a false statement?

## Other offences?

### *Children found in clandestine drug laboratories*

- 12.57 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 Police have 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.
- 12.58 The Law Commission has recently recommended the revision of much of Part 8 of the Crimes Act, which deals with offences against the person.<sup>916</sup> 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."

915 A prescription would normally give the patient the right to lawfully obtain and use those controlled drugs under an exemption in section 8 of the Misuse of Drugs Act.

916 New Zealand Law Commission *Review of Part 8 of the Crimes Act 1961: Crimes Against the Person* (NZLC R111, Wellington 2007).

12.59 The relevant recommendations from the Commission's review include:<sup>917</sup>

- (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 will also be extended to apply to children under the age of 18 years, and the maximum penalty will be 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 will be defined as meaning actual bodily harm, will 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 does any unlawful act or omits to perform any statutory duty commits an offence punishable by up to two years imprisonment if, in the circumstances, that act or omission is likely to injure another. Where injury results, the maximum penalty is up to three years imprisonment. The lesser "gross negligence" standard will also apply to these offences.

12.60 The above recommendations, which have been accepted by the Government,<sup>918</sup> 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 provision for an offence is required.

Q77 In the light of the recommendations outlined in paragraph 12.59, do you agree that no additional offence is required to impose liability on those who expose children to the harms of drug manufacture?

### *Other offences*

12.61 We are not aware of any other proposals for the inclusion of new offences in the Misuse of Drugs Act. Nor do we consider there to be any gaps in the scope of the current offences that should be addressed. However, we are interested in views on areas where new offences may be required.

Q78 Are any new offences required?

<sup>917</sup> Ibid, chapters 4 and 5.

<sup>918</sup> See Simon Power, Minister of Justice "Govt to Strengthen Crimes Act to Protect Children" (18 December 2009) Press Release [www.beehive.govt.nz/release/govt+strengthen+crimes+act+protect+children](http://www.beehive.govt.nz/release/govt+strengthen+crimes+act+protect+children) (accessed 18 January 2010).



- 12.62 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.<sup>919</sup> The offences to which this penalty apply 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 the 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)).
- 12.63 We do not have any difficulty with the existence of a general penalty provision. However, a review of the penalty itself may be desirable to ensure it is relative to regulatory offences of similar seriousness.
- 12.64 In other parts of this paper, we have provisionally recommended the repeal of or amendment to some of the offences above including those under section 20 (see (d) above), section 24 (see (g) above), and section 25 (see (h) and (i) above). This chapter also discusses the offence under section 21 (see (e) above). When we have finally determined the scope of the offences to which the general maximum penalty should apply, we will consider what the penalty in relation to those offences should be. The scope of the relevant offences is unlikely to be finalised until the preparation of our final report (after consultation on this paper has taken place).

Q79 Should the general maximum penalty contained in section 27 be reviewed?

Q80 Bearing in mind that the scope of the offences to which the general maximum penalty will apply is not yet clear, do you have a view on what the maximum penalty should be?

<sup>919</sup> Misuse of Drugs Act 1975, s 27.

## LIMITATION PERIODS

- 12.65 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.<sup>920</sup> An exception is made for dealing,<sup>921</sup> cultivation of a prohibited plant,<sup>922</sup> or aiding offences against the corresponding law of another country.<sup>923</sup> There is no time limit on when charges in relation to these offences can be laid.
- 12.66 In respect of criminal charges more generally, charges that are laid in the summary jurisdiction<sup>924</sup> 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 \$2000 fine,<sup>925</sup> and no limitation period for offences with a greater maximum penalty.
- 12.67 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.
- 12.68 We do not consider that a minimum limitation period of four years can be justified for all offences in the Act. In particular, a four-year limitation period does not seem necessary, appropriate, or proportionate to the seriousness of personal use offences. There is no reason why, for example, a person that Police apprehend for possession of BZP should be able to be prosecuted for that offence up to four years later (even if that is unlikely to occur in reality).
- 12.69 However, a longer limitation period, whether four years or more, does seem justified for more serious matters (including commercial dealing) and those matters that are likely to be difficult to investigate (such as offences that occur overseas). More than one limitation period therefore seems required.
- 12.70 The four-year limitation period was included when the Act was first introduced. The removal of any limitation period for dealing, cultivation of a prohibited plant, or aiding offences against the corresponding law of another country occurred in 1980. We are unsure of the rationale for either provision, but assume the latter was due to concern that four years did not provide the police with sufficient time, in the most serious and complex cases, to carry out an adequate investigation.

920 Misuse of Drugs Act 1975, s 28(2).

921 Misuse of Drugs Act 1975, s 6.

922 Misuse of Drugs Act 1975, s 9.

923 Misuse of Drugs Act 1975, s 10.

924 Broadly, the summary jurisdiction deals with less serious cases where the option of trial by jury is not available. The indictable jurisdiction deals with more serious cases which are heard by a jury.

925 Crimes Act 1961, s 10B.

12.71 In our view, there is no reason why the limitation periods in drugs cases should differ from the limitation periods that apply more generally in criminal cases. The general limitation periods are subject to some limited review as part of the Criminal Procedure (Simplification) Project.<sup>926</sup> Broadly, the current proposal is that:<sup>927</sup>

- (a) a six-month limitation period will apply to offences with a maximum penalty of a \$7500 fine or a maximum penalty of up to three months imprisonment (irrespective of what fine may be imposed for the offence);
- (b) a 10-year limitation period will apply to offences with a maximum penalty of between three months imprisonment and up to three years imprisonment;
- (c) there will be no limitation period for offences with a maximum penalty of three years imprisonment or more.

Q81 Do you agree that a minimum four-year limitation period (contained in section 28) is not required for drugs offences?

Q82 Do you agree that the limitation periods should not differ from the limitation periods for general criminal offences? If not, what is it about drugs offences that require limitation periods to be different?

## LIABILITY FOR THE ACTS OF ANOTHER

### Liability of a principal for the acts of an agent

12.72 Under section 17(1), a principal is liable for an offence committed by his or her agent, 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.<sup>928</sup> 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.

12.73 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.

926 The Criminal Procedure (Simplification) Project is a joint project between the Law Commission and the Ministry of Justice to reform and simplify criminal procedure – see [www.lawcom.govt.nz/ProjectGeneral.aspx?ProjectID=149](http://www.lawcom.govt.nz/ProjectGeneral.aspx?ProjectID=149) (accessed 18 January 2010).

927 See Commentary to the Criminal Procedure (Simplification) Bill Plan, paras 59–66 [www.justice.govt.nz/policy-and-consultation/crime/documents/Criminal-Procedure-Simplification-Project/Criminal%20Procedure%20-Simplification-%20Bill%20Plan%20Commentary.pdf](http://www.justice.govt.nz/policy-and-consultation/crime/documents/Criminal-Procedure-Simplification-Project/Criminal%20Procedure%20-Simplification-%20Bill%20Plan%20Commentary.pdf) (accessed 18 January 2010).

928 Misuse of Drugs Act 1975, s 17(1).

- 12.74 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.<sup>929</sup>
- 12.75 In contrast to section 17(1), section 66 does not extend parties' liability to a person whose negligence enables an offence to occur. Unless a case for an exception can be made, section 17(1) should either be limited so that it is consistent with section 66 or be repealed altogether (in which case section 66 would apply as it does to any other offence).
- 12.76 However, section 17(1) is replicated in a number of other statutes, all of which apply in a regulatory context.<sup>930</sup> This is because it is in the regulatory context, rather than in the criminal context, that these types of relationships are likely to arise and where principals are likely to have relationships with agents that affect their fulfilment of specific statutory obligations. The question is whether the drugs context can also be considered a regulatory context.
- 12.77 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.
- 12.78 On balance, we think that section 17(1) should be retained. In the drugs context, for example, pharmacists have specific obligations to ensure that controlled drugs are held in a secure manner.<sup>931</sup> Section 17(1) reflects the principle that a pharmacist should be liable if, due to his or her neglect, or with his or her consent or connivance, an employee is able to deal in controlled drugs that the pharmacy holds. We think that the liability of the pharmacist in this situation is appropriate. We also note that a similar provision exists in the Medicines Act 1981.<sup>932</sup> Given the overlap in substances covered by the two Acts, it would be odd to have liability imposed upon a principal in one context but not in the other.
- 12.79 However, there is a question about whether 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 dealt with was a Class A drug.

929 Crimes Act 1961, s 66(1).

930 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.

931 See Misuse of Drugs Regulations 1977, reg 28.

932 Medicines Act 1981, s 79.

Q83 Do you agree that section 17(1) should be retained?

Q84 If section 17(1) is retained, should there be a lower maximum penalty when section 17(1) applies due to negligence?

### Corporate liability

12.80 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.

12.81 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.

12.82 As with section 17(1), we think that there may need to 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.

Q85 Do you agree that section 17(2) should be retained?

Q86 If section 17(2) is retained, should there be a lower maximum penalty when section 17(2) applies due to negligence?

## MATTERS OF PROOF, ONUSES, AND DEFENCES

### Matters of proof

12.83 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*

12.84 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.<sup>933</sup>

12.85 Under section 29B, the prosecution must prove the presence of THC when an offence of dealing, possessing or using a cannabis preparation is alleged.<sup>934</sup> The required processing is then deemed to have occurred unless the preparation

933 Misuse of Drugs Act 1975, 2nd sch, part 1.

934 Misuse of Drugs Act 1975, s 29B(a).

is in a form that is clearly recognisable as plant material.<sup>935</sup> A preparation that is clearly recognisable as plant material does not fall within the definition of cannabis preparation (because it has not been subject to the required processing). 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.<sup>936</sup>

- 12.86 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.<sup>937</sup> It provides a straightforward 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.
- 12.87 We are not aware of any difficulties with the operation of section 29B, and propose no changes to it.

Q87 Do you agree that section 29B should be retained?

Q88 Are any amendments to section 29B required?

### *Evidence of analysis*

- 12.88 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.<sup>938</sup>
- 12.89 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.
- 12.90 A certificate may only be given by an “analyst” as that term is defined in the Act.<sup>939</sup> The certificate must state the date on which the substance, preparation, mixture or article was received, the circumstances in which it was received, and the results of the analysis.<sup>940</sup>
- 12.91 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

935 Misuse of Drugs Act 1975, s 29B(b).

936 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)).

937 See *Tarlton v Police* (1986) 2 CRNZ 283, 284 (HC) Thorp J; and *R v Gillan* [2005] DCR 319, 326 Judge Abbott.

938 Misuse of Drugs Act 1975, s 31(2).

939 Any person designated by the Minister of Health by Gazette notice as the analyst in charge of an approved laboratory or any person who works in an approved laboratory and is authorised by the analyst in charge to act as an analyst for the purposes of the Act. Misuse of Drugs Act 1975, s 31(1).

940 Misuse of Drugs Act 1975, s 31(2).



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 requirement to the prosecution at least three clear days before the hearing.<sup>941</sup> The court may also direct, on its own initiative or on application by the defence, that the analyst be called as a witness.<sup>942</sup>

- 12.92 We are not aware of any difficulties with the operation of section 31. 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. We propose its retention (although we think it could be drafted much more clearly).

Q89 Do you agree that section 31 should be retained?

Q90 Are any amendments to section 31 required?

### Evidential onuses on the defendant

- 12.93 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.
- 12.94 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 (see paragraph 12.112 to 12.124 below), they do not shift the burden of proof. They are therefore more likely to be consistent with the New Zealand Bill of Rights Act 1990.
- 12.95 Currently, a defendant has a clear evidential onus in relation to anything that might be categorised as a defence. 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, 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.
- 12.96 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.

941 Misuse of Drugs Act 1975, s 31(3).

942 Misuse of Drugs Act 1975, s 31(4).

12.97 There are a number of explicit evidential onuses in the Act.<sup>943</sup>

- (a) 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.<sup>944</sup>
- (b) A defendant charged with an offence of laundering drug proceeds which resulted from acts done overseas has the onus of pointing to evidence that the act which is alleged to constitute the offence was not an offence in the country where it occurred.<sup>945</sup>
- (c) A defendant charged with committing an offence outside New Zealand has the onus of pointing to evidence that the act to which the charge relates was not an offence where it was done.<sup>946</sup>
- (d) In summary proceedings, when possession is the offence charged, or is an element of the offence charged, the defendant has the onus of pointing to evidence that the amount possessed was not of a usable quantity.<sup>947</sup>

12.98 We do not think there is a continued need to explicitly state that the evidential onus in (a) exists. Regardless of whether it is expressly stated in legislation, the defence will always have the onus of pointing to evidence which suggests that a reasonable excuse exists.

12.99 We are less certain about the evidential onuses in (b) and (c). 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 prove this in every case.

Q91 Do you agree that the evidential onus in paragraph 12.97(a) (section 12AC(4)), requiring the defence to point to evidence that the defendant had a reasonable excuse for importing or exporting a precursor substance, does not need to be explicitly stated?

Q92 Should the evidential onuses in paragraphs 12.97(b) and (c) (sections 12B(8) and 12C(5)), requiring the defence to point to evidence that the act (or omission) was not an offence in the country where it occurred, be explicitly stated?

943 We do not deal with those provisions which create a defence without explicitly imposing an evidential onus on the defendant. As noted in paragraph 12.95, the defendant also has an evidential onus in respect of those defences – see, for example, Misuse of Drugs Act 1975, s 10 (that an act or omission was not an offence where it was done or omitted) and Misuse of Drugs Act 1975, s 12B(6) (that drug proceeds were laundered in connection with enforcement of the Act).

944 Misuse of Drugs Act 1975, s 12AC(4).

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

946 Misuse of Drugs Act 1975, s 12C(5).

947 Misuse of Drugs Act 1975, s 29A.

*That the amount possessed is not of a usable quantity*

- 12.100 In 1975, the Court of Appeal held that a drug could not be possessed if the amount held was not of a usable quantity – that is, if it was “minute and useless residue”.<sup>948</sup> This was on the basis that the object of the then Narcotics Act 1965 was to prevent the illicit use of drugs and not to eliminate the existence of drugs as an end in itself.<sup>949</sup>
- 12.101 Although the requirement that the amount possessed be of a usable quantity remains,<sup>950</sup> it has not been incorporated into statute. However, section 29A was inserted into the Act in 1978 requiring that, in summary proceedings which involve possession (whether as the alleged offence itself or as an element of the offence), 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.<sup>951</sup> If the defence does so, the prosecution must prove that the amount possessed was usable beyond a reasonable doubt.
- 12.102 At the same time, procedural provisions were introduced giving the prosecution the opportunity to respond to the issue once raised. This includes the requirement that the hearing be adjourned if the prosecutor requires time to arrange for the appropriate witness to be called, and that the court allow the prosecutor to re-open its case if it has closed its case by the time the defence raises the matter.<sup>952</sup>
- 12.103 Section 29A raises two issues. The first is whether there should be a usable quantity requirement at all. If the requirement is retained, the second question is whether the substantive content of section 29A, including the evidential onus and the other procedural provisions outlined in paragraph 12.102, are required and, if so, what they should contain.

*Should the usable quantity requirement be retained?*

- 12.104 The requirement that the possessed drug be of a usable quantity avoids the prospect of prosecutions being commenced in respect of minute quantities or traces of a drug.<sup>953</sup> The minor nature of the offence in these cases means that the time and cost of a prosecution is unlikely to be in the public interest. It also avoids any risk that a person will be prosecuted and convicted as a result of cross-contamination (for example, from the individual’s suitcase or other belongings coming in contact with traces of a controlled drug during transit).
- 12.105 The requirement also seems consistent with the objective of the Act, as applied to its predecessor by the Court of Appeal in 1975, to prevent the misuse of drugs rather than to eradicate drugs altogether. Applying our proposed justification for drug regulation (that regulation of drug use is only justified to the extent

948 *Police v Emirali* [1976] 2 NZLR 476, 480.

949 *Ibid.*

950 For a recent decision in which the defence was considered, see *Tamati v Police* (30 July 2008) HC NAP CRI-2008-441-13.

951 Misuse of Drugs Act 1975, s 29A(1).

952 Misuse of Drugs Act 1975, s 29A(2).

953 For example, in *R v Boyesen* [1982] AC 768 (HL), charges were laid in respect of traces of cannabis resin found in a “tiny” polythene bag in a metal tin. In *Williams v R* [1978] HCA 49, charges were laid in respect traces of cannabis, invisible to the naked eye, that were found in the defendant’s coat.

necessary to prevent harm to others), if the quantity of a drug possessed is so small that it cannot be consumed, sold or otherwise dealt with, it is of no risk of causing harm to others and therefore should not be subject to regulation.

- 12.106 However, as the courts have recognised, small quantities of a drug can be combined with other substances, or accumulated, to make a substance with psychoactive effects.<sup>954</sup> In addition, the focus of the offence of possession is possession of the drug itself, not the use to which the drug will be put.<sup>955</sup> This suggests that any quantity of a drug should be able to be “possessed” within the meaning of the Act. The risk of prosecution and conviction for trivial amounts may also be minimal, because when only minute quantities or traces of a drug are found, the other requirements of possession are unlikely to be satisfied (including, for example, that the defendant knew of the drug’s presence and intended to exercise control over it).<sup>956</sup>
- 12.107 The usable quantity requirement also appears to be out-of-step with some comparable jurisdictions. For example, the House of Lords has held that, in order for a possession offence to be committed in the United Kingdom, it is not necessary for the drug possessed to be capable of being used but, rather, that it must amount to “something” that is “visible, tangible, and measurable”.<sup>957</sup> The High Court of Australia has also rejected a usable quantity requirement,<sup>958</sup> as have some other Australian state jurisdictions and some Canadian jurisdictions.<sup>959</sup>
- 12.108 We do not have a firm view on whether the usable quantity requirement should be retained. Although the approaches taken in each jurisdiction (including New Zealand) differ, they are all broadly aimed at achieving the same objective – that is, to exclude from the ambit of the offence the possession of miniscule or barely detectable amounts. If the requirement is retained, we think that this is something that should be dealt with in primary legislation rather than be left to case law, particularly if the evidential onus and procedural provisions outlined in paragraph 12.102 remain. It seems strange to include procedural provisions in a statute, without dealing explicitly with the substantive requirement itself.

If the requirement is retained, what procedural provisions are required (if any)?

- 12.109 If the requirement is retained, we query whether the evidential onus remains necessary. As discussed above, even if the onus is not explicitly stated, the defence is likely to have to raise this issue in cases where it is relevant. In most cases, the fact that the quantity is usable will be clear, and the issue will not arise.

954 *Police v Emirali*, above n 948, 480; *R v Yorston* [2008] NZCA 285, para 18.

955 *R v Boyesen*, above n 953, 165; *Williams v R*, above n 953, para 12.

956 *R v Boyesen*, above n 953, 166; *Paul v Collins Jnr* [2003] WASCA 238, para 10; *R v Keizer* [1990] NSSC.

957 *R v Boyesen*, above n 953, 166.

958 *Williams v R*, above n 953, para 19 Gibbs and Murphy JJ – there must be “possession of such a quantity as makes it reasonable to say as a matter of common sense and reality that it is the prohibited plant or drug of which the person is presently in possession”.

959 Western Australia – see *Paul v Collins Jnr*, above n 956; British Columbia – see *R v Brett* (1986) 41 CCC (3d) 190.

12.110 We are also unsure why section 29A only applies to summary proceedings and not to indictable proceedings. It may reflect an assumption that charges laid indictably will necessarily be more serious, and involve larger quantities, so that the issue will never arise. However, cases in which this was an issue have arisen in the indictable jurisdiction.<sup>960</sup> In addition, whether a case is heard in the summary jurisdiction or indictable jurisdiction may depend on whether the defendant elects to be tried by a jury. It seems inappropriate for the application of these procedural requirements to depend on the defendant's election decision.

12.111 However, if other proposals under consideration are implemented, we do not think that the procedural provisions outlined in paragraph 12.102 are necessary. As part of the Criminal Procedure (Simplification) Project, a new process is being proposed that requires the defence in all cases to identify, before a summary or indictable trial, the issues that are in dispute.<sup>961</sup> If the defence fails to do so, it is proposed that the fact-finder be able to draw an adverse inference about the defendant's guilt from that failure. This proposed new process should prevent the possibility of an "ambush attack" at which the procedural provisions in section 29A were aimed. It would essentially make the section 29A procedural provisions redundant.

Q93 Should the requirement remain that where an offence involves possession (whether as the alleged offence itself or as an element of the offence), the amount possessed must be of a usable quantity?

Q94 If the requirement identified in Q93 does remain, should there be an evidential onus on the defence to raise the issue?

Q95 If the proposal to require the defence in all cases to identify the issues in dispute is implemented, do you agree that the procedural provisions that give the prosecution additional opportunity to respond to the usable quantity issue once raised should be abolished?

### Legal onuses of proof on the defendant

12.112 In chapter 10, we discussed the onus of proof that is placed on the defendant in relation to the presumption of supply.

12.113 Three other reverse onuses of proof are provided in the Act. These relate to whether a defendant is acting under a statutory exemption, licence or regulations; whether a defendant possessed a controlled drug analogue for specified purposes; and whether the seed or fruit of a prohibited plant possessed by the defendant was of the species *Papaver somniferum* (opium poppy) and was possessed for an "innocent" purpose.

960 See, for example, *R v Yorston*, above n 954.

961 See Commentary to the Criminal Procedure (Simplification) Bill Plan, paras 85–94 [www.justice.govt.nz/policy-and-consultation/crime/documents/Criminal-Procedure-Simplification-Project/Criminal % 20 Procedure % 20-Simplification- % 20Bill % 20Plan % 20Commentary.pdf](http://www.justice.govt.nz/policy-and-consultation/crime/documents/Criminal-Procedure-Simplification-Project/Criminal%20Procedure%20-%20Simplification-%20Bill%20Plan%20Commentary.pdf) (accessed 18 January 2010).



- 12.114 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.
- 12.115 In *R v Hansen*,<sup>962</sup> 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. It is necessary to consider the future of the other three reverse onuses of proof in the Misuse of Drugs Act in light of this decision.

### *Acting under an exemption or pursuant to a licence*

- 12.116 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.<sup>963</sup> Section 30 applies, for example, when an individual is charged with dealing,<sup>964</sup> possessing or using a controlled drug,<sup>965</sup> or cultivating a prohibited plant.<sup>966</sup>
- 12.117 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.<sup>967</sup> 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).
- 12.118 However, an evidential onus may be more consistent with other provisions in the Act. In particular, 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.<sup>968</sup> These excuses include that a medical practitioner, dentist, veterinarian or pharmacist is acting in accordance with a statutory exemption.<sup>969</sup> 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 noted in paragraph 12.98, we do not think there is a need to make explicit provision for the evidential onus in section 12AC.)

### Q96 Should the legal onus in section 30 be retained?

<sup>962</sup> *R v Hansen* [2007] 3 NZLR 1 (SC).

<sup>963</sup> Note that we recommend that exemptions and permissions contained in regulations be moved into primary legislation – see chapter 13.

<sup>964</sup> Misuse of Drugs Act 1975, s 6.

<sup>965</sup> Misuse of Drugs Act 1975, s 7.

<sup>966</sup> Misuse of Drugs Act 1975, s 9.

<sup>967</sup> *R v Hunt* [1987] 1 AC 352, 374 (HL) Lord Griffiths.

<sup>968</sup> Misuse of Drugs Act 1975, s 12AC(1).

<sup>969</sup> Misuse of Drugs Act 1975, s 12AC(2).



Q97 If so, should there also be a legal onus in section 12AC?

### *Controlled drug analogues*

- 12.119 A controlled drug analogue is a substance with a chemical structure that is substantially similar to a controlled drug<sup>970</sup> and that may mimic the effect of a controlled drug. As discussed in chapter 9, controlled drug analogues are defined as Class C drugs, unless otherwise classified.<sup>971</sup>
- 12.120 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;<sup>972</sup> 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.<sup>973</sup>
- 12.121 Section 29C was inserted by the Misuse of Drugs Amendment Act (No. 2) 1987, which extended the Act's coverage to controlled drug analogues.
- 12.122 Like possession of controlled drugs, the Act views possession of controlled drug analogues as intrinsically culpable. However, unlike controlled drugs, controlled drug analogues are not specifically proscribed. Instead, the legislature is prepared to make an exception for people whose motive in possessing them is innocuous. It contemplates that a defendant may be aware of the psychoactive effect of a substance but not possess it or intend to supply it for that purpose. However, because possession of a controlled drug analogue is intrinsically culpable behaviour, and the motive for its possession is peculiarly within the knowledge of the defendant, it seems reasonable to place the onus for proving that motive on the defendant.

Q98 Do you agree that the legal onus on the defendant in section 29C should be retained?

### *Possession of *Papaver somniferum* for an innocent purpose*

- 12.123 When charged with cultivation of a prohibited plant, or possession of a seed or fruit, the defendant has the onus of proving that a 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.<sup>974</sup>

970 Misuse of Drugs Act 1975, s 2.

971 Misuse of Drugs Act 1975, s 2. Listed in Part 7 of Schedule 3.

972 Misuse of Drugs Act 1975, s 29C(a).

973 Misuse of Drugs Act 1975, s 29C(b).

974 Misuse of Drugs Act 1975, s 9(4).

12.124 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.

Q99 When a defendant is charged with the possession of a seed or fruit, or cultivation of a prohibited plant, should there be a legal onus on the defendant to prove that:

- (a) the seed, fruit, or plant was not of the species *Papaver somniferum*; or
- (b) the seed, fruit, or plant 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?

### Mistake as to the nature of the controlled drug or precursor substance

12.125 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 Class C (which is a separate offence under section 7(1)(b)).<sup>975</sup>

12.126 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.)

<sup>975</sup> For a case example, see *Marks v R* (5 November 2002) HC AK M67202 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.

12.127 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.<sup>976</sup> In that case, the defendant did not think he or she was acting illegally and should therefore not be held criminally liable for his or her actions.

12.128 An analogy in this context may be made with the offence of receiving. For a person to be guilty of that offence, it is necessary to establish that he or she knew that the received property was stolen, or was reckless as to that possibility.<sup>977</sup> If he or she honestly believed that the received property was not stolen, the required mental element for the offence would be lacking and the offence would not be proved. However, if a person knew that the property was stolen, but thought that it was worth only \$400 when it was in fact worth \$5000, he or she would still be liable for the offence of receiving and the maximum penalty applicable to the higher value (seven years instead of three months imprisonment). The actual value of the property would then become relevant to the defendant's sentence.

12.129 Our preliminary view is therefore that section 29 should remain. However, as a drafting matter, the drafting of the section is quite complex and could be vastly simplified to make its meaning more clear.

Q100 Do you agree that section 29 should be retained?

## FORFEITURE

### Current legislative framework

12.130 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).<sup>978</sup> These articles are then sold, destroyed or otherwise disposed of as directed by the Minister of Health.<sup>979</sup>
- (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;<sup>980</sup>
  - (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 manifestly unjust to do so in the circumstances of the case.<sup>981</sup>

976 See, for example, *R v Strawbridge* [1970] NZLR 909 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.

977 Crimes Act 1961, s 246(1).

978 Misuse of Drugs Act 1975, s 32(1).

979 Misuse of Drugs Act 1975, s 32(2).

980 Misuse of Drugs Act 1975, s 32(3) – This applies where the judge is satisfied that money found in 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 section 6.

981 Misuse of Drugs Act 1975, s 32(4).

- 12.131 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).<sup>982</sup> The goods are condemned and disposed of upon conviction.<sup>983</sup> If a conviction does not eventuate, a civil forfeiture regime applies.<sup>984</sup>
- 12.132 In addition to these two regimes, the Misuse of Drugs Amendment Act 1978 enables a court to indirectly forfeit dealing proceeds. Under these provisions, when sentencing a person convicted of a drug 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;<sup>985</sup> 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.<sup>986</sup>
- 12.133 Until recently, the Misuse of Drugs Act's forfeiture regime has supplemented the Crown's general ability under the Proceeds of Crime Act 1991 to recover any criminal proceeds (whether property or profits) derived from the commission of an offence that was punishable by five years imprisonment or more. This includes criminal proceeds derived from those drugs offences that are not covered by the specific Misuse of Drugs Act forfeiture regime.
- 12.134 The Criminal Proceeds (Recovery) Act 2009, which came into force on 1 December 2009, replaces the Proceeds of Crimes Act. Under the 2009 Act, the courts can impose:
- (a) an assets forfeiture order to recover tainted property (for example, a house that has been bought with the proceeds of crime);<sup>987</sup>
  - (b) a profit forfeiture order to recover monetary benefits;<sup>988</sup>
  - (c) an instrument forfeiture order to recover property used to commit, or to facilitate the commission of, the offence (for example, vehicles).<sup>989</sup>

982 Customs and Excise Act 1996, s 225. See section 54(1)(a) in relation to pipes and other utensils.

983 Customs and Excise Act 1996, s 236.

984 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 their disposal if that application is unsuccessful.

985 Misuse of Drugs Amendment Act 1978, s 38.

986 Misuse of Drugs Amendment Act 1978, s 39(1).

987 This is defined in section 5 as property that has wholly or partly been acquired, or directly or indirectly derived, from significant criminal activity as defined in section 6.

988 Criminal Proceeds (Recovery) Act 2009, s 55.

989 Criminal Proceeds (Recovery) Act 2009, s 70; Sentencing Act 2002, s 142N.

## Orders to forfeit assets and profit

- 12.135 The Criminal Proceeds (Recovery) Act puts in place an assets and profit forfeiture regime that is much broader in scope than that under either the Misuse of Drugs Act or the Proceeds of Crime Act. First, unlike either regime, an order to forfeit assets or profit can be made whether or not any criminal proceedings have been taken against the offender.<sup>990</sup> The Criminal Proceeds (Recovery) Act regime can therefore be used instead of, or in addition to, criminal proceedings.
- 12.136 Secondly, assets and profit forfeiture orders can be made in relation to a greater range of offending than was previously possible. In addition to proceeds derived from offences punishable by a maximum penalty of five years or more, an order to forfeit assets or profit can be made in respect of any offence from which property, proceeds or benefits of a value of \$30,000 or more was derived or acquired.<sup>991</sup> The Criminal Proceeds (Recovery) Act also enables assets and 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.<sup>992</sup> 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.<sup>993</sup>
- 12.137 Thirdly, the application 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<sup>994</sup> or a profit forfeiture order has been made.<sup>995</sup> In addition, the defendant has the onus, on the balance of probabilities, to show that any property, proceeds or benefits that are identified in the application for the order were not derived from criminal activity.<sup>996</sup> This places a greater burden on the defendant than under the Proceeds of Crime Act<sup>997</sup> or the Misuse of Drugs Act.<sup>998</sup>
- 12.138 In our view, the Misuse of Drugs Act regime, at least as it relates to the forfeiture of profits, has effectively been replaced by the Criminal Proceeds (Recovery) Act and can therefore be abolished. The Misuse of Drugs Act regime only applies to profits found in the offender’s possession<sup>999</sup> that are derived from dealing offences and only when there is a conviction, while the Criminal Proceeds (Recovery) Act

990 Criminal Proceeds (Recovery) Act 2009, s 6(2).

991 Criminal Proceeds (Recovery) Act 2009, s 6(1).

992 Criminal Proceeds (Recovery) Act 2009, s 7.

993 Bruce Robertson (ed) *Adams on Criminal Law* (Loose leaf, Brookers, Wellington, 1992) para CP 3.02 (last updated 19 January 2010) [www.brookersonline.co.nz](http://www.brookersonline.co.nz) [*Adams on Criminal Law*].

994 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.

995 Criminal Proceeds (Recovery) Act 2009, s 53.

996 Criminal Proceeds (Recovery) Act 2009, s 53(2).

997 See *Adams on Criminal Law*, above n 993. 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.

998 The court must be satisfied on balance of probabilities.

999 This may include money in bank accounts that is not able to be forfeited under the Misuse of Drugs Act. See Don Mathias *Brookers Misuse of Drugs* (Loose leaf, Brookers, Wellington, 1998) para 1702 (last updated 30 November 2007) [www.brookersonline.co.nz](http://www.brookersonline.co.nz) [*Brookers Misuse of Drugs*].



is much broader in scope. There is no forfeiture order that can be made under the Misuse of Drugs Act that cannot also be made under the Criminal Proceeds (Recovery) Act.<sup>1000</sup>

- 12.139 The only possible reason to retain the Misuse of Drugs Act regime is its procedural advantages. In particular, under that Act, forfeiture can be dealt with at sentencing rather than through the separate application process required under the Criminal Proceeds (Recovery) Act. However, we do not think that this is sufficient reason to retain a stand-alone regime that only applies upon conviction and is narrow in scope.
- 12.140 Nor do we think there is any need to retain the court's residual discretion in the Misuse of Drugs Amendment Act 1978 to indirectly forfeit dealing proceeds through the imposition of a greater fine. Again, the Criminal Proceeds (Recovery) Act regime seems to cover the ground. We also have some reservations about the 1978 provisions including, for example, the ability to impose a fine in relation to offences for which a prosecution has not been taken and a conviction has not been entered.

Q101 Do you agree that the forfeiture regime in the Misuse of Drugs Act, as it relates to the forfeiture of profits, should be abolished?

Q102 Do you agree that the provisions in the Misuse of Drugs Amendment Act 1978, which enable the court to indirectly recover the proceeds of drug dealing, should be repealed?

### Orders to forfeit instruments

- 12.141 Instrument forfeiture orders are provided for under new provisions in the Sentencing Act 2002.<sup>1001</sup> Unlike Criminal Proceeds (Recovery) Act orders, instrument forfeiture orders can only be made in conjunction with criminal proceedings, following conviction for a qualifying offence.
- 12.142 The Sentencing Act regime differs from the Misuse of Drugs Act regime in two key respects:
- (a) Under the Sentencing Act, the sentencing judge may 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.<sup>1002</sup> 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 automatically forfeited upon conviction for any Misuse of Drugs Act offence.

1000 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 chapter 10.

1001 See Sentencing Act 2002, ss 142A–142Q in particular.

1002 Sentencing Act 2002, s 4. This 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.



- (b) Instrument forfeiture orders must be taken into account in an offender's sentence.<sup>1003</sup> Until now, forfeiture under the Misuse of Drugs Act has been additional to any sentence imposed for the offending. Under the Sentencing Act, any instrument forfeiture that qualifies for the regime must be reflected in the offender's sentence, even if that forfeiture occurs under another regime.<sup>1004</sup>

12.143 In respect of drug offending, the Sentencing Act regime will enable the forfeiture of any instruments used to commit any drug offence that is punishable by a term of imprisonment of five years or more. It is necessary to consider whether the breadth of the new instrument forfeiture order means that the specific Misuse of Drugs Act forfeiture regimes in relation to vehicles and articles are no longer required.

### *Forfeiture of vehicles and other conveyances*

12.144 The Sentencing Act forfeiture regime encompasses the current ability under the Misuse of Drugs Act to forfeit a vehicle or other conveyance following a conviction for a dealing offence. A separate regime in the Misuse of Drugs Act to enable this to occur is therefore no longer required.

Q103 Do you agree that the Misuse of Drugs Act forfeiture regime, as it relates to vehicles and other conveyances, should be abolished?

### *Forfeiture of articles*

12.145 The meaning of "articles" in the Misuse of Drugs Act is not entirely clear. It appears to include controlled drugs and precursor substances, pipes and utensils, equipment used to manufacture or cultivate a controlled drug (for example, point bags and scales), and any other drug-related paraphernalia.<sup>1005</sup> The courts have held that it does not include vehicles or other conveyances, because that would be inconsistent with the establishment of the discretionary forfeiture regime available following conviction for a dealing offence.<sup>1006</sup>

12.146 "Articles" therefore includes items that have been found to be unlawfully possessed (such as controlled drugs or precursor substances) as well as items that have been used for an unlawful purpose but are otherwise lawfully in the offender's possession (such as point bags and scales).

### *Forfeiture of unlawful articles*

12.147 There is no doubt that, regardless of the seriousness of the offence, an ability to forfeit unlawful items is required following conviction. We therefore propose that a separate forfeiture regime be retained for this purpose.

1003 Sentencing Act 2002, s 10B(1)(a).

1004 Misuse of Drugs Act 1975, ss 32(1), (3) and (4). Even if forfeiture takes place under the Misuse of Drugs Act, 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 section 10B(1)(b) of the Sentencing Act 2002.

