Inquiry into the public health strategies related to cannabis use and the most appropriate legal status

Report of the Health Committee

Forty-seventh Parliament
(Steve Chadwick, Chairperson)
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- that it note the heavy use of cannabis by 18 to 24-year-olds, and the trend to increasing use by 15 to 17-year-olds—in particular young women—and develop policy to reverse this trend. (Page 13)
- that it adopt an all-of-Government approach to enhance the quality, and ensure the accuracy, of youth-appropriate health messages. (Page 17)

Research

- that the Institute of Environmental Science and Research Limited (ESR) undertake survey work to establish the level of THC in artificially grown cannabis in New Zealand. (Page 15)
- that it require the ESR to test all suicide referrals for traces of all illegal drugs and alcohol, including cannabinoids, in order to further investigate the extent of the relationship between cannabis use and suicide in New Zealand. (Page 18)
- that the ESR develop a mechanism by which impairment by cannabis could be detected. (Page 25)
- that the ESR test all people killed in road accidents for traces of all illegal drugs and alcohol, including cannabinoids. (Page 25)
- that it undertake research into the effectiveness of community action programmes in New Zealand. (Page 43)
- that the Ministry of Education conduct research into school stand-downs, suspensions, and expulsions as a result of incidents involving cannabis. (Page 47)

Health programmes and education

- that it commit to ongoing funding for the community action programmes and community-based education programmes, on the basis of evidence-based outcomes. (Page 43)

- that there be continued delivery of effective programmes that take into account cultural perspectives to minimise cannabis and alcohol-related harm, on the basis of evidence-based outcomes and conditional on successful project evaluations. (Page 45)
- that programmes with a specific cultural orientation be expanded to encompass other cultural groups in New Zealand. (Page 45)
- that it note our concern that most young people who use cannabis do so in an environment that is not conducive to well-informed decision-making, and ensure that useful information is readily available. (Page 47)
- that drug and alcohol education be an integral and ongoing part of the health curriculum. (Page 47)
- that the Ministry of Education examine how best to support schools and students in responding to cannabis use in a way that preserves educational opportunities. (Page 47)
- that it ensure provision of harm reduction information designed to minimise lung damage resulting from the smoking of cannabis. (Page 21)

Legal status

- that the Expert Advisory Committee on Drugs give a high priority to its reconsideration of the classification of cannabis. (Page 49)
- that it pursue the possibility of supporting the prescription of clinically tested cannabis products for medicinal purposes. (Page 57)

Policing and diversion

- that it follow up the allegations that the police discriminate against Māori as highlighted in the Christchurch Health and Development Study (CHDS). (Page 29)
- that the Ministry of Justice consider the content of this report as part of its review of the eligibility criteria for legal aid as set out in the Legal Services Act 2000 and the Legal Services Regulations 2000. (Page 36)
- that it consider diverting minor cannabis offenders into compulsory health assessment for first possession and use offences, rather than a criminal conviction. (Page 66)
- that the Police expand the diversion scheme for cannabis offences, and apply diversion consistently in all parts of New Zealand so that fewer minor cannabis offences are prosecuted through the courts. (Page 66)
- that the Police examine procedures relating to diversion for cannabis offences in order to determine how greater consistency and fairness might be achieved. (Page 66)

Summary of recommendations to the House

The Health Committee makes the following recommendations to the House:

- that the Justice and Electoral Committee consider the use of search without warrant powers by police under the Misuse of Drugs Act 1975. (Page 36)
- that the Justice and Electoral Committee consider an appropriate legal status for cannabis. (Page 9)

Conduct of the inquiry

In 1998, the Health Committee of the 45th Parliament conducted an inquiry into the mental health effects of cannabis, and made 18 recommendations to the Government. One recommendation suggested that the Government review the appropriateness of existing policy on cannabis and its use and reconsider the legal status of cannabis.[1]

Partly in response to this, in late 2000 the Health Committee of the 46th Parliament (the previous committee) resolved to initiate an inquiry into public health strategies related to cannabis use and, as a result, the most appropriate legal status. That committee received more than 500 submissions, nearly 200 of which were heard by the committee at hearings in Wellington, Auckland, Christchurch, Dunedin, Hamilton, and Paihia between May and November 2001.