1005 For example, recipes for manufacturing methamphetamine – see *R v Collins* (3 March 2009) HC AK CRI 2007-090-005304 & CRI 2008-404-000326, Wylie J.

1006 *Attorney-General v May* (1985) 2 CRNZ 75, 81.

- 12.148 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.<sup>1007</sup> 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.<sup>1008</sup> We propose 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.
- 12.149 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.
- 12.150 With the exception of offences related to import or export,<sup>1009</sup> there is no statutory provision that enables the forfeiture of unlawful items when a conviction does not eventuate (for example, because a first offender has successfully completed diversion). However, we understand that problems in this respect rarely arise. If there is no one with a legitimate claim to possession, the destruction or disposal of allegedly unlawful items presents no difficulty in practice.<sup>1010</sup>
- 12.151 In chapter 11, we proposed a new approach to offences of personal use offences which would mean that conviction for these offences would occur much less often. The options proposed in that chapter were an infringement offence regime, a cautioning scheme, or an approach that enabled the police to target the response to the particular circumstances of the offence and the offender (a "menu of options").
- 12.152 If any of those three options are implemented, we think explicit statutory provision should also be made to enable forfeiture of unlawful items. This would provide greater certainty and transparency for both individuals and for the police.
- 12.153 Whichever option is implemented, the police should still be able to seize any unlawful items (for example, controlled drugs) as evidence in the event that a prosecution for the offence is taken. Forfeiture would then follow if the offender admitted responsibility for the offence. This would occur in the following ways:
- (a) If an infringement offence regime is adopted, any seized unlawful items should be forfeited at the conclusion of the period in which the defendant is able to challenge the imposition of an infringement notice. If the defendant does challenge the notice (and, by doing so, denies responsibility for the offence), the unlawful items should only be forfeited upon conviction in the way proposed in paragraph 12.148.

<sup>1007</sup> Misuse of Drugs Act 1975, s 32(2).

<sup>1008</sup> See, for example, *R v Sawtell* (24 July 2009) HC WN CRI 2008-078-000910, Wild J; *R v Spear* (13 November 2008) HC ROT CRI 2007-063-003004, Duffy J. Other judges make an order only in relation to forfeiture – see, for example, *R v Tahana* (21 November 2008) HC ROT CRI 2007-63-1030, Allan J.

<sup>1009</sup> For which a civil forfeiture regime applies – see Part 14 of the Customs and Excise Act 1996.

<sup>1010</sup> New Zealand Law Commission *Search and Surveillance Powers* (NZLC R97, Wellington, 2007) 411.

- (b) If a cautioning scheme is adopted, any seized items should be able to be forfeited as part of the conditions of a caution notice. If an individual does not wish to have the items forfeited, he or she will be able to decline consent to the issuing of the caution notice,<sup>1011</sup> and a prosecution will commence instead.
- (c) If the proposed “menu of options” is adopted, the approach taken to forfeiture would be a mixture of that proposed in (a) and (b). Forfeiture would always be possible on conviction. Otherwise, forfeiture would occur when the defendant consented to a caution notice or other response, or did not challenge imposition of the infringement notice.

12.154 Finally, Customs 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. It may be possible to introduce a statutory provision that would allow enforcement agencies to retain a representative sample of the seized articles and dispose of the remainder. Any dispute that eventuated 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.

Q104 Do you agree that there should be a requirement that a judge order the forfeiture and destruction of unlawful articles following conviction for any drug offence?

Q105 Do you agree that the forfeiture of unlawful items should not be taken into account in an offender’s sentence?

Q106 Do you agree with our proposed approach to forfeiture, outlined in paragraph 12.153, in the event that a new approach is taken to dealing with personal use offences?

Q107 Should a statutory provision be introduced allowing enforcement agencies to retain a representative sample of seized articles and to dispose of the remainder?

<sup>1011</sup> See paragraph 11.43 of chapter 11, where we have suggested that in order for a caution notice to be issued, the offender must acknowledge guilt and consent to the notice.

## Forfeiture of lawful articles

12.155 As noted above, the Sentencing Act forfeiture regime applies to offences with a maximum penalty of five years or more. There are a number of offences in the Misuse of Drugs Act with maximum penalties of less than five years.<sup>1012</sup> For most of these offences, the issue of forfeiture will not usually arise, or it will only arise in relation to unlawful items such as controlled drugs or precursor substances.<sup>1013</sup>

12.156 The exception is the offence in section 12 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.<sup>1014</sup> That offence is punishable by a maximum penalty not exceeding three years.<sup>1015</sup> We do not consider it necessary to establish a specific forfeiture regime in relation to this offence. Parliament has decided that 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 this offence.

12.157 In chapter 11, we also questioned whether the possession of pipes and utensils should remain illegal. If pipes and utensils were legal, there would be no justification for enabling their forfeiture. If the forfeiture of pipes and utensils was considered desirable (for example, because they were harmful items in themselves), their continued prohibition would be required.

12.158 Issues of forfeiture may need to be considered again as part of our final report, once the scope of relevant offences and their maximum penalties have been determined.

Q108 Do you agree that there does not need to be separate provision for forfeiting lawful articles used in the commission of an offence under section 12 of the Misuse of Drugs Act?

IMMUNITY  
FROM  
LIABILITY

12.159 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.<sup>1016</sup> This includes where they have acted without jurisdiction, or on the basis of a mistake of law or fact.<sup>1017</sup>

1012 For example, import or export of precursor substance without reasonable excuse (s 12AC) – punishable by 12 months imprisonment and/or \$1000 fine; miscellaneous offences – possession of utensils (s 13(1)(a) and (aa)), possession of seed or fruit (s 13(1)(b)) – punishable by 12 months imprisonment and/or \$500 fine; making a false statement in relation to licence (s 15) – punishable by 12 months imprisonment and/or \$1000 fine; all offences subject to general maximum penalty (see paragraphs 12.61–12.63); contravention of Minister’s prohibition notice on import etc of controlled drugs or utensils (s 22) – punishable by general maximum penalty (for controlled drug offence) or three months imprisonment and/or \$1000 fine (utensils offence committed by individual); contravention of Minister’s notice on prescribing (s 23) – punishable by six months imprisonment and/or \$1000 fine (lesser maximum penalty applies for Class C).

1013 For example, Misuse of Drugs Act 1975, s 12A.

1014 Misuse of Drugs Act 1975, s 12(2).

1015 Ibid.

1016 Misuse of Drugs Act 1975, s 34.

1017 Ibid.

12.160 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.<sup>1018</sup> The protection extends to any other member of the police who is directing or assisting the officer in the investigation.<sup>1019</sup> Prosecutions in these circumstances can only be taken with the Attorney-General's leave.<sup>1020</sup>

12.161 Both types of protection are a necessary corollary to the Act's enforcement. They also have parallels in other Acts that include enforcement provisions.<sup>1021</sup> We propose their retention.<sup>1022</sup>

Q109 Do you agree that the provisions in the Misuse of Drugs Act that provide immunity from liability for those acting under, or enforcing, the Act should be retained?

## EXTRADITION

12.162 In accordance with New Zealand's international obligations, particularly in the 1988 Convention, the Act includes provisions to facilitate the extradition of offenders from New Zealand for drug offences committed in other countries.<sup>1023</sup> The provisions deal with:

- (a) the offences under the Act that are to be treated as being included in existing extradition treaties between New Zealand and countries that are parties to the conventions;<sup>1024</sup>
- (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;<sup>1025</sup>
- (c) an evidential provision about how to establish that a foreign country is a party to the 1961, 1971 or 1988 Conventions.<sup>1026</sup>

12.163 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 their retention.

1018 Misuse of Drugs Act 1975, s 34A(1).

1019 Ibid.

1020 Misuse of Drugs Act 1975, s 34A(2).

1021 See, for example, the Search and Surveillance Bill 45-1 (2009), clauses 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, section 220, which confers civil and criminal liability on fishery officers in the same terms as the Misuse of Drugs Act. Other examples: 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.

1022 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 993, MD 34A.01, suggests both are covered as a matter of policy.

1023 Misuse of Drugs Act 1975, ss 35, 35A, 35C and 35D.

1024 Misuse of Drugs Act 1975, ss 35 and 35A.

1025 Misuse of Drugs Act 1975, s 35C.

1026 Misuse of Drugs Act 1975, s 35D.

Q110 Should the extradition provisions in the Act be retained?

Q111 Are any amendments to the extradition provisions required?

#### MISCELLANEOUS PROVISIONS **Reports to an offender's professional body**

- 12.164 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.
- 12.165 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.
- 12.166 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 propose that section 33 be repealed.
- 12.167 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.<sup>1027</sup> If section 33 is repealed, a provision requiring that convictions under the Misuse of Drugs Act be notified to the Veterinary Council of New Zealand should be included in the Veterinarians Act 2005.

Q112 Do you agree that section 33 should be repealed, so that:

- (a) the notification of convictions under the Misuse of Drugs Act of a medical practitioner, pharmacist, dentist, midwife or designated prescriber is left to section 67 of the Health Practitioners Competence Assurance Act 2003;
- (b) the notification of convictions of veterinarians under the Misuse of Drugs Act is the subject of a separate provision in the Veterinarians Act 2005?

<sup>1027</sup> Veterinarians Act 2005, s 9.



## Suppression of name of controlled drug

12.168 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.<sup>1028</sup> It is an offence to do so, punishable by a maximum penalty of three months imprisonment and/or a \$500 fine.<sup>1029</sup> 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.<sup>1030</sup>

12.169 We assume that the rationale of this provision, which dates back to the Narcotics Act 1965, 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 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.<sup>1031</sup> We do not consider that the suppression of the names of drugs meets these criteria. We therefore propose the repeal of section 21.

Q113 Do you agree that section 21 should be repealed?

1028 Misuse of Drugs Act 1975, s 21(1).

1029 Misuse of Drugs Act 1975, s 21(2).

1030 Misuse of Drugs Act 1975, s 21(1).

1031 New Zealand Law Commission *Suppressing Names and Evidence* (NZLC R109, Wellington 2009) 7.

# Chapter 13

## Exemptions to prohibition

### SUMMARY

This chapter considers what authorisations are needed to facilitate legitimate access to controlled drugs, and the types of restrictions and limits that might be imposed on them. It also considers whether specific exemptions are desirable to authorise the medicinal use of cannabis and cannabis-based products.

- INTRODUCTION** 13.1 Many prohibited drugs have important medical uses. Opioids such as morphine and codeine are used primarily for pain relief. Methadone is used in drug treatment and many other drugs are used in other areas of medicine as tranquillisers, sedatives, stimulants and antipsychotics. Legislation prohibiting the dealing and use of drugs must therefore contain exemptions that:
- authorise the production and distribution of some prohibited drugs so they are available for use in medical treatment; and
  - authorise the supply of prohibited drugs to people who need to use them for medical reasons.
- 13.2 Exemptions are also needed to authorise the use of prohibited drugs in medical and other research and drug studies.
- 13.3 There are also a few prohibited drugs that have some limited uses in industry. Industrial grade hemp (that is, cannabis plant with a very low tetrahydrocannabinol (THC) content<sup>1032</sup>) is used for making various products (for example, rope, soap and cloth). In addition, a few prohibited drugs (for example, gamma-hydroxybutyrate (GHB)) are occasionally used in food production processes. Exemptions are therefore also needed to authorise the use of prohibited drugs in industry.
- 13.4 Exemptions enabling the medical and industrial use of prohibited drugs must strike a balance between facilitating the supply of these drugs for these legitimate purposes and minimising the risk of the drugs being diverted into the illegal drugs market or being inappropriately used for their psychoactive effects. If the

<sup>1032</sup> 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.

restrictions on medical use are too strictly drawn, inadequate supplies of prohibited drugs may be available for use in treatment. Health professionals may also become reluctant to prescribe them and people with medical problems that require treatment with particular prohibited drugs might not be able to access these substances even under medical supervision.

- 13.5 In this chapter, we consider what authorisations are needed to facilitate legitimate access to drugs, and the types of restrictions and limits that might be imposed on them.

## PRODUCTION AND DISTRIBUTION

- 13.6 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 undertake these activities and 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.
- 13.7 In chapter 5, we discussed the current licensing requirements applying to the production and distribution of prohibited drugs. A person, who would otherwise be prohibited from doing so, may undertake these activities with controlled drugs under licence.

### A new licensing scheme

- 13.8 The licensing scheme for prohibited drugs is largely constituted by regulation made under the Misuse of Drugs Act 1975. We noted in chapter 5 that many significant provisions are contained in regulations rather than the Act. We think that in order to comply with the Legislation Advisory Committee Guidelines, all matters of substantive policy should be included in primary legislation and not left to regulation.
- 13.9 The matters that should be included in primary legislation are:
- the establishment or appointment of a licensing authority (currently the Director-General of Health is appointed as licensing authority under regulations);
  - the monitoring and enforcement powers of the licensing authority;
  - the categories of licence that may be granted (currently the regulations specify four types of licence: “dealers”, “licences to possess” (for research), “import and export” and “cultivation”);
  - any limitations or restrictions on the purposes for which different categories of licence may be granted or the types of activities licences may authorise (currently some of these are in the Act and others in regulation);

- 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; and
  - rights of review and appeal.
- 13.10 Primary legislation also needs to contain appropriate regulation-making powers so that regulations can provide for other more detailed aspects of the licensing scheme.
- 13.11 In chapter 5, we raised an issue over the role of the Minister of Health in licensing matters. Currently the Minister of Health, and not the Director-General (the licensing authority), has the power to revoke licences. In addition, the Minister's approval is currently required before the Director-General can grant a licence to any person who has been convicted of an offence against the Act (or its predecessor) or to any person who has had an earlier licence revoked.<sup>1033</sup> Similarly, regulations currently require that the Minister give his or her written approval before a licence can be granted authorising dealing in or importing or exporting certain specified drugs.<sup>1034</sup>
- 13.12 These provisions all unnecessarily involve the Minister in licensing matters. Decisions about individual cases should not be made at the ministerial level because these should not be political decisions. The decision-making criteria should be set out in legislation and licensing decisions should be made by the licensing authority who applies those criteria in individual cases. There is no reason why the Minister should be involved. We therefore think the Director-General should continue to be the licensing authority under the Act and should determine all licensing matters.

Q114 Do you agree that the main components of the licensing scheme should be in the Act?

Q115 Do you agree that the Director-General of Health should continue to be the licensing authority?

Q116 Do you agree that the Minister of Health should not be involved in individual licensing decisions?

#### EXEMPTIONS FOR SUPPLY AND USE OF MEDICINES

- 13.13 Exemptions are needed to authorise the supply of prohibited drugs to patients and to authorise the medical use of those drugs by patients.
- 13.14 Section 8 of the Misuse of Drugs Act contains statutory exemptions authorising certain types of institutions and certain classes of people to undertake various authorised activities necessary to treat patients with controlled drugs. Further specific authorisations in the form of permissions are contained in regulations

<sup>1033</sup> Misuse of Drugs Act 1975, s 14.

<sup>1034</sup> These are all Class A drugs other than cocaine, all Class B drugs in Part 1 of Schedule 2 other than morphine or opium, and all Class C drugs in Part 1 of Schedule 3.

made under the Act. Though it is not apparent on the face of the Act, these exemptions operate differently depending on whether the controlled drug is an approved medicine or an unapproved medicine under the Medicines Act 1981. We have examined this matter already in chapter 5 but for the purposes of this chapter we need to summarise briefly the exemptions that currently authorise the supply and use of prohibited drugs for medical purposes.

## Prescriber and pharmacy exemptions

13.15 The ambit of the current authorisations for prescribers and pharmacists are unclear for the reasons discussed in paragraphs 5.24 to 5.44 of chapter 5. 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.
- Registered midwives may procure, prescribe, supply or administer the controlled drug pethidine and any other controlled drugs specified in regulation. Other groups of health professionals (termed “designated prescribers”) may, if expressly authorised by regulation, prescribe, supply or administer any controlled drugs specified in regulation.
- Medical practitioners, dentists, registered midwives and designated prescribers may procure, sell, supply and administer controlled drugs that are not approved drugs, but may not produce, manufacture, or pack and label these controlled drugs and may only procure and supply them for particular and identifiable patients and not more generally.<sup>1035</sup>
- 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.
- Pharmacists can also (in response to a specific request from a medical practitioner) procure a controlled drug that is an unapproved medicine from the medicine’s supplier and supply that medicine to the medical practitioner or supply it on the practitioner’s behalf to a patient to fill a prescription issued by the medical practitioner.
- 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.

13.16 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

<sup>1035</sup> Although restrictions imposed on the supply of unapproved medicines by section 29 of the Medicines Act mean that suppliers of unapproved medicines are only authorised to supply them to medical practitioners and not to dentists, registered midwives and designated 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.

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 separately at the specific restrictions that apply to treating drug dependency later in this chapter.

*Should some health professionals be able to produce or manufacture prohibited drugs under exemptions?*

- 13.17 One of the exemptions discussed above 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. On their face, these exemptions seem to authorise the manufacture of controlled drugs without a licence.
- 13.18 We are unsure to what extent these groups of health professionals actually need to manufacture or produce controlled drugs. We think it is desirable to restrict the exemption to only those activities that these groups need to perform with controlled drugs.

Q117 Do some health professionals need exemptions that permit them to manufacture and produce controlled drugs?

### Other health care exemptions

- 13.19 The other statutory exemptions that apply to the medical use of controlled drugs appear to apply to both approved and unapproved medicines. These exemptions, in section 8 of the Act, 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.<sup>1036</sup>
  - Patients may procure and self-administer any controlled drugs that have been lawfully supplied or prescribed for them<sup>1037</sup> and those responsible for the care of patients may administer controlled drugs to them in accordance with the directions given by the prescribing professional.<sup>1038</sup> A similar exemption allows controlled drugs to be administered to an animal when they have been prescribed by a vet.<sup>1039</sup>
  - Any person may, when leaving or entering New Zealand, possess up to one month's supply of 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.<sup>1040</sup>
  - Any person may procure and administer any C6 controlled drug.

<sup>1036</sup> Misuse of Drugs Act 1975, s 8(2A)(b).

<sup>1037</sup> Misuse of Drugs Act 1975, s 8(2)(c).

<sup>1038</sup> Misuse of Drugs Act 1975, s 8(2)(d) and (da).

<sup>1039</sup> Misuse of Drugs Act 1975, s 8(2)(e).

<sup>1040</sup> Misuse of Drugs Act 1975, s 8(2)(l).



- District Health Boards, other certified hospitals and institutions and any manager or licensee of a certified hospital or institution that has the care of patients for whom controlled drugs are lawfully prescribed or supplied may possess those drugs to treat patients.<sup>1041</sup>

13.20 As we noted in chapter 5, the scope of this last exemption is uncertain. Firstly, 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. We think the former should be the case. Secondly, there is 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. We suggest that the exemption might simply be confined to District Health Boards and other certified hospitals.

13.21 We also query whether all of the various exemptions for prescribers, pharmacists, and others are still needed and whether any different exemptions might be needed. We would like to see a number of the separate exemptions consolidated to produce a simpler and clearer list of authorisations.

Q118 Should District Health Boards and other certified hospitals be authorised to hold general supplies of controlled drugs for the purposes of treating patients as practicality dictates?

Q119 Should any other institutions also be authorised to hold general supplies of controlled drugs for the purposes of treating their patients?

Q120 Are all of the current exemptions in section 8 still needed? Are any other exemptions needed?

## Permissions in the Misuse of Drugs Regulations 1977

13.22 In chapter 5, we also noted that 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 by retail or wholesale any Class C3 drug (other than one containing pseudoephedrine).
- Pharmacies may sell Class C3 controlled drugs that contain pseudoephedrine by retail as “pharmacy-only medicines”.<sup>1042</sup>

<sup>1041</sup> Misuse of Drugs Act 1975, s 8(2)(f).

<sup>1042</sup> This will likely soon change because the Government has proposed a policy change to reclassify pseudoephedrine as a Class B drug. Once legislation implementing that decision is in place pseudoephedrine will only be available on prescription.

- Any person may procure and administer a Class C3 drug (including one that contains pseudoephedrine).<sup>1043</sup>
  - 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 controlled drugs.<sup>1044</sup>
  - A controlled drug can be supplied in an emergency without a prescription provided this complies with other regulations governing emergencies.
  - 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.<sup>1045</sup>
  - 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.<sup>1046</sup>
  - 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.<sup>1047</sup> A controlled drug may also be supplied to a person who has control of an approved first-aid kit without a prescription.
- 13.23 As we discussed in chapter 5, these permissions are simply further exemptions. The breadth of the current regulation-making powers in the Act has allowed significant matters of policy to be implemented by regulation. We are not sure whether all of these exemptions are still needed, but those that do need to be retained should be included in the Act. While we acknowledge that there is a need for flexibility in this area to deal with new and changing circumstances, our view is that the regulation-making powers should be much more limited, and should authorise exemptions in regulations only for a limited time to deal with emergencies.

Q121 Are all of the exemptions currently in regulations still needed or are some obsolete? Are any new exemptions needed?

Q122 Do you agree that the exemptions should in principle be in the Act and that more limited regulation-making powers that authorise exemptions only for a limited time to deal with emergencies would be appropriate?

### Duplication of exemptions in the Medicines Act 1981

- 13.24 The exemptions in the Medicines Act and the Misuse of Drugs Act both apply to controlled drugs that are medicines. We discussed this issue in chapter 5 and noted there that the relationship between the two Acts lacks transparency.

<sup>1043</sup> Once pseudoephedrine becomes a Class B drug it will only be available on prescription.

<sup>1044</sup> Misuse of Drugs Regulations 1977, reg 15.

<sup>1045</sup> Misuse of Drugs Regulations 1977, reg 17.

<sup>1046</sup> Misuse of Drugs Regulations 1977, reg 18.

<sup>1047</sup> Misuse of Drugs Regulations 1977, reg 19.

There is also considerable overlap and duplication between the two regimes. The difficulties are compounded by the fact that the exemptions in the Misuse of Drugs Act are framed differently from those in the Medicines Act. This makes determining the precise scope of the exemptions difficult in some circumstances. Given an offence is committed when a person acts outside the authority provided by an exemption, this is unsatisfactory.

- 13.25 We have suggested that the exemptions that apply to controlled drugs should be in one Act (with appropriate cross-references) and subject to one consolidated set of conditions. The options are to place the exemptions in either the Medicines Act or in new legislation to replace the Misuse of Drugs Act.
- 13.26 One advantage in having all the exemptions in the Medicines Act is that all authorisations and conditions applying to the medicinal use of substances would be consolidated in one Act. There would be one set of rules governing the supply and use of all medicines. There may need to be some specific requirements in the Medicines Act that only apply to controlled drugs, to reflect additional restrictions on their use that do not apply to prescription medicines. The international drug conventions require more detailed records of transactions with controlled drugs to be kept than may be necessary for other prescription medicines. But the inclusion of controlled drugs within the Medicines Act, even as a special category of prescription medicines, would produce a more transparent result.
- 13.27 If the exemptions applying to controlled drugs remain in the misuse of drugs regime, controlled drugs should be expressly excluded from the duplicating aspects of the Medicines Act. Under this second option there would still be two different sets of exemptions governing the prescribing and use of different medicines, although only one regime would ever apply to any particular substance. The main advantage of this option would be that the exemptions that apply to the medicinal use of controlled drugs would be in the same piece of legislation as the prohibitions and other controls that apply to controlled drugs. There may also be some symbolic value in separating controlled drugs out from other substances that are used as medicines. This option would not require significant change to the Medicines Act.
- 13.28 It should be noted that under both options other aspects of the Medicines Act, which regulate the safety and efficacy of all medicines, would still 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 sold or distributed as approved medicines. The exemptions for the supply and use of controlled drugs would still need to differentiate between those drugs that had been approved for medical use and those that had not been approved.

Q123 Do you agree that the exemptions that apply to controlled drugs should all be in one Act (with appropriate cross-references)?

## Diversion and misuse of drugs under exemptions

- 13.29 The misuse of prescription drugs, and their diversion into the recreational drugs market, is recognised as a worldwide issue by the International Narcotics Control Board (INCB). In its 2006 report, the INCB stated that:<sup>1048</sup>

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.

- 13.30 For example, the INCB reports that statistics for the United States suggest that the levels of abuse of prescription medicines is second only to cannabis. 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.<sup>1049</sup>
- 13.31 Until recently, there has been little information available on the extent of prescription drug misuse and diversion in New Zealand. A 2008 study<sup>1050</sup> 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.<sup>1051</sup>
- 13.32 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.<sup>1052</sup> Most of the opioids used by intravenous drug users are sourced from diverted prescription drugs. Frequent drug users in the IDMS identify morphine derivatives (MST®, M-Eslon®, Kapanol®) as the opioids with which they are most familiar.<sup>1053</sup> A portion of frequent drug users also reported using benzodiazepines (for example Valium®) and methylphenidate (Ritalin®) as well as prescription opioids.<sup>1054</sup> 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 % of 18 to 30 year olds self-reported using prescription drugs for non-medical purposes,<sup>1055</sup> although it should be noted that these types of self-selecting surveys may oversample certain populations.

1048 International Narcotics Control Board *Report of the International Narcotics Control Board for 2006* (United Nations, New York, 2007) 6.

1049 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) 22–33.

1050 Ibid.

1051 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, 10.

1052 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].

1053 Sheridan and Butler, above n 1049; IDMS, above n 1052, 105.

1054 Ibid, 32; ibid, 38–39 respectively.

1055 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* (Auckland University, Auckland, 2009).

- 13.33 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.<sup>1056</sup>
- 13.34 The 2008 study found that drug seekers tend to utilise a few common methods of deception when trying to obtain supplies through the primary health care system. In particular, “doctor shopping” (sometimes called “prescription shopping” or “multiple scripting”) was identified as a widespread and commonly identified phenomenon. This involves patients obtaining prescriptions from more than one healthcare practitioner, and may involve obtaining the same drugs from different sources or a range of different drugs from a range of services. Some studies have found that two or three concurrent prescriptions were the norm for many people, although some people exceed this. In 2005, one man in Australia reportedly obtained 425 scripts from 287 general practitioner visits over a five month period.<sup>1057</sup> Globally, “doctor shopping” has been highlighted as one of the most common methods of obtaining prescription medicines for illicit purposes. Other techniques involve either manipulating health professionals or presenting fake, altered or stolen prescriptions.
- 13.35 Most of the drug-related harm arising from prescription drug misuse is similar to that for other types of drugs.<sup>1058</sup> We have already canvassed these in chapter 2. One important difference, however, is the cost to New Zealand’s public pharmaceutical budget. 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.

### *Statutory measures to address misuse and diversion of prescription drugs*

- 13.36 There are a number of statutory restrictions that are imposed on the prescribing exemptions. Some of these are contained in the Misuse of Drugs Act, while others are imposed by regulation. A number of these provisions are aimed at reducing the opportunities for drug seeking in the health system.

### *Section 20 – Statements regarding drug dependent persons*

- 13.37 Under section 20 of the Misuse of Drugs Act, 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 controlled drugs being supplied 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;

<sup>1056</sup> Sheridan and Butler, above n 1049, 32.

<sup>1057</sup> David Nankervis “One-man GP Spree for Drugs” (17 July 2005) *Sunday Mail Brisbane* 6.

<sup>1058</sup> The list of harms in the report is similar to Sheridan and Butler, above n 1049, 32.



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.<sup>1059</sup>

- 13.38 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.<sup>1060</sup>
- 13.39 There are a number of significant problems with section 20. Firstly, the breadth of the authorisation to publish statements is extremely wide. On the face of section 20(1), a medical officer of health may make any statement at all “to all or any of the members of all or any of the classes of person” provided that statement is one “relating to” the person believed to be dependent. This provides a far wider authorisation than would seem to be necessary. It also consequently confers a very broad immunity from defamation. The class of person to whom statements may be made is particularly broad. It includes, without restriction, the police, managers of prisons, and all persons who deal in drugs in the course of their business. We do not think such a broad class of people always has an interest in suspected dependence and think disclosure should really be limited to members of these classes who might be reasonably considered to have a direct interest in the information.
- 13.40 Another problem is the threshold for triggering the power to make a statement. Before a medical officer of health can make a statement, he or she need only have reason to believe that a person is likely to become dependent on any controlled drug. It is difficult to see how medical officers of health could assess this. They do not have direct contact with the person, so would be reliant on information provided by others. A test of “reason to believe” also sets a low threshold. 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.
- 13.41 We question also whether the provision is even necessary. A specific statutory authority is not necessary 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. Like all other types of health information, we suggest it should simply be dealt with under that regime.

1059 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.

1060 Misuse of Drugs Act 1975, s 20(5).



- 13.42 If the provision remains, it should be more limited than the current provision to address the points discussed above. We also think that there should be a requirement that the person who is the subject of the statement should be notified, and should have the opportunity to challenge any statement he or she believes is incorrect. At present there is no mechanism allowing the person to do this.
- 13.43 We suggest that the test should also be focused on drug seeking and not suspected dependence. For example, the provision might require a medical officer of health to be satisfied before issuing a notice that the person is obtaining, has been obtaining or has attempted to obtain controlled drugs from several different sources and is likely to continue to do so.
- 13.44 Finally, if a provision is retained, we do not think it needs to confer qualified privilege by statute. At common law, communications are protected by qualified privilege if they are made by a person having a legal, social or moral interest or duty to make the statement to the person to whom it is made and the person to whom it is made has a corresponding interest or duty to receive the communication.<sup>1061</sup> We suggest that the common law will adequately cover disclosures made by a medical officer of health under statutory authority to a person entitled to receive them.

Q124 Do you agree that section 20 should be repealed or should a more confined version of section 20 be retained under which medical officers of health can publish (in a limited way) information about people suspected of being drug seekers?

Q125 If it is retained, do you agree that it should only apply to drug seeking behaviour and that the person who is the subject of the statement should have an opportunity to challenge any statement?

## Section 25 – Restriction on supply to an identified person

- 13.45 As we discussed in chapter 5, 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 and prohibits any further supply of controlled drugs to the restricted person. Alternatively, the notice may allow for some continued supply of controlled drugs by specified prescribers or from specified sources.
- 13.46 Section 25 is specifically directed at preventing and 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 high. It may be too high because a medical officer of health must be satisfied that a person has been obtaining a controlled drug over a prolonged period. 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

<sup>1061</sup> *The Laws of New Zealand* (LexisNexis NZ Limited) Defamation para 101 (last updated 1 November 2009) [www.lexisnexis.com](http://www.lexisnexis.com).

is satisfied that the person has been obtaining any prescription medicine from several different sources and is likely to continue to do so. We suggest that this might be a more appropriate test for controlled drugs also.

- 13.47 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. It is also an offence for a restricted person, who knows he or she is a restricted person, to procure or attempt to procure a prescription or supply of a controlled drug in contravention of the notice. The maximum penalty for both offences is a term of imprisonment of three months or a fine of \$500 or both.<sup>1062</sup> We are not sure that these specific offences are still necessary.
- 13.48 In the case of prescribers, knowingly supplying or prescribing in breach of a notice would be a disciplinary matter and could possibly affect their suitability to practise and ongoing registration under the Health Practitioners Competence Assurance Act 2003. We suggest that the disciplinary mechanisms in that Act are adequate to deal with these types of breaches of statutory restrictions. Specific offences, which can only be committed by a practitioner who has authority to prescribe or supply controlled drugs, should not also be necessary. However, there may be some symbolic importance for 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.
- 13.49 In the case of the restricted person, the offence should be retained but the conduct is of a nature that broadly equates to the personal use offences discussed in chapter 11. If a new enforcement approach (with emphasis on therapeutic interventions and treatment) is taken to personal use offences, it should be applied here as well.

Q126 Do you agree that medical officers of health should continue to have the power to issue notices imposing restrictions on the supply of controlled drugs to restricted persons?

Q127 If so, do you agree that the test in section 49 of the Medicines Act, which sets a lower threshold, would be a better test to use?

Q128 Do you agree that the offence of supplying or prescribing a controlled drug to a person in contravention of a restricted person notice should be repealed?

<sup>1062</sup> Section 27 sets this general penalty for any offence under the Act where a specific penalty is not provided.

## Section 23 – Prohibition on prescribing and supply

- 13.50 We discussed in chapter 5 the power the Minister of Health has under section 23 to issue *Gazette* notices prohibiting any person from exercising their rights under any exemption in section 8 of the Act. We identified there a number of problems with the powers given to the Minister by section 23 which need to be addressed.
- 13.51 Firstly, the power is too broad because it allows the Minister to prohibit patients authorised by section 8 from using any controlled drugs that have been prescribed by their doctor for them. It is not appropriate for the Minister to have the power to do this.
- 13.52 Secondly, when the power is exercised in respect of prescribers and pharmacists, it is essentially concerned with professional regulation because:
- the power cannot be exercised by the Minister except on the recommendation of the relevant 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.
- 13.53 We are therefore uncertain why the Minister even has this power under section 23. The Minister's function is so circumscribed that it is difficult to see what objective his or her involvement might serve. It also does not seem appropriate for the Minister to be involved in this way with a professional disciplinary matter involving an individual practitioner. We suggest that section 23 should be repealed and the registration authorities should take appropriate disciplinary action under the Health Practitioners Competence Assurance Act in cases where individual prescribers or pharmacists are found to be abusing their prescribing privileges under the exemptions.

Q129 Do you agree that section 23 should be repealed?

## Controls currently in the Misuse of Drugs Regulations 1977

- 13.54 The Misuse of Drugs Regulations 1977 contain other important restrictions imposing various conditions and limitations on the supply of controlled drugs. Regulations, for example, limit the number or amounts of drugs which may be prescribed on any one occasion; impose requirements on the form written prescriptions must take; and set requirements for the storage, custody and transportation of controlled drugs and for the keeping of drug registers and other records and returns so that activities with controlled drugs can be monitored. We do not propose to go into the detail contained in the Regulations but note here that many of these further limit the availability of controlled drugs within the health system and the opportunity for their diversion.
- 13.55 As well as these broader restrictions, there are a few regulations that specifically address aspects of drug seeking. For completeness we mention these here also.

- 13.56 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 the possession and use of those drugs obtained by deception, even if under a prescription or from a doctor, will be an offence under section 7 of the Act. We think that a significant limitation of this nature should be in the Act and not left to regulation.
- 13.57 Regulation 32 addresses, at least partially, the risk of fake, stolen or altered prescriptions being presented to pharmacists by imposing requirements for the verification of prescriptions. Briefly, regulations provide that:
- a pharmacist supplying controlled drugs under a prescription must be satisfied that the signature on the prescription is genuine before dispensing the drugs;
  - only the prescriber who issued a prescription may alter it once it has been issued;
  - if a pharmacist thinks that a prescription has been altered by someone else or is not genuine, he or she is obliged to retain the prescription and notify the police or the medical officer of health.
- 13.58 Regulations can go some way to addressing matters of detail like the verification of prescriptions. It is therefore important that appropriate regulation-making powers are available and that regulations are reviewed and amended as necessary to address any changes in the methods and approaches used to divert prescription drugs into the illegal market. It is also essential that regulations keep pace with changing technology and do not impede technical innovations that would help manage the risks around fake, stolen and altered prescriptions.
- 13.59 However, legislation can never be sufficiently nuanced to address the full range of situations and circumstances that may arise in an area like this. There are clearly limits on what can be done in this area with regulatory controls. Professional training, appropriate administrative systems, and other non-legislative approaches, which are discussed in the next section, are also essential.

Q130 Overall, do you think that the legislative controls that are in place are adequate? If not, what further legislative controls do you think are necessary?

### Professional education, guidance and monitoring

- 13.60 Prescribers exercise professional and personal judgement whenever they provide controlled drugs to a patient, as do pharmacists and other professionals in the health care system acting under other exemptions. Administrative or non-legislative measures, such as professional guidance, monitoring and review, also help to ensure that only appropriate medical use is made of controlled drugs under the exemptions. A balance needs to be struck between the flexibility and discretion that professional guidance allows and the certainty that legal rules offer.

- 13.61 The 2008 study discussed earlier<sup>1063</sup> identified a number of areas where improvements might be made in the national guidance issued to primary care professionals on the issue of prescription drug misuse. Many primary care practitioners interviewed in the 2008 study identified a lack of clear guidance on managing prescription drug misuse as a problem. They also identified a lack of training and support as barriers to their involvement in harm reduction interventions and treatment, with most just trying to prevent patients from obtaining prohibited drugs for inappropriate use.
- 13.62 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.
- 13.63 We are not proposing to review the range of professional controls and monitoring systems that are either in use or are available. That is well beyond the scope of our review. Our interest in this area is to ensure that the statutory controls are appropriate to underpin and support these types of approaches. They must be workable in practice and allow health practitioners sufficient flexibility and discretion when assessing and treating their patients. It is unhelpful and problematic for legislative controls to extend too far. If the controls on prescribing are considered inadequate to address the misuse and diversion of controlled drugs, consideration also needs to be given to addressing these problems through improved professional practice supported by education and guidance and appropriate monitoring systems.