The previous committee was not able to complete its inquiry before the 46th Parliament was dissolved. We resolved to resume the inquiry with the same terms of reference and using the evidence heard during the previous parliamentary term for the purposes of completing the report. Only three members of this committee were involved in the previous inquiry: Steve Chadwick, Dr Lynda Scott, and Nandor Tanczos. We have relied on their experience in producing this report.

Terms of reference

The Health Committee of the 46th Parliament established the following terms of reference for its inquiry:

> To inquire into the most effective public health and health promotion strategies to minimise the use of and harm associated with cannabis and consequently the most appropriate legal status of cannabis.

Overview of submissions

In addition to the 552 written submissions, the previous committee sought and received nine expert submissions. The previous committee also received 1,978 'form' submissions, which stated that a public health perspective should replace a criminal justice approach to cannabis. These were not included in our analysis of substantive submissions (see Appendix C). Written submissions were received from a variety of sources. Four hundred and thirty-nine of the total submissions received were from individuals. The remaining submissions were from community, health, political and educational organisations, church and religious groups, experts, and others. A range of views were expressed, and the major themes recurring during the hearings are discussed in the relevant sections below.

Findings

We have considered the public health impact of cannabis use, and made several recommendations about the most appropriate public health strategies to deal with this issue. We agree that the aim of cannabis legislation needs to be focused on preventing young people from using cannabis, and protecting them from the harms associated with

1 Inquiry into the Mental Health Effects of Cannabis, Report of the Health Committee, 1998, *AJHR*, I.6A, p. 5.

use of this controlled drug. However, we have not been able to agree on the most appropriate legal status for cannabis, and have made our separate recommendations regarding the best legislative options in the relevant sections of the text. Some of us think that the Justice and Electoral Committee should further consider the issue of the most appropriate legal status for cannabis.

Recommendation

1. We recommend to the House that the Justice and Electoral Committee consider an appropriate legal status for cannabis.

Structure of the report

This report is divided into three parts. Part 1 provides background information relating to the use of cannabis in New Zealand, the public health impacts of cannabis use, cannabis use among Māori, and the cannabis economy. This part also contains information on the enforcement of the current prohibition regime, including police resourcing and police powers, which impact significantly on minor cannabis offenders.

In Part 2, current and prospective public health and health promotion strategies to minimise the use of and harm associated with cannabis are outlined. This part focuses on community action programmes, Māori-controlled initiatives and school-based drug education programmes.

Part 3 relates to the legal status of cannabis in New Zealand. It discusses the international drug conventions New Zealand is party to, current drug policy in New Zealand, the legislative options for cannabis, and cannabis policy in overseas jurisdictions.

Submitters' views on the preferred legal status of cannabis, as well as other issues raised during this inquiry, are discussed in the relevant sections of the report.

Abbreviations used in this report

APHRU	Alcohol and Public Health Research Unit (Auckland University)
Whariki	Māori Health Research Group working in partnership with APHRU
CHDS	Christchurch Health and Development Study
LTSA	Land Transport Safety Authority
ESR	Institute of Environmental Science and Research Limited
NDARC	National Drug and Alcohol Research Centre (University of New South Wales)

Definition of terms

Cannabis	Generic name given to several different preparations of the plant species cannabis sativa and cannabis indica.
THC	Delta-9-tetrahydrocannabinol—the primary psychoactive ingredient in cannabis.
Marijuana	Dried leaves, flowering tops and small stalks of the cannabis plant.
Hashish	Dried resin and compressed flowers of the cannabis plant. Concentrated and pressed into small slabs or blocks.
Hash oil	Viscous oil derived from cannabis by solvent extraction. Higher potency than other preparations.
Hydroponics	Horticultural method of producing very high potency plants under artificial conditions.
Skunk	Along with other types of dwarf marijuana, skunk is often grown indoors using hydroponic horticultural techniques. Generally more potent than marijuana from standard sized plants.
Bong	Water pipe for smoking cannabis. Use of a bong cools the smoke before inhalation and limits the loss of cannabis through side stream smoke (includes an inhalation hose and has two or more holes).

Degrees of cannabis use

Definitions related to the degree of cannabis usage vary. In 1998, an Alcohol and Public Health Research Unit (APHRU) report completed by the Whariki Māori Health Research Group defined a 'light user' as someone who had used cannabis in the past 12 months; a 'moderate user' as someone who had used cannabis in the past 30 days; and a 'heavy user' as someone who had used cannabis at least 10 times in the past month.[2]

The APHRU's national surveys comparison (2002) also defines 'current users' as those who have used cannabis in the past year and not stopped, and 'more frequent users' as people who have used cannabis 10 or more times in the past month.[3] There are other terms used by health specialists to define the extent of cannabis use. For example, the Royal College of Australian and New Zealand Psychiatrists cites research that refers to 'heavy' use (at least daily) and 'chronic' use (more than 10 years) of cannabis. The Institute of Environmental Science and Research Limited (ESR) recognises 'moderate' (four times a week), 'heavy' (daily), and 'heavy chronic' (more than five joints a day) in its screening for metabolites of the active ingredient THC excreted in urine.

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2 *Te Ao Taru Kino - Drug Use Among Māori, 1998*, Alcohol and Public Health Research Unit, University of Auckland, March 2000, p. 26.

3 *Drug Use in New Zealand National Surveys Comparison 1998 & 2001*, Alcohol and Public Health Research Unit, University of Auckland, May 2002, pp. 8-9.

Acute and chronic effects of cannabis use

The literature distinguishes between potential:

- acute effects—acting while the drug is in the system, or from a single dose of the drug. These are generally short-term effects.

- chronic effects—occurring after a period of regular use (for example, daily) over a long time period (for example, years or decades). In other words, long-term effects from frequent and heavy use.

Examples of potential acute and chronic effects of cannabis use are described in the section 'Effects of cannabis use' in Part 1 (page 15). Another distinction to consider is that cannabis use may pose risks to users themselves; to other people, for example if the user is operating machinery while intoxicated; or to both, for example consumption by a pregnant woman having health effects for both mother and unborn child.

Part 1 Background information

Patterns of cannabis use in New Zealand

Cannabis is currently the third most popular drug used in New Zealand, after alcohol and tobacco. Next to alcohol, cannabis is the most commonly used psychoactive (mood-altering) recreational drug in New Zealand excluding caffeine and tobacco. It is widely used for its euphoric effect. The prevalence of cannabis in New Zealand is comparable with that of the United States of America, but it is lower than in Australia and higher than in the Netherlands.

The most recent statistical analysis related to cannabis use in New Zealand is the Alcohol and Public Health Research Unit's *Drug Use in New Zealand National Surveys Comparison 1998 & 2001* published in May 2002. The findings are based on random national samples of approximately 5,500 people aged 15 to 45, who were interviewed about their use of alcohol, tobacco, cannabis, and other drugs, using a computer-assisted telephone interviewing system. The analysis includes the findings on the use of cannabis (marijuana, including skunk), hashish, and hash oil in New Zealand.