Q131 Do the legislative controls that are in place provide adequate support for professional education and guidance and appropriate monitoring systems? If not, what changes do you think are necessary?

### Drug treatment for drug dependence

- 13.64 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.
- 13.65 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.<sup>1064</sup> This effectively precludes all other medical practitioners from treating drug dependence with controlled drugs.

<sup>1063</sup> Sheridan and Butler, above n 1049.

<sup>1064</sup> Misuse of Drugs Act 1975, s 24(1) and (1A).

- 13.66 In contrast to the other exemptions, the exemption for treatment of dependence with controlled drugs is tightly drawn. The purpose is clearly to restrict the supply of prohibited drugs to people who are dependent by minimising the opportunity for doctor shopping and drug diversion. By limiting the range of medical practitioners who can prescribe prohibited drugs for dependence, the access of drug dependent patients can be limited and more closely monitored. However, this exemption does also reduce the opportunity for general practitioners to be involved in drug and alcohol treatment and therefore restricts the treatment options for people who are drug dependent (but note that general practitioners can obtain an authorisation under section 24 and the restriction does ensure that specialist alcohol and drug clinics normally oversee treatment).
- 13.67 Currently, despite this provision, methadone diverted from methadone substitution treatment is, after morphine, the second most widely available street opioid. This suggests that the restriction is not particularly effective at preventing diversion anyway.
- 13.68 We are therefore interested to know whether section 24 is considered too restrictive. Should other medical practitioners be able to play a greater role in drug treatment?

Q132 Is section 24 too restrictive? If so, what changes are needed?

### Other restrictions on the exemptions

- 13.69 There are two other restrictions on the exemptions considered in chapter 5 that should be briefly mentioned again here.

### Section 22 – Prohibition notices

- 13.70 Under section 22 of the Act, the Minister of Health may issue a prohibition notice prohibiting the production, distribution and use of any controlled drug.<sup>1065</sup> As we discussed in chapter 5, this is essentially a reserve power that is available to deal with unanticipated and urgent safety issues. Prohibition notices override authorisations in any licence issued under the Act as well as any applicable exemptions.
- 13.71 We think that there does need to be provision made in replacement legislation to deal with unanticipated and urgent safety issues that arise in respect of controlled drugs. Such powers should in practice only rarely be used. A high threshold for their use should be set in legislation.

Q133 Do you agree that a provision allowing the Minister of Health to impose restrictions on exemptions to deal with unanticipated and urgent safety issues should be retained?

<sup>1065</sup> Note that s 22 also covers prohibition notices that prohibit the importation or supply of pipes or other utensils, other than needles and syringes.



## Regulation 22 – Restrictions on the supply of certain drugs

- 13.72 Regulation 22 of the Misuse of Drugs Regulations 1977 places significant restrictions on the authority of prescribers to deal in controlled drugs. The Minister's approval is required before a prescriber can provide, or a patient can use, any specified controlled drug.<sup>1066</sup> For the reasons we have already outlined in chapter 5, we think that a restriction that places such significant restraints on the use of these controlled drugs should be agreed to by Parliament. It should therefore be in the Act rather than regulation.
- 13.73 We also question whether the restriction itself is an appropriate one. Under the regulation, 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.

Q134 Should the Minister of Health's approval be required before certain controlled drugs can be supplied or used?

### MEDICINAL CANNABIS

- 13.74 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).
- 13.75 Below, we consider whether further 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 controversial issue.

### History of therapeutic use

- 13.76 The use of cannabis for therapeutic purposes can be traced back thousands of years in Asia and the Middle East,<sup>1067</sup> although only approximately 200 years in the western world.<sup>1068</sup> Cannabis was available over the counter in pharmacies in the United States in the 19<sup>th</sup> century, and was also widely used as a mainstream medicine at that time in Britain. It was used for medicinal purposes in Australia until the mid 1960s.<sup>1069</sup> In New Zealand cannabis was a common ingredient

<sup>1066</sup> Specified controlled drugs are any Class A controlled drug other than cocaine; any Class B drug listed in Parts 1 and 2 of Schedule 2 other than morphine or opium; or any Class C drug listed in Part 1 of Schedule 3.

<sup>1067</sup> See Philip Robson "Therapeutic Aspects of Cannabis and Cannabinoids" (2001) 178 *British Journal of Psychiatry* 107, 107, who notes that "the first formal report of cannabis as a medicine appeared in China nearly 5000 years ago when it was recommended for malaria, constipation, rheumatic pains and childbirth and, mixed with wine, as a surgical analgesic."

<sup>1068</sup> Ibid, 107; Wayne Hall and Rosalie Liccardo Pacula *Cannabis Use and Dependence: Public Health and Public Policy* (Cambridge University Press, Cambridge (UK), 2003); Wayne Hall, Louisa Degenhardt and Michael Lynskey *The Health and Psychological Effects of Cannabis Use* (Monograph Number 44, 2001) 130.

<sup>1069</sup> Commonwealth of Australia *Legislative Options for Cannabis Use in Australia* (Monograph Number 26, 1994) 22.

in the 19<sup>th</sup> century in many of the imported patent medicines, being prescribed for ailments such as gastric illnesses, rheumatism, headaches, and menstrual cramps.<sup>1070</sup> It was not subject to legal restrictions until 1925.

- 13.77 The use of cannabis for therapeutic purposes declined in the early 20<sup>th</sup> century, due to difficulties controlling its potency and effectiveness, the development of drugs such as the opiates and aspirin that could be “given in standard doses to produce predictable effects”, and its inclusion in the international movement to prohibit the recreational use of narcotic drugs.<sup>1071</sup>
- 13.78 The 1970s and 1980s saw a revival of interest in the potential therapeutic benefits of cannabis. Pressure from cannabis users themselves, combined with support from parts of the medical and research community, has led to a number of jurisdictions now allowing some legitimate, albeit limited, use of cannabis or cannabis-based products for therapeutic purposes. However, even in those jurisdictions where there is no legitimate access to cannabis for therapeutic purposes, it continues to be used by people suffering from chronic and debilitating illness for that purpose.

### Therapeutic benefits

- 13.79 There is continuing debate about the nature and extent of the therapeutic benefits of cannabis. However, there is general agreement 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:<sup>1072</sup>
- 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).
- 13.80 Despite the increasing interest in the potential therapeutic effects of cannabis, it does not appear to be widely used for therapeutic purposes. 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.
- 13.81 The traditional way that cannabis has been used for therapeutic purposes is in its raw or natural form. However, there is increasing focus on the development of whole plant extracts and synthetic products, which contain extracts of THC and/or other cannabinoids. These products seek to overcome some of the

1070 Jim McAloon “Hops, Tobacco and Hemp – Hemp” *Te Ara – the Encyclopedia of New Zealand* [www.TeAra.govt.nz](http://www.TeAra.govt.nz) (accessed 17 December 2009).

1071 Hall, Degenhardt and Lynskey, above n 1068, 130. See also Robson, above n 1067, 107.

1072 New Zealand Drug Foundation *Evidence Review on Medicinal Cannabis* (NZDF, Wellington, 2006) 4–6.

problematic aspects of using raw cannabis (for example, the ability to control toxicity and potency, and eliminating the health risk from smoking cannabis), and are more likely to meet medicinal manufacturing standards.

- 13.82 Sativex® is a buccal (mouth) spray that contains cannabis extracts and cannabidiol. It is not an approved medicine in New Zealand, although some “off-label” prescribing for specific chronic diseases and terminal illness is permitted under the exemptions for unapproved medicines in the Medicines Act. Trials on the effectiveness of Sativex® in treating and alleviating particular conditions are ongoing.<sup>1073</sup>

### Approach taken in other jurisdictions

- 13.83 A number of jurisdictions, particularly in North America, now authorise the use of cannabis for some therapeutic purposes. These regimes differ slightly from each other but, overall, enable people with specified illnesses or conditions, on the basis of established medical need, to use cannabis for therapeutic purposes without the risk of criminal sanction. The recreational use of cannabis in those jurisdictions is still prohibited.
- 13.84 Jurisdictions that have been at the forefront of this movement are California and Canada. In California, a 1996 referendum (Proposition 215) approved the enactment of legislation which enabled seriously ill<sup>1074</sup> Californians and their primary caregivers to obtain and use cannabis for medical purposes on a physician’s recommendation.<sup>1075</sup> Following difficulties with the implementation of Proposition 215, the Government established the Medical Marijuana Programme in 2004. That programme established a voluntary identification card system for medical cannabis users and their caregivers. It was not necessary for a person claiming the protections for compassionate use to apply for or hold a card, but it gave some protection from arrest. The amendments in 2004 also placed limits on the amount of cannabis that could be cultivated and possessed by medical cannabis users.<sup>1076</sup>
- 13.85 In 2006, it was estimated that there were over 250 community-based medical cannabis dispensaries or “compassion clubs”<sup>1077</sup> in California supplying over 200,000 state authorised patients.<sup>1078</sup> It is estimated that the numbers of both have since increased significantly. There are now estimated to be up to 400,000 state

1073 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. See *ibid*, 19.

1074 Including those suffering from “cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief” (section 11362.5(b)(1)(A), California Health and Safety Code added by Proposition 215).

1075 Rowena Johns *Medical Cannabis Programs: A Review of Selected Jurisdictions* (New South Wales Parliamentary Library Research Service, Sydney, 2004) 39.

1076 California Senate Bill 420, 2003.

1077 “Compassion” or “cannabis” clubs are organisations established with the broad aim of facilitating access to a safe supply of cannabis for medical purposes. They dispense medical cannabis. See Philippe G Lucas “Regulating Compassion: An Overview of Canada’s Federal Medical Cannabis Policy and Practice” (2008) 5 *Harm Reduction Journal* 1, 3.

1078 *Ibid*, 3.

authorised patients.<sup>1079</sup> Twelve other states in the United States have also enacted similar laws<sup>1080</sup> and several others have proposals pending. Even in states where the medical use of cannabis has been authorised, distributors have been vulnerable to federal prosecution because medical use is prohibited at the federal level. Until recently federal agencies enforced the federal prohibition and a number of people, particularly those distributing and dispensing cannabis, were prosecuted even though they were complying with state medical cannabis laws.<sup>1081</sup> More recently, the United States Attorney-General has announced that the enforcement of federal drug laws in this area will now be restricted to traffickers who falsely masquerade as medical dispensaries and use medical cannabis laws as a shield.<sup>1082</sup>

- 13.86 The legal use of medical cannabis in Canada has largely been prompted by court decisions that challenged the constitutionality of laws that prohibited the cultivation and possession of cannabis for medical purposes.<sup>1083</sup> Under Canada's programme, those who are suffering from a serious or debilitating illness<sup>1084</sup> and who wish to use cannabis for medical purposes must apply to the Government, on the basis of medical evidence, for authorisation to possess cannabis.
- 13.87 The Canadian Government must also ensure a legal supply of cannabis for medical purposes, and has established a licensing system for this purpose. Authorised users may be licensed to produce their own cannabis or they may designate a supplier for this purpose. The Government can also license dealers, and has done so for one private company (Prairie Plant Services), which is the sole Government supplier of cannabis. As at July 2008, 2812 people were authorised to possess dried cannabis and 2017 people were licensed to cultivate or produce cannabis for medical purposes.<sup>1085</sup> The Canadian Government medicines licensing agency, Health Canada, has also approved Sativex® for use as a medicine on a limited basis by multiple sclerosis and cancer sufferers.
- 13.88 Outside North America, few jurisdictions authorise the use of cannabis for therapeutic purposes. Medical cannabis was permitted in the Netherlands from September 2003. In the Netherlands, the Dutch company Bedrocan BV has been contracted by the Office of Medicinal Cannabis (which is part of the Ministry of Health, Welfare and Sport) since 2005 to grow cannabis under quality controlled and standardised conditions. The product comes as cannabis flos with

1079 A recent article in the Times estimated the number of businesses involved in some way in the distribution of medical cannabis to be over 2000. See Mike Harvey "California Dreaming of Full Marijuana Legalisation" (28 September 2009) *The Times* London.

1080 The other states are Alaska, Colorado, Hawaii, Maine, Michigan, Montana, New Mexico, Nevada, Oregon, Rhode Island, Vermont, Washington.

1081 The Drug Enforcement Administration, for example, closed down a number of compassion clubs in California and prosecuted their directors and others involved in providing medical cannabis. See Johns, above n 1075, 42.

1082 David Johnston and Neil Lewis "Obama Administration to Stop Raids on Medical Marijuana Dispensers" (19 March 2009) *New York Times* New York, A20.

1083 *Queen v Parker* (2000) 188 DLR (4th) 385 (Ontario Court of Appeal); *Hitzig v Queen* (2003) 231 DLR (4th) 104 (Ontario Superior Court of Justice).

1084 The programme is limited to serious or debilitating illnesses, including cancer, AIDs, HIV infection, epilepsy, multiple sclerosis, and severe forms of arthritis. Medical Marijuana Regulations, Schedule 1.

1085 Health Canada "Marihuana for Medical Purposes – Statistics" (4 July 2008) [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca) (accessed 26 January 2009).

a consistent composition (THC level 19 %) and is free from contamination. In the Netherlands, medicinal cannabis products can be prescribed by doctors and are distributed through pharmacies.<sup>1086</sup>

- 13.89 Sativex® is available on a “named patient” basis in the United Kingdom for use by multiple sclerosis sufferers. Sativex® is also available on a compassionate access basis in the Catalan region of Spain. As far as we are aware, no Australian state yet allows the therapeutic use of cannabis of any form.

### Current approach in New Zealand

- 13.90 The approach taken in New Zealand to cannabis-based medicines and raw unprocessed cannabis differs somewhat in practice, although the legal requirements are currently the same.

### *Cannabis-based medicines*

- 13.91 Cannabis-based products, such as Sativex® or other equivalents, may be 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. We understand that 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 importation of the drug. Medical practitioners can obtain an import licence which would allow them to directly import the drug also.
- 13.92 Sativex® is not an approved medicine in New Zealand. This means it can only be procured and supplied by a medical practitioner under the closely controlled exemption for unapproved medicines. Moreover, because Sativex® is a Class B1 drug, the Minister of Health’s approval is required before it can be supplied, prescribed or administered.<sup>1087</sup> Over the last few years, a small number of applications from practitioners to prescribe Sativex® for use by individual patients have been approved by the Minister.<sup>1088</sup> If other cannabis-based products are developed, they would also be available on the same basis.
- 13.93 An application for a medicines approval for Sativex® in New Zealand has been made by its United Kingdom manufacturer. If Sativex®, or any other cannabis-based product, is approved for use as a medicine, it would be available on prescription on the same basis as any other approved controlled drug.

### *Legal access to raw cannabis*

- 13.94 The legal approach to raw or unprocessed cannabis is the same as that described above. However, there are currently administrative and practical barriers that effectively preclude its use for medicinal purposes. Cannabis plant is classified as a Class C drug, and the cultivation or importation of cannabis is therefore prohibited without a licence. While a licence to import or cultivate cannabis for

<sup>1086</sup> There is further information on the Dutch scheme at [www.bedrocan.nl](http://www.bedrocan.nl) (accessed 10 December 2010).

<sup>1087</sup> We discussed regulation 22, which imposes this requirement, in paragraph 13.72 – 13.73 and suggested there that it might be repealed because it seems to us inappropriate for the Minister to be involved in treatment decisions.

<sup>1088</sup> The Ministry of Health has advised that as at December 2009 14 authorisations had been granted, although only three people have actually used the product due to it not being funded.



use in or as a therapeutic product could theoretically be obtained under the Act, in reality such licences are not made available. We have been advised by the Ministry of Health that some people have applied for a licence to cultivate cannabis for medical use, but these have not been granted. Licences have only ever been granted for cultivating cannabis for the purposes of research.

- 13.95 The result is that there is no legally produced or imported stock of raw cannabis. Thus, if a medical practitioner determines that cannabis is the best treatment in the circumstances, he or she cannot legally procure that drug since a licence would not be issued.

## Discussion

- 13.96 The use of cannabis for therapeutic purposes is not prohibited by the international drug conventions. However, as discussed in chapter 6, the conventions impose restrictions on the production, supply, and use of cannabis for medical and scientific purposes. To recap:
- manufacture, trade, import, and export can only be conducted by government organisations or under licence;<sup>1089</sup>
  - detailed records must be kept of the quantities of drugs manufactured and of each individual transaction;<sup>1090</sup>
  - the quantities of drugs manufactured and imported must be limited to the amount needed for medical and scientific purposes;<sup>1091</sup>
  - all import and export transactions must be individually authorised and subject to strict controls;<sup>1092</sup>
  - supply to individuals requires a medical prescription;<sup>1093</sup> and
  - a government agency must oversee licensing of any cannabis cultivation.<sup>1094</sup>
- 13.97 The current licensing scheme and exemptions would seem to 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 at some stage in the future one or more cannabis-based products will be approved for use in New Zealand. Until then, it would seem appropriate to take the same cautious approach that is taken with all new medicines before they are assessed and approved.
- 13.98 The more difficult issue is 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 effective for all those who could benefit medically from cannabis use. Some patients who use cannabis medically argue that

1089 Single Convention on Narcotic Drugs (30 March 1961) 520 UNTS 151 [1961 Convention], arts 29–31. Licensees and senior persons in government organisations must be adequately qualified to carry out duties in accordance with the law – Article 34(2).

1090 Ibid, art 34.

1091 Ibid, art 21.

1092 Ibid, art 31(4).

1093 Ibid, art 30(2)(b)(i).

1094 Ibid, arts 26(1) and 28(1).



smoking raw cannabis is more effective than products derived from cannabis.<sup>1095</sup> 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 currently funded by PHARMAC and it is estimated to cost users between \$500 and \$600 a month.<sup>1096</sup>

- 13.99 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.<sup>1097</sup> 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.<sup>1098</sup>
- 13.100 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. This is why access to them is carefully regulated and overseen by suitably qualified health professionals.
- 13.101 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 and dried cannabis and other products of that sort are not normally manufactured in a standardised quality-controlled process, so that there are also issues of contamination.
- 13.102 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.
- 13.103 Finally, the debate about allowing the therapeutic use of cannabis tends to get caught up in the debate about allowing use of cannabis for recreational purposes. Some opponents of recreational cannabis use fear that allowing its therapeutic use “will be the thin edge of a wedge to legalise cannabis”.<sup>1099</sup> There seems to be a perception that authorising some medicinal use might lead to a greater

1095 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 New Zealand Drug Foundation 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 1072, 19.

1096 Estimate of the cost to a patient supplied by the Ministry of Health.

1097 See Chapter 2 for a discussion of these and other health harms.

1098 See New Zealand Drug Foundation, above n 1072, 8.

1099 Hall, Degenhardt and Lynskey, above n 1068, 137.

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 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 a chronic and debilitating illness would have any impact on the use and prevalence of cannabis recreationally.

- 13.104 Provided adequate controls are put in place to stop or limit the risk that cannabis intended for medical use will be diverted into the recreational market, we see no reason why it should not be utilised in its raw form as a therapy by people suffering from a chronic or debilitating illness. Where there is evidence that cannabis would alleviate symptoms and therefore provide an effective form of treatment for these people, we do not think they should be prohibited, as they currently are, from using it simply because other people use it as a recreational drug. We suggest that, on compassionate grounds, a scheme should be established so that people suffering from a chronic or debilitating illness can be authorised to use raw cannabis under medical supervision where it would provide relief from the symptoms of that illness, particularly where conventional treatment options have failed to provide effective relief.

Q135 Do you agree that the law should authorise the medicinal use of cannabis by people suffering from a chronic or debilitating illness?

### Regulatory options for authorising medicinal cannabis

- 13.105 If a scheme allowing the medical use of cannabis is considered desirable, there are a number of regulatory models for implementing this. As will be evident from the discussion below, there are a range of difficulties with all of them.

#### *Options for cultivation of cannabis*

- 13.106 The international drug conventions require that cultivation of cannabis for medical use can only be undertaken by government organisations or under licence. In broad terms there are three options for giving effect to this:
- license cultivators in the same way as other dealers in controlled drugs;
  - license medicinal cannabis users to cultivate cannabis for their own use; or
  - authorise a government organisation to cultivate cannabis for use under a medicinal cannabis scheme.

#### Option 1: Licensing cultivators

- 13.107 The first option uses the licensing model already contained in the Misuse of Drugs Act. The licensing authority would grant one or more cultivation licences to allow the cultivation and production of cannabis plant for medical use. Dealers' licences issued under the Act would also be made available to authorise the distribution of the unprocessed cannabis.

- 13.108 Under this option, there would be relatively few licence holders, even if the number of users increased over time. A detailed licensing scheme, with similar provisions to that regulating the cultivation, processing and distribution of industrial hemp, would be used. Stringent controls could be enforced concerning the numbers of plants, the range of cultivars permitted, and the locations at which cannabis could be grown under licence. Security requirements could be readily enforced. Maximum and minimum THC levels could be specified and testing undertaken, as it currently is with industrial hemp. As with industrial hemp, restrictions could also specify which parts of the plant were available for supply to medicinal cannabis users. Access to seeds and new cultivars could be managed.
- 13.109 This option allows for close control of cultivation and therefore presents a lower risk that the cannabis grown under the scheme would be diverted into the recreational drugs market. The model is already utilised for other controlled drugs and for industrial hemp. The monitoring and enforcement infrastructure is therefore already in place, although additional resources would be required.
- 13.110 Because this option is essentially a commercial model, it relies on a person or corporate body choosing to meet the stringent conditions and obtain a licence to cultivate cannabis. Drug companies and cultivators currently producing industrial hemp would seem to be the most likely participants in this type of licensing scheme. These companies are unlikely to be interested unless it is commercially viable. Given that only relatively small numbers of people are likely to be eligible to use cannabis medicinally, this is uncertain. Another issue is whether the model would actually produce adequate cannabis for supply at a reasonable cost. The questions around commercial viability also raise issues around price and whether price would need to be controlled. It may be that a few not-for-profit organisations, with similar objectives to the types of compassion clubs established in North America, would be suitable licence holders.

## Option 2: Licensing medicinal cannabis users

- 13.111 The second option is to license people who are permitted to use cannabis as therapy to cultivate a limited number of cannabis plants for their own use. This was the type of approach taken in the recent Misuse of Drugs (Medicinal Cannabis) Amendment Bill, a Member's bill promoted by the Green Party.<sup>1100</sup> A lower level of regulatory control is likely under this model. There would still be restrictions on the numbers of plants that could be cultivated at any one time. However, because cultivation would occur in a number of scattered private residences, these types of restrictions and many other aspects of the licensing scheme would be virtually impossible to enforce. Instead of monitoring a small number of licence holders, the licensing authority would need to monitor a larger number of small cultivators and would also need to enter private residential dwellings to do this.

<sup>1100</sup> Under the Bill medicinal cannabis identification card holders could cultivate at their place of residence an amount of any plant of the genus cannabis. Where the cardholder was unable to cultivate their own cannabis they could nominate a designated agent who, if approved, would be issued a Designated Agent Identification Card which was effectively a licence permitting the cultivation of cannabis for the cardholder's use. See clause 10 of the Misuse of Drugs (Medicinal Cannabis) Amendment Bill sponsored by Green party MP Metiria Turei.

- 13.112 There would also be issues to resolve around eligibility criteria for licences and appropriate provisions for vetting applicants. Medical users would presumably need to meet some statutory criteria before they were licensed to cultivate their own cannabis. Criteria might include a requirement that cultivators can ensure their plants and cannabis material are kept secure and that they agree to inspections and monitoring requirements. Consideration would also need to be given to the grounds on which a person would be ineligible for a licence or on which a licence could be revoked. Presumably a conviction for supplying cannabis or other drugs would preclude a person from obtaining a licence.
- 13.113 Even with appropriate criteria and restrictions on licence holders, there would still seem to be a greater risk of diversion into the recreational market with this option than option one because of the larger number of licence holders involved. This includes the risk that medicinal users might have plants and cannabis stolen as well as the risk that some would cultivate more than they needed and supply others. The seeds produced from legally grown plants might also be distributed. It is difficult to see how this model might satisfy the international requirement that detailed records are kept of the quantities of drugs manufactured<sup>1101</sup> and that the quantities of cannabis manufactured are limited to the amount needed for medical and scientific purposes.<sup>1102</sup>
- 13.114 Another problem under this option is that many of the people who are likely to be eligible to use cannabis medicinally are suffering from serious debilitating illnesses, so that they would not necessarily have the resources or capacity to cultivate their own cannabis plants. The cannabis material needs to be dried and prepared for use. There would also be at least some users who would not be eligible for a cultivation licence because they could not meet the minimum set of criteria for licence holders. Some alternative back-up cultivation and production mechanism would therefore be needed.
- 13.115 The approach taken in the Misuse of Drugs (Medicinal Cannabis) Amendment Bill was to allow the medicinal user to nominate a designated agent if they were unable to cultivate cannabis themselves. The designated agent was then issued a licence by the licensing authority. There are, however, problems with this. Why authorise each individual user to nominate an agent when the licensing authority could simply license one agent to cultivate one back-up supply? The licensing of numerous agents under this model simply proliferates the opportunities for diversion and the difficulties of monitoring.
- 13.116 Option two also allows for a much more variable range of cannabis to be grown. This seems problematic. For example, potentially cannabis with very high levels of THC might be cultivated with the associated additional health risks this might cause.
- 13.117 Another issue is the sourcing of seeds for cultivation. Under both licensing models, access to seeds is needed. This is less of an issue under option one if a licence holder is able to import their seeds or source them from another licence holder who is authorised to supply seeds. This is the approach taken in respect of industrial hemp. It presumes that an initial source of seeds can

<sup>1101</sup> 1961 Convention, above n 1089, art 34.

<sup>1102</sup> *Ibid*, art 21.

be lawfully accessed from somewhere in the world. Under option two, licence holders would need to source their seeds from a legal supply within New Zealand. A government organisation would therefore need to be authorised to supply these, or another body or person would need to be licensed to do this. The seeds could be legally sourced overseas, or taken from cannabis confiscated and forfeited to the Crown. The Member's bill proposed that the police provide licence holders with cannabis seeds sourced from cannabis seized during law enforcement activities.<sup>1103</sup>

### Option 3: Government cultivation

13.118 The third option is for a government organisation to cultivate and supply cannabis. For a range of practical reasons, this alternative would necessitate a contractor to grow cannabis on behalf of a government agency. This occurs in both Canada and the Netherlands. In both cases, the contracted companies are licensed to meet the requirements of the conventions.

13.119 Contracting or licensing one agent to cultivate cannabis for a government organisation would provide a high degree of control over the cultivation of cannabis for therapeutic purposes. However, it would require a government organisation to actively take on responsibility for cultivating cannabis. We are not sure that this is necessary or desirable in New Zealand. Canada appears to have only taken this step because of court decisions determining that the Government had to ensure a legal supply of cannabis for medical purposes.<sup>1104</sup>

13.120 Canada's programme of government cultivation has been subject to criticism since its implementation in 2001 because the federal cannabis supply is considered to be of poor quality and over-priced.<sup>1105</sup> It is estimated that approximately 80 % of those who are authorised to possess cannabis do not obtain it from the federal supply.<sup>1106</sup> In Canada, the federal supply is not the only source of legal cannabis. Authorised users may also be licensed to produce their own cannabis or may designate another supplier.

13.121 While criticisms over the quality and price of cannabis could be levelled at any particular cultivator under any of the options, this is probably more likely where there is a single supply of medicinal cannabis. If only one agent is licensed to cultivate cannabis for a government agency, and that is the only legal supply, there is a risk that users will choose instead to obtain their cannabis from other illegal sources, particularly if it is cheaper to do this, or if the official source is considered to be of an inferior quality.

### Our preferred option

13.122 Our preliminary view is that the licensing option in option one is the best alternative. It is a closely controlled model and therefore minimises the risks of diversion. It would produce a limited supply of cannabis material in a standardised

1103 See Misuse of Drugs (Medicinal Cannabis) Amendment Bill, cl 12.

1104 For example *Hitzig v Queen*, above n 52.

1105 Lucas, above n 1077, 5–7.

1106 *Sfetskopoulos v Attorney-General of Canada* [2008] FC 33, para 12.



way which addresses at least some of the health issues. We think that it would provide a better option than licensing users and their carers to cultivate their own supply.

### *Options for supplying medicinal cannabis*

13.123 Under the international conventions, the supply of cannabis to any individual requires a medical prescription.<sup>1107</sup> There seem to be three options for the approach to be taken to requiring medical prescription:

- treat cannabis no differently from other controlled drugs and require a specific prescription from a medical practitioner or other relevant prescriber for so many days supply;
- provide an ongoing authorisation for registered patients on the recommendation or application of a medical practitioner; or
- a combination of the first two approaches.

### *Option 1: Standard prescription approach*

13.124 This option treats cannabis no differently from other controlled drugs. Anyone suffering from a condition for which cannabis was an appropriate treatment would obtain a prescription from their doctor as they do for other drugs. The decision as to whether cannabis was an appropriate treatment would be a matter of assessment for the medical professional. Guidelines on appropriate use would be needed. Consideration would need to be given to the distribution chain. Would it be realistic to have community pharmacies dispense cannabis in the same way as other drugs or would some specific supply arrangements be necessary?

13.125 An advantage of this option is that it would maintain a high degree of direct medical supervision. It would also utilise existing prescribing and patient monitoring systems. It would require health professionals to assess a patient's situation and make decisions on treatment with cannabis in the same way as occurs for other drugs. This has the attraction of not making a special case for cannabis. However, a disadvantage would seem to be the difficulties in collating and nationally monitoring the levels of prescribing and maintaining data on the numbers of authorised users. It is important to ensure that the Ministry of Health is able to monitor levels of prescribing and use.

### *Option 2: Authorising use by registered patients*

13.126 The second option is to provide ongoing authorisation for registered patients. Maintaining a register of patients seems to be the approach taken in some overseas jurisdictions. In Canada, patients apply with supporting medical evidence from their doctor or specialist to obtain an authorisation. An authorisation, once granted, entitles the person to possess a certain amount of cannabis. In Canada, an authorised person can possess up to a maximum of 30 days supply.

<sup>1107</sup> 1961 Convention, above n 1077, art 30(2)(b)(i).



13.127 Under this option, there might be less scope for recreational drug seekers to target doctors. The application process might better protect general practitioners and other prescribers from being pressured for scripts for cannabis. It would be important, though, that the application process was not unnecessarily complex. In Canada, the programme has been criticised because it unduly restricts access to cannabis due to its complex application process.<sup>1108</sup> Some form of registration system and authority with oversight is needed if an application-based approach is adopted. A government agency, like the Ministry of Health, would also need to assess and process applications, and ensure they fell within any specified criteria. It would need to maintain a register and issue some form of authorisation. This option might therefore require some additional administrative infrastructure.

### Option 3: Combine aspects of both approaches

13.128 We see merit in both options and suggest a combined approach. On balance, we favour the establishment of a central register of authorised users because it provides a clear picture of the numbers of users and is more readily monitored. We think, however, that in order to maintain direct medical supervision, authorised users, once registered, should continue to obtain prescriptions for cannabis from their medical practitioner or another authorised prescriber. This would ensure that a health professional periodically assesses the person's situation and make decisions, as and when appropriate, with him or her on any course of treatment with cannabis in the same way as occurs for other controlled drugs that are used as medicines. This has the attraction of not making a special case for cannabis and ensures that the other regulatory requirements that apply to prescribing and supplying Class B or C drugs will apply equally to cannabis. We suggest also that this type of two-stage process may assist in protecting prescribers from being pressured for scripts for cannabis.

### Scope of scheme

13.129 Careful consideration also needs to be given to the scope of any scheme and the range of medical conditions for which cannabis might be an option.

13.130 The approach taken in the recent Member's bill was to restrict eligibility for registration to patients suffering from one of a number of specific conditions specified in legislation.<sup>1109</sup> That is one approach. Another would be to leave it to the discretion of the treating physician. That is the approach taken in California.<sup>1110</sup> There has been concern expressed about the breadth of the eligibility criteria used in the Californian scheme.

13.131 It is important also to remember that cannabis is not at present an approved treatment for any condition or illness. A cautious approach is therefore appropriate. If a scheme is established, some clear restrictions should be placed on the range of conditions for which cannabis could be offered as a treatment.

<sup>1108</sup> Lucas, above n 1077, 5–7.

<sup>1109</sup> During the first reading debate on the Bill a number of members criticised the inclusion of a number of the conditions listed.

<sup>1110</sup> In addition to the use of cannabis for the treatment of serious and debilitating illnesses (for example, chronic pain, AIDS, anorexia), Proposition 215 enables the use of cannabis, subject to a physician's recommendation, "for any...illness for which marijuana provides relief."

We think the Californian approach provides doctors with too broad a discretion. It exposes them to pressure and encourages the medicinal use of cannabis in situations where other suitable alternatives are available. We suggest that the list of conditions listed above in paragraph 13.79 might be considered as an appropriate starting point.

Q136 If a medicinal cannabis scheme is established, which of the three cultivation options outlined in paragraphs 13.105 to 13.121 do you think would be best?

Q137 If a medicinal cannabis scheme is established, which of the three prescribing and supply approaches discussed in paragraphs 13.123 to 13.128 would be best?

Q138 If a medicinal cannabis scheme is established, should specific conditions for which cannabis can be prescribed be specified by legislation or should medical practitioners determine the circumstances in which it might be used?

# Chapter 14

## Enforcement

### SUMMARY

This chapter outlines the key enforcement mechanisms available in relation to the Misuse of Drugs Act, in both the Act itself and in the general criminal law. It also discusses the changes to search and surveillance powers, including those in the Act, that are proposed by the Search and Surveillance Bill. Finally, it considers whether further powers are required to ensure that any proposed regime is able to be enforced effectively.

- INTRODUCTION** 14.1 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.
- 14.2 The Search and Surveillance Bill 2009 implements the Law Commission's report on search and surveillance powers.<sup>1111</sup> 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.
- 14.3 This chapter deals with two types of power – law enforcement and regulatory. The former is a power that contains a threshold of reasonable grounds to believe or suspect commission of an offence. Such a power is primarily aimed at the gathering of evidence of offending so that the law can be enforced through the imposition of criminal sanctions. Regulatory powers do not require such a level of belief or suspicion before they may be exercised. Rather, such powers generally

<sup>1111</sup> New Zealand Law Commission *Search and Surveillance Powers* (NZLC R97, Wellington, 2007).

permit inspection for the purposes of monitoring compliance with the Act, and thereby create incentives for those operating in the regulated environment to comply with the applicable rules and conditions.

#### A HARM MINIMISATION APPROACH TO ENFORCEMENT

- 14.4 Recently, there has been an increased focus on the impact of enforcement activities on drug markets and drug users.
- 14.5 A recent review of the international evidence regarding the impact of drug law enforcement activities found the quality of evaluations to be “extremely variable” and the coverage “patchy”.<sup>1112</sup> Despite this, researchers have reported numerous consequences of and responses to intensive drug policing that have an effect on harm reduction. These include:
- reluctance to carry syringes and unsafe disposal of injecting equipment;
  - hurried preparation and injection of drugs;
  - displacement of drug users (which in turn has consequences in terms of the ability of those persons to be able to access their usual service points, risks of overdose or other medical emergencies, destabilisation of social and injecting networks, spread of drug use to new geographical areas, and the need for users to find new dealers);
  - dangerous drug storage and concealment;
  - drug users changing the mode of drug use to a quicker and stronger form (that is, from smoking to injecting);
  - increased incarceration; and
  - exacerbation of stigma and marginalisation.<sup>1113</sup>
- 14.6 A number of commentators have therefore argued for a more balanced approach to policing with a view to making enforcement activities more “harm reduction-friendly”. This would involve not only an awareness of the potentially harmful impacts of enforcement actions, but also some rethinking of the objectives of enforcement and the ways in which its performance is measured.<sup>1114</sup>

#### LAW ENFORCEMENT POWERS

##### Search powers

##### *General search warrant power authorising search of places, vehicles, and other things*

- 14.7 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 constable) may apply to a District Court judge, justice, community magistrate or registrar for a search warrant.
- 14.8 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

<sup>1112</sup> United Kingdom Drug Policy Commission *Refocusing Drug-Related Law Enforcement to Address Harms* (London, 2009) 22.

<sup>1113</sup> See New Zealand Law Commission, above n 1111; Joanne Csete *Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs* (Canadian HIV/AIDS Legal Network, 2007).

<sup>1114</sup> See United Kingdom Drug Policy Commission, above n 1112; Peter Homel & Katie Willis *A Framework for Measuring the Performance of Drug Law Enforcement* (Australian Institute of Criminology, February 2007).

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.<sup>1115</sup>

14.9 Under the Search and Surveillance Bill, this general search warrant power in respect of offences punishable by imprisonment will be retained but will be amended in several important ways:

- the ability to apply for a warrant will be limited to constables;
- the threshold to be met will be 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 will be able to be issued to search a place, vehicle (defined broadly), or other thing.<sup>1116</sup>

14.10 The application for, issue of, and execution of the warrant will be subject to the detailed generic procedural provisions set out in Part 4 of the Bill.

### *Specific warrantless powers of search in relation to drugs*

14.11 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:<sup>1117</sup>

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.

### *Warrantless searches of places and vehicles*

14.12 Section 18(2) of the Misuse of Drugs Act provides a warrantless power of search to 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 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, some Class B and C drugs, and some precursor substances. The power authorises the police officer and any assistants accompanying him or her to enter and search the particular site, and as noted above, to search any person found in or on the search site.

<sup>1115</sup> Also of relevance is section 198A of the Summary Proceedings Act 1957 which provides that a constable executing a search warrant may require a specified person to provide information or assistance that is reasonable and necessary to allow the constable to access data held in, or accessible from, a computer that is on the premises specified in the warrant.

<sup>1116</sup> Search and Surveillance Bill 45-1 (2009), cl 6.

<sup>1117</sup> New Zealand Law Commission, above n 1111, para 5.64.

- 14.13 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:<sup>1118</sup>
- the threshold now reflects the approach taken across that Bill so that a constable must have reasonable grounds to believe a specified drug or precursor is in or on a place or vehicle, and reasonable grounds 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;
  - the constable must also have reasonable grounds to believe that, if entry and search is not carried out immediately, evidential material relating to the suspected offence will be destroyed, concealed, or damaged;<sup>1119</sup> and
  - 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.

### Warrantless searches of people

- 14.14 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 specified drug or precursor 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.
- 14.15 When the Commission considered this as part of its search and surveillance powers exercise, it concluded that section 18(3) should be retained, since there is an overriding public interest in ensuring that items such as drugs and precursor substances are not in circulation in the community.<sup>1120</sup>
- 14.16 Accordingly, section 18(3) is repeated in the Part of the Search and Surveillance Bill which contains police powers.<sup>1121</sup> Again, the threshold for the power has been amended to ensure consistency with the approach adopted throughout the Bill so that a constable must have reasonable grounds to:
- believe the person is in possession of a specified drug or precursor substance; and
  - 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.

<sup>1118</sup> Search and Surveillance Bill 45-1 (2009), cl 19.

<sup>1119</sup> New Zealand Law Commission, above n 1111, rec 5.11. When the Commission considered section 18(2), it noted the Court of Appeal judgment in *R v Laugalis* (1993) 10 CRNZ 350 (CA) where the Court held that a search conducted pursuant to a warrantless statutory power would be unreasonable where there were no urgent circumstances and where a warrant could have been applied for. Where there is no risk that evidential material will be lost or damaged and there is sufficient time to apply for and obtain a search warrant, the Court held that using a warrantless search power will be unnecessary, and therefore such a search would be unreasonable. On the basis of this reasoning the Commission recommended that, while section 18(2) of the Misuse of Drugs Act should be retained, it should be amended so it is clear on its face that use of the power is proscribed unless the police officer exercising the power believes on reasonable grounds that it is not practicable to obtain a warrant.

<sup>1120</sup> New Zealand Law Commission, above n 1111, para 8.25.

<sup>1121</sup> Search and Surveillance Bill 45-1 (2009), cl 21.



## Internal searches of person under arrest

- 14.17 Section 18A of the Misuse of Drugs Act authorises internal searches of persons under arrest for an offence under sections 6, 7 or 11 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.
- 14.18 Section 18A(3) proscribes 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.
- 14.19 Section 18A(1) makes clear that a police officer may search a person's mouth with the consent of the person.
- 14.20 As with section 18(3), the Commission recommended the retention of section 18A due to the overriding public interest in ensuring drugs are not in circulation in the community.<sup>1122</sup> Section 18A has been carried over into the Search and Surveillance Bill in the Part dealing with police powers.<sup>1123</sup>

## Power to search persons at a place or vehicle being searched

- 14.21 Under current New Zealand law, it is generally unclear whether there is a power to search those who are found in places or vehicles that are the subject of a lawful search.<sup>1124</sup>
- 14.22 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 that 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 constable has grounds to conduct a warrantless search. There is no requirement in either case for the constable 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).

<sup>1122</sup> New Zealand Law Commission, above n 1111, para 8.25.

<sup>1123</sup> Search and Surveillance Bill 45-1 (2009), cls 22 and 23.

<sup>1124</sup> New Zealand Law Commission, above n 1111, para 8.10.

14.23 The Commission previously 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 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.<sup>1125</sup> This is to be implemented by way of the Search and Surveillance Bill.<sup>1126</sup>

14.24 The Commission also considered whether any change to section 18(1) and (2) of the Misuse of Drugs Act was warranted and concluded that these exceptions to the general position should be retained.<sup>1127</sup>

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.

14.25 Accordingly, these provisions are retained in Part 2 of the Search and Surveillance Bill which sets out police powers of search.<sup>1128</sup>

#### *Controlled deliveries and related search powers*

14.26 The concept of controlled deliveries is recognised by article 11 of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988:

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.

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...

1125 New Zealand Law Commission, above n 1111, rec 8.2.

1126 Search and Surveillance Bill 45-1 (2009), cl 115(1).

1127 New Zealand Law Commission, above n 1111, para 8.16.

1128 Search and Surveillance Bill 45-1 (2009), cl 20. We note that the power to search persons found at a scene being searched pursuant to a warrant is not covered by this provision. This is clearly a drafting error and will need to be amended at a later stage of the legislative process.

- 14.27 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.
- 14.28 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.
- 14.29 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.
- 14.30 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.
- 14.31 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.
- 14.32 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 1978 should be retained, although it considered some deficiencies identified by Customs should be addressed.
- 14.33 Firstly, 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 search power for 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.<sup>1129</sup>

<sup>1129</sup> New Zealand Law Commission, above n 1111, rec 5.12.

- 14.34 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 meet changes in controlled delivery operations.<sup>1130</sup>
- 14.35 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.<sup>1131</sup> The Bill also amends section 12 to deal with changes in controlled delivery operations, as the Commission recommended.<sup>1132</sup>

### *Powers in relation to internal concealment*

#### Detention under the Misuse of Drugs Amendment Act 1978 and associated powers

- 14.36 Sections 13A to 13M of the Misuse of Drugs Amendment Act 1978 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 Class B controlled 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. It 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.
- 14.37 There are three stages in the procedures: the initial detention by police or a customs officer;<sup>1133</sup> 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.
- 14.38 When a person is initially detained by the police or a customs officer under section 13A, they 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 (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.<sup>1134</sup>

1130 Ibid.

1131 Search and Surveillance Bill 45-1 (2009), cls 78 and 79.

1132 Search and Surveillance Bill 45-1 (2009), cl 305.

1133 A customs officer may only exercise powers conferred by sections 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.

1134 Misuse of Drugs Amendment Act 1978, s 13B.

- 14.39 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.<sup>1135</sup>
- 14.40 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 controlled drug for any unlawful purpose; and
  - the premises where the person is being or is to be detained are suitable for the purpose.<sup>1136</sup>
- 14.41 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 their person any Class A or Class B controlled drug.<sup>1137</sup> 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.
- 14.42 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.<sup>1138</sup>
- 14.43 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.
- 14.44 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 Class B controlled drug;
  - 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 Class B controlled 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.<sup>1139</sup>

1135 Misuse of Drugs Amendment Act 1978, s 13D.

1136 Misuse of Drugs Amendment Act 1978, s 13E.

1137 Misuse of Drugs Amendment Act 1978, s 13EA.

1138 Misuse of Drugs Amendment Act 1978, s 13F.

1139 Misuse of Drugs Amendment Act 1978, s 13H.



## Police concerns regarding the current detention regime

14.45 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 under the Misuse of Drugs Amendment Act 1978. The Commission decided that fuller consideration of the desirability of prolonged periods of detention or detention or compelled examination or medical treatment would be necessary. It did not take the issue further in the context of that report, but recommended that further work be done on the issue.

14.46 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 the 21 day period they could effectively wait out the period of detention, with the police having no way of recovering the drugs. The Police referred the Commission to the case of *Police v Isitt*<sup>1140</sup> where Ms Isitt was suspected of having concealed a small container of morphine sulphate tablets in her vagina. She would not consent to a medical examination. Medical evidence before the Court suggested to Judge Unwin that anything that had been inserted in the vagina would stay there until removed and would not expel itself. Judge Unwin concluded:

...time was not the factor in this case. Accordingly any renewal [of the warrant] had little chance of success [and] was a futile waste of public resources.

14.47 The issue of vaginal retention was considered by Parliament when the law was amended in 1985. Judge Unwin in *Isitt* cited Mr RFH Maxwell's speech in the House at that time:

Detention without arrest must have some limitation, and there was widespread and long discussion of that aspect. It was decided that there was no justification at this stage for extending the time limit beyond the 21 days suggested... Evidence was presented that vaginal retention could occur for longer periods than that, but that would create some medical problems and was therefore unlikely. Given that the legislation is unprecedented and that caution should be exercised, I was prepared to accept 21 days as the maximum detention period. Of course, there is no reason the House should not ask for a review of the effect of the legislation, and, if necessary, it would be prepared to extend that time limit, because people likely be proved guilty are getting away with their crime for that one reason.

14.48 The Commission was also referred to the case of *O v S*<sup>1141</sup> as evidence that drugs could also be concealed anally in excess of 21 days.

14.49 The Police suggested that these deficiencies could be addressed by law reform that:

- (a) allows a judge to order a person to undergo a CAT-scan, x-ray, ultrasound scan, or other form of medical examination if there are reasonable grounds to believe the person is concealing Class A or Class B controlled drugs; and/or
- (b) forces a person to undergo an examination ordered by a judge; and/or

1140 *Police v Isitt* (24 December 1997) DC NEL M 87–97 Judge EW Unwin.

1141 *O v S* (1994) 11 CRNZ 427.



- (c) extends the period of maximum detention on the basis that the longer the potential detention period, the greater the incentive the detainee has to submit to an examination; and/or
- (d) creates an offence of refusing to undergo an examination.

#### Issues raised overseas in relation to similar powers

- 14.50 New South Wales enacted the Police Powers (Internally Concealed Drugs) Act 2001 in response to concerns about drug dealing and its impacts on the community in a particular area. That Act created a new police power to detain and search a person suspected of swallowing drugs to conceal evidence of an offence. In particular, where the police had reasonable grounds to suspect that a person had swallowed or was otherwise concealing drugs for the purpose of supply, the person could be detained and taken to a medical facility where an internal search could be carried out to determine whether there were drugs inside the person's body. The Act permitted searching by x-ray, magnetic resonance imaging (MRI), CAT scan, or other forms of medical imaging but did not authorise intrusion into the person's body cavities.
- 14.51 In 2005, after a review of the operation of the Act, the New South Wales Ombudsman recommended that Parliament should consider whether the Act remained in force. It has since been repealed. The Ombudsman's review of the Act is of interest because of its consideration of a range of issues known to arise in this area.
- 14.52 The Act had been used just once since its enactment. The Ombudsman concluded that the main reasons for it not being properly implemented were:
- industrial issues between police and health professionals as to who should be responsible for the retrieval of evidence from faecal matter;
  - concerns about the capacity of medical imaging to identify internally concealed drugs and doubts about whether drugs could be recovered intact if they were allowed to pass through the body;
  - the costs of detention at a hospital and imaging possibly being out of proportion to the seriousness of the offending in question.<sup>1142</sup>
- 14.53 One of the key conclusions of the Ombudsman's review was that the costs and resources involved in detention and imaging under the Act were significant, and while the use of internal search powers in federal legislation was generally targeted at those suspected through intelligence of trafficking significant quantities of drugs, at the State level police were more likely to be dealing with street dealers.<sup>1143</sup>
- 14.54 The distinctions in the type of suspect likely to be detained were consistent with the distinctions commonly made between those persons concealing drugs who are referred to as "body stuffers" and "body packers". A "body stuffer" is a person who has spontaneously swallowed unwrapped or poorly packaged drugs when fearing apprehension. A "body packer" internally conceals drugs that are typically

<sup>1142</sup> New South Wales Ombudsman *Review of the Police Powers (Internally Concealed Drugs) Act 2001* (July 2001, Sydney).

<sup>1143</sup> *Ibid*, 18.

carried in larger quantities and packaged for the purpose of transportation in the body.<sup>1144</sup> The view of the Ombudsman was that it was the former who were more likely to be detained under the New South Wales legislation.<sup>1145</sup>

- 14.55 These differences in the manner of concealment are also relevant to the potential limitations of medical imaging in detecting internally concealed drugs. The available evidence seems to suggest that detection rates will increase in proportion to the number of packages or amount of drugs ingested and the experience of the reporting clinician. The sensitivity of abdominal x-rays in detecting drug packets is reported to range from 45 % to 97 %. The performance of x-rays may be enhanced by repeat imaging and the use of oral contrasts. X-rays are generally unhelpful when faced with a “body stuffer” as opposed to a “body packer” because of the smaller quantities of drugs usually involved. There is limited evidence about the use of ultrasound to detect concealed drugs. There is some suggestion that CAT scans may be superior to x-rays, although again, the evidence seems to be limited.<sup>1146</sup>
- 14.56 The Ombudsman also considered whether reform of the Act to make it more workable was possible. The Police suggested a power to force regurgitation. This was opposed by health authorities and the Attorney-General’s Department because of medical risks. Similarly, powers to carry out internal cavity searches were not supported because of medical risks and the highly intrusive nature of such searches.<sup>1147</sup>
- 14.57 The Ombudsman’s report noted concerns raised by medical practitioners and other health care workers about the ethics of carrying out procedures that are of no therapeutic value to the patient. It noted that the British Medical Association and Association of Police Surgeons issued joint guidance in 1999 advising against doctors carrying out intimate searches where the person has not consented to the procedure.<sup>1148</sup>

### Options

- 14.58 In view of the suggestions made by the Police and the issues raised overseas, there are several aspects of the current internal concealment regime that might be changed. These are:
- the circumstances in which a person may be detained because of a belief that he or she is internally concealing drugs;
  - the maximum time period for detention;
  - the requirement for the detainee to consent to any examination; and
  - the types of examination that may be used to detect concealed drugs, in particular, the type of medical imaging technology that may be used.

1144 Stephen J Traub, Robert S Hoffman, Lewis S Nelson “Body Packing – The Internal Concealment of Illicit Drugs” (2003) 349 *New England Journal of Medicine* 2519; RJ Booker, JE Smith, MP Rodger “Packers, Pushers and Stuffers – Managing Patients with Concealed Drugs in UK Emergency Departments: A Clinical and Medicolegal Review” (2009) 26 *Emergency Medicine Journal* 316.

1145 New South Wales Ombudsman, above n 1142, 16.

1146 RJ Booker and others, above n 1144, 317–318.

1147 New South Wales Ombudsman, above n 1142, 22–23.

1148 *Ibid*, 27.

### *Circumstances in which a person may be detained*

- 14.59 We favour limiting the circumstances in which a person can be detained by redefining “unlawful purpose”. Currently, that phrase is 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. Given our proposals regarding personal possession and use, we think it would be incongruous to permit a person to be detained for up to 21 days, and to be searched and asked to undergo highly invasive procedures, where the only offence they had committed was one of possession of a small quantity of drugs (albeit that those drugs are currently those classified as Class A or Class B). We therefore suggest that “unlawful purpose” be limited to dealing offences.
- 14.60 An additional reason to limit the circumstances in which a person may be detained for internal concealment is the cost and resources involved in such detentions. One of the factors that led to the demise of the New South Wales legislation 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.<sup>1149</sup> We note that in their correspondence with the Commission regarding the internal concealment provisions, the Police acknowledged the “huge costs associated with closely monitoring people for up to 21 days”. It would seem inappropriate for these resources to be expended where the offence is relatively minor.

Q139 Do you agree that the circumstances in which a person may be detained by reason of internal concealment of drugs should be limited to situations where the person is suspected of concealing for the purposes of a drug dealing offence?

### *Maximum period of detention*

- 14.61 We are not attracted to the idea of extending this period beyond 21 days. While the Police have referred us to two cases where individuals were able to continue to conceal drugs beyond the 21 day detention period, we are not persuaded that this is a big enough problem to warrant an extension of what is already a very significant detention period.
- 14.62 Furthermore, 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.

Q140 Do you agree that the maximum period of detention for internal concealment should not be extended beyond 21 days?

<sup>1149</sup> Ibid, 18.

*Requirement for detainee to consent to an examination before it may be performed*

- 14.63 We are also not persuaded that the requirement for consent should be dispensed with. There is already a power to conduct a rub-down or a strip search without the consent of the person being held pursuant to a detention warrant where there is cause to suspect that the person has any Class A or Class B controlled 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.
- 14.64 We note also that 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.

Q141 Do you agree that the requirement for a person to consent to an examination under section 13C should be retained?

*Use of medical imaging techniques and technologies*

- 14.65 We favour amending the internal concealment regime to permit the use of a wider range of medical imaging techniques and technologies. We think that the 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 development of new imaging technologies or improvements in current ones, in the light of experience in their use and in the reliability of the evidence obtained.

Q142 Do you agree that the law should permit the use of a wider range of medical imaging techniques and technologies in relation to internally concealed drugs?

**Surveillance powers**

- 14.66 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.<sup>1150</sup>
- 14.67 However, there is some statutory regulation of audio surveillance and the use of tracking devices, which is discussed below, before the proposed generic surveillance device regime in the Search and Surveillance Bill is outlined.

<sup>1150</sup> New Zealand Law Commission, above n 1111, ch 11.

That regime will apply to the investigation of all suspected offending in respect of which a search warrant can be obtained and therefore will cover offending under the Misuse of Drugs Act which is punishable by a term of imprisonment.

### *Interception under the Misuse of Drugs Amendment Act 1978*

- 14.68 Part 9A of the Crimes Act 1961 is the starting point. That Part deals with the interception of private communications through the use of interception devices. It prohibits the use of interception devices to intentionally intercept any private communication.<sup>1151</sup>
- 14.69 A private communication is defined in a relatively narrow way so that a communication (whether oral, written or otherwise) will only be “private” if made in circumstances that reasonably indicate that any party to it desires the communication to be confined to the parties to it.<sup>1152</sup> Interception is defined (non-exhaustively) to include hearing, listening to, recording, monitoring, acquiring, or receiving a private communication, either while it occurs or while it is in transit.
- 14.70 It is important to note that Part 9A of the Crimes Act only deals with interception of communications using an interception device, and does not cover the accessing of a communication after its transmission is completed.
- 14.71 There are a number of exceptions to the general prohibition on the interception of private communications in Part 9A. One of these is the Misuse of Drugs Amendment Act 1978 which permits interception by the police in relation to drug dealing offences and dealing in cannabis on a substantial scale.<sup>1153</sup>
- 14.72 The key features of the interception scheme (which largely mirror the interception regime in Part 11A of the Crimes Act) are as follows:
- (a) Interception can only occur on the basis of an interception warrant or an emergency permit.<sup>1154</sup>
  - (b) An application for an interception warrant may only be made by a commissioned officer of police.<sup>1155</sup>
  - (c) Only a High Court judge may issue an interception warrant or an emergency permit.

<sup>1151</sup> Crimes Act 1961, s 216B.

<sup>1152</sup> Crimes Act 1961, s 216A.

<sup>1153</sup> 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 Schedule 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).

<sup>1154</sup> An emergency permit may be granted by a High Court judge where circumstances exist that would justify the grant of an interception warrant, but the urgency of the situation requires that the interception should begin before a warrant could be obtained (Misuse of Drugs Amendment Act 1978, s 19(1)).

<sup>1155</sup> Misuse of Drugs Amendment Act 1978, ss 14(2) and 15A(2).

- (d) A warrant or permit can only be issued where the judge is satisfied that:
    - to do so is in the best interests of the administration of justice; and
    - there are reasonable grounds to believe that a drug dealing offence has been, is being, or will be committed, or that a member of an organised criminal enterprise has planned, participated in, or committed a prescribed cannabis offence involving dealing in cannabis on a substantial scale; and
    - evidence relevant to the case will be obtained; and
    - other investigative techniques and procedures:
      - have been tried and failed; or
      - are unlikely to facilitate the successful conclusion of the case; or
      - are likely to be too dangerous to adopt; or
      - are impractical due to urgency; and
    - privileged communications are not likely to be intercepted.<sup>1156</sup>
  - (e) In each case the judge must consider the extent to which the privacy of any person or persons would be interfered with.<sup>1157</sup>
  - (f) An interception warrant has a limited life of 30 days with an emergency permit being valid for a maximum of 48 hours.<sup>1158</sup>
  - (g) Irrelevant records of information obtained through interception must be destroyed as soon as practicable after they have been made and relevant records must be destroyed as soon as it appears that no proceedings (or further proceedings) will be taken.<sup>1159</sup>
  - (h) Notice must be given of an intention to adduce evidence obtained pursuant to an interception warrant or an emergency permit.<sup>1160</sup>
  - (i) Unlawfully intercepted private communications (together with derivative evidence) are (subject to some limited exceptions) inadmissible in evidence.<sup>1161</sup>
  - (j) Police must report to a judge (usually the judge who issued the warrant or permit) on the use that was made of the warrant or permit as soon as practicable after its expiry.<sup>1162</sup>
  - (k) The Commissioner of Police must provide collated information on interception warrants and emergency permits to Parliament in the annual report.<sup>1163</sup>
- 14.73 As well as significantly limiting the types of offences for which it can be used, the regime governing the use of interception devices to obtain evidence of drug offending is far more restrictive in its terms than the regime governing the issue of ordinary search warrants in respect of the same types of suspected offending.

1156 Misuse of Drugs Amendment Act 1978, ss 15(1) and 15B(1).

1157 Misuse of Drugs Amendment Act 1978, s 15(2) and 15B(2).

1158 Misuse of Drugs Amendment Act 1978, ss 16(3) and 19(6).

1159 Misuse of Drugs Amendment Act 1978, ss 21 and 22.

1160 Misuse of Drugs Amendment Act 1978, s 24.

1161 Misuse of Drugs Amendment Act 1978, s 25.

1162 Misuse of Drugs Amendment Act 1978, s 28.

1163 Misuse of Drugs Amendment Act 1978, s 29.



### *The current regime governing the use of tracking devices*

- 14.74 The other area of surveillance that is subject to a specific legislative regime is the use of tracking devices. Sections 200A to 200P of the Summary Proceedings Act govern the installation, use and removal of tracking devices. 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.<sup>1164</sup>
- 14.75 A High Court or District Court judge can issue a tracking device warrant upon application by a police officer or a customs officer, if satisfied that:
- there are reasonable grounds to believe that an offence has been, is being, or will be committed;
  - information relevant to the offending can be obtained by use of a tracking device; and
  - it is in the public interest for a warrant to be issued having regard to the seriousness of the offence, the degree to which privacy or property rights will be interfered with, and whether the information can be obtained in another way.<sup>1165</sup>
- 14.76 As well as authorising the installation, monitoring, maintenance and removal of a tracking device, a warrant also authorises entry onto any premises specified in the warrant, the breaking open or interfering with any thing, or the temporary removal of any thing from any place.<sup>1166</sup>
- 14.77 A tracking device may be installed, monitored or removed without warrant if it is not practicable to obtain a warrant and the officer believes that a judge would issue a warrant if time permitted. A device installed in such circumstances may only be monitored for up to 72 hours.<sup>1167</sup>
- 14.78 As with the interception regime, a range of reporting requirements are imposed in respect of not only individual warrant applications and the use of devices without warrant, but also the general use of tracking devices.<sup>1168</sup>
- 14.79 While not as restrictive as the interception regime under the Misuse of Drugs Amendment Act, the tracking device regime is still more restrictive in its terms than the ordinary search warrant regime applying to searches in respect of the same kinds of offending.

### *Proposed surveillance device warrant regime under Search and Surveillance Bill*

- 14.80 In the Commission's report on search and surveillance powers it recommended that a new generic surveillance device regime be created, which would replace the current interception and tracking device regimes. The Commission envisaged

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<sup>1164</sup> Summary Proceedings Act 1957, s 200A.

<sup>1165</sup> Summary Proceedings Act 1957, s 200C.

<sup>1166</sup> Summary Proceedings Act 1957, s 200D(2).

<sup>1167</sup> Summary Proceedings Act 1957, s 200G.

<sup>1168</sup> Summary Proceedings Act 1957, ss 200H and 200J.

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.<sup>1169</sup>

14.81 The detailed recommendations regarding the features of this proposed scheme were accepted and are reflected 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.<sup>1170</sup>
- An enforcement officer must obtain a warrant for the following activities:
  - use of an interception device to intercept a private communication;
  - use of a tracking device;
  - observation (and any recording) of private activity using a visual surveillance device warrant;
  - 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.<sup>1171</sup>
- An enforcement officer does not require a warrant for:
  - entering private premises lawfully and recording what is seen or heard there;
  - covert audio recording of a voluntary oral communication between two or more persons made with the consent of at least one of them.<sup>1172</sup>
- In certain circumstances of urgency a surveillance device may be used without warrant for up to 72 hours.<sup>1173</sup>
- 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.<sup>1174</sup>
- 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 he or she 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.<sup>1175</sup>

1169 New Zealand Law Commission, above n 1111, recs 11.3 and 11.4.

1170 Search and Surveillance Bill 45-1 (2009), cl 46.

1171 Search and Surveillance Bill 45-1 (2009), cl 42.

1172 Search and Surveillance Bill 45-1 (2009), cl 43.

1173 Search and Surveillance Bill 45-1 (2009), cl 44.

1174 Search and Surveillance Bill 45-1 (2009), cls 53 and 54.

1175 Search and Surveillance Bill 45-1 (2009), cls 55 and 56.

14.82 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.

14.83 Given the comprehensive coverage of the proposed surveillance device regime in the Search and Surveillance Bill, 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

14.84 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.

14.85 We do not propose any change to this power.

## REGULATORY POWERS

### Current powers

14.86 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.

14.87 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.

14.88 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

14.89 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 licences issued in accordance with our proposals in chapter 13. This is the role currently carried out by section 19 of the Act.

- 14.90 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.
- 14.91 In chapter 8 we proposed a regulated environment for the manufacture, importation, sale and supply of non-convention drugs. In that chapter we noted the need for a regulatory inspection power to monitor compliance with the regime proposed. We propose that there be a power to enter premises (other than a private dwelling house) and to inspect documents and take samples of substances for the purposes of monitoring compliance with any approval to manufacture or sell under that regime and any standard or additional conditions associated with that approval. Again, Part 4 of the Search and Surveillance Bill would apply, with the exclusion of provisions relating to the detention of persons found on the premises.
- 14.92 Where entry to a private dwelling house is necessary, we propose that a warrant from an issuing officer authorising entry to those premises be required, as is common with regulatory inspection powers across the statute book.

Q143 Do you agree that the current section 19 inspection power should be retained and made subject to the generic regime in the Search and Surveillance Bill?

Q144 Do you agree that a power to enter premises, inspect documents, and take samples of substances is required for the purpose of monitoring compliance with any approvals given under our proposed regime for non-convention drugs (discussed in chapter 8)?

# Chapter 15

## Achieving balance in drug policy

### SUMMARY

This chapter examines problem limitation and demand reduction strategies. It also considers options for providing better support for these pillars of drug policy.

**INTRODUCTION** 15.1 The international drug conventions impose a responsibility on national governments to make treatment available for drug dependent users. Under article 38 of the Single Convention on Narcotic Drugs 1961 and article 20 of the Convention on Psychotropic Substances 1971, parties are required to:<sup>1176</sup>

...take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved...

Over recent years the United Nations Office on Drugs and Crime (UNODC), which historically has concerned itself primarily with strategies aimed at suppressing the supply of drugs, has also begun to stress the importance in drug policy of achieving a balance between strategies and measures aimed at eliminating the supply of drugs and those aimed at reducing demand through prevention and treatment.<sup>1177</sup> In a similar vein the United Nations agreed in 1998 that:<sup>1178</sup>

The most effective approach towards the drug problem consists of a comprehensive, balanced and coordinated approach, encompassing supply control and demand reduction reinforcing each other, together with the appropriate application of the principle of shared responsibility. There is now a need to intensify our efforts in demand reduction and to provide adequate resources towards that end.

<sup>1176</sup> Article 38 and Article 20 contain the same wording.

<sup>1177</sup> See, for example, Antonio Maria Costa "Health: The First Principle of Drug Policy" (18 March 2008) Costas Corner [www.unodc.org](http://www.unodc.org) (accessed 15 December 2009).

<sup>1178</sup> The United Nations in this context uses the term "demand reduction" to include policies that aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse. See The Declaration on the Guiding Principles of Drug Demand Reduction – UNGA Resolution 20/3 (8 September 1998) A/RES/S-20/3, paras 4 and 8.

- 15.2 As we discussed in chapter 3, New Zealand's National Drug Policy takes a similar approach. Our drug policy emphasises the need for a balance of strategies and measures that support demand reduction and problem limitation as well as the more traditional supply controls centred on prohibition.
- 15.3 In this chapter we consider demand reduction strategies aimed at delaying or preventing the uptake of drug use, and problem limitation measures, such as treatment interventions and harm reduction initiatives, aimed at reducing the harm arising from existing drug use. There is a substantial body of evidence demonstrating the effectiveness of drug treatment and other problem limitation measures aimed at reducing drug-related harm.<sup>1179</sup> Demand reduction and problem limitation strategies are recognised as essential components of a broad and effective response to drug-related harm. Despite this, we are concerned that these aspects of drug policy do not receive the level of support and attention that they require.

#### DRUG TREATMENT

- 15.4 For the purposes of our discussion we use the term "treatment" broadly to mean the application of any intervention that aims to have a beneficial impact upon the behaviour and welfare of a problem 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.<sup>1180</sup>

#### Drug use amenable to treatment

- 15.5 Problem drug use takes a number of forms. In the alcohol and drug treatment sector alcohol and drug use is often seen as occurring on a continuum that extends from no use or abstinence at one end through to addiction or severe dependence at the other end. Conceptually a continuum of use also provides a useful approach for considering different levels of treatment to respond to the nature and severity of alcohol or drug use.<sup>1181</sup> The diagram below illustrates this continuum and the level of treatment response proposed by the National Committee for Addiction Treatment.<sup>1182</sup> Under this continuum, hazardous use, harmful use and any pattern of dependency all constitute problem drug use that might benefit from some form of drug treatment.<sup>1183</sup>

1179 See, for example, the review of the research and evidence base for drug treatment undertaken by UNODC. United Nations Office on Drug and Crime *Contemporary Drug Abuse Treatment: A Review of the Evidence Base* (United Nations, New York, 2002).

1180 Alex Stevens, Christopher Hallam and Mike Trace *Treatment for Dependent Drug Use: A Guide for Policymakers* (R 10, The Beckley Foundation Drug Policy Programme, Beckley (UK), 2006) 2.

1181 National Addiction Centre *Orientation to the Addiction Treatment Field Aotearoa New Zealand* (National Addiction Centre, Christchurch, 2008) 3.

1182 National Committee for Addiction Treatment (NCAT) *Investing in Addiction Treatment – A Resource for Funders, Planners, Purchasers and Policy Makers* (NCAT, Christchurch, 2008) 7.

1183 National Addiction Centre, above n 1181, 3.



TABLE 5:

## The abstinence to addiction continuum

No use	No treatment required.
Low risk use	Public or population health initiatives apply.
Hazardous use	Likely to benefit from less intensive treatment options, need treatment but do not necessarily need specialist treatment.
Harmful use	
Mild dependency	
Dependency	Need intensive, specialist treatment options.

- 15.6 While more intensive forms of specialist treatment are probably required where a person has become dependent on drugs,<sup>1184</sup> less intensive treatment options can be utilised where drug use is hazardous or harmful or drug dependency is mild. Drug treatment strategies therefore need to include a range of services and options. Low level and brief interventions, which may be provided in a generalist setting (for example, primary care) rather than by addiction treatment specialists, are needed at an early stage where drug use is first identified as hazardous or harmful, while withdrawal management and specialist community-based and intensive residential treatment options are more applicable where dependency has become severe.
- 15.7 The New Zealand Mental Health Survey 2006 has estimated the prevalence of different groups of mental health disorders including substance abuse disorders (abuse of or dependence on alcohol or drugs). For the survey, substance abuse is defined as a “maladaptive pattern of substance use that involves recurrent and significant adverse consequences”.<sup>1185</sup> In terms of the continuum discussed above, substance abuse would cover both harmful use and hazardous use. For the survey, dependence is characterised by symptoms including an increased tolerance to a drug, withdrawal symptoms, more prolonged and intense use of a drug and unsuccessful attempts to control use.<sup>1186</sup>
- 15.8 Results from the survey estimate that in the preceding 12 months, 2.6 % of the population experienced alcohol abuse, 1.3 % alcohol dependence, 1.2 % other drug abuse and 0.7 % other drug dependence.<sup>1187</sup> Alcohol abuse was 2.3 times more prevalent than other drug abuse and alcohol dependence was 1.8 times more common than drug dependence.<sup>1188</sup> The rates of substance use disorder were markedly higher for young people and also for Māori. Of young people in the 16 to 24 year age group, 7.1 % experienced alcohol abuse, 3.0 % alcohol dependence, 3.8 % other drug abuse and 2.1 % drug dependence.<sup>1189</sup> For Māori, 7.4 % experienced

1184 NCAT, above n 1182, 7.

1185 J E 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) 12.

1186 Ibid, 12.

1187 Ibid, 19.

1188 Ibid, 23.

1189 Ibid, 25.

an alcohol disorder (that is, abuse or dependence) and 4.0 % experienced other drug disorders.<sup>1190</sup> In crude terms, these figures represent the proportion of the population that potentially might benefit from alcohol and drug treatment.<sup>1191</sup>

### Alcohol and drug treatment in New Zealand

- 15.9 The alcohol and drug treatment sector in New Zealand encompasses a broad range of treatment types and services. It is beyond the scope of this project to assess the various models or approaches to treatment or their relative effectiveness. However, because we are proposing a rebalancing of the pillars of drug policy with greater emphasis on treatment within drug policy, we believe it is important to understand the nature of drug treatment and its effectiveness at addressing drug-related harm.
- 15.10 In this section we give a brief overview of the treatment sector and the range of treatment services and models of treatment currently available within New Zealand.

#### *Non-specialist health services – “screening” and “brief interventions”*

- 15.11 “Screening”, as the name suggests, involves administering a range of screening tools that have been developed to determine the likelihood that a person has a drug-related problem. Screening may also identify the presence of related or co-existing problems and whether there is any immediate risk for the person or others. Screening services provide an essential filter for access to specialist treatment. Where screening indicates that there is a more severe problem like dependence, people can be referred through to specialist services.
- 15.12 Attempts to have primary care services screen for alcohol and drug problems have not been particularly successful to date. Currently screening is undertaken by a few general practitioners and others working in primary care, but not routinely. Some screening is done at emergency services when people present with emergencies and injuries related to alcohol or other drugs, but again it is not undertaken as a matter of course. Probation officers also administer some screening tools as part of the pre-sentence report process and on that basis refer people on to specialist services.
- 15.13 The term “brief intervention” is used to identify other low level interventions that can form part of a preliminary layer of services. Brief interventions include one-off therapeutic consultations, the provision of tailored information and advice about the consequences of current patterns of drug use and possibly some support services to address related social or family issues.<sup>1192</sup>

1190 Note that these unadjusted prevalence rates describe the actual burden of substance use disorder experienced by Māori. When comparisons are being made with other ethnic groups, adjustments reflecting differences in age and other socioeconomic correlates need to be made. See *ibid*, 32.