Light and current use of cannabis

The survey results indicated that 69 percent of those interviewed who admitted to having tried cannabis had stopped using the drug. The number of 15 to 45-year-old New Zealanders who admitted to having tried cannabis increased slightly from 50 percent of the sample in 1998 to 52 percent of people interviewed in 2001. This compares with 40 percent in 1990. Both the 1998 and 2001 results reflect that 20 percent of interviewees admitted to using cannabis in the 12 months prior to the survey, and 15 percent stated that they were current users.[4] The surveys comparison indicated an increase—from 44 percent to 50 percent—among the 40 to 45-year-old group for men and women who reported having tried cannabis. Women aged 15 to 17 years who admitted to having tried cannabis increased from 26 percent in 1998 to 38 percent in 2001. The number in this age group who admitted to having used cannabis in the past month also increased from 6 percent in 1998 to 15 percent in 2001.

Frequent and heavy use of cannabis

The surveys comparison indicates that the heaviest users of cannabis continue to be 18 to 24-year-old men and women, with a marked increase in cannabis use by young women aged 15 to 17 years. There was an increase in the number of young people aged 15 to 17 years who admitted to using cannabis 10 or more times in the past month, from 1 percent of the sample in 1998 to 4 percent in 2001. This was due mainly to a reported increase in cannabis use by young women in this age group, from 0 percent to 4 percent. The highest average number of joints smoked by age group was found in the 15 to 17-year-old age group in both surveys, although there was actually a slight overall decrease between 1998 (0.87 joints) and 2001 (0.83 joints). There were strong feelings among submitters about the harm to youth resulting from cannabis use, and support for a clearly defined age limit was almost unanimous.

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4 Current users were defined as those who had used cannabis in the past year and not stopped.

Age cannabis first used

In 2001, by age 15 years, 30 percent of those who admitted to having tried cannabis had started using it. There was no change in the age of first use of cannabis between the surveys. The sharpest increases occurred at ages 15, 16, 17, and 18 years old, with 14 percent, 15 percent, 13 percent, and 16 percent reporting first starting using cannabis at these ages respectively. The results indicate that a significant proportion of New Zealanders have used cannabis at a young, formative age.[5]

Driving under the influence of cannabis

In 2001, people who had used cannabis in the 12 months prior to being interviewed were asked how much of their driving they did while under the influence of cannabis. Responses indicated that this was fairly rare. However, the number who reported having used cannabis in the past year and who drove under the influence of cannabis increased between 1998 and 2001, and the increase was especially notable among young people. The number of people who stated they never drove under the influence fell from 67 percent in 1998 to 59 percent in 2001 (in the 15 to 17-year-old group, the fall was from 84 percent in 1998 to 65 percent in 2001).

Community concerns about cannabis

Community concerns about cannabis use do not appear to have changed much over the decade, with cannabis rated as the fifth most serious drug issue, after alcohol, solvents, other illegal drugs, and tobacco. However, cannabis had come to be perceived as a more serious problem by the end of the 1990s, especially among the 15 to 17-year-old age group. Older age groups were less concerned about cannabis, regarding regular cigarette smoking as more risky than regular cannabis smoking. There were no significant changes in the perception of alcohol and cannabis as community problems from 1998 to 2001.[6]

We recognise the difficulty of establishing an accurate profile of cannabis use through telephone surveying when operating under a prohibition policy. The authors of the APHRU national surveys comparison admit that it is likely that the results from any survey of drug usage in a general population will underestimate the true number of users to some extent. Illicit drug users are particularly hard to reach for research purposes, and therefore the actual prevalence of use could be higher than shown by these survey results.

Recommendations

2. We recommend to the Government that it take a leading role in promoting the message that young people should not use cannabis.

3. We recommend to the Government that it note the heavy use of cannabis by 18 to 24-year-olds, and the trend to increasing use by 15 to 17-year-olds—in particular young women—and develop policy to reverse this trend.

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5 APHRU submission, p. 12.

6 *Drug Use in New Zealand National Surveys Comparison 1998 & 2001*, pp. 12-13; APHRU submission, p. 12.