1191 It is important to note that the population surveyed were people aged 16 and over living in permanent private dwellings throughout New Zealand, so this excludes the prison population and people living in other circumstances.

1192 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) 225.

- 15.14 As was discussed in the Commission's issues paper *Alcohol in Our Lives*,<sup>1193</sup> there is good evidence that brief interventions can be highly cost-effective for treating less severe alcohol-use problems.<sup>1194</sup> They can change patterns of alcohol consumption and reduce alcohol-related problems, but are under-utilised in New Zealand.<sup>1195</sup> 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 because many people with drug problems also have alcohol problems and require similar interventions for both. For that reason there is a combined telephone Alcohol and Drug Helpline that provides support, advice and information.
- 15.15 Brief interventions are not widely provided within primary care services, although primary care is regarded as best placed to address alcohol and drug screening, problem recognition, early intervention and general management.<sup>1196</sup>
- 15.16 While we recognise that there are obviously some barriers and practical difficulties that need to be overcome,<sup>1197</sup> increased use should be made of the opportunities for screening and brief interventions within primary care.

### *Specialist treatment services*

- 15.17 Specialist alcohol and drug services are provided by approximately 150 specialist teams spread across the 21 District Health Boards and 16 large non-government organisations. There are also a few alcohol and drug treatment practitioners in Māori health and in services catering for young people. It is estimated that approximately 22,500 people or 0.5 % of the population receive some assistance from specialist alcohol and drug treatment services annually.<sup>1198</sup> Only a very small portion of people attend residential or intensive day programmes. These are relatively expensive and are only available on a publicly funded basis for those with severe alcohol or drug dependence. The majority of people access specialist alcohol and drug services through outpatient or community-based treatment programmes.

1193 New Zealand Law Commission *Alcohol in Our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws* (NZLC IP15, Wellington, 2009) 206.

1194 T Babor and others *Alcohol: No Ordinary Commodity* (Oxford University Press, New York, 2003).

1195 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; J P McMenamin "Detecting Young Adults with Alcohol Use Disorder in General Practice" (1997) 110 *New Zealand Medical Journal* 127.

1196 Helen Moriarty, Maria Stubbe and Sarah Bradford *Opportunities for Alcohol and Other Drug Advice in the GP Consultation* (University of Otago, Wellington, 2009) 4.

1197 These include time pressures in general practice, the acuteness of other complaints as well as individual practitioners' confidence and experience; see *ibid*.

1198 Between May 2007 and April 2008, 22,696 people accessed specialist alcohol and drug treatment services.

15.18 In the 2007/08 year \$103.5 million of Vote Health was spent on alcohol and drug treatment, comprising:<sup>1199</sup>

- \$69.50 million on community alcohol and drug treatment;
- \$14 million on residential treatment;
- \$13 million on methadone substitution programmes;
- \$7 million in total on detoxification (this includes \$1.5 million spent as a component of community alcohol and drug treatment and \$0.6 million as a component of residential treatment).

Some of the non-government organisations providing alcohol and drug treatment also receive funding from other sources including government departments.

15.19 The specialist treatment sector and most specialist alcohol and drug treatment programmes available in New Zealand provide a range of different interventions.

### Comprehensive assessment

15.20 A comprehensive assessment is needed after a person has been identified through screening as requiring specialist alcohol and drug treatment. These assessments are normally undertaken by specialists involved in outpatient or community addiction treatment services or as a first step of a residential or therapeutic community placement. The objective is to properly and adequately determine the nature of the drug problem, and other relevant co-existing problems.<sup>1200</sup> A full risk assessment is also undertaken. Many people accessing alcohol and drug treatment have a range of other issues and needs as well. These include mental and other health problems and social, legal, and family issues. The National Committee for Addiction Treatment reports that in one study, 74 % of a representative sample of people seeking alcohol and drug treatment from Community Alcohol and Drug Services had a co-existing psychiatric disorder.<sup>1201</sup> Treatment for this group is unlikely to be effective unless it also addresses these types of broader underlying issues. Ideally a treatment plan that addresses a person's particular needs is developed in this way.

### Detoxification or withdrawal management

15.21 Where a person has developed a dependence on a drug, he or she is likely to experience withdrawal symptoms when the use of the drug is stopped. Withdrawal from some drugs such as alcohol, benzodiazepines and barbiturates may cause symptoms that are life threatening,<sup>1202</sup> while withdrawal from others, such as opiates, can be extremely unpleasant and involve severe pain, fever, chills and diarrhoea as well as intense drug craving and emotional distress.<sup>1203</sup> All such symptoms can be minimised, as far as possible, by detoxification treatment and withdrawal management, so that the person can withdraw from drug use as comfortably and safely as possible.<sup>1204</sup> The aim is to reduce physiological

1199 Figures provided by the Ministry of Health.

1200 National Addiction Centre, above n 1181, 17.

1201 NCAT, above n 1182, 27.

1202 Stevens, Hallam and Trace, above n 1180, 4.

1203 Ibid, 4.

1204 Ritter and Lintzeris, above n 1192, 227.

and emotional instability so as to avoid medical or psychiatric complications.<sup>1205</sup> Detoxification will therefore normally involve medical care and the use of other drugs to manage withdrawal symptoms.

- 15.22 Detoxification is not a stand-alone treatment option, as it is now well recognised that by itself detoxification is unlikely to produce a long term withdrawal from drug use.<sup>1206</sup> Detoxification is normally approached as a preliminary step in an ongoing rehabilitation programme and should lead to further treatment aimed at supporting the person's lifestyle changes and avoiding relapse. Withdrawal from heroin, for example, may increase the risk of subsequent death by overdose by reducing tolerance to heroin, so it is particularly important that ongoing treatment and support is available.
- 15.23 In New Zealand, detoxification or withdrawal management is undertaken on an in-patient basis within either a dedicated in-patient detoxification facility in a hospital or a general hospital setting. Detoxification is also undertaken in the community while the person remains in his or her own home with the necessary medical support being provided by visiting nursing and medical staff. Home-based detoxification will only be an option where adequate medical support can be provided by visiting nursing and medical staff, which will not always be the case. In addition the City Mission in Auckland and Christchurch provides some residential detoxification in circumstances where medical oversight is not required.<sup>1207</sup> The Government has recently announced an intention to increase the number of beds available in detoxification facilities of this kind.<sup>1208</sup>
- 15.24 There is little evidence available on the comparative efficacy of in-patient and community-based detoxification processes, although inpatient programmes are significantly more expensive.
- 15.25 A large portion of people who enter withdrawal management are seeking a temporary break from the adverse physical, psychological, or social harms arising from their drug use. However, they may not be prepared or be in a position to make the fundamental behavioural changes that are required to maintain longer term abstinence. For these people it is suggested there is still some benefit in completing withdrawal.<sup>1209</sup>

### Pharmacological therapies – opioid substitution treatment

- 15.26 Drug users who are drug dependent can benefit from ongoing pharmacological treatment and therapies. Pharmacological treatment can take two forms: (a) substitution treatment where a safer legal drug, like methadone, is substituted for illegal street opiates; or (b) prescription of antagonist medications, like naltrexone, that block the effects of other drugs and reinforce a person's

1205 Stevens, Hallam and Trace, above n 1180, 4.

1206 Ritter and Lintzeris, above n 1192, 229.

1207 This usually involves a short stay of between one to seven nights in a supportive setting for safe withdrawal.

1208 Department of Prime Minister and Cabinet *Tackling Methamphetamine: An Action Plan* (DPMC, Wellington, 2009) 41.

1209 Ritter and Lintzeris, above n 1192, 229.



decision not to use those other drugs. In New Zealand, relatively little use is made of the second type of pharmacological treatment, so the rest of the discussion concerns drug substitution.<sup>1210</sup>

- 15.27 Many studies have shown that opioid substitution is effective and it is a well established form of drug treatment. Currently almost all opioid substitution treatment in New Zealand is undertaken with methadone. A more recently developed drug buprenorphine is registered for use as a medicine in New Zealand, but it is not funded by PHARMAC, and is not readily available for use. Internationally buprenorphine is increasingly being used in opioid substitution. It has been used widely in France in treatment since the 1990s and is now established in many countries. Studies have compared it to methadone and found it to have some advantages. It is less likely to lead to overdose, needs to be administered less frequently and provokes milder withdrawal symptoms when use is ceased. However, it costs significantly more than methadone. In some countries, like the United Kingdom, diamorphine (heroin) is also used, although only as a drug of last resort and largely as a harm reduction measure. We consider the issue of prescription heroin later in the chapter as a specific problem limitation measure. Methadone is still by far the most widely used substitution medication.
- 15.28 We should note here that, although there may be cost and approval barriers that limit the use that is currently made of naltrexone, buprenorphine and other newer pharmacological treatments, there are not legal barriers. Such drugs can be supplied under provisions in the Misuse of Drugs Act 1975 in the same way as methadone. The Ministry of Health guidelines on opioid substitution treatment now also cover buprenorphine.<sup>1211</sup>
- 15.29 Methadone substitution treatment is delivered either by specialist addiction services or by authorised general practitioners supported by specialist addiction services. Methadone is generally administered or dispensed at community pharmacies. Approximately 4500 people currently receive methadone treatment in New Zealand and, as noted above, \$13 million was spent on methadone substitution programmes in 2005/06.<sup>1212</sup>
- 15.30 Participants in opioid substitution programmes report significant quality of life improvements, and studies show that it is helpful in reducing the use of street opiates, the risks associated with intravenous drug use, and drug-related property crimes. A portion of people in opioid substitution programmes are seeking a temporary break from the adverse physical, psychological, or social harms arising from intravenous drug use.
- 15.31 Many studies of pharmacological treatments for drug dependence stress that substitution treatment should also involve psycho-social assistance. Guidelines governing opioid substitution in New Zealand stress the importance of methadone

<sup>1210</sup> For a discussion on other pharmacological treatments see *ibid*, 242.

<sup>1211</sup> Ministry of Health *Practice Guidelines for Opioid Substitution Treatment in New Zealand* (Ministry of Health, Wellington, 2008).

<sup>1212</sup> Figures provided by the Ministry of Health.



substitution being approached as only a component of treatment and the need for specialist alcohol and drug treatment services to accompany the substitution with a range of psycho-social therapies.<sup>1213</sup>

## Psycho-social therapies

15.32 Psycho-social therapies are an important part of drug treatment. Included within this broad category are all forms of individual or group counselling, motivational interviewing, cognitive-behavioural therapies, community reinforcement approaches, coping and social skills training, and relapse prevention therapies. Psycho-social therapies form a core component of most drug treatment approaches and residential and non-residential treatment programmes.

15.33 The National Committee for Addiction Treatment says that a wide range of psycho-social therapies have been shown to be effective.<sup>1214</sup> Similarly the UNODC in its report *Contemporary Drug Abuse Treatment: A Review of the Evidence Base*<sup>1215</sup> identifies four categories of psycho-social therapies that have been associated with a lower risk of relapse:<sup>1216</sup>

- **General outpatient drug-free counselling** – in individual or group sessions with a counsellor or facilitator. According to the UNODC, studies evaluating the effectiveness of this in the United States suggest that it is associated with reductions in drug use and crime together with improvements in health and well being.
- **Specific cognitive psychotherapies** – most notably “motivational interviewing”, in which the counsellor focuses on the client’s experiences and directs him or her towards resolving ambivalence and making a commitment towards change.
- **Cognitive-behavioural approaches** – these are based on the assumption that dependent drug users can learn new skills and strategies for avoiding drug use and relapse.
- **Community reinforcement** – this approach focuses on changing external social factors like unemployment, homelessness and social networks that play an important part in reinforcing drug dependence. Alternative reinforcements, such as employment, social contact with non-drug users and improved family relationships, are developed and encouraged.

15.34 There seems to be evidence of the effectiveness of all these different forms of psycho-social therapies in reducing problematic drug use, although for some the evidence suggests that the approach is more often effective when used in combination with a range of other measures.<sup>1217</sup> Participation in peer-support networks and self-help groups of individuals who meet for the purpose

1213 Ministry of Health, above n 1211.

1214 NCAT, above n 1182, 22. A similar view is also expressed by the NHS National Treatment Agency for Substance Misuse in the United Kingdom; see the review of studies and evidence on the effectiveness of counselling in the NHS National Treatment Agency for Substance Misuse *Models of Care for the Treatment of Drug Misusers* (Department of Health, London, 2002) 64.

1215 United Nations Office on Drug and Crime, above n 1179.

1216 Ibid, 11–13.

1217 Stevens, Hallam and Trace, above n 1180, 6; see also the review of studies and evidence on the effectiveness of counselling in the NHS National Treatment Agency for Substance Misuse, above n 1214, 64.

of supporting each other's efforts to maintain sobriety, such as Alcoholics Anonymous or Narcotics Anonymous, is also generally recognised as a valuable support to other treatment, although little formal evaluation has been done.<sup>1218</sup>

### Post-treatment care

- 15.35 The treatment sector has identified the provision of continuing or post-treatment support as an important component of recovery.<sup>1219</sup> Drug users face a high risk of relapse in the period after treatment ends. Post-treatment care, which may include relapse prevention therapy, recovery support groups, or ongoing individual support, can assist those trying to maintain a drug-free lifestyle. Twelve step fellowships like Alcoholics Anonymous or Narcotics Anonymous and other peer-support networks may also form part of this post-treatment care approach.
- 15.36 Access to a broad range of community services and support is also an important part of post-treatment care, particularly where people have other needs arising from mental health issues or social dislocation.<sup>1220</sup> Access to broader advisory services, accommodation, education or training, and employment support might also be included as part of a strategy of post-treatment care and relapse prevention. There is a need to ensure that there are links between drug treatment and other health and social services to provide ongoing community support for changes made through treatment.

### Treatment goals – abstinence or harm reduction

- 15.37 There are two distinct philosophies underpinning the work of the alcohol and other drug treatment sector, representing different sides of one of the most longstanding debates in the treatment field. One promotes abstinence as the only valid goal of treatment; the other identifies a reduction in specific harms arising from drug use and related behaviour as the goal, with abstinence, if it can be achieved, as only one among a number of ways of doing this. In drug treatment there are genuine tensions between abstinence and harm reduction approaches. Some people might argue that providing services that reduce the harm and hardship associated with drug use simply supports drug use and delays a user's decision to become abstinent, while others argue that requiring abstinence for participation in treatment sets too high a threshold because it means that those who continue to use drugs are excluded. This latter group suggests that there are benefits in encouraging those who continue to use drugs to contact alcohol and drug services. For example, problems like the risks of overdose and intravenous infection may be reduced, trust can be developed, and a basis for behavioural change established.<sup>1221</sup>
- 15.38 At a policy level the approach in New Zealand is to recognise that where eliminating drug use is not possible, the personal and social cost associated with such behaviour should still be minimised.<sup>1222</sup> In the treatment context this has translated into

1218 United Nations Office on Drug and Crime, above n 1179, 13.

1219 Stevens, Hallam and Trace, above n 1180, 8.

1220 NCAT, above n 1182, 16.

1221 Stevens, Hallam and Trace, above n 1180, 4.

1222 Ministerial Committee on Drug Policy *National Drug Policy 2007–2012* (Ministry of Health, Wellington, 2007) 5.

support for a wide range of approaches, including abstinence-oriented strategies, but also publicly funded treatment interventions for people who continue to use drugs. Most treatment services seem to provide a blend of both approaches.<sup>1223</sup> The National Committee for Addiction Treatment suggests that abstinence-based approaches are normally targeted at people with moderate to severe dependence, while treatment informed by harm reduction tends to be most appropriate for people with a mild level of dependence or for people who are severely dependent but unable to achieve a drug-free lifestyle.<sup>1224</sup>

### *The choice of treatment*

- 15.39 Different levels of treatment and different types of approach are appropriate for different people depending on their degree of drug use or dependence and other surrounding circumstances. For severe dependence, specialist treatment via an intensive community-based or residential programme may be necessary over several months, followed by ongoing community support and after-care. A less severe problem with drug use may be resolved by access to advisory or information services or some counselling. Drug users often need to engage with different treatment services in an episodic manner over a number of years.<sup>1225</sup> Treatment consequently should be seen as a process, which provides a mix of different interventions and services, rather than one single event.<sup>1226</sup>
- 15.40 The length of time in treatment has been found to be one of the most consistent predictors of favourable post-treatment outcomes among drug users.<sup>1227</sup> For this reason the National Committee for Addiction Treatment advocates that intensive intervention provided by residential programmes should be of at least three months duration.<sup>1228</sup> As with all treatment it needs to be of sufficient quality and duration to facilitate change. The relatively high cost of longer intensive programmes acts as something of a barrier to this.
- 15.41 Some programmes, both residential and community-based, cater for specific needs – for example, those of youth, Māori or Pacific people. The National Committee for Addiction Treatment says that kaupapa Māori addiction treatment options have been steadily developing based on evidence that treatment programmes and interventions that are firmly based on Māori beliefs, values and experiences can increase access to and retention in treatment.<sup>1229</sup> In a recent stock-take of services undertaken for the Ministry of Health, out of a representative sample of 100 service providers, 20 provided kaupapa Māori community treatment, two provided kaupapa Māori residential services for adults and two took a kaupapa Māori approach in residential services for youth.<sup>1230</sup>

1223 NCAT, above n 1182, 13.

1224 Ibid, 7.

1225 Ibid, 2.

1226 Ibid.

1227 Micheal Gossop “Developments in the Treatment of Drug Problems” in Philip Bean and Teresa Nemitz *Drug Treatment: What Works?* (Routledge, United Kingdom, 2004) 65, 70.

1228 NCAT, above n 1182, 12.

1229 Ibid, 23.

1230 Allen & Clarke *Stocktake of Services and Resources to Minimise the Harm from Drugs* (Allen & Clarke, Wellington, 2009).

### Cost-effectiveness of drug treatment

- 15.42 It is not always possible or particularly helpful to try and determine the effectiveness of different components of treatment in isolation. Many working in the alcohol and drug treatment field would argue that treatment needs to be seen as a process that provides an ongoing mix of different interventions and services, rather than a single point of engagement with one form of treatment or one programme. Typically a person suffering from dependence has 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.
- 15.43 Notwithstanding this, there is clear evidence that specialist alcohol and drug treatment can be cost-effective.<sup>1231</sup> The National Committee for Addiction Treatment states that most reviews consistently find that addiction treatment yields net economic benefits to society.<sup>1232</sup> It cites 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.<sup>1233</sup> There is also evidence that drug and alcohol treatment for people convicted of a crime can be as effective when people are coerced as when they choose to go into treatment voluntarily.<sup>1234</sup> Similarly, reports prepared by both the Beckley Foundation and the UNODC reviewing the research evidence on drug treatment have concluded that there is evidence that drug treatment can be cost-effective.<sup>1235</sup>

### Access to treatment and gaps in current services

- 15.44 Currently treatment services do not appear to be adequate to deal with existing demands for treatment. The capacity problems seem to be more pronounced in some regions and for some types of services than others. In a recent stock-take of treatment services completed for the Ministry of Health<sup>1236</sup> gaps in services were identified in many areas. These included:
- services in rural areas;
  - specialist services catering for youth, particularly residential facilities;
  - adult residential services in some regions;
  - treatment services specifically catering for woman, particularly those with young children;
  - specialist services for specific population groups, including Māori, Pacific people, and Asian people in some regions;
  - detoxification beds and services and better support for community-based detoxification; and
  - services for prisoners, including those being released from prison following completion of treatment.

1231 Babor, above n 1194; Ritter and Lintzeris, above n 1192, 225.

1232 NCAT, above n 1182, 2.

1233 These figures, cited by the NCAT, seem to be based on information the National Institute on Drug Abuse on evaluations in the United States rather than in New Zealand. See NCAT, above n 1182, 2.

1234 NCAT, above n 1182.

1235 See Stevens, Hallam and Trace, above n 1180; UNODC, above n 1179.

1236 Allen & Clarke, above n 1230.

- 15.45 The overall impression we have gained from the stock-take is that there is generally insufficient capacity across the full spectrum of treatment services, with more acute capacity problems in some geographical areas and for some service types, such as residential. Some population groups, particularly youth, are also not adequately provided for in some parts of the country. This is consistent with other feedback we have received in both this project and our project reviewing the Sale of Liquor Act.<sup>1237</sup>
- 15.46 The National Committee for Addiction Treatment estimated in 2008 that the capacity of addiction treatment services needed to double over three years in order to have the capacity to treat 1 % of the population and broadly meet treatment targets that have been set by government.<sup>1238</sup>
- 15.47 A major barrier to increasing treatment provision, however, is a shortage of skilled practitioners, both specialist addiction treatment practitioners and non-specialist professionals with the capability to provide lower level treatment services.<sup>1239</sup> There is a limited alcohol and drug treatment workforce of approximately 1300. Workforce development for the addiction treatment sector has been identified as an area of need, and is being addressed through existing strategies.<sup>1240</sup> There will be a time lag between training new people for this workforce and their availability to contribute to it.
- 15.48 It is important also to consider the alcohol and drug treatment workforce outside the health sector – for example, in Corrections, Police, and social and youth services. Additional workforce development will require further government investment. Non-specialist workforce limitations could be mitigated in part by increasing the use of electronic or web-based brief interventions, which are known to be well-received and effective in some settings.<sup>1241</sup> This is a new area of research that would benefit from further investigation because it has the potential to be highly cost-effective.
- 15.49 The types of treatment services that should be publicly funded and the optimal mix and configuration of those services are matters that fall outside the scope of this project and the Commission’s expertise. However, we draw attention to the existing capacity issues because, although these are not legal matters, the alcohol and drug treatment sector would need an increased capacity before a number of the reform proposals discussed in chapter 11 of this paper could be effectively implemented.

1237 See New Zealand Law Commission, above n 1193.

1238 NCAT, above n 1182, 2.

1239 Ibid.

1240 Minister of Health *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Ministry of Health, Wellington, 2006).

1241 K Kypri and others “Randomized Controlled Trial of Web-based Alcohol Screening and Brief Intervention in Primary Care” (2008) 168 *Archives of Internal Medicine* 530.



THE CRIMINAL  
JUSTICE  
SYSTEM

- 15.50 A significant portion of defendants that appear before the criminal courts have alcohol or other drug dependence or abuse issues. The drug involved is usually alcohol.<sup>1242</sup> Many jurisdictions, including in New Zealand, have put processes in place to ensure that offenders in the criminal justice system with issues such as these are identified and referred to appropriate treatment if required.
- 15.51 Where 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.<sup>1243</sup> The judge may then take into account an offender's treatment needs when deciding on the appropriate sentence.<sup>1244</sup>
- 15.52 Offenders sentenced to non-custodial sentences may be required to attend community-based alcohol and drug treatment programmes funded by District Health Boards, residential programmes, or intensive day programmes provided by community organisations.<sup>1245</sup>
- 15.53 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.<sup>1246</sup> These units have had some demonstrated success in reducing reoffending amongst participants.<sup>1247</sup>
- 15.54 Where a defendant is an identified substance abuser and appropriate treatment is available, a judge may decide 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.
- 15.55 Publicly funded programmes are expected to accept offenders referred through the court system. However, due to capacity issues, the treatment sector may not be able to respond immediately to referrals from the courts. Delays in accessing treatment can prevent its delivery as a condition of a sentence.
- 15.56 Some District Court judges have expressed concern to us about the absence of adequate assessment and treatment facilities and programmes in some regions to which they can refer people during the remand and sentencing process.

1242 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 New Zealand Law Commission, above n 1193.

1243 As we have already noted in chapter 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* (R5, Beckley Foundation Drug Policy Programme, Beckley (UK), 2005).

1244 For example, participation in treatment may be a condition of a sentence of supervision, intensive supervision, or home detention, or may be a special condition that applies on release of an offender from a short-term sentence of imprisonment.

1245 Department of Corrections *Drug and Alcohol Treatment Strategy 2009–2014* (Department of Corrections, Wellington, 2009) 8.

1246 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.

1247 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 1245, 8.



Because the courts cannot direct that treatment be provided, 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.

- 15.57 Attempts have been made to put in place processes that more effectively identify and address the drug and alcohol treatment needs of offenders through the court process. This includes an Addictions Assessment Services Pilot that was implemented at the Tauranga District Court in 2006. The pilot provided screening and assessment of addiction problems (which included alcohol, drug or gambling addictions and co-existing mental health problems) and referral to a brief intervention and further treatment if required. We understand that this pilot has since been extended to the Whangarei, Kaikohe, Wellington and Porirua District Courts.
- 15.58 Since 2002, a Youth Drug Court has been operating at the Christchurch Youth Court. The Youth Court targets young offenders with moderate to severe alcohol and/or other drug dependence that is linked to their offending.<sup>1248</sup> Young offenders are expected to follow an alcohol and drug treatment plan and are monitored by the same judge throughout the process. Services to young offenders are coordinated via a multidisciplinary team that includes the judge, a social worker, the youth justice coordinator, a police prosecutor, the youth advocate, and health and education workers.<sup>1249</sup>
- 15.59 Drug courts and other court-based drug diversion programmes have proliferated in other jurisdictions. For example, over 2000 drug courts are now in place in the United States following their inception in the late 1980s.<sup>1250</sup> Drug courts are also in place in Australia, Canada and the United Kingdom.
- 15.60 The Australian drug courts can operate before sentencing,<sup>1251</sup> or post-adjudication and post-sentencing.<sup>1252</sup> The courts all target serious high-end offenders<sup>1253</sup> with significant drug dependence issues that are linked to their offending. They are presided over by a judicial officer, who provides intensive judicial supervision, and involve an interdisciplinary team of specialists who take a collaborative approach. There is a system of graduated rewards and sanctions, with participants required to undergo frequent random tests for drug use.<sup>1254</sup>

1248 Wendy Searle and Philip Spier *Christchurch Youth Drug Court Pilot: One Year Follow-up Study* (Ministry of Justice, Wellington, 2006) 21.

1249 Ibid, 20–21.

1250 *Summary of Drug Court Activity by State and County: Bureau of Justice Assistance Drug Court Clearinghouse Project* (2009) [www1.spa.american.edu/justice/documents/2150.pdf](http://www1.spa.american.edu/justice/documents/2150.pdf) (accessed 28 September 2009).

1251 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.

1252 For example, Drug Court Act 1998 (NSW), s 5A; Sentencing Act 1991 (Vic), s 18Z; Drug Court Act 2000 (Qld), s 19.

1253 The programmes only apply to individuals facing a term of imprisonment or who have had a custodial sentence imposed.

1254 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) 20–21.

- 15.61 All of the Australian states and territories also have less intensive court-based drug diversion programmes in place. Most programmes are in the lower level courts, and are limited to less serious offences committed by adults (although some jurisdictions have similar programmes for youth).<sup>1255</sup>
- 15.62 Evaluations of drug courts and similar programmes tend to indicate that they can reduce drug use by participants and have a positive impact on participants' general health and wellbeing.<sup>1256</sup> Evidence about their impact on rates of reoffending is more mixed.<sup>1257</sup> Depending on the programme design, they can also be heavily resource-intensive.<sup>1258</sup>
- 15.63 We think that greater use should be made of the opportunity to provide assessment and treatment within the court system where alcohol or other drug abuse and dependence are identified. In this sense, drug courts and similar programmes, which ensure that appropriate focus is given to the particular needs of drug users in the criminal justice system, are desirable. However, further refinements to programmes like these seem required before they can become an established part of the criminal justice system.
- 15.64 The programmes often have multiple, confusing, and poorly articulated aims. Potential aims of these programmes may include, for example, to divert the offender from the conventional criminal justice process or into alternative programmes or penalties, to provide a greater and more active monitoring role for the judge, to ensure that all relevant agencies are involved in the court process, or to prioritise treatment resources and provide the courts with access to these resources.
- 15.65 In addition, there is a potential for some delay in the court process if offenders who would otherwise be dealt with on their first appearance must instead be remanded to the specialist court or programme. Depending on how the programme itself is implemented, the time required to dispose of a case may also be longer.
- 15.66 Perhaps most fundamentally, the effectiveness of these programmes relies on adequate treatment services being available. As we have noted above, there is concern that current treatment services available to the court system are insufficient to meet demand. There is also a risk that the delivery of assessment and treatment services will become focused on the programme's clients at the expense of services in geographical areas where a 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.

Q145 Should greater use be made of treatment as a disposition option within the courts for people with alcohol and other drug dependence and abuse problems? If so, how?

<sup>1255</sup> Ibid, 11.

<sup>1256</sup> Ibid, 105 and 107; Searle and Spier, above n 1248, 78.

<sup>1257</sup> Ibid, 107–108 and above n 1248, 12–14.

<sup>1258</sup> See Wundersitz, above n 1254, 11–12.

- 15.67 Problem limitation measures aim at reducing the specific harms that result from existing drug use. In addition to treatment there are a range of other strategies and approaches that have developed internationally. Some are controversial because they implicitly tolerate ongoing drug use. Presently such measures in New Zealand focus on intravenous drug use.
- 15.68 The New Zealand Drug Foundation estimates that in 2008 approximately 31,000 people injected drugs.<sup>1259</sup> Opiates are the most commonly injected substances. To a lesser extent amphetamine-type stimulants like methamphetamine and benzodiazepines are also injected.

### Needle exchange programme

- 15.69 Needle and syringe exchange programmes were introduced in 1988 after an amendment was made to the Misuse of Drugs Act authorising the possession of needles and syringes obtained through the needle exchange programme. This was a response to concern over the risk of the HIV virus spreading among intravenous drug users. Under the exchange 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. Many years before the term “harm reduction” was coined, the risks of HIV/AIDS among injecting drug users prompted the widespread introduction of needle and syringe exchange programmes within a number of countries across Europe, Oceania,<sup>1260</sup> parts of North America and, more latterly, within developing countries.<sup>1261</sup>
- 15.70 As well as addressing the immediate concern about HIV, a reduction in the reuse or sharing of injecting equipment also reduces the risk of other blood-borne illnesses (for example, hepatitis). Clean needles can also reduce the risk of infections and related complications for intravenous drug users. A review of studies relating to needle and syringe programmes by the World Health Organisation in 2004 concluded that there was compelling evidence that increasing the availability and use of sterile injecting equipment by intravenous drug users reduced HIV infection substantially. It also found that there was no convincing evidence of any major unintended negative consequences.<sup>1262</sup>
- 15.71 A review of the needle and syringe exchange programme in New Zealand was completed in 2002. It found that most of the scientific evidence available clearly demonstrated that needle and syringe programmes worldwide were effective in reducing the prevalence and/or incidence of HIV infection in injecting drug users. It also found that New Zealand had one of the lowest rates of HIV infection

1259 Catherine Cook “The Global State of Harm Reduction” (2008) 18 *Matters of Substance*.

1260 The term is used in United Nations publications to cover Australia, New Zealand, Pacific and Melanesian states.

1261 Neil Hunt, Mike Trace and Dave Bewley-Taylor *Reducing Drug-Related Harms to Health: An Overview of the Global Evidence* (R4, The Beckley Foundation Drug Policy Programme, Beckley (UK), 2004) 1.

1262 Cited by *ibid*, 5.

in intravenous drug users (0.9 %) among more developed nations.<sup>1263</sup> Provisional figures from Needle Exchange New Zealand indicate that this figure was reduced to 0.3 % in 2009.<sup>1264</sup>

- 15.72 However, the rates of infection with the Hepatitis C virus are much higher. Surveys during the 1990s found that the virus is thoroughly entrenched in New Zealand's injecting drug user population, just as in Australia and other Western countries. In a number of studies during the 1990s infection rates among different populations of injecting drug users ranged from 53 % to 84 %.<sup>1265</sup> A study undertaken for Needle Exchange New Zealand estimated that in 2004 nearly three out of four injecting drug users had been exposed to the Hepatitis C virus, although a similar study in 2009 indicated a significant drop to around half.<sup>1266</sup> Needle Exchange New Zealand attributes this reduction to the impact of the exchange programmes.<sup>1267</sup>
- 15.73 Needle exchange is now well established across the country, although there are some access difficulties for people living in more remote areas.<sup>1268</sup> To some degree this is unavoidable given New Zealand's geography and population size. The needle exchange programme also provides information on safer injecting practices and information on drugs and the risks of different methods of use. Needle exchanges may also function as a point of early access to referral to drug treatment. This is suggested by research in the United Kingdom which found that as many as 40 % of a sample of visitors to one programme acted on a referral to external help.<sup>1269</sup>

### Provision of heroin in substitution treatment

- 15.74 We discussed opioid substitution treatment in paragraphs 15.26 to 15.31 earlier in the chapter. In a few European jurisdictions harm reduction initiatives also include limited state provision of heroin to addicts where other opioid substitution treatment is not effective.<sup>1270</sup> Some commentators say that state provision of heroin to chronic addicts offers some health and social gains for long term users where other approaches have been exhausted,<sup>1271</sup> although the evidence base is still relatively limited.

1263 Campbell Atkins *New Zealand's Needle and Syringe Exchange Programme Review* (Centre for Harm Reduction, Wellington, 2002) 5.

1264 Figures provided by the Ministry of Health.

1265 A range of surveys from this period are cited in Atkins, above n 1263, 30.

1266 Figures are from Needle Exchange New Zealand "NZ Needle Exchange One of World's Most Successful" (19 November 2009) Press Release.

1267 Ibid.

1268 Another issue relating to access that has been identified by Needle Exchange New Zealand and also by the New Zealand Drug Foundation is the absence of needle exchange programmes within New Zealand prisons. In recent years clean needle and syringe programmes have been developed within prisons in a few European jurisdictions.

1269 Hunt, Trace and Bewley-Taylor, above n 1261, 5.

1270 Heroin has been prescribed to treat addicts in the United Kingdom since the 1920s and limited schemes have been adopted in the Netherlands and Switzerland also.

1271 Hunt, Trace and Bewley-Taylor, above n 1261, 5.

- 15.75 Given New Zealand's low rates of heroin use there would seem to be a limited benefit in providing it here at present. However, we suggest that the exemptions (which were discussed in chapter 13) authorising the pharmacological treatment of drug dependence needs to remain flexible enough to accommodate the development of new drug-based treatments in the future.

### Drug consumption rooms

- 15.76 A number of overseas jurisdictions have also established what are termed drug consumption rooms or supervised injecting facilities for intravenous drug users.<sup>1272</sup> Drug consumption rooms or supervised injecting facilities are considered to provide a protected place for the hygienic consumption of pre-obtained drugs in a non-judgemental environment and under the supervision of trained staff.<sup>1273</sup> They reduce harm by providing a relatively safe and clean environment for intravenous drug users. Normally there is access to sterile equipment and a degree of medical supervision. In some countries these types of facilities are combined with the state provision of heroin.<sup>1274</sup> The primary form of harm addressed by supervised injecting facilities, which is not addressed by needle exchange, is the risk of overdose associated with intravenous drug use, particularly hurried covert use. The clean conditions also minimise blood-borne disease. As well as the benefits for users, society obviously benefits from avoiding the social costs associated with those types of problems.
- 15.77 Internationally these types of facilities have been established in large cities and other locations where large numbers of intravenous drug users are concentrated, and where drug use in the streets causes a degree of public nuisance.<sup>1275</sup> The establishment by states of drug consumption rooms, although it has occurred in a few jurisdictions, is still a controversial harm reduction measure. The International Narcotics Control Board does not believe that drug consumption rooms conform with international drug control obligations under the Single Convention on Narcotic Drugs 1961 and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988. The Board's view is that states violate their international obligations if they authorise the possession and consumption, within these facilities, of drugs that have not been medically prescribed.<sup>1276</sup>
- 15.78 Again, in New Zealand's case, the relatively low rates of intravenous drug use suggest that the provision of these types of facilities may not be warranted anyway. New Zealand also does not at present have the public nuisance issues around drug use in the streets that occur in some international cities.

<sup>1272</sup> These are mainly in European countries, although there is a pilot of a medically supervised safer injecting facility in Vancouver in Canada.

<sup>1273</sup> Hunt, Trace and Bewley-Taylor, above n 1261, 11.

<sup>1274</sup> For example, in Zurich, Switzerland.

<sup>1275</sup> For example, in Sydney, Vancouver and Zurich.

<sup>1276</sup> International Narcotics Control Board *Report of the International Narcotics Control Board on Follow-up to the Twentieth Special Session of the General Assembly* (United Nations, New York, 2009) 21.