Potency of cannabis

Cannabis is mainly used in New Zealand in the form of cannabis (marijuana, including skunk), hashish, and hash oil. The APHRU submission notes that over the past 20 years, analyses of cannabis grown in New Zealand have found levels of the active ingredient delta-9-tetrahydrocannabinol (THC) ranging from 3.5 to 5 percent potency. The hydroponic samples of cannabis, which comprise a very small amount of the cannabis analysed, have recorded THC at levels between 5 and 9 percent.

The ESR has concluded that there is no evidence of a significant general increase in cannabis potency over the past 25 years. An Australian study concurs with this view. However, the ESR recognises the limitations on the data available, which was gathered from intermittent analyses over this period.

The ESR study (1976 to 1996) analysed cannabis plant and cannabis oil from two sources: police seizures from users, dealers, manufacturers, and growers, known as case seizures; and the Police National Cannabis Recovery Operation. The ESR notes that although the average potency of the cannabis crop may not have changed significantly over this period, it could be argued that the quality and potency of the plant material being consumed has on average improved through user selection of hash oil. There has been a proliferation of crude hash oil laboratories in New Zealand, aiming to add value to low-potency cannabis leaf and stalk by processing this into cannabis oil. According to ESR research, hash oil potency itself is significantly lower now than it was 10 to 15 years ago when the bulk of it was imported. The range of THC for New Zealand-manufactured hash oil samples is wide, from 0.1 percent (less potent than leaf) up to 67 percent, but the average is currently between 12 and 14 percent.

Table 1: ESR analysis of cannabis potency in New Zealand

Cannabis leaf 1976 to 1996	1.0% to 1.6% THC
Female flowering heads 1976 to 1996	2.5% to 3.8% THC (some cases of 10% THC)
Hash oil 1983 to 1995	10% to 23% THC (average)

Although the potency of cannabis grown outdoors does not appear to have changed over the survey period, the ESR highlights that very high potency plants may be produced in New Zealand under artificial conditions, using hydroponics, atmosphere control, and artificial lighting. The ESR states that there is a glaring omission in the available data on yields and potency of cannabis grown under artificial conditions in New Zealand. There are reports from overseas, particularly the Netherlands, of the appearance of strains of cannabis containing very high levels of THC (in excess of 20 percent). The ESR believes that in principle this could also be true for New Zealand, since the horticultural expertise is clearly available, and sophisticated hydroponic set-ups have already been detected. The ESR continues to test samples of cannabis seized by police, but it is not currently undertaking any survey work into the potency of cannabis. The Police National Cannabis Recovery Operation is no longer available as a source of plant material for survey purposes, since it was replaced by aerial spraying operations.

Some of us are concerned that there is potential for cannabis grown hydroponically to reach very high levels of potency, and we would like to see the ESR resume its survey work to establish the actual levels of THC in artificially grown cannabis in New Zealand.

Recommendation

4. We recommend to the Government that the Institute of Environmental Science and Research Limited (ESR) undertake survey work to establish the level of THC in artificially grown cannabis in New Zealand.

Findings on cannabis-related harm

Cannabis dependency

Overseas data indicates that an estimated 10 percent of regular cannabis users develop substance dependence disorder, a recognised mental illness. The current understanding is that the dependence is a psychological dependency rather than a physical addiction. In New Zealand, a 1999 Ministry of Health estimate is that nearly 20 percent of the population will suffer an alcohol use disorder, around 6 percent will meet the clinical criteria for drug abuse or drug dependence, and some 2 to 3 percent of the population are at serious risk of a cannabis dependence disorder. In 1996, the Ministry of Health reported that cannabis dependence is more likely to occur among users who are also dependent on alcohol.

The Christchurch Health and Development Study (CHDS)—a 21-year longitudinal study of the health, development, and adjustment of a birth cohort of 1,265 children born in urban Christchurch during mid-1977—draws a picture of cannabis as a social drug with common usage among young people. The study emphasises that for the majority of occasional recreational cannabis users there is no evidence to suggest that usage has harmful effects. In summation, the authors state that 'cannabis use is likely to be no more harmful than alcohol use and may very well be shown to be less harmful than alcohol use.' However, for a minority of regular and heavy users, there is evidence of potential harmful effects.