## Interventions to reduce overdose and poisoning

- 15.79 A range of measures have also been developed and adopted to varying degrees in a number of countries as a response to concern over accidental overdose and drug-related poisoning. Illegal drugs are not subject to the types of manufacturing and distribution controls that apply to legally available drugs supplied through a regulated market. Harm can arise from contamination, adulteration, misrepresentation and uncertainty over strength and purity. As well as fatalities through overdose and poisoning, there have been cases of botulism and other infections from contaminated drugs.<sup>1277</sup> In response two types of harm reduction responses have developed: early warning systems; and pill testing.

### *Early warning systems*

- 15.80 In the United Kingdom and a number of other jurisdictions information campaigns have been undertaken to encourage drug users to call emergency services in the event of an unanticipated drug reaction. Information concerning overdose and its prevention and management has been provided to drug users, recognising that other users are most likely to be present at the time a user overdoses or has a severe reaction. In addition, opioid antagonist medications have been supplied to drug users and those associated with them for use in such an emergency.<sup>1278</sup>
- 15.81 Systems for posting early warnings, such as the European Early Warning System on New Synthetic Drugs, have also developed as another way of getting out messages in response to contamination and adulteration problems. For example, alerts are issued through the Internet when contaminated ecstasy or other synthetic pills surface, so that potential users are made aware of the problem and can, if they wish, avoid the identified batches of drugs.<sup>1279</sup>

### *Pill testing*

- 15.82 Pill testing is one of the newest and probably most controversial harm reduction approaches implemented in some European countries. It aims at reducing fatalities due to the impurity and/or adulteration of substances by providing drug users with access to quality control analysis for drugs. Pill testing normally takes place either on site at dance and rave parties or in clubs where pill use is anticipated, using relatively inexpensive self-test kits, or alternatively it occurs in advance at a government designated facility. Although they provide relatively instant results, there are currently questions over the accuracy and comprehensiveness of tests undertaken with simple pill testing kits. Apparently these are not always effective at identifying different substances and the results are not always clear or easy to understand.<sup>1280</sup> Testing facilities, in contrast, use more accurate laboratory test techniques but are slower and much more costly. Since these do not give on the spot information they tend to be used, as they are in the

1277 Hunt, Trace and Bewley-Taylor, above n 1261, 11.

1278 Ibid.

1279 Ibid.

1280 Adam R Winstock, Kim Wolff and John Ramsey, "Ecstasy Pill Testing: Harm Minimization Gone too Far?" (2001) 96 *Addiction* 1139, 1143.



Netherlands, to feed information into an early warning system. Where pills of a high strength or contaminated or adulterated pills are identified through testing, warnings are posted.<sup>1281</sup>

- 15.83 State-sanctioned pill testing, although it occurs in a few jurisdictions, is still a particularly controversial approach to harm reduction. The International Narcotics Control Board has, for example, suggested that “the defeatism at the base of this approach and the misleading message it sends to society at large, run contrary to the spirit of the Convention”.<sup>1282</sup> The Board does recognise, however, that this type of initiative can minimise suffering and hospitalisation<sup>1283</sup> and there is at least an argument that pill testing is done for medical purposes and therefore falls within the scope of the drug conventions.
- 15.84 The Beckley Foundation cites some evidence that these types of measures can be effective at preventing overdose and improving emergency responses, but suggests that the evidence is still relatively limited.<sup>1284</sup> There has been one study undertaken that involved surveying ecstasy users. The responses suggest that pill testing made relatively little difference to the surveyed groups’ use of the drug. In fact some pill users reported that they used more pills where they were identified as being of a high quality.<sup>1285</sup>
- 15.85 We suggest a cautious approach should be taken to pill testing in New Zealand. One option would be to allow it to develop, if there is sufficient demand, in relation to the legally available regulated psychoactive substances discussed in chapter 8 and evaluate its role in reducing harm in that context. If it proved effective, consideration could be given to extending the range of substances that might be tested. Of course, pill testing may not be required at all in that context, because the conditions attached to the manufacture and supply of legal psychoactive substances might be sufficient to maintain appropriate quality and potency.

### Problem limitation measures in legislation

- 15.86 Many of the measures discussed above can only be implemented by legislation.
- 15.87 We think that it is important that legislation anticipates the development and adoption of new types of harm reduction measures. Although some of the measures discussed are not currently appropriate or necessary, they may become so in the future if there are significant changes in patterns of drug use. The technology for pill testing, for example, is currently developing, and some legislative flexibility that would allow an expansion of a pill testing regime beyond regulated substances would seem to be desirable.
- 15.88 It is also likely that over time other strategies and approaches will develop and prove effective at reducing the risk of harm resulting from drug use.

1281 Ibid.

1282 International Narcotics Control Board “Flexibility of Treaty Provisions as Regards Harm Reduction Approaches” (30 September 2002) E/INCB/2002/W.13/SS.5.

1283 Ibid.

1284 Hunt, Trace and Bewley-Taylor, above n 1261, 11.

1285 Winstock, Wolff and Ramsey, above n 1280, 1145.

- 15.89 For these reasons we suggest that a new legislative framework should allow for additional measures aimed at reducing the harm associated with drug use to be adopted by regulation, where specified statutory criteria are met.

Q146 Do you think that the new legislative framework should allow for additional problem limitation measures to be adopted by regulation?

## DEMAND REDUCTION

- 15.90 The demand reduction pillar encompasses drug education, health promotion, social marketing and community action. Each of these components has a different focus and approach. Drug education is the delivery of information to improve knowledge and awareness. Health promotion is the process of enabling people to increase control over and improve their health. Social marketing uses commercial marketing technologies to persuade target audiences to make behaviour changes. Community action is a process under which local resources and knowledge are utilised to address social issues.
- 15.91 In practice many demand reduction initiatives can incorporate a number of these different components, so it is not always useful to put a demand reduction measure in one category or another. Health promotion in particular tends to be integral to all programmes. We do not therefore consider this separately.

### Drug education

- 15.92 The target group for drug education has traditionally been youth at school, although there are also a range of other audiences. To be effective and not counterproductive, drug education must be well designed, have clear and realistic objectives,<sup>1286</sup> and be based on evidence of what works and does not work. One-off sessions that only use ex-addicts, scare tactics or “just say no” approaches have, for example, been shown not to work.<sup>1287</sup>
- 15.93 Drug education in schools forms part of health education and must comply with the Health and Physical Education in the New Zealand Curriculum. To support the curriculum the Ministry of Education and other agencies provide drug education guidance for teachers, principals, and boards of trustees.<sup>1288</sup> These outline essential elements of drug education and give advice on developing drug education programmes and policies. However, to deliver the curriculum effectively teachers need adequate professional development and sufficient allocation of time to teach it. The New Zealand Drug Foundation found in 2003 that anecdotal evidence suggested only a limited number of schools had teachers trained to properly deliver the Health and Physical Education curriculum, so that the quality of health education was uneven. Implementation of the curriculum and drug education guidelines was hindered by health education and

1286 United Nations Office on Drugs and Crime “Reducing the Adverse Health and Social Consequences of Drug Abuse: A Comprehensive Approach” (22 January 2008) 2.

1287 Ministry of Youth Development *Strengthening Drug Education in School Communities – A Practical Guide for Years 7–13* (Ministry of Youth Development, Wellington, 2004) 7.

1288 For example Ministry of Education *Drug Education: A Guide for Principals and Boards of Trustees* (Learning Media Ltd, Wellington, 2000); Ministry of Youth Development, above n 1287; *Drug Education Matrix of Learning Outcomes for Levels 1–8 within the New Zealand Health and Physical Education Curriculum* [www.tki.org.nz](http://www.tki.org.nz) (accessed 23 October 2009).

health policies not being given a high priority in some schools.<sup>1289</sup> An updated set of drug education guidelines is in the process of being released to schools at present.

- 15.94 Research undertaken for the Ministry of Youth Development in 2003 found that targeted drug education programmes delivered outside the school system could be effective and were needed for at-risk youth.<sup>1290</sup> There was positive evidence about the effectiveness of family-based drug education as a strategy for reducing drug-related harm, particularly among high-risk populations.<sup>1291</sup> Similarly, community-based education could be effective, particularly when it was based on collaborative action by groups and agencies that already had responsibility for reducing drug-related harm.<sup>1292</sup>

### Community action programmes

- 15.95 Community action programmes aim to promote inter-sectoral collaboration between existing community resources utilising local knowledge to facilitate positive social change and build social resilience. Social change of this kind takes time, so community action projects have to be sustained over a reasonable period of time before they show results.<sup>1293</sup>

### Community Action on Youth and Drugs

- 15.96 The Community Action on Youth and Drugs (CAYAD) programme contains the best example of a community action programme aimed at youth at risk. It focuses on reducing drug-related harm to young people and their families. The current projects are based on earlier projects which began initially in a few locations as a collaborative approach between communities and researchers from Massey University Centre for Social Health Outcomes Research and Evaluation (SHORE) and its Māori partner Te Ropu Whariki (Whariki) with public funding through the health and education budgets.<sup>1294</sup> In 2000/01 the Ministry of Health took over the funding of CAYAD from the Ministry of Education. Over time additional locations or sites have been added to CAYAD.
- 15.97 CAYAD is considered a successful community action initiative because it utilises evidence-based research and formative evaluation alongside a combined community action and kaupapa Māori approach. The overall goal of CAYAD is to reduce alcohol and other drug-related harm experienced by young people. Projects do this by meeting a number of objectives:
- increased informed community discussion and debate about issues relating to illegal drugs;

1289 New Zealand Drug Foundation *New Zealand Drug Foundation Policy Paper on Drugs in Schools* (Wellington, 2003) 6.

1290 Allen & Clarke *Effective Drug Education for Young People: Literature Review and Analysis* (Ministry of Youth Development, Wellington, 2003).

1291 Ibid, 15.

1292 Ibid.

1293 Ibid.

1294 Centre for Social and Health Outcomes Research and Evaluation and Te Ropu Whariki *Community Action on Youth and Drugs Project (CAYAD) Final Impact Evaluation Report Summary* (Massey University, Auckland, 2006).

- effective policies and practices to reduce harm adopted;
  - increased local capacity to support young people in education, employment and recreation; and
  - reduced supply of drugs to young people.
- 15.98 Currently CAYAD projects are located in both rural and urban settings across New Zealand. There are now 25 providers operating in 30 sites.<sup>1295</sup> Funding for CAYAD projects was approximately \$4 million in 2007/08.<sup>1296</sup> An impact evaluation involving four CAYAD projects was undertaken by SHORE and Whariki between 2004 and 2006. The evaluation found evidence of progress in meeting their objectives in most sites over the evaluation period.<sup>1297</sup> It needs to be stressed that the project sites evaluated were still at an early stage and that the timeframe for the evaluation was relatively short for a community action approach.<sup>1298</sup> Against this backdrop the evidence of progress against the objectives can be considered quite promising.

### Social marketing and health promotion

- 15.99 Drug education can also be delivered through mass media and other types of interventions like product labelling. The research commissioned by the Ministry of Youth Development concluded that these types of strategies may slowly change the social cultures around tobacco, alcohol and drugs that influence individual behaviour, and reinforce messages provided through school-based education and community action programmes.<sup>1299</sup>
- 15.100 Currently there are a number of these types of social marketing and lifestyle campaigns, such as those undertaken by the Alcohol Advisory Council about the way New Zealanders drink and by the Ministry of Health and Health Sponsorship Council promoting smoke-free lifestyles. Social marketing campaigns undertaken at a mass media level have been utilised as a public health tool to convey other messages.<sup>1300</sup> To date they have not been used in New Zealand for campaigns around drugs other than alcohol and tobacco. This is probably because education campaigns with messages about the safer use of illegal drugs are seen as inconsistent with the aims of prohibition.
- 15.101 New Zealand and overseas evidence suggests that providing information about treatment is more effective than general drug education social marketing campaigns.<sup>1301</sup> The Ministry of Health is currently funding a demand reduction campaign to improve public awareness, access to, and utilisation of demand reduction resources, services and community initiatives. This will centre on a new web-based resource that will provide reliable and accurate information about drugs

1295 Figures provided by the Ministry of Health.

1296 Figures provided by the Ministry of Health.

1297 Centre for Social and Health Outcomes Research and Evaluation and Te Ropu Whariki, above n 1294.

1298 Ibid.

1299 Allen & Clarke, above n 1290, 16.

1300 As well as the ALAC and smoke free campaigns they are used for promoting exercise SPARC “push play”; Education “20 minutes a day with your kids”; Family violence “it’s not Ok”, for example.

1301 See Ministry of Health *Literature Review on Models and Efficacy of Illegal Drug Social Marketing Campaigns* (Wellington, 2008).

and about where to access help with drug-related problems. The objective of the campaign is to enable people to be aware of the risks of taking drugs and to access reliable information about drugs and sources of advice and help when they are concerned about their own or another's drug use. Approximately \$1 million will be available over the next three years for improving informational resources to support the programme.<sup>1302</sup> The alcohol and drug treatment sector will be involved in developing and managing the web resources.

## SUPPORT FOR TREATMENT AND DEMAND REDUCTION

15.102 We suggest that a greater balance is needed between the pillars of drug policy and that any new legislative framework resulting from the Commission's review should recognise and support all three pillars. We have suggested that there particularly needs to be much more emphasis on treatment.

15.103 With the exception of the statutory exemption to allow pharmacological treatment for drug dependency (considered in chapter 13), the drug treatment strategies discussed in this chapter do not require legislation.<sup>1303</sup> Similarly, demand reduction strategies aimed at preventing or limiting the uptake of harmful drug use can also be implemented without legislation. However, there could be advantages in providing increased statutory recognition and support for drug treatment and demand reduction measures. We have noted already in chapter 4 that the Blake-Palmer Committee's recommendations in its 1973 report, that treatment options and support for those dependent on drugs be improved and high quality community education about the risks of drug abuse and drug dependence be developed,<sup>1304</sup> have not received the attention they deserved. A possible explanation for this is that, unlike supply control measures, their implementation did not require legislation. As a consequence, insufficient support, attention, and resources may have been devoted to drug treatment, other problem limitation measures and education strategies and programmes. Instead the criminal law, and its enforcement, has been the main focus of drug policy, at least for drugs other than alcohol and tobacco. It has certainly dominated the debate around policy in respect of illegal drugs, perhaps at the expense of other measures that may better reduce harm.

15.104 The apparent lack of emphasis on treatment may have been exacerbated by the devolution of decision-making to District Health Boards. Under the New Zealand Public Health and Disability Services Act 2000 each individual District Health Board is responsible for the provision of health services specified in its Crown funding agreement within its regions. District Health Boards (within the limits allowed by the funding arrangements) set their own priorities and approach within their treatment services. This has the advantage of allowing priorities to be set closer to the community, but carries an inherent risk that the result will not produce a coherent national strategy or service. The very recent establishment of the National Health Board, which will sit within the Ministry of Health and oversee how the 21 District Health Boards plan and fund health services,

1302 Figures provided by the Ministry of Health.

1303 It should be noted that specific legislative authority is needed for any form of compulsory treatment. Currently the Alcohol and Drug Addiction Act 1966 authorises the detention for treatment of alcoholics and drug addicts where certain conditions are met. We examine this Act and the options for compulsory treatment separately in the next chapter.

1304 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report* (New Zealand, Board of Health Report Series, No 18, Wellington, 1973) 89.



should help address this issue. The Board is to supervise all spending on health IT, workforce planning and capital investment and will also inject a stronger national perspective into service planning.

### Statutory mechanisms

15.105 We have considered whether there ought to be some further statutory mechanisms to support and encourage government efforts in the treatment area. The first type of approach would be to impose a statutory responsibility on the Minister of Health for developing and reporting against a national strategy on alcohol and drug treatment. However, this would partly duplicate reporting against the National Drug Policy and the Mental Health Strategy. It would also inevitably occur at a high level of generality. It may therefore add little value to the current planning and reporting arrangements.

15.106 Another option would be to establish an advisory committee. It could have a number of functions:

- (a) It could provide an independent voice on policy choices that would not be constrained by the immediate priorities of the Government of the day. However, we are not convinced that a body that is outside of government would be effective in this area. Drug policy (as with much health policy) is ultimately about determining detailed funding and performance arrangements for District Health Boards. It is difficult to see how an independent body that sits outside government could perform this function better than the Ministry of Health and officials from other departments under current arrangements.<sup>1305</sup> It is also difficult to see how this would make the current arrangements work better.
- (b) It could hold the Government publicly to account for implementing drug policy in a balanced and effective way. There are already a number of mechanisms that are designed to do this both inside and outside government.<sup>1306</sup> Outside government the Alcohol Advisory Council and the Mental Health Commission already have this type of role, although in the case of the Alcohol Advisory Council its role is confined to alcohol. To some degree the New Zealand Drug Foundation also informally has this role. These external bodies have limited capacity to hold government to account because they are removed from the process of budget setting, which in the health context with District Health Boards is complex and detailed. However, to the extent that they can do this, they do already and there would appear to be no value in duplication.
- (c) It could have a public advocacy role – identifying issues and lobbying for change. Again the three bodies mentioned above already perform this function. There is also the National Committee for Addiction Treatment, which is a “voluntary grouping” of service leaders, educators, representative groups and elected individuals established by the treatment sector to provide

<sup>1305</sup> The Ministry of Health is the Government’s primary source of advice on demand reduction and problem limitation issues and more generally on drug policy. Other government departments and the Police also have advisory functions in various areas of drug policy.

<sup>1306</sup> Within Government there is currently an Inter-Agency Committee on Drugs (IACD) made up of officials drawn from the interested government departments and agencies that monitors the implementation of National Drug Policy to ensure that policies and programmes pursued by agencies are consistent and mutually supportive.



a national voice and advocate best practice within the treatment sector. There would seem little value in duplicating the role of all these bodies and committees. We suggest that between them these bodies already articulate the problems around alcohol and drug use and the benefits and effectiveness of treatment. We believe the problem is not a lack of advocacy or understanding of the benefits of treatment, but rather that priority is not given to it despite the recognition of its benefits.

- 15.107 We are not therefore convinced that the imposition of additional reporting requirements or the establishment of an advisory committee will alter the balance within drug policy in favour of treatment. While there may be some benefits, they would, in our view, be unlikely to outweigh the costs.

Q147 Do you agree that additional reporting requirements or the establishment of an advisory committee with policy, accountability, and advocacy functions for drugs and alcohol would have insufficient benefit to justify the cost? If not, what benefits would there be?

### Alternative approach – Mental Health Commission proposal

- 15.108 As an alternative to a statutory mechanism, the Law Commission has identified during its review of the Sale of Liquor Act an approach that the Commission is proposing to support as one of the recommendations of that review.

- 15.109 The proposal is that the Mental Health Commission be supported to develop a blueprint for drug and alcohol and other addiction service delivery for the next five years. The work would be led by the Mental Health Commission and would be undertaken with support from key groups, such as the Alcohol Advisory Council, New Zealand Drug Foundation, and National Committee for Addiction Treatment, along with input from all relevant government agencies and departments. The Mental Health Commission has proposed that the blueprint should be based on best practice principles and address:

- the level and type of service, how much, what type, and where it is based;
- required resourcing and staffing levels, including workforce issues;
- the design of a service system, including models of care pathways, service delivery systems and co-ordination;
- transition and implementation planning; and
- monitoring and oversight.

- 15.110 We believe that developing a blueprint, which includes transition and implementation planning, provides a very practical way to increase the emphasis on treatment. Our tentative view is that the Mental Health Commission would be an appropriate agency to lead such work.

Q148 Do you agree that the development of a blueprint for drug and alcohol and other addiction service delivery could provide a practical way of significantly increasing the emphasis on treatment?

Q149 What else might be done to provide greater support for demand reduction and problem limitation measures?

### Administration of the proposed legislative framework

- 15.111 Finally, we suggest that a strong signal would also be given through changing the way drugs legislation is administered. Currently parts of the Misuse of Drugs Act are administered by the Ministry of Justice and other parts by the Ministry of Health.
- 15.112 We propose that in order to further emphasise prevention and treatment and to ensure a coordinated legislative approach to the whole of drug policy, the new legislative framework should be administered solely by the Ministry of Health. This may be seen as partly symbolic, but it will also help ensure that the health dimension of the legislation remains at the fore of future policy debate on drug use. It may also affect the nature of public information and advice within government on the Act and its implementation and enforcement. As a result of this change we anticipate that information and advice on the Act would be principally shaped by a public health rather than a criminal justice perspective. This may further assist in shifting the balance within drug policy.

# Chapter 16

## Alcoholism and Drug Addiction Act 1966

### SUMMARY

This chapter provides an overview of the Alcoholism and Drug Addiction Act 1966 and considers the main issues and problems that have arisen under it. It then canvasses some different approaches that might be taken to reform and invites feedback on these. It also considers whether any new compulsory treatment regime should be incorporated in legislation replacing the Misuse of Drugs Act.

- INTRODUCTION 16.1 The Alcoholism and Drug Addiction Act 1966 is currently under review by the Ministry of Health.<sup>1307</sup> The Act is now quite out of date and there are difficulties in reconciling the broad powers of detention for treatment contained in the Act with the rights and protections enacted by the New Zealand Bill of Rights Act 1990. Over the years some provisions of the Act have also fallen into disuse and the overall framework of the Act has not kept pace with subsequent changes in allied legislation such as the Mental Health (Compulsory Assessment and Treatment) Act 1992. Reform of the Alcoholism and Drug Addiction Act is long overdue.
- 16.2 One of the options the Law Commission is canvassing as part of its review of the Misuse of Drugs Act is whether a modified regime for compulsory treatment should be included in any new legislative framework the Commission proposes. We have for this reason included in this chapter an overview of the main issues and problems that arise under the Alcoholism and Drug Addiction Act and canvassed the different approaches that might be taken to reform. We ask for feedback on whether any new regime should be incorporated in legislation replacing the Misuse of Drugs Act.

<sup>1307</sup> The review of the Alcoholism and Drug Addiction Act 1966 has been brought forward by the Government and the Ministry of Health is to report to the Cabinet on its review by November 2010. See Department of the Prime Minister and Cabinet *Tackling Methamphetamine: an Action Plan* (DPMC, Wellington, 2009) 45.

## THE ALCOHOLISM AND DRUG ADDICTION ACT

- 16.3 The Alcoholism and Drug Addiction Act came into force on 1 January 1969, repealing and replacing the Reformatory Institutions Act 1909.<sup>1308</sup> It provides for the compulsory detention of alcoholics and drug addicts in certified institutions so that they may undergo assessment, detoxification and treatment. Although it retains a compulsory element it represents a shift away from the punitive approach provided for in the earlier penal statute to a more therapeutic approach to alcohol and drug treatment.<sup>1309</sup>

### Coverage of Act

- 16.4 The term “alcoholic” replaced the earlier term “habitual inebriate” contained in the 1909 Act. Section 2 defines an alcoholic as:

any person whose persistent and excessive indulgence in alcoholic liquor is causing or is likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to others or renders him incapable of properly managing himself or his affairs.

Section 3 also provides that the Act shall apply, in the same way it applies to an alcoholic, to:

...any person whose addiction to intoxicating, stimulating, narcotic, or sedative drugs is causing or is likely to cause serious injury to his health or is a source of harm, suffering, or serious annoyance to others or renders him incapable of properly managing himself or his affairs.

- 16.5 Like the definition of alcoholic, the description of a drug addict appears quite widely drawn. Each has two limbs that need to be satisfied before a person falls within the coverage of the Act. Firstly, a person must either persistently and excessively indulge in alcohol or be addicted to drugs. Secondly, that excessive indulgence in alcohol or addiction to drugs must: (i) be causing, or be likely to cause, serious injury to his or her health; or (ii) be a source of harm or suffering or serious annoyance to others; or (iii) render the person incapable of properly managing himself or herself or his or her affairs.
- 16.6 The definitions determine the coverage of the Act and raise some issues. In particular, it seems that a person must have an actual addiction to drugs to qualify as a drug addict, whereas the definition of alcoholic requires only persistent and excessive indulgence in alcohol. This means that a higher threshold applies before drug use comes within the coverage of the Act.

<sup>1308</sup> The 1909 Act was designed to “make provision for the establishment and control of reformatory institutions for the reception of habitual inebriates and fallen women.” Under that Act reformatory homes were established for “fallen women” and separate inebriate homes were established for “habitual inebriates”. The definition of “habitual inebriate” included any person who habitually took or used drugs as well as alcohol. See Reformatory Institutions Act 1908, ss 2, 11 and 12.

<sup>1309</sup> For a discussion on the 1909 Act, problems with the 1909 Act, and the resulting debate that lead to the new Act, see M B Webb “*Addiction and the Law: A Case-Study of the Alcoholism and Drug Addiction Act*” (MA Thesis, University of Canterbury, 2001) 38–47.

## Certified treatment facilities

- 16.7 Only an institution that has been certified by Order in Council may receive patients under the Act.<sup>1310</sup> Orders certifying institutions are made by the Governor-General on the recommendation of the Minister of Health. An order certifying an institution can also only be revoked by the Governor-General. The Act authorises the Minister to appoint a supervising committee for any certified institution. A supervising committee must be chaired by a District Court judge. The other members are the superintendent of the institution, a medical practitioner attending at the institution, and one other person. Certain functions under the Act, which are otherwise exercised by the superintendent of the institution, may also be exercised by a supervising committee where one has been appointed.

### *Current facilities and the nature of programmes*

- 16.8 There are currently 13 institutions certified to accept people committed under the Act – nine public hospitals and four non-government organisation provided facilities. Three of the latter are Salvation Army Bridge Programmes located in Auckland, Wellington and Christchurch and the fourth is Nova Lodge in Christchurch. The majority of patients committed under the Act go into the Salvation Army Bridge Programmes and Nova Lodge. These facilities run abstinence-based treatment programmes which combine educational work, counselling and variations on 12 step programmes.<sup>1311</sup> Each of the four non-government organisation certified institutions currently have supervising committees appointed by the Minister of Health.

## Committal under the Act

- 16.9 There are three different routes by which a person can be committed under the Act for treatment.

### *Section 8 – Voluntary applications for detention*

- 16.10 Firstly, people may make a voluntary application to the court for an order requiring their own detention for treatment in a certified institution. Under section 8 any person may apply in writing to a District Court judge seeking to be detained for treatment in a certified institution. The application must identify the institution and the applicant must undertake to remain in the institution for treatment until released or discharged under the Act. The judge may order detention if satisfied, either by the admission of the applicant or by any other evidence, that the applicant is an alcoholic or drug addict and understands the nature and effect of the application. Before making an order the judge must also be satisfied that the institution named in the application is willing to accept the person for treatment.

<sup>1310</sup> See Alcoholism and Drug Addiction Act 1966, s 5.

<sup>1311</sup> Michael Webb “Dying for a Drink” [2003] NZLJ 121, 122.



- 16.11 It is the application that is voluntary and not the following detention.<sup>1312</sup> Once a person is subject to an order for detention he or she is compulsorily detained and must remain in the institution until the order expires or he or she is discharged. The courts have consequently considered it particularly important to ensure that applications are genuinely voluntary and have not been made, for example, in response to strong family pressures or to avoid imprisonment. In the case *Lynette Anne Jury v North Shore District Court and the Attorney General*, Simon France J quashed a voluntary committal order and ordered the immediate release of a woman when it became apparent on appeal that she had agreed to a section 8 order after being presented with a choice between remaining in custody for resisting a constable or accepting committal to an addiction facility.<sup>1313</sup> The Judge considered that the application was not truly voluntary because the defendant incorrectly believed she would be held in custody if she did not agree to an order under section 8.<sup>1314</sup>
- 16.12 In 2008, 85 % of orders made under the Act followed a voluntary application, which suggests that this process has some value. Yet the voluntary application process is something of an enigma in the Act. There are no parallels elsewhere on the statute book. One might expect that a person entering treatment on a truly voluntary basis would be willing to attend the treatment facility and remain there for the course of the treatment without court intervention. However, although many people do voluntarily access treatment without court intervention, some people make applications under section 8 and seek the intervention of the court. This may be for a number of reasons. They may, for example, want to address their dependence, but believe they will be unable to do so voluntarily. They may perceive detention, because it takes the decision out of their hands, as a way of forcing themselves to make changes they recognise as beneficial.
- 16.13 Notwithstanding this, we do not think it is appropriate to retain the process of self-initiated applications to the court currently contained in the Act. Later in this chapter we propose some alternative approaches that we think are preferable. In particular, we look at the approach taken under mental health legislation which provides for a staged assessment and treatment process with specialist clinical involvement. Under that type of model people might still initiate the process that would ultimately result in their detention, but there would be a requirement for appropriate medical evidence and a specialist assessment. This would preclude detention simply because the person admitted that he or she was an addict and wanted to be detained for treatment.

### *Section 9 – Court-ordered detention on application of relative or other person*

- 16.14 Under section 9 of the Act a relative of an alleged drug addict or alcoholic, a police officer or “any other reputable person” may apply for an order requiring the alleged addict or alcoholic to be detained for treatment. If an application is made by a police officer or by another person who is not a relative, the application must

1312 Sylvia Bell and Warren Brookbanks (eds) *Brookers Incapacity* (Online, Brookers, Wellington, 2003) AD8.04 (accessed 15 January 2010).

1313 *Lynette Anne Jury v North Shore District Court and the Attorney General* (10 June 2005) HC AK CRI 2005-404-000200.

1314 It seems that in that case, even though the appellant was entitled to bail as of right on the criminal charge and could not be lawfully held in custody, the appellant believed that she could be kept in custody.

contain a statement of the reasons why it is made by that person instead of a relative. The term “any other reputable person” used in the section has been held to cover any person who is of good repute and respectable.<sup>1315</sup> The definition of relative was amended from 26 April 2005 to cover civil union and *de facto* partners.<sup>1316</sup>

- 16.15 Where an application is made under section 9 a District Court judge may issue a summons requiring the alleged alcoholic or drug addict, who is the subject of the application, to show “cause” why an order should not be made for his or her detention for treatment in an institution.<sup>1317</sup> The judge may also issue a warrant for the arrest of the person who is the subject of an application and may order the person to submit to a compulsory medical examination, but only if the judge believes that he or she will not comply with the terms of the summons or not consent to an examination by two medical practitioners for the purposes of the Act.<sup>1318</sup> The medical examination is intended to determine whether the person is an alcoholic or addict as defined in the Act and also whether it would be expedient in the person’s own interests or the interests of his or her relatives for an order to be made. The court may not issue an order detaining a person for treatment under the section unless two medical practitioners have either given evidence or certified that they believe this to be the case.<sup>1319</sup>
- 16.16 Before making an order a judge must also be satisfied that there is an institution willing to accept the person for treatment. The person must also appear before the judge before an order may be made.<sup>1320</sup> This requirement sometimes results in the hearing of applications at hospital bedsides or in police holding cells.<sup>1321</sup> Where an order is made, the person who is the subject of the order may be arrested by the police and taken into custody for detention in accordance with the order.<sup>1322</sup>
- 16.17 Only 14 applications for section 9 orders were made in 2008 and 11 of these were granted. This suggests that the application process, which requires applications to be made by specific people directly to the court, may be a barrier to the use of the Act. Again, we consider alternative approaches later in this chapter.
- 16.18 Another problem with the current process concerns the power to make interim arrangements for a person who is the subject of an application. Under section 13 of the Act a District Court judge is able to issue directions for arrangements pending a person’s reception into a certified institution, but only after an order that the person be detained under the Act has first been made. Thus, where there is a need for immediate intervention to facilitate short term confinement

1315 Chrisholm J rejected the proposition that a reputable person needed to have some special standing in the community: see *Hall v Snell* (1999) 5 HRNZ 103 (HC).

1316 Before the amendment the definition of relative was not thought to include same sex or *de facto* partners: see *S v Tahana-Reese & Anor* [2000] NZAR 481 (HC) 486.

1317 See Alcoholism and Drug Addiction Act 1966, s 9(1).

1318 See Alcoholism and Drug Addiction Act 1966, s 9(4).

1319 See Alcoholism and Drug Addiction Act 1966, s 9(6).

1320 See Alcoholism and Drug Addiction Act 1966, s 9(7).

1321 Webb, above n 1309, 52.

1322 Section 14 of the Act provides a power of arrest. Any member of the police may arrest any person ordered to be detained under the Act and take him or her into custody for detention in accordance with the order.

in a hospital for the purposes of beginning a medically supervised detoxification process, directions to facilitate this can only be issued after the judge has first made a detention order. Sometimes final orders have therefore been made while a patient has been intoxicated or unconscious.<sup>1323</sup>

### *Transfers of prisoners*

- 16.19 The third way in which a person might be compulsorily detained for treatment is under section 21, which empowers the Minister of Corrections to order the transfer of any prisoner detained in a prison into a certified institution for the purposes of treatment for alcoholism or drug addiction. While the prisoner is at the certified institution the term of the prison sentence continues to run.
- 16.20 The procedure for transfer is analogous to the procedure for transfer of an inmate for treatment under section 45 of the Mental Health (Compulsory Assessment and Treatment) Act. However, whereas the procedure in the Mental Health Act is initiated by the general manager of the penal institution, and the decision is a clinical one made by two medical practitioners, a decision to transfer under the Alcoholism and Drug Addiction Act is taken at ministerial level. The Act does not contain any criteria to guide the Minister when considering whether to transfer a prisoner. It has been suggested that involuntary transfers should meet the criteria under section 9 and voluntary transfers should meet the criteria under section 8.<sup>1324</sup>
- 16.21 The provision does not seem to be used now, presumably because, as was discussed in the previous chapter, alcohol and drug treatment units have subsequently been established within prisons. We therefore suggest the provision be repealed.

### *Period of detention*

- 16.22 Any person subject to the Act is detained for two years unless he or she is discharged or otherwise released under the Act before this. There is no power in the Act to extend an order beyond two years and it is an offence to deliberately detain or procure the detention of a person for a period that exceeds the two year maximum.

<sup>1323</sup> For example, in *Savage v Savage* (19 March 1984) HC HAM M48/84, the High Court considered an appeal from Mrs Savage who had been unconscious at the time the order for her detention was made by the District Court. The District Court Judge had seen but had not been able to consult Mrs Savage because she was unconscious. On the basis of the medical evidence, an order was made and she was admitted to hospital so that she could be treated until fit enough to go to the relevant certified institution. Tompkins J who heard the appeal in the High Court considered that this had been entirely appropriate given the evidence and the opportunity the Judge had to observe the condition of Mrs Savage.

<sup>1324</sup> Bell and Brookbanks, above n 1312, AD21.02.

### Number of committals

- 16.23 The number of committal orders made under the Act has fallen over recent decades. The annual number of committal orders fell from over 400 a year in the 1970s to under 200 a year in the 1990s.<sup>1325</sup> The decline in the numbers of committal orders made under the Act has continued. Between 2004 and 2008 an average of approximately 75 orders were made each year.<sup>1326</sup>
- 16.24 The ratio of section 9 to section 8 orders has also changed during that time. During the 1990s there was typically a 2:1 or 3:2 ratio of section 9 to section 8 orders.<sup>1327</sup> In 2008, 85 % of the 77 orders were made under section 8 and only 15 % under section 9.<sup>1328</sup>
- 16.25 In proportion to the general population, Māori and women are under-represented in applications made under the Act.

### Adequacy of medical evidence

- 16.26 Medical evidence is currently not always required before detention for treatment is ordered under the Act. Even where it is required, there are questions about whether the level of clinical evidence that is required is adequate to justify compulsory detention and treatment, potentially for two years.

### Section 8 applications

- 16.27 Currently there is no requirement for any medical evidence to be submitted when a judge is considering a voluntary application under section 8. The judge may call for or hear medical evidence on the applicant's drug or alcohol use, but is not obliged to do so. Detention may be ordered where the applicant admits to being an alcoholic or drug addict and the judge is satisfied that the applicant understands the nature and effect of the application. In our view, even where the committal process is self-initiated, appropriate clinical evidence is required to determine whether the person meets the criteria for detention and treatment.

### Section 9 applications

- 16.28 An order can only be made under section 9 of the Act after two medical practitioners have either given oral evidence or issued a certificate confirming that the person named in the application is an alcoholic or addict and it is expedient in the person's own interests or the interests of his or her relatives for an order to be made. There are two significant problems with the requirements applying here. Firstly, any medical practitioner can currently issue a certificate or give evidence under the Act. Secondly, the provision does not require that both medical practitioners personally examine the person prior to making their assessment. The High Court in *S v Tahana-Reese & Anor* held that an examination of the alleged alcoholic by both medical practitioners is not a prerequisite to making

<sup>1325</sup> Webb, above n 1311, 122.