The study identified that one in every 10 young people in the cohort had developed symptoms consistent with cannabis dependence, although it is not clear whether this is indicative of long-term harm. Both the CHDS and the Dunedin Multidisciplinary Health and Development Study indicate that by the age of 21 more than 9 percent of cohort members met criteria for cannabis dependence.[7] These were the groups that also reported cannabis use by age 15. One study (Hall, 1994) estimates that about 9 percent of all cannabis users and about 33 to 50 percent of daily users meet the criteria for dependence at some point.

Effects of cannabis use

Effects of cannabis use can include relaxation, mood elevation, a sense of tranquillity, hilarity, and mood swings. Lethal overdose is almost impossible. However, harmful acute and chronic effects of cannabis use are associated with frequent and heavier use. Potential

7 Nine hundred and forty-three young adults from a birth cohort of 1,037 subjects born in Dunedin in 1972–73 were studied at age 21.

acute effects can include not only cognitive and psychomotor impairment leading to increased risk of injury, loss of short-term memory, and interference with learning, but also brief periods of psychosis. Potential chronic effects can include harm to the central nervous system (neurotoxicity, impaired cognitive functioning and cognitive decline), possible psychosis and exacerbation of schizophrenia in vulnerable individuals, cannabis dependence, and damage to the respiratory, immune and cardiovascular systems. The behavioural effects caused by the active ingredient THC are complex and vary between individuals. They can include sedation, weakness, fatigue, euphoria, a rapid flow of thoughts, feelings of tranquillity, dizziness, dry mouth, appetite stimulation, impairment of perception and memory, analgesia, tachycardia, and a reduction in nausea, vomiting, and intraocular pressure. The Royal College of Australian and New Zealand Psychiatrists cited research that suggests heavy (at least daily) and chronic (more than 10 years) use of cannabis is associated with anxiety, paranoia, depression, and associated adverse motivational and societal issues.

High risk groups

Youth, particularly Māori youth, have been consistently identified in a number of reports in the past decade as a high-risk group with regard to cannabis abuse and cannabis-related harm. Numerous reports and studies indicate a significant level of adolescent use, and identify problems associated with frequent cannabis use by adolescents. Although frequent cannabis use by adolescents may be symptomatic of broader and more complex social issues, it has been linked in much of the literature to truancy and poor performance, impairment in school and behavioural functioning, and a pattern of multiple substance abuse from adolescence to young adulthood. People with co-existing drug use and other mental disorders, polydrug users, and pregnant women have also been identified as being at greater risk of drug-related harm.

Expert submitters' views of cannabis-related harm

While the expert submissions viewed the cannabis issue from different areas of expertise, one theme that emerged was that the risk of cannabis-related harm relates to the extent of use and to vulnerability. The effects of using cannabis vary widely between individuals, and depend on a number of factors, including:

- frequency of use
- method of administration and experience
- the amount and potency of the cannabis
- the individual's body weight.

The ESR stated that blood THC levels are dose dependent; that is, they depend on how potent the cannabis is and how much is absorbed. However, for the 5 to 10 percent of mainly young New Zealanders who use cannabis heavily, various social, mental, and physical harms can result. Those people tend to come from already socially disadvantaged groups and have pre-existing problems. For the majority of occasional cannabis users, there is a low risk of cannabis-related harm.

Recommendation

5. We recommend to the Government that it adopt an all-of-Government approach to enhance the quality, and ensure the accuracy, of youth-appropriate health messages.