<sup>1326</sup> Ministry of Health *Office of the Director of Mental Health Annual Report 2008* (Ministry of Health, Wellington, 2009) 35.

<sup>1327</sup> Webb, above n 1311, 122.

<sup>1328</sup> Ministry of Health, above n 1326, 35.

an order under section 9. Hansen J did note that at a practical level it would be quite unlikely that a medical practitioner would give evidence or provide a certificate if he or she had not undertaken some form of examination.<sup>1329</sup>

- 16.29 We think that the type of clinical assessment needed before a person should be subject to compulsion under the Act requires specialist expertise. It should be undertaken by a doctor who has expertise in drug and alcohol dependence and treatment and should always require a personal examination. In any event, it is arguable that an order made in the absence of such appropriate evidence could be challenged as constituting an arbitrary detention under section 22 of the Bill of Rights Act.

### Compulsion and the right to refuse treatment

- 16.30 Whether the law should authorise the compulsory treatment of alcoholics and drug addicts is the most fundamental issue raised by the review of the current Act. A competent adult has the right to refuse medical treatment. This longstanding right is now protected by section 11 of the Bill of Rights Act. In recognition of this right, the Code of Health and Disability Services Consumer Rights also emphasises the need for patients to give informed consent, to the extent their competence allows.
- 16.31 Sections 8 and 9 of the Act both provide for “the detention for treatment” of alcoholics or drug addicts against their will. It might be argued that the Act does not expressly confer the power to compulsorily treat any person, on the basis that the compulsion attaches to the detention for the purpose of treatment, rather than to the treatment itself. However, commentators suggest that in practice the Act is best regarded as conferring some power to compulsorily treat a detained person.<sup>1330</sup> We agree, as detention cannot be justified unless treatment takes place.
- 16.32 In some cases committal orders have been made and treatment begun while the person who is the subject of the order has lacked capacity because he or she has been intoxicated or even unconscious.<sup>1331</sup>
- 16.33 The right to refuse to undergo any medical treatment is not absolute but under section 5 of the Bill of Rights Act is subject to reasonable limits that can be demonstrably justified in a free and democratic society. Where there is a lack of capacity and a high risk of harm to self or others there may be an adequate justification for compulsion. In *S v Tahana-Reese and Anor*<sup>1332</sup> the High Court found that compulsory detention for treatment under the Alcoholism and Drug Addiction Act could be justified under section 5. It also noted that, even if it was not, section 4 provides that the Bill of Rights Act does not override the provisions of other enactments of specific application simply because they are inconsistent.

1329 See *S v Tahana-Reese*, above n 1316.

1330 In *Brookers Incapacity* the authors suggest that for practical purposes the Act is treated as though there is a power to treat compulsorily – see Bell and Brookbanks, above n 1312, AD9.05 (accessed 15 January 2010).

1331 See *Savage v Savage*, above n 1323.

1332 *S v Tahana-Reese*, above n 1316, 485.



- 16.34 However, while consistency with the Bill of Rights Act does not require an end to compulsory treatment altogether, it does necessitate better procedural protections and more tightly drawn restrictions on the use of compulsion than those currently contained in the Act.

### Civil detention and the right not to be arbitrarily detained

- 16.35 The District Court's power to make an order under section 9 is a discretionary one. An order will not necessarily be appropriate just because an application meets all of the criteria discussed earlier. In a recent case<sup>1333</sup> Principal Family Court Judge Boshier held that the threshold for intervention is high. The Court must have regard to the individual's right to be free from arbitrary detention contained in section 22 of the Bill of Rights Act. Thus, although the Act authorises an order for detention to be made where treatment would be "expedient" in the person's own interest or those of his or her relatives, a gloss needs to be read into the wording of section 9 to apply a threshold for intervention similar to that used in the Mental Health (Compulsory Assessment and Treatment) Act. On this approach, the court can only deprive people of their liberty if satisfied that their addiction is such that they pose a serious danger to themselves or to others or they are demonstrably unable to care for themselves. Mere inconvenience should not be enough.
- 16.36 Once a person has completed or no longer requires treatment for alcoholism or addiction, there is no lawful basis for his or her continued detention under the Act. Some commentators argue that once treatment ceases to be effective, or is persistently rejected, the mandate for detention is withdrawn and the patient should also be discharged.<sup>1334</sup> Where competent patients refuse to submit to treatment, there would seem to be no legal basis to continue to detain them. If detention continues when there is no therapeutic basis for it, it may constitute unlawful detention and breach section 22. In practice it seems that any patient who persistently refuses to engage in treatment is normally discharged from the institution.

### Legal representation

- 16.37 Section 35(2) of the Act expressly provides that every person who is the subject of an application under the Act is entitled to be heard and to give and call evidence and may be represented by a solicitor or by counsel. In many earlier cases judges considered access to legal representation to be very desirable, because a person was facing civil detention for up to two years. However, they did not always consider it a necessary pre-requisite to an order, and people who were the subject of applications were not always legally represented.
- 16.38 The right to legal representation at a committal hearing under the Act seems to have now been put beyond question by section 23(1)(b) of the Bill of Rights Act, which confers on everyone who is arrested or detained under any enactment "the right to consult and instruct a lawyer without delay and to be informed

1333 *JJH v PCH* (15 July 2008) FC NWP FAM43/82, para 22 Boshier J.

1334 This is for example the argument put forward by S A Bell and W J Brookbanks *Mental Health Law in New Zealand* (Brookers, Wellington, 1998) 252 and Webb, above n 1311, 123.



of that right”. To be consistent with this principle the person who is the subject of an application should always be given access to a lawyer before any order is made.<sup>1335</sup>

### Appeal provisions

- 16.39 Section 23 provides that the appeal provisions under the Summary Proceedings Act 1957 apply to orders under sections 8 and 9 of the Act. Orders for the return or removal of a patient to a certified institution made by a District Court judge can also be appealed to the High Court. An appeal must be lodged within three weeks of the order. However, because of the difficulties a person held under an order may experience accessing legal representation and because a person’s liberty is involved, the courts are generous in granting extensions of time.<sup>1336</sup> The Act does not specify any particular grounds upon which an appeal can be brought. It has been suggested that the courts are in practice willing to contemplate broad grounds of appeal on the basis that the jeopardy faced by the person held under an order is analogous to that of a person charged with a criminal offence carrying up to two years imprisonment.<sup>1337</sup>

### Discharge of committed patient

- 16.40 Section 17 gives the Minister, a supervising committee appointed for the institution (if there is one), or the person in charge of the certified institution the power to discharge, transfer or release on leave any patient detained under the Act.<sup>1338</sup> If a person no longer requires treatment for alcoholism or addiction, he or she must be discharged from the institution. The Act does not confer a power of preventive detention and the only legal basis for detention is “for treatment for alcoholism”<sup>1339</sup> within the specified institution. If no further treatment is needed, the justification for detention accordingly no longer exists.

### Leave and transfers

- 16.41 A leave of absence can be granted by the Minister, a supervising committee, or the person in charge of the certified institution for any period up to the expiry date of the original order. The Act imposes no statutory criteria for determining whether to grant leave. In practice it seems that special conditions, such as attending outpatient clinics or Alcoholics Anonymous meetings, are sometimes imposed by supervising committees. Those who are on leave can be discharged during the period of leave. If they breach the terms of the leave, an application can be made to the District Court for an order revoking it and requiring their return to the institution or another institution to be detained under the original order.<sup>1340</sup>

1335 *In re Mrs M* [1993] DCR 673, 674 Bremner J.

1336 *Re Skelchy* (20 March 1992) HC AK AP1/92, Williams J.

1337 Bell and Brookbanks, above n 1312, AD23.01 (accessed 15 January 2010).

1338 It should be noted that a transferred prisoner cannot be discharged or released on leave without the consent of the Minister of Corrections. The Minister may, with the concurrence of the Minister of Health, also impose terms and conditions on any such discharge or leave of absence.

1339 See Alcoholism and Drug Addiction Act 1966, ss (8)(4) and (9)(7).

1340 See Alcoholism and Drug Addiction Act 1966, s 20.

- 16.42 A supervising committee, the person in charge of the institution or even the Minister can also transfer a patient to another certified institution. To do this they first need the agreement of the receiving institution. A patient who is transferred cannot be detained by the receiving institution for a period longer than the remaining time on the original detention order.

### *Requests for discharge*

- 16.43 After six months in an institution a patient who is being detained under an order made under sections 8 or 9 may request a discharge.<sup>1341</sup> A request for discharge must be made to either the Minister, the supervising committee for the institution, or the superintendent of the institution. Once an order for discharge has been made, the order under which the person has been detained is deemed to have been revoked.
- 16.44 If the request is refused, the person may apply to a High Court judge for an order directing that he or she be discharged under the Act. On such application the High Court judge may order that the patient be brought before the court for examination. The judge must determine, following the examination and on such medical and other evidence as the judge requires, whether it is still expedient either in the interests of the patient or in the interests of others that the patient continues to be detained for treatment.
- 16.45 A person held under the Act also has the right to challenge that detention by an application for a writ of habeas corpus under the Habeas Corpus Act 2001. A patient can do this at any time during such detention, so this is the only mechanism for review available to a patient during the first six months.
- 16.46 We think that this provides inadequate access to a review. The Act itself should provide patients with the ability to seek a discharge at any stage during their detention under the Act. Where that request is turned down by the superintendent of the institution responsible for their treatment, then they should be able to apply to the Family Court for a review of that decision. We think that such reviews should be undertaken by the District Court (which committed the patient) rather than the High Court.

### *Other points*

- 16.47 A number of other points arise under the current discharge process:
- Patients currently have no direct access to an independent tribunal or court.
  - The Minister of Health has the authority to determine an application for discharge. (The question of whether the powers the Minister currently has under the Act are appropriate is discussed below.)
  - Applications for discharge can be determined without the patient being examined.
  - An independent clinical assessment is not required at any stage, although the court can ask for an independent clinical report.

<sup>1341</sup> A transferred prisoner is not able to formally apply for a discharge in this way.

16.48 More generally the Alcoholism and Drug Addiction Act offers few of the types of procedural protections that have been incorporated into more recent mental health legislation to safeguard the rights and interests of vulnerable people. In the course of the 1999 review of the Alcoholism and Drug Addiction Act, the Health and Disability Commissioner and others suggested that a new advocacy/oversight role similar to that of district inspectors under the Mental Health (Compulsory Assessment and Treatment) Act would be desirable for patients detained under the Alcoholism and Drug Addiction Act. Under the recently enacted Drug and Alcohol Treatment Act 2007 (NSW), which is being piloted in parts of Sydney, official visitors are appointed with functions similar to those of district inspectors. These include, for example, acting as an advocate for patients within the alcohol or drug dependence treatment system and inspecting treatment centres and reporting on matters of significant concern as they relate to patient safety.<sup>1342</sup> We discuss other aspects of the New South Wales Act later in the chapter.

### *Length of detention*

- 16.49 Although all orders authorise detention for two years, almost all patients are discharged or otherwise released (often on leave) well before two years.<sup>1343</sup> It seems that over half of all the people committed for treatment are discharged or released on leave within three months, and that the vast majority are discharged or released on leave within six months.<sup>1344</sup> Where patients are released on leave, rather than discharged, they technically remain within the ambit of the Act because the order under which they were detained is still in force.<sup>1345</sup>
- 16.50 Most inpatient residential treatment programmes offered within certified institutions are completed within three or six months. The inpatient programme for those detained at Nova Lodge runs for six months, although some are discharged before completing it. The period of two years authorised by the Act thus far exceeds what is normally necessary for an inpatient programme. If detention for compulsory treatment is retained, the maximum length of detention should, as a matter of principle, be no longer than is necessary to treat the person so that he or she no longer meets the criteria for detention. This suggests that the maximum period needs to be revisited.

### *Role of the Minister of Health*

- 16.51 The Minister of Health has, at least on the face of the legislation, a much more active role under the Act than under other analogous legislation. The Minister has, for example, the power to discharge, to transfer, or to grant or cancel a patient's leave of absence.
- 16.52 We understand that historically these types of Ministerial powers have seldom been exercised and over more recent decades they have not been used at all. In the 1999 consultation document on the Act the Ministry of Health stated that

<sup>1342</sup> See Drug and Alcohol Treatment Act 2007 (NSW), ss 26 and 27 for a full list of functions.

<sup>1343</sup> Bell and Brookbanks, above n 1312, AD10.04 (accessed 15 January 2010).

<sup>1344</sup> Webb, above n 1311, 122.

<sup>1345</sup> Although as we have already noted where a person is released on leave (except for a specific period) a court order is required to revoke such leave.

only the Minister's power to re-certify institutions was now exercised.<sup>1346</sup> The power to appoint new members to supervising committees is also periodically exercised as need be. We suggest that the other Ministerial powers, which reflect an earlier era, are no longer appropriate and should be repealed.

- 16.53 The process of certifying institutions and programmes by Order in Council also seems now to be out of step with the approach taken to certifying other types of health care providers. Hospitals and other institutions providing health care are currently certified by the Director-General of Health after being assessed as appropriate under the Health and Disability Services (Safety) Act 2001.<sup>1347</sup> Under the certification process in that Act, providers need to meet appropriate standards related to the type of care they provide. It would be appropriate that certification of alcohol and drug treatment facilities be similarly undertaken by the Director-General of Health rather than by an Order in Council process.

### Access to treatment facilities

- 16.54 There are some significant practical problems that arise under the Act. Firstly, the Act provides only for detention in a certified institution. However, there are few certified facilities, with none outside the three main centres. In addition, none will take people who are under the age of 20 years, so that young people under that age cannot receive inpatient treatment under the Act.
- 16.55 The unavailability or unwillingness of facilities to accept patients and the limited geographical spread of institutions have posed ongoing problems for the courts. In several cases judges have commented that applications have failed only because applicants in need of treatment have been unable to find an institution willing to take them.<sup>1348</sup>
- 16.56 A second but related issue is that the Act provides only for residential treatment. However, studies seem to indicate that while inpatient treatment is superior for patients with a severe dependence, it fares no better than outpatient treatment for the rest.<sup>1349</sup> If this is true, outpatient or community-based treatment is likely to be a better option for most people accessing drug or alcohol treatment because it is less disruptive. If provision for compulsory treatment extending beyond short term treatment and detoxification is retained, then it may be appropriate to provide for community-based orders.

<sup>1346</sup> Ministry of Health *Review of the Alcoholism and Drug Addiction Act 1966* (Ministry of Health, Wellington, 1999).

<sup>1347</sup> The certification process in the Act also covers "hospital mental health care" provided under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

<sup>1348</sup> In *Edmonds v Lucas-Edmonds*, for example, Judge Grace dismissed an application after noting that the absence of a certified institution meant that an order could not be made in respect of a young man of 17. The Judge expressed his deep concern that this was a situation "where no assistance [was] available to a person who clearly need[ed] it." *Edmonds v Lucas-Edmonds* (23 May 2003) FC WN MFP085/4/03, Judge Grace. Applications have similarly been dismissed in other cases because there have not been any places available; for example, see *B v DR* [1984] NZFLR 898.

<sup>1349</sup> Review of the Alcoholism and Drug Addiction Act 1966, above n 1346.

## Offences

- 16.57 The Act creates a number of offences. In broad terms these can be separated into offences committed by people held under the Act and offences committed by others. The maximum penalty for all offences (other than that of unlawful detention) is three months imprisonment and/or a fine of up to \$200.<sup>1350</sup> The maximum penalty for unlawful detention is one year imprisonment and/or a fine of up to \$1000.

### *Escaping from an institution*

- 16.58 It is an offence under section 25 for a person detained as a patient under the Act to escape or attempt to escape from an institution or from other lawful custody under the Act or to wilfully refuse or fail to return to the institution at the end of a period of lawful absence.<sup>1351</sup> It is also an offence under the section for another person to induce or knowingly assist a patient to escape or to knowingly assist a patient to avoid being caught. The police or any employee of the institution may arrest without warrant any patient who is unlawfully absent from an institution and return him or her to the institution.
- 16.59 In comparison, there is no equivalent offence of escaping from a psychiatric institution under the Mental Health (Compulsory Assessment and Treatment) Act. The rationale is that those suffering from a mental disorder that is serious enough to result in their compulsory detention under that Act have diminished capacity, so it is not appropriate to hold them culpable for escaping in those circumstances. The same argument might be made in respect of a person who is detained under the Alcoholism and Drug Addiction Act.
- 16.60 On the other hand, it can be argued that an offence of this kind reinforces the compulsory nature of the detention and gives it more “teeth”.

### *Improper conduct*

- 16.61 It is an offence for a patient detained under the Act to wilfully engage in violent, unruly, insubordinate, destructive, indecent, offensive or insulting conduct. Commentators describe this offence as an historical anachronism and suggest that it seems anomalous to threaten people with punishment for insubordinate and unruly behaviour, who, by the nature of their condition, are likely to be so disposed.<sup>1352</sup> There is no case law on the section.
- 16.62 Some of the prescribed conduct is already covered by other general offences. For example, violence is covered by the assault and injury provisions in Part 8 of the Crimes Act 1961, the destruction of property by the offence of wilful damage and other provisions protecting property, and indecency and offensive conduct by other general provisions. Where it is not, we do not think that it should be criminalised; only conduct that would be an offence if it occurred outside an institution should be an offence within an institution. Behaviour that is merely unruly, insulting or insubordinate should not be an offence.

<sup>1350</sup> See Alcoholism and Drug Addiction Act 1966, s 36.

<sup>1351</sup> See Alcoholism and Drug Addiction Act 1966, s 25.

<sup>1352</sup> Bell and Brookbanks, above n 1312, AD26.01 (accessed 15 January 2010).



### *Ill-treatment of patients*

- 16.63 There are two separate offences in section 29 dealing respectively with the ill-treatment and wilful neglect of any patient in an institution. Section 29 does not appear to apply to a patient who is on leave or otherwise absent from an institution. The section is analogous to section 114 of the Mental Health (Compulsory Assessment and Treatment) Act which defines the offence of intentionally ill-treating or neglecting any mentally disordered person. However, the difference in penalties is significant: two years imprisonment under the Mental Health (Compulsory Assessment and Treatment) Act<sup>1353</sup> but only three months imprisonment under the Alcoholism and Drug Addiction Act.<sup>1354</sup>
- 16.64 The Law Commission has recently proposed substantial reforms to the law relating to the ill-treatment and neglect of children and vulnerable adults.<sup>1355</sup> The Commission has proposed a redraft of section 195 of the Crimes Act 1961 (formally entitled “cruelty to a child”), addressing ill-treatment and neglect by those with care or charge of a child or vulnerable adult. At present section 195 only applies to child victims. We consider that vulnerable adults<sup>1356</sup> are entitled to the same protection. The Commission has proposed a broader and objective “gross negligence” test as part of that reform. Rather than requiring a finding of deliberate neglect or ill-treatment, as at present, a court would only need to be satisfied that the conduct alleged was a major departure from the standard of care to be expected of a reasonable person.<sup>1357</sup>
- 16.65 In view of the Commission’s proposal to broaden the scope of section 195 to cover the ill-treatment or neglect of patients detained in institutions, it is unnecessary to retain specific offences such as that contained in section 29. If the Commission’s proposals for section 195 of the Crimes Act are adopted, section 29 of the Alcoholism and Drug Addiction Act should be repealed.
- 16.66 The Commission has also proposed two other substantial reforms to Part 8 of the Crimes Act that would apply to patients detained in certified institutions under the Alcoholism and Drug Addiction Act. These are:
- A new offence where a staff member of a residence fails to take reasonable steps to protect a vulnerable person in that residence from any known risk of death, serious injury or sexual assault.<sup>1358</sup>

1353 Ibid, AD29.01 (accessed 15 January 2010).

1354 See Alcoholism and Drug Addiction Act 1966, s 36.

1355 New Zealand Law Commission *Part 8 of the Crimes Act 1961: Crimes Against the Person* (NZLC R111, Wellington, 2009) chapter 5.

1356 For the purposes of the reforms a vulnerable adult is a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person.

1357 New Zealand Law Commission, above n 1355, 52.

1358 Ibid, 55–57.



- An extension to the scope of the duty provision in section 151 of the Crimes Act, by introducing an additional requirement to take reasonable steps to protect a vulnerable person from injury.<sup>1359</sup>

### *Supplying drugs or alcohol to patients*

- 16.67 It is an offence for any person, other than a medical practitioner or someone acting under his or her authority, to supply any drugs or alcohol to any patient held under the Act. This offence also covers any period when the patient is on a leave of absence or otherwise absent from the institution.

### *Unlawful detention in an institution*

- 16.68 Under section 24 it is an offence to deliberately detain a person in an institution under the Act for a period longer than is legally authorised or to detain a person “otherwise than in due course of law”. This appears to cover any situation where continued detention is not otherwise lawful, or any failure to discharge a patient from the institution where a court has ordered the patient’s discharge.

### *Trespass*

- 16.69 Finally, it is also an offence under section 28 for any person to deliberately trespass on any land knowing or having reasonable cause to believe that it is part of a certified institution.

## OPTIONS FOR REFORM

- 16.70 In broad terms the options for reform are to either:
- repeal the Act and dispense with civil committal for compulsory alcohol or drug treatment; or
  - retain (in a modified form which addresses all of the issues identified above) civil committal for the detention and treatment of alcohol and drug dependence.
- 16.71 A simple repeal of the Act gives primacy to the value of personal autonomy and individual freedom and the right to refuse medical treatment. However, repealing the Act without providing an alternative will leave a number of gaps.
- 16.72 Firstly, people who would otherwise be considered to be suffering from a mental disorder because they have an abnormal state of mind that would meet the test in the Mental Health (Compulsory Assessment and Treatment) Act for compulsory treatment have been expressly excluded from that Act if their mental disorder has resulted solely from substance abuse. In practice some of these people are, prior to a diagnosis of substance abuse, compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act, because it is not immediately apparent that their disorder is solely attributable to alcohol or drug use. However, once this is diagnosed they must be discharged.
- 16.73 There are two categories of people in this group. The first suffer from a disorder of volition as a result of dependence, which is temporary, and can be addressed by treatment for dependence. The second have suffered cognitive damage from

<sup>1359</sup> Ibid, 60.

chronic alcohol or drug use that is much longer lasting or possibly permanent. They are likely also to have a disorder of volition as a result of dependence that would be addressed by treatment.

- 16.74 If the Alcoholism and Drug Addiction Act were repealed, the assessment and treatment needs of this group would need to be provided for. How would this best be done? Might it be sufficient to simply remove the exemption and treat mental disorders attributable to substance abuse under the Mental Health (Compulsory Assessment and Treatment) Act? Or, does the nature of substance abuse require a different type of treatment regime, with differences in the nature and length of detention? Some might argue that it does. This is because unlike other mental disorder patients, there is no benefit in or justification for detention beyond the time needed for detoxification and to engender motivation to engage with drug and alcohol treatment programmes, and any subsequent treatment should be voluntary.
- 16.75 The second potential gap is in relation to people who suffer from dependence that does not result in a mental disorder. It is true that this group's substance dependence seriously impairs their capacity to make rational choices about their substance use and their personal welfare, so that they have impaired volition, which is part of the definition of mental disorder under the Mental Health (Compulsory Assessment and Treatment) Act. However, not everyone who experiences a disorder of mood, perception, volition or cognition is diagnosed as having "an abnormal state of mind", which is a pre-requisite for a diagnosis of mental disorder under that Act.
- 16.76 If the Alcoholism and Drug Addiction Act were repealed, therefore, there would be no regime for detaining and treating anyone falling within this group. We suggest this would leave a significant gap, because it would prevent the detention of anyone in this group for detoxification and some preliminary engagement with drug and alcohol treatment. Such people are often incapable of making decisions over their substance use and personal welfare, so that their access to treatment may be significantly eroded.
- 16.77 We suggest that, if the Alcoholism and Drug Addiction Act is repealed, some alternative provision will be needed to cover both groups. Beyond these groups we do not think that there is any justification for detention for treatment. In an emergency or life threatening situation or in some other similar situation where it is not practicable to communicate with a person and obtain consent, the common law principle of necessity allows such action as is reasonable in the circumstances to be taken in the best interests of the person.<sup>1360</sup> Under this principle treatment is provided, often by emergency services, to manage intoxicated people where their safety and that of others is at risk. But it should not normally extend beyond that which is necessary to address that situation.<sup>1361</sup>

<sup>1360</sup> *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 73–74 (HL).

<sup>1361</sup> There is some question as to whether the common law justification of necessity would be applied in non-emergency situations in New Zealand given the existence of various legislation provisions for addressing these. See the discussion in P D G Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 250.

### Justification for compulsion

- 16.78 The law generally supports personal autonomy and adults are, as a rule, presumed to be competent to make their own decisions and accept the consequences of those decisions. However, for the two groups identified above, the use of and dependence on alcohol and drugs has resulted in a seriously diminished capacity to function and preserve their own health and safety. The right to refuse to undergo any medical treatment is not an absolute right, but is subject to such reasonable limits as can be demonstrably justified in a free and democratic society.
- 16.79 We suggest that compulsion may be justified where a person who falls into one of these groups is at risk of causing significant harm to himself or herself. In this, as in other contexts, the degree of intervention that may be justified in this way is the minimum necessary to address the risk of harm posed and to preserve the person's health and safety. Detention for treatment should be considered a last resort.
- 16.80 Once a person, normally after completing detoxification, has regained capacity he or she may be in a position to voluntarily engage with ongoing treatment. For most drug and alcohol dependent people the acute risks of harm tend to be short-lived. We therefore suggest that detention for detoxification and to engender motivation to engage with drug and alcohol treatment after withdrawal or detoxification is completed can be justified in the circumstances discussed above, but continued compulsion cannot. In practice this approach would generally permit detention only for a relatively short period during which detoxification and supporting treatment could be undertaken in appropriate facilities.
- 16.81 On a practical level it is also important to remember that most ongoing drug treatment requires active cooperation and participation. Thus, while a short period of compulsion may provide an opportunity to motivate a person to engage with a treatment programme, the success of the programme will depend on his or her ongoing participation and active engagement.

### A new model

- 16.82 We therefore propose that a limited compulsory civil detention and treatment regime containing appropriate safeguards be retained.
- 16.83 We are suggesting something different from the temporary detention of intoxicated people for a few hours while they sober up. Provision has already been made in section 36 of the Policing Act 2008 to deal with acutely intoxicated people who are a risk to themselves and need medical or other supervision for a short time.<sup>1362</sup> Under section 36, police have powers to take an intoxicated person found in a public place or trespassing on private property to the person's home, or to a temporary shelter, or if it is not reasonably practicable to provide for the person's care and protection in his or her home or at a temporary shelter, into custody. Police officers may only exercise these powers where they believe that people are incapable of looking after themselves, or are likely to cause physical harm to another person or significant damage to property. A person can normally

<sup>1362</sup> Section 36 dealing with the care and protection of intoxicated people replaced section 37A of the Alcoholism and Drug Addiction Act 1966 which was repealed from 1 September 2008 and had previously provided police with similar powers.

only be detained for 12 hours under section 36, although provision is made for detention for a further 12 hours where this is necessary and a health practitioner is satisfied that the person is still intoxicated and incapable of caring for himself or herself.

- 16.84 Most of the intoxicated people picked up by police under section 36 only need supervision briefly and will sober up within a few hours. The vast majority do not have the type of chronic alcohol and other drug dependence that would place them in one of the groups that meet the criteria discussed above.
- 16.85 We have considered two civil detention regimes that might provide useful guidance for a new more limited compulsory civil detention and treatment regime for alcohol and other drug dependence. These are the Drug and Alcohol Treatment Act 2007 (NSW) currently being piloted in parts of Sydney, and the Mental Health (Compulsory Assessment and Treatment) Act.

#### *Drug and Alcohol Treatment Act 2007 (NSW)*

- 16.86 The Drug and Alcohol Treatment Act (NSW) was enacted to provide the legal basis for a two-year trial of short-term involuntary care and treatment of adults living in areas covered by the Sydney West Area Health Services.<sup>1363</sup>
- 16.87 The Act provides for the involuntary detention of a person who has severe substance dependence. The objects of the Act are:<sup>1364</sup>
- (a) to provide for the involuntary treatment of persons with a severe substance dependence with the aim of protecting their health and safety, and
  - (b) to facilitate a comprehensive assessment of those persons in relation to their dependency, and
  - (c) to facilitate the stabilisation of those persons through medical treatment, including, for example, medically assisted withdrawal, and
  - (d) to give those persons the opportunity to engage in voluntary treatment and restore their capacity to make decisions about their substance use and personal welfare.

The intention is therefore to provide short-term detoxification and treatment in order to restore a person's capacity to engage voluntarily in longer-term rehabilitation services.

- 16.88 Although the Act authorises the detention of dependent persons for the purposes of involuntary treatment, there are a number of safeguards around the exercise of this power. The objects section requires that the Act must be interpreted, and the functions conferred by the Act should be performed, so far as practicable to ensure that:<sup>1365</sup>
- involuntary detention and treatment is a consideration of last resort;

1363 Regulations made under the Act provide that these are Auburn, Blacktown City, Blue Mountains City, Hawkesbury City, Holroyd City, Lithgow City, Parramatta City (other than the site of the Cumberland Hospital), Penrith City and The Hills Shire. See Regulation 4 of the Drug and Alcohol Treatment Regulations 2009.

1364 Alcohol and Drug Treatment Act 2007, s 3(1).

1365 Alcohol and Drug Treatment Act 2007, s 3(2).

- the interests of a person involuntarily detained and treated under the Act are paramount in all decision-making about the person under the Act;
  - a person involuntarily detained under the Act will receive the best possible treatment in the least restrictive environment that will enable treatment to be effectively given; and
  - any interference with the rights, dignity and self-respect of a person involuntarily detained under the Act will be kept to the minimum necessary.
- 16.89 An accredited medical practitioner may only issue a “dependency certificate”, which states that the person may be detained for a specified period if, after assessing the person, he or she determines that:<sup>1366</sup>
- (a) the person has a severe substance dependence, and
  - (b) care, treatment or control of the person is necessary to protect the person from serious harm, and
  - (c) the person is likely to benefit from treatment for his or her substance dependence but has refused treatment, and
  - (d) no other appropriate and less restrictive means for dealing with the person are reasonably available.
- “A severe substance dependence” is defined in the Act to mean the person:<sup>1367</sup>
- (a) has a tolerance to a substance, and
  - (b) shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance, and
  - (c) has lost the capacity to make decisions about his or her substance use and personal welfare due primarily to his or her dependence on the substance.
- 16.90 There are time limits imposed on this detention. It must be for no more than 28 days and the practitioner must, as soon as practicable after issuing the certificate, bring the person before a magistrate to review the issuing of the certificate.<sup>1368</sup> In a review, the magistrate may confirm the issuing of the dependency certificate for the same or a shorter period, or order that the person be discharged.<sup>1369</sup>
- 16.91 An accredited medical practitioner can apply to a magistrate to extend the period of a dependency certificate if the practitioner is satisfied that the person is suffering a drug or alcohol related brain injury and more time is needed for treatment or to plan the person’s discharge. The extension can be for no more than three months from the date of issue of the dependency certificate.<sup>1370</sup> The accredited medical practitioner may decide to release the detained person at any time if he or she is satisfied that continued detention will not achieve the purpose of treatment.<sup>1371</sup> If a patient consistently refused to engage in treatment

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1366 Alcohol and Drug Treatment Act 2007, s 9.

1367 Alcohol and Drug Treatment Act 2007, s 5.

1368 Alcohol and Drug Treatment Act 2007, s 14.

1369 Alcohol and Drug Treatment Act 2007, s 34.

1370 Alcohol and Drug Treatment Act 2007, s 36.

1371 Alcohol and Drug Treatment Act 2007, s 25.



while detained, he or she might be released under this provision. The Act requires the discharge of any dependent person if the person no longer meets the criteria for detention and treatment.

- 16.92 The Act provides for information to be promptly given to the dependent person about his or her legal rights and other entitlements<sup>1372</sup> and appeal rights.<sup>1373</sup>
- 16.93 There is also provision for the involvement of the dependent person's family. A dependent person may appoint a primary carer under section 13. Notice of the detention must be given to the person's primary carer within 24 hours of the issue of the certificate.<sup>1374</sup> The primary carer should also receive notice of certain events: that the person is absent without permission; that the person has been discharged; or that an application has been made to extend the period of the dependency certificate.<sup>1375</sup>
- 16.94 The Act is designed to ensure that the person is adequately assessed by an appropriate medical practitioner. A dependency certificate can only be issued by an accredited medical practitioner after he or she has assessed the person.<sup>1376</sup> An accredited medical practitioner is appointed by the Director-General of Health. If the practitioner is unable to access the person to conduct the assessment requested, a magistrate may make an order authorising them to visit and assess the person.<sup>1377</sup> The provision gives the accredited medical practitioner (and any other person authorised under the Act to assist them) authority to enter premises, if need be by force, to carry out the assessment.

### *Model in current mental health legislation*

- 16.95 The model used in the Mental Health (Compulsory Assessment and Treatment) Act also provides useful guidance. Like the Drug and Alcohol Treatment Act (NSW), it takes a tiered approach under which the District Court does not make the initial committal decision but only reviews the decision on application.
- 16.96 Anyone who believes that a person may be suffering from a mental disorder can apply to the Director of Area Mental Health Services for a compulsory assessment. The application must be supported by a doctor's certificate stating that in the doctor's opinion there are reasonable grounds for believing that the person may be suffering from a mental disorder and giving reasons for this. Once a valid application is received, the Director of Area Mental Health Services must ensure that the proposed patient is examined and assessed "forthwith".<sup>1378</sup>
- 16.97 The doctor who carries out the assessment examination is independent and is a specialist. The Act provides that the examination must be conducted by a psychiatrist, or failing this, a doctor with specific credentials approved

<sup>1372</sup> Alcohol and Drug Treatment Act 2007, s 16.

<sup>1373</sup> Alcohol and Drug Treatment Act 2007, s 18.

<sup>1374</sup> Alcohol and Drug Treatment Act 2007, s 17.

<sup>1375</sup> Alcohol and Drug Treatment Act 2007, s 19.

<sup>1376</sup> Alcohol and Drug Treatment Act 2007, s 9.

<sup>1377</sup> Alcohol and Drug Treatment Act 2007, s 10.

<sup>1378</sup> *Sestan v Director of Area Mental Health Services Waitemata DHB* [2007] 1 NZLR 767, paras 26 and 27.

by the Director of Area Mental Health Services for that purpose.<sup>1379</sup> Following this preliminary clinical assessment by a specialist, a person can be detained for a period of five days (the first period) for further compulsory assessment and treatment. During this first period of compulsory assessment and treatment, the patient and various other people with an interest in the matter, including the applicant, may apply at any time to the District Court<sup>1380</sup> for a review of the decision.<sup>1381</sup> The court has the power to discharge the patient if the judge considers that he or she is no longer mentally disordered.<sup>1382</sup>

- 16.98 During the first period the patient is treated as necessary. If at any stage the patient is considered fit to be released, he or she must be discharged. If the responsible clinician believes that the person still exhibits a mental disorder and further compulsion is necessary, the clinician is authorised to maintain compulsory assessment and treatment for a further 14 days (the second period). A certificate authorising the second period must be completed during the first period and copies sent to certain people specified in the Act. These include the patient, the applicant, the patient's doctor and also a district inspector.
- 16.99 The involvement of a district inspector at this stage adds an important protection. The district inspector is obliged to talk to the patient and decide whether an application should be made to the court for a review of the patient's condition. If the district inspector is of the view that an application should be made, he or she may encourage and assist the patient or any other recipient of the certificate to make the application for review. The district inspector may also report the matter to the court, which may review the patient's condition of its own motion.
- 16.100 The responsible clinician must issue a final certificate of assessment during this second period. If the clinician believes that the person still exhibits a mental disorder and further compulsion is necessary, he or she must apply to the District Court for a compulsory treatment order.
- 16.101 The application process in the mental health model has advantages over the approach currently taken in the Alcoholism and Drug Addiction Act. Under this model any interested party can initiate the first step of the process, but can only do so where he or she can obtain appropriate medical support, normally from the person's doctor. A preliminary specialist assessment is also required before a person can be detained for interim treatment and a more extensive assessment. The degree of intervention authorised during these preliminary stages is the minimum necessary to preserve the person's health and safety.
- 16.102 When an application is made to the court for a treatment order, there is a comprehensive clinical assessment available to the court and a proposed plan for any necessary further compulsory treatment. At each stage, as there is greater interference with the person's autonomy, greater certainty of diagnosis is required and additional safeguards are also applied.

1379 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 9(3).

1380 Wherever possible these reviews are undertaken in the Family Court.

1381 We should note also that a person's earlier detention for a preliminary assessment can be challenged under section 23 of the Bill of Rights Act or by way of a habeas corpus application.

1382 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 16.

### *Framework for new scheme*

16.103 A new regime authorising involuntary detention and treatment of alcohol and drug dependence would need to have similar features and safeguards to those discussed above. In particular we think that:

- It should provide for detention and involuntary treatment of alcohol and drug dependence only as a last resort.
- Only the degree of intervention necessary to address the risk of harm or danger posed to the detained person should be authorised.
- A clear threshold that must be met before a person may be detained for treatment should be specified (considered further below).
- An assessment to determine whether a person meets the threshold for detention should always require a personal examination and should only be performed by a medical practitioner who has expertise in drug and alcohol dependence and has been accredited to undertake such assessments under the Act.
- The accredited medical practitioner should be empowered to authorise the detention of a person who meets all the criteria for detention on an interim basis (for example, for five days).
- Any person subject to the Act, and other people with an interest in the person's welfare (such as family members), should be able to apply to the District Court (Family Division) for a review of the decision to detain that person.
- Inspectors similar to those provided under the Mental Health (Compulsory Assessment and Treatment) Act should be appointed, both to ensure that any person being detained has access to advocacy and support from an independent lawyer and to provide more general oversight of the operation of the Act.
- The accredited medical practitioner responsible for the person's treatment during the interim period should be required to apply to the court if he or she believes that the person still meets the criteria and further compulsion is necessary at the end of the interim period. The court would review the decision to detain and treat the person and determine the maximum period of detention. The court would also have the power to immediately discharge the person where there is no ongoing basis to detain him or her.
- Provision should be made in the Act for leave of absence.
- Subject to an order for extension, the maximum period of detention should be 28 days (discussed further below).
- The accredited medical practitioner responsible for the person's treatment should be able to apply to the court in some exceptional circumstances for an extension of the period of court-ordered detention and treatment (discussed further below).
- The accredited medical practitioner responsible for the person's treatment should be required to release the detained person at any time if satisfied that the person no longer meets the criteria for detention for treatment.

16.104 The Act will need to make appropriate provision for accrediting suitably qualified medical practitioners. Under the Mental Health (Compulsory Assessment and Treatment) Act, assessment examinations must be conducted by a psychiatrist or another suitably qualified practitioner who has been specifically approved

by the Director of Area Mental Health Services for this purpose.<sup>1383</sup> Under the Drug and Alcohol Treatment Act (NSW), suitably skilled practitioners are appointed by the Director-General of Health. We suggest that a similar approach, which requires individual practitioners to be expressly authorised, should be taken here. Consideration will need to be given to the appropriate skills and expertise that practitioners will need to perform this function and also to the process by which they should be accredited.

Q150 Do you agree that a regime allowing civil committal for the detention and treatment of alcohol and drug dependence should be retained?

Q151 If civil committal for the detention and treatment of alcohol and drug dependence is retained, do you agree with the key features and safeguards outlined in paragraph 16.103? Are there any others you would add?

Q152 If a regime for civil detention and treatment is retained, should there be an offence of escaping from an institution as discussed in paragraphs to 16.58 to 16.60?

Q153 Do you agree that alcohol and drug treatment facilities operating within a new regime should, as discussed in paragraph 16.53, be certified by the Director-General of Health under the Health and Disability Services (Safety) Act 2001 in the same way as other health care providers?

### Setting the threshold for compulsory treatment

- 16.105 Earlier we identified two groups of people who might potentially be subject to a compulsory treatment regime. The first are people who have so significant a dependence on drugs or alcohol that they have an abnormal state of mind. The second are people who suffer from substance dependence that seriously impairs their capacity to make rational choices about their substance use and about their personal welfare but does not necessarily constitute an abnormal state of mind as the term is used under mental health legislation.
- 16.106 The appropriate threshold for compulsion depends on which of these groups should be covered by the regime. If the threshold required an abnormal state of mind, it would not capture the second group because, although their dependence has seriously impaired their capacity to make rational choices about their substance use and personal welfare, it does not necessarily constitute an abnormal state of mind.
- 16.107 In our view a test, like that in the New South Wales Act, which simply focuses on severe dependence, would be preferable as it would cover both groups. Importantly it also explicitly and transparently places “a severe dependence on drugs or alcohol” at the centre of the test, rather than the resulting abnormal

<sup>1383</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, s 9(3).

state of mind. Of course, the existence of dependence should not in itself be sufficient to trigger detention and compulsion. There must also be a requirement that compulsory care and treatment is necessary to protect the person from harm to his or her health or safety.

- 16.108 We are inclined to the view that a risk of harm is the only threshold requirement. Some might argue that it should also be sufficient that people are drug dependent and unable to care for themselves. Our tentative view is that this is not required. An inability to care for oneself will also pose a risk of harm. In the occasional case where it does not, it should not of itself be sufficient for detention.
- 16.109 We do not consider it appropriate to include the alternative ground “poses a serious danger to the health or safety of ... others”, even though this is currently included in the Mental Health (Compulsory Assessment and Treatment) Act. Even if this ground is appropriate in general mental health legislation, because it is possible to predict with a reasonable degree of accuracy which groups of people will pose a serious risk to others, we do not think this can be done with drug and alcohol dependence. We have discussed the perceived link between the use of some drugs and violence in chapter 2 and the paucity of evidence supporting it. Even in the case of a drug such as methamphetamine, where there is some evidence of a link to violent behaviour, there are enormous difficulties in predicting what risk of harm to others any particular individual might pose. We suggest that it is impossible to do this with sufficient accuracy to justify detaining a person to prevent that risk.
- 16.110 In addition, we favour the inclusion of a requirement similar to that in section 9 of the New South Wales Act that a person must be likely to benefit from treatment and have refused voluntary treatment and that no other less restrictive options for dealing with him or her are reasonably available.

Q154 Do you agree that the threshold for compulsion should be:

- (a) that the person has a “dependence” on alcohol or other drugs; and
- (b) detention and treatment is necessary to protect the person from significant harm; and
- (c) the person is likely to benefit from treatment for his or her alcohol or drug dependence but has refused treatment; and
- (d) no other appropriate and less restrictive means are reasonably available for dealing with the person.

“Dependence” means that a person has:

- (i) a tolerance to a substance; and
- (ii) shows withdrawal symptoms when he or she reduces the level or stops using the substance; and
- (iii) has a substantially impaired capacity to make decisions about his or her substance use and personal welfare due primarily to his or her dependence on the substance.



Q155 If you do not agree with the approach we have set out in Q154, what criteria do you suggest?

Q156 Do you agree that people should not be able to be detained on the grounds that they are unable to care for themselves when detention is not necessary to protect them from significant harm?

Q157 Do you agree that people should not be able to be detained on the grounds that they are perceived to pose a serious danger to others?

### Maximum time limits on detention and treatment

- 16.111 Another issue that needs to be resolved is whether the legislation should specify a maximum period of detention, like the Drug and Alcohol Treatment Act (NSW) does, or allow the court reviewing the matter to determine the period of time compulsory treatment may continue, as under the mental health model. We favour a maximum period being specified in legislation, with the court having the power to extend this up to a further specified maximum in exceptional cases where that is necessary to complete treatment and plan the person's release into the community. This would provide the clearest indication of the short-term nature of detention. A maximum period of 28 days might be appropriate with the court being able to extend this to no more than three months in exceptional cases. These are the time limits used in the New South Wales Act. A period of 28 days would seem to be sufficient to enable detoxification or withdrawal from most substances and a brief window to engender motivation to engage with drug and alcohol treatment. Three months is adequate to cover exceptional cases.
- 16.112 Where a person has suffered cognitive damage as a result of chronic alcohol or drug use, he or she may respond more slowly to treatment and take longer to recover. In these cases the court could extend the treatment order (up to a maximum of three months), but this should be an option only where there is ongoing benefit in continued compulsory treatment. However, some people, who have suffered permanent cognitive damage, may not benefit from further treatment. Our tentative view is that after these people have recovered (to the extent they can through treatment), compulsory treatment under the proposed regime has to cease and they should be dealt with under some other regime. Ongoing detention under the regime we propose here can only be justified where the person is being treated.
- 16.113 Earlier we suggested that community-based treatment orders might be considered as an alternative to inpatient treatment if compulsory treatment extends beyond the short term. However, we have proposed a compulsory treatment regime that permits only short-term detention. There would consequently seem to be limited scope for the use of community-based treatment orders.

Q158 Do you think that the legislation should, like the Drug and Alcohol Treatment Act 2007 (NSW), set a maximum period for detention? If so, what should the maximum be?

Q159 Should provision be made allowing the courts to extend this? If so, for how long and on what grounds?

Q160 Should provision be made for community-based treatment orders?

### Different legislative vehicles

- 16.114 If it is considered desirable to retain some form of compulsory detention and treatment, as we have suggested, there are a range of legislative vehicles that might be used. A new Act could be developed to replace the Alcoholism and Drug Addiction Act. Alternatively, provision for a new compulsory treatment regime could be included in any legislation that implements the recommendations of this review and replaces the current Misuse of Drugs Act. A third alternative that might also be considered is an amendment to the Mental Health (Compulsory Assessment and Treatment) Act to provide for the compulsory treatment of alcohol and drug dependency within that legislative framework.
- 16.115 We think that there are some clear advantages in incorporating any retained compulsory treatment regime into a new broader legislative framework for regulating drugs.

### *Include within a new legislative framework for drugs*

- 16.116 As it currently stands the Misuse of Drugs Act provides little in the way of support for any type of drug treatment. The Act is essentially a criminal justice statute. The use of drugs, even by those who are dependent on them, is currently treated solely as a matter for the criminal law rather than health policy. There is therefore something of a philosophical mismatch between the current Misuse of Drugs Act and any treatment regime. However, as we have proposed elsewhere in this paper, the existing focus of drugs legislation should be broadened, because it does not align well with New Zealand's drug policy, which emphasises preventing and reducing health, social and economic harms through an appropriate balance of strategies.

16.117 As part of this broader approach a new legislative framework to replace the Misuse of Drugs Act could include, to the extent it is retained, any civil regime for compulsory drug and alcohol assessment, detoxification and treatment. We suggest that this approach has some important advantages:

- There is a symbolic significance in including alcohol in the drugs regime. Alcohol is more harmful than many other drugs that are prohibited under the Misuse of Drugs Act but for a range of historical and cultural reasons is regulated differently. The inclusion of measures to deal with alcohol dependence in the proposed new legislative framework for drugs would be one way to acknowledge the risks posed by alcohol even though it remains legally available.
- It fits well with National Drug Policy with its three pillars of demand reduction, supply control and problem limitation. The current focus of the Misuse of Drugs Act gives an incorrect impression that supply control rather than harm minimisation is the primary objective of drugs policy. If all demand reduction and problem limitation initiatives that require legislation are dealt with in the same statute as more conventional supply control measures, it will help to reinforce harm minimisation as the key plank of drug policy.
- As outlined in earlier chapters, the review is also considering the option of including a degree of compulsion or coerced assessment as an alternative to criminal sanctions for personal use and/or social supply. If this approach is taken, similar issues arise over the justification for and efficacy of compulsion or coercion into treatment in both contexts and a consistent approach is needed. Consistency and appropriate linkages between the provisions would be easier to manage within one piece of legislation.
- Finally, all legislative provision for drug and alcohol treatment would be contained in the one Act. This would greatly assist in making the law transparent and accessible.

#### *A separate Act*

16.118 The second option is to enact a separate stand-alone Act dealing solely with civil compulsory treatment for drug and alcohol abuse. For all the reasons already outlined, a separate Act to deal with this one aspect of treatment would not seem to be warranted when other aspects, which require legislation, will be incorporated into the new legislative framework developed to replace the Misuse of Drugs Act. However, there are some reasons why a separate Act might be preferred. Firstly, the proposed broader legislative framework may take time to progress. A single issue stand-alone bill might in contrast be relatively straightforward and expedient. Secondly, some people may still feel reticent about including this aspect of alcohol and drug treatment in the proposed legislative framework for drugs because, notwithstanding our proposed focus on harm minimisation, that legislation will still be primarily concerned with prohibiting or imposing restrictions on the use of drugs and establishing offences. Drugs legislation has a long association with criminal law and there may be some disquiet about placing a civil regime for compulsory drug and alcohol assessment, detoxification and treatment in that regime.

### *Incorporate into mental health legislation*

16.119 The final option is to extend the coverage of mental health legislation so that it also covers mental disorders resulting solely from substance abuse. Rather than extend the definition of mental disorder and the regime covering mentally disordered people, we envisage a separate regime in a new part of the Mental Health (Compulsory Assessment) Act that would be stand-alone but would access other provisions and mechanisms within the Act to the extent this was appropriate.

16.120 There are some advantages to this option:

- The Act already applies where people have co-existing mental disorder and substance abuse disorders. The Ministry of Health estimates that approximately 30 % of patients who present in crisis to mental health services have co-morbidity mental illness and substance use disorder or dependence. This suggests that treatment for substance abuse could fit within the framework of the Mental Health (Compulsory Assessment and Treatment) Act.
- The Act already contains an appropriate application process for assessment and comprehensive rights protections where people are detained for compulsory assessment and treatment.
- There are other mechanisms within the Act, such as the district inspector regime, that could also be applied to a new regime for compulsory drug and alcohol assessment, detoxification and treatment.

16.121 However, there are important practical issues that need to be considered under this option relating to the configuration and management of services. The implementation would involve significant changes to mental health services. The Ministry of Health takes the view that those suffering from substance addiction have quite distinct treatment needs from people suffering from severe mental disorders which require compulsory assessment and treatment under the Act. Those suffering from severe substance disorders need access to detoxification facilities in the first instance and then access to ongoing drug and alcohol treatment programmes. If people with substance disorders were managed under mental health legislation, this would have quite a significant impact on the way mental health services and resources are currently configured to support the Mental Health (Compulsory Assessment and Treatment) Act. However, the Ministry also acknowledges the reality of co-morbidity and the need for integrated care for those people.

Q161 Which of the options outlined in paragraphs 16.116 to 16.121 do you think provides the best legislative vehicle for any civil regime for compulsory drug and alcohol assessment, detoxification and treatment?





# Appendix



# Appendix

## List of questions

We welcome your views on the following questions, based on the issues discussed in this paper. Please feel free however to make any other comments or submissions in relation to this review. Information on how to make a submission is on our website.

### CHAPTER 8

#### Our proposed approach to drug regulation

- Q1 Do you agree that the model for regulating drugs other than convention drugs should generally be regulation with restrictions, rather than prohibition, but with prohibition available as a last resort where regulation has proved ineffective?
- Q2 Do you agree that a psychoactive substance falling within the ambit of the proposed regime should require an approval from the regulatory body before it can be manufactured or imported?
- Q3 Do you agree that all new psychoactive substances that are manufactured or imported for recreational use should be covered by the proposed new regulatory regime?
- Q4 Do you agree that the following should be standard minimum requirements:
- (a) restrictions on the sale or supply of recreational psychoactive substances to persons under 18 (if so, should the age be changed in the event of a change to the purchase age for alcohol?);
  - (b) advertising restrictions along the lines of the restrictions on advertising tobacco products under the Smoke-free Environments Act;
  - (c) a prohibition on the promotion of these substances similar to that currently applying to restricted substances;
  - (d) a prohibition on the sale of these substances at:
    - (i) places where alcohol is sold;
    - (ii) petrol stations;
    - (iii) non-fixed premises such as vehicles, tents, and mobile street cars;
    - (iv) places where children gather;
    - (v) pharmacies;
  - (e) a prohibition on the manufacture, importation and sale of these substances by any person:
    - (i) under the age of 18 years; or
    - (ii) who has been convicted within the previous five years of a dealing offence

- under the Misuse of Drugs Act or an offence under the Crimes Act punishable by seven years imprisonment; or
- (iii) who has been convicted of an offence under the regime applying to these substances and has been prohibited by the court from undertaking any of these activities;
- (f) a requirement that these substances be stored in child-proof and tamper-proof containers; and
- (g) a requirement that the labels should contain the contact details of the National Poisons Centre?
- Q5 Are there other matters that should become minimum standard requirements?
- Q6 Do you agree that the regulating body should have power to impose additional conditions on an approval for a new recreational psychoactive substance? If so, should the conditions cover:
- (a) additional place of sale restrictions;
- (b) labelling restrictions and requirements;
- (c) packaging restrictions and requirements;
- (d) health warning requirements;
- (e) signage requirements;
- (f) quantity, dosage, form and serving requirements;
- (g) storage and display restrictions;
- (h) record-keeping requirements;
- (i) any other requirements considered necessary or desirable to minimise harm that might occur as a result of use of these products?
- Q7 Should the regulatory body have the power to issue manufacturing codes of practice?
- Q8 Do you agree that there should be a power of recall? If so, in whom should that power vest?
- Q9 Should penalty levels for offences be set at the levels currently provided for in HSNO or should they be set at similar levels to penalties in regimes regulating drugs like alcohol and tobacco?
- Q10 Do you agree that new recreational psychoactive substances should be regulated by a separate regime designed specifically for new recreational psychoactive substances rather than HSNO?
- Q11 Under the proposed separate regime, do you agree that the Minister of Health rather than the Director-General should issue approvals?
- Q12 Is any formal mechanism required to ensure effective coordination between the various regulatory bodies responsible for foods, medicines, hazardous substances and new psychoactive substances?

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**CHAPTER 9      Drug classification system**

- Q13 Do you favour:
- (a) no classes and a single maximum penalty for all drugs;
  - (b) a two-tier classification system;
  - (c) retention of the current three-tier system based on an improved assessment of risk and regular reviews;
  - (d) a more nuanced classification system (four-tier plus) based on a scientifically based drug harm matrix;
  - (e) some other approach? (please specify)
- Q14 Do you agree that there should be separate criteria for the decision to regulate a drug and the decision to classify a drug in order to determine penalty? Is it appropriate to classify drugs on the basis of their risk of harm? If so, should harm include physical harms, dependence potential and social harms? Is prevalence a relevant factor in defining drug harm? Are any other factors relevant?
- Q15 Do you agree that there is a need for an expert committee to advise on drug regulation and drug classification (if a classification system is retained)? Should the committee be independent? Should it have consumer representation? What expertise is required? What is the committee's optimal size?
- Q16 Do you agree that controlled drug analogues should by default be included as Class C drugs, but only on an interim basis so that they can be evaluated and appropriately classified?
- Q17 Do you agree that drug classifications should be made by primary legislation rather than by Order in Council? If so, should there be a requirement for the Minister to table an expert report on drug harms when legislation is introduced?
- Q18 If the Order in Council process is retained, should it be available for reducing classifications as well as increasing them?

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**CHAPTER 10      Dealing**

- Q19 Should the scale of supply rather than whether or not the supply was for profit be the focus of the supply offence?
- Q20 Do you agree that the scale of offending should be treated as a sentencing matter rather than be reflected in the offence?
- Q21 Should social supply be treated differently from other types of supply for all classes of drugs? Should the factors that indicate social supply be broadened as set out in paragraph 10.31?
- Q22 If so, do you agree that social supply should be dealt with as a sentencing matter rather than through the creation of a separate offence?
- Q23 Should there be a presumption against imprisonment in cases of social supply?

- Q24 Should the current maximum penalties for the supply of Class A (imprisonment for life) and Class B (14 years imprisonment) drugs be maintained?
- Q25 Do you agree that seven years imprisonment is an appropriate maximum penalty for the supply of Class C drugs?
- Q26 Should there be a presumption in favour of imprisonment for Class A drugs in cases of large-scale commercial offending?
- Q27 Do you agree that the presumption of imprisonment should not extend to Class B and C drugs?
- Q28 Do you agree that, in relation to Class C drugs, supply to those under 18 years of age should be an aggravating factor on sentence rather than a separate and more serious offence?
- Q29 Are any other offences in this area required?
- Q30 Do you agree that the offence of possession for supply should be repealed and replaced with two possession offences: simple possession and aggravated possession (the latter involving a quantity that is indicative of supply)?
- Q31 If not, which of the following options do you favour:
- (a) remove the presumption;
  - (b) establish an evidential presumption;
  - (c) retain the presumption at its current levels; or
  - (d) retain the presumption, but set at levels that are more likely to be found justified under the Bill of Rights Act?
- Q32 If the offence of possession for supply is retained, do you agree that there should be a single offence and a presumption against imprisonment where the possession is for the purpose of social supply?
- Q33 What should the maximum penalties for possession for supply be?
- Q34 Do you agree that:
- (a) there should be a single offence, with scale of offending dealt with as a sentencing matter; and
  - (b) importation, exportation, production, manufacture and cultivation should have the same maximum penalty as supply?
- Q35 Do you agree that importation, exportation, production, manufacture and cultivation for personal use or for social supply should be distinguished from other forms of dealing?
- Q36 If so, is a presumption against imprisonment the most appropriate way to make this distinction?
- Q37 Do the maximum penalties for these offences need to be revised?

- Q38 Do you agree that the presumption of imprisonment for importation, exportation, production, manufacture and cultivation of Class A drugs should be excluded where the offending is for the purposes of personal use or social supply?
- Q39 Do you agree that “administering” should be made a separate offence rather than continuing to be grouped with supply?
- Q40 If the former, do you agree that the maximum penalty should be two years imprisonment? If not, what should it be?

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## CHAPTER 11 Personal use

- Q41 Should there continue to be a criminal offence for drug use?
- Q42 If so, should that offence encompass all drug use or only use in specified circumstances?
- Q43 What circumstances, other than those identified in paragraph 11.10, could be considered an “aggravated” form of use?
- Q44 Should the possession of utensils for the purpose of using drugs remain a criminal offence?
- Q45 Do you agree that a new enforcement approach should be taken to personal use offences?
- Q46 If so, should there be a cautioning regime (option 1), an infringement regime (option 2) or an approach based on a menu of options (option 3)? Why?
- Q47 Would you change any of the proposed key components of options 1 to 3?
- Q48 Should any other options be considered (including any from Table Three that we propose not be progressed)?
- Q49 How should any new approach taken to personal use offences apply to the offence of possession?
- Q50 If use remains a criminal offence, should “aggravated” use be excluded from any new approach taken to personal use offences?
- Q51 Should the possession of utensils for the purpose of using drugs, if it remains a criminal offence, be included in any new approach taken to personal use offences?
- Q52 Should cultivation of a prohibited plant for personal use be included within any new approach taken to personal use offences?
- Q53 Do you agree that the manufacture, production, and import or export of drugs for personal use should not be included in any regime that is applied to other personal use offences?
- Q54 Do you agree that the approach that is taken to personal use offences committed by adults should not be extended to personal use offences committed by youth?



- Q55 Should any new approach taken to personal use offences be reviewed after a specified period?
- Q56 Where prosecutions are initiated for personal use should any of the following options apply:
- (a) greater use of Police Adult Diversion Scheme;
  - (b) less severe penalties;
  - (c) court-based diversion into assessment and treatment?
- Why?
- Q57 Should any other options be considered?

## CHAPTER 12

### Other offences and penalties, and procedural provisions

- Q58 Do you agree that precursor substances should not be able to be classified as both precursor substances and controlled drugs?
- Q59 Should precursor substances always be classified as controlled drugs in themselves when they are largely or solely used for illegitimate purposes? Is there a need to clarify that the indirect harms they cause should be taken into account in determining their appropriate classification level?
- Q60 Are there any matters relating to precursor substances that could be usefully addressed as part of the Law Commission's review, rather than by the working group established under the Government's methamphetamine action plan?
- Q61 Is an offence prohibiting the supply and import of utensils still required?
- Q62 If an offence of prohibiting the supply and import of utensils is required:
- (a) Do you agree that it should be in primary legislation, rather than be established via a regulation-making power?
  - (b) Should the offence be broadened to cover utensils for using other drugs as well as cannabis and methamphetamine?
- Q63 If an offence is not required, should the supply and import of utensils be regulated? If so, what regulatory controls are required?
- Q64 Should the offence in section 12(1) of the Misuse of Drugs Act of knowingly permitting any premises, vessel etc to be used for the purpose of committing an offence be retained?
- Q65 Are any amendments required to the offences in paragraphs 12.25 (b) and (c) (sections 12A(1)(a) and 12A(2)(a))?
- Q66 Should the maximum penalties for the offences referred to in Q64 and 65 be revised? If so, what should they be?
- Q67 Do you agree that extra-territorial jurisdiction under section 12C should extend to those "ordinarily resident" in New Zealand?
- Q68 Are any other changes to section 12C required?

- Q69 Should the maximum penalties for section 10 be reviewed, to ensure appropriate relativities with acts or omissions committed in New Zealand?
- Q70 Are any other changes to section 10 required?
- Q71 Are any changes to section 12B required?
- Q72 Should section 11 be retained?
- Q73 Should section 13(1)(b) be retained?
- Q74 Are any changes to section 13(1)(b) required?
- Q75 Should it continue to be an offence for a person to make a false statement for the purposes of obtaining a licence under the Act (section 15)?
- Q76 In what other circumstances under the Act should it be an offence for a person to make a false statement?
- Q77 In the light of the recommendations outlined in paragraph 12.59, do you agree that no additional offence is required to impose liability on those who expose children to the harms of drug manufacture?
- Q78 Are any new offences required?
- Q79 Should the general maximum penalty contained in section 27 be reviewed?
- Q80 Bearing in mind that the scope of the offences to which the general maximum penalty will apply is not yet clear, do you have a view on what the maximum penalty should be?
- Q81 Do you agree that a minimum four-year limitation period (contained in section 28) is not required for drugs offences?
- Q82 Do you agree that the limitation periods should not differ from the limitation periods for general criminal offences? If not, what is it about drugs offences that require limitation periods to be different?
- Q83 Do you agree that section 17(1) should be retained?
- Q84 If section 17(1) is retained, should there be a lower maximum penalty when section 17(1) applies due to negligence?
- Q85 Do you agree that section 17(2) should be retained?
- Q86 If section 17(2) is retained, should there be a lower maximum penalty when section 17(2) applies due to negligence?
- Q87 Do you agree that section 29B should be retained?
- Q88 Are any amendments to section 29B required?
- Q89 Do you agree that section 31 should be retained?
- Q90 Are any amendments to section 31 required?

- Q91 Do you agree that the evidential onus in paragraph 12.97(a) (section 12AC(4)), requiring the defence to point to evidence that the defendant had a reasonable excuse for importing or exporting a precursor substance, does not need to be explicitly stated?
- Q92 Should the evidential onuses in paragraphs 12.97(b) and (c) (sections 12B(8) and 12C(5)), requiring the defence to point to evidence that the act (or omission) was not an offence in the country where it occurred, be explicitly stated?
- Q93 Should the requirement remain that where an offence involves possession (whether as the alleged offence itself or as an element of the offence), the amount possessed must be of a usable quantity?
- Q94 If the requirement identified in Q93 does remain, should there be an evidential onus on the defence to raise the issue?
- Q95 If the proposal to require the defence in all cases to identify the issues in dispute is implemented, do you agree that the procedural provisions that give the prosecution additional opportunity to respond to the usable quantity issue once raised should be abolished?
- Q96 Should the legal onus in section 30 be retained?
- Q97 If so, should there also be a legal onus in section 12AC?
- Q98 Do you agree that the legal onus on the defendant in section 29C should be retained?
- Q99 When a defendant is charged with the possession of a seed or fruit, or cultivation of a prohibited plant, should there be a legal onus on the defendant to prove that:
- (a) the seed, fruit, or plant was not of the species *Papaver somniferum*; or
  - (b) the seed, fruit, or plant 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?
- Q100 Do you agree that section 29 should be retained?
- Q101 Do you agree that the forfeiture regime in the Misuse of Drugs Act, as it relates to the forfeiture of profits, should be abolished?
- Q102 Do you agree that the provisions in the Misuse of Drugs Amendment Act 1978, which enable the court to indirectly recover the proceeds of drug dealing, should be repealed?
- Q103 Do you agree that the Misuse of Drugs Act forfeiture regime, as it relates to vehicles and other conveyances, should be abolished?
- Q104 Do you agree that there should be a requirement that a judge order the forfeiture and destruction of unlawful articles following conviction for any drug offence?
- Q105 Do you agree that the forfeiture of unlawful items should not be taken into account in an offender's sentence?

- Q106 Do you agree with our proposed approach to forfeiture, outlined in paragraph 12.153, in the event that a new approach is taken to dealing with personal use offences?
- Q107 Should a statutory provision be introduced allowing enforcement agencies to retain a representative sample of seized articles and to dispose of the remainder?
- Q108 Do you agree that there does not need to be separate provision for forfeiting lawful articles used in the commission of an offence under section 12 of the Misuse of Drugs Act?
- Q109 Do you agree that the provisions in the Misuse of Drugs Act that provide immunity from liability for those acting under, or enforcing, the Act should be retained?
- Q110 Should the extradition provisions in the Act be retained?
- Q111 Are any amendments to the extradition provisions required?
- Q112 Do you agree that section 33 should be repealed, so that:
- (a) the notification of convictions under the Misuse of Drugs Act of a medical practitioner, pharmacist, dentist, midwife or designated prescriber is left to section 67 of the Health Practitioners Competence Assurance Act 2003;
  - (b) the notification of convictions of veterinarians under the Misuse of Drugs Act is the subject of a separate provision in the Veterinarians Act 2005?
- Q113 Do you agree that section 21 should be repealed?

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## CHAPTER 13 Exemptions to prohibition

- Q114 Do you agree that the main components of the licensing scheme should be in the Act?
- Q115 Do you agree that the Director-General of Health should continue to be the licensing authority?
- Q116 Do you agree that the Minister of Health should not be involved in individual licensing decisions?
- Q117 Do some health professionals need exemptions that permit them to manufacture and produce controlled drugs?
- Q118 Should District Health Boards and other certified hospitals be authorised to hold general supplies of controlled drugs for the purposes of treating patients as practicality dictates?
- Q119 Should any other institutions also be authorised to hold general supplies of controlled drugs for the purposes of treating their patients?
- Q120 Are all of the current exemptions in section 8 still needed? Are any other exemptions needed?

- Q121 Are all of the exemptions currently in regulations still needed or are some obsolete? Are any new exemptions needed?
- Q122 Do you agree that the exemptions should in principle be in the Act and that more limited regulation-making powers that authorise exemptions only for a limited time to deal with emergencies would be appropriate?
- Q123 Do you agree that the exemptions that apply to controlled drugs should all be in one Act (with appropriate cross-references)?
- Q124 Do you agree that section 20 should be repealed or should a more confined version of section 20 be retained under which medical officers of health can publish (in a limited way) information about people suspected of being drug seekers?
- Q125 If it is retained, do you agree that it should only apply to drug seeking behaviour and that the person who is the subject of the statement should have an opportunity to challenge any statement?
- Q126 Do you agree that medical officers of health should continue to have the power to issue notices imposing restrictions on the supply of controlled drugs to restricted persons?
- Q127 If so, do you agree that the test in section 49 of the Medicines Act, which sets a lower threshold, would be a better test to use?
- Q128 Do you agree that the offence of supplying or prescribing a controlled drug to a person in contravention of a restricted person notice should be repealed?
- Q129 Do you agree that section 23 should be repealed?
- Q130 Overall, do you think that the legislative controls that are in place are adequate? If not, what further legislative controls do you think are necessary?
- Q131 Do the legislative controls that are in place provide adequate support for professional education and guidance and appropriate monitoring systems? If not, what changes do you think are necessary?
- Q132 Is section 24 too restrictive? If so, what changes are needed?
- Q133 Do you agree that a provision allowing the Minister of Health to impose restrictions on exemptions to deal with unanticipated and urgent safety issues should be retained?
- Q134 Should the Minister of Health's approval be required before certain controlled drugs can be supplied or used?
- Q135 Do you agree that the law should authorise the medicinal use of cannabis by people suffering from a chronic or debilitating illness?
- Q136 If a medicinal cannabis scheme is established, which of the three cultivation options outlined in paragraphs 13.105 to 13.121 do you think would be best?

- Q137 If a medicinal cannabis scheme is established, which of the three prescribing and supply approaches discussed in paragraphs 13.123 to 13.128 would be best?
- Q138 If a medicinal cannabis scheme is established, should specific conditions for which cannabis can be prescribed be specified by legislation or should medical practitioners determine the circumstances in which it might be used?

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## CHAPTER 14    **Enforcement**

- Q139 Do you agree that the circumstances in which a person may be detained by reason of internal concealment of drugs should be limited to situations where the person is suspected of concealing for the purposes of a drug dealing offence?
- Q140 Do you agree that the maximum period of detention for internal concealment should not be extended beyond 21 days?
- Q141 Do you agree that the requirement for a person to consent to an examination under section 13C should be retained?
- Q142 Do you agree that the law should permit the use of a wider range of medical imaging techniques and technologies in relation to internally concealed drugs?
- Q143 Do you agree that the current section 19 inspection power should be retained and made subject to the generic regime in the Search and Surveillance Bill?
- Q144 Do you agree that a power to enter premises, inspect documents, and take samples of substances is required for the purpose of monitoring compliance with any approvals given under our proposed regime for non-convention drugs (discussed in chapter 8)?

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## CHAPTER 15    **Achieving balance in drug policy**

- Q145 Should greater use be made of treatment as a disposition option within the courts for people with alcohol and other drug dependence and abuse problems? If so, how?
- Q146 Do you think that the new legislative framework should allow for additional problem limitation measures to be adopted by regulation?
- Q147 Do you agree that additional reporting requirements or the establishment of an advisory committee with policy, accountability, and advocacy functions for drugs and alcohol would have insufficient benefit to justify the cost? If not, what benefits would there be?
- Q148 Do you agree that the development of a blueprint for drug and alcohol and other addiction service delivery could provide a practical way of significantly increasing the emphasis on treatment?
- Q149 What else might be done to provide greater support for demand reduction and problem limitation measures?



- Q150 Do you agree that a regime allowing civil committal for the detention and treatment of alcohol and drug dependence should be retained?
- Q151 If civil committal for the detention and treatment of alcohol and drug dependence is retained, do you agree with the key features and safeguards outlined in paragraph 16.103? Are there any others you would add?
- Q152 If a regime for civil detention and treatment is retained, should there be an offence of escaping from an institution as discussed in paragraphs 16.58 to 16.60?
- Q153 Do you agree that alcohol and drug treatment facilities operating within a new regime should, as discussed in paragraph 16.53, be certified by the Director-General of Health under the Health and Disability Services (Safety) Act 2001 in the same way as other health care providers?
- Q154 Do you agree that the threshold for compulsion should be:
- (a) that the person has a “dependence” on alcohol or other drugs; and
  - (b) detention and treatment is necessary to protect the person from significant harm; and
  - (c) the person is likely to benefit from treatment for his or her alcohol or drug dependence but has refused treatment; and
  - (d) no other appropriate and less restrictive means are reasonably available for dealing with the person.
- “Dependence” means that a person has:
- (i) a tolerance to a substance; and
  - (ii) shows withdrawal symptoms when he or she reduces the level or stops using the substance; and
  - (iii) has a substantially impaired capacity to make decisions about his or her substance use and personal welfare due primarily to his or her dependence on the substance.
- Q155 If you do not agree with the approach we have set out in Q154, what criteria do you suggest?
- Q156 Do you agree that people should not be able to be detained on the grounds that they are unable to care for themselves when detention is not necessary to protect them from significant harm?
- Q157 Do you agree that people should not be able to be detained on the grounds that they are perceived to pose a serious danger to others?

- Q158 Do you think that the legislation should, like the Drug and Alcohol Treatment Act 2007 (NSW), set a maximum period for detention? If so, what should the maximum be?
- Q159 Should provision be made allowing the courts to extend this? If so, for how long and on what grounds?
- Q160 Should provision be made for community-based treatment orders?
- Q161 Which of the options outlined in paragraphs 16.116 to 16.121 do you think provides the best legislative vehicle for any civil regime for compulsory drug and alcohol assessment, detoxification and treatment?