Mental illness

The 1998 report on the mental health effects of cannabis by the Health Committee of the 45th Parliament considered the effect of cannabis use on people's development and the role of cannabis as a trigger for mental illness. That committee observed that the linkages between cannabis use and mental illness were not clearly defined. It noted the view of the Mental Health Research Institute of Victoria that 'cannabis may contribute to the early onset of psychosis amongst those who are already predisposed to schizophrenia,' but that scientific evidence had not demonstrated a causal effect; and that permanent brain damage or the development of an amotivational syndrome amongst users was unproven.[8]

Since that time, more evidence has been produced on the subject of mental illness and cannabis, and the current inquiry prompted a number of submissions expressing concern about the potential health effects of cannabis use, such as depression, schizophrenia, paranoia, suicide, anxiety, and personality disorders. Eighty-five submitters were concerned about these adverse mental health effects, and identified children, youth, individuals with a mental health illness or susceptibility to a mental health disorder, and pregnant women as being particularly adversely affected.

Psychosis

The Royal College of Australian and New Zealand Psychiatrists recognises that cannabis psychosis is a contentious issue, and is difficult to prove. While extant research does not appear to substantiate a link between cannabis use and psychosis, the college notes that there are reports of distinct psychosis occurring in heavy cannabis users, commonly paranoid ideation and marked aggression. The psychosis is always brief, however, and there is no evidence that a chronic psychosis is induced by cannabis. The New Zealand Medical Association stated that in susceptible individuals, excessive cannabis use can cause psychosis and other mental illness.

Schizophrenia

The Royal College of Australian and New Zealand Psychiatrists noted that there is no convincing evidence that cannabis use causes schizophrenia. There appears to be only limited evidence that leads to the hypothesis that cannabis abuse and dependence may increase the risk of schizophrenia. The college notes that the possibility that cannabis is an independent cause of schizophrenia cannot be disproven, but the absence of an increased incidence of schizophrenia over the past 30 years, during which time cannabis use has become much more prevalent, is strongly against such a possibility. However, people with pre-existing psychiatric disorders such as schizophrenia are especially vulnerable to the adverse health effects of cannabis use because cannabis generally provokes relapse and aggravates existing symptoms.

8 Inquiry into the Mental Health Effects of Cannabis, Report of the Health Committee, 1998, *AJHR*, I.6A, p. 43.

Cognitive changes

The Royal College of Australian and New Zealand Psychiatrists noted there is no evidence that there is irreversible brain damage from cannabis use. Long-term use does raise concerns about cognitive changes, especially when the use has been heavy and prolonged. However, research into residual cognitive changes after cessation of cannabis use has found only minor deficits or no difference between users and non-users.

Suicide

The Royal College of Australian and New Zealand Psychiatrists noted that studies into the relationship between cannabis use and suicide have not established a clear linkage independent of background social variables and the presence of mental illness. However, acute suicidal feelings, and possibly actions, in susceptible persons may be associated with amine depletion in cannabis users after cannabis ingestion. The findings of the 21-year CHDS suggest that there are significant associations between cannabis use—particularly regular cannabis use—and juvenile delinquency, depression, and suicidal behaviours among the cohort members. The study notes that 'As a general rule, young people reporting at least weekly use of cannabis emerged as being at increased risks of these outcomes.'[9]

The ESR has conducted some toxicological analysis into youth suicide and cannabis use, but the results are inconclusive. Only about one third of all youth suicides each year are received at ESR for toxicological testing, and ESR analyses for cannabis only if requested to do so by the police. In the case of carbon monoxide poisoning—one of the more prevalent methods of youth suicide—ESR is rarely asked to analyse for anything other than carbon monoxide. For mid-1997 to mid-1998, 21 of the 46 cases of youth suicide in the 15 to 24-year age group referred to ESR were for carbon monoxide poisoning. The remaining 25 were screened for a range of drugs including cannabis, and 14 (30.4 percent of all cases referred to ESR, or 56 percent of all cases screened for drugs) tested positive for cannabis. As those results were from people tested because drug use was suspected, we would expect to find high levels of positive results. This does not indicate any relationship between cannabis and suicide.

We recognise the limits on the available data, but we are concerned that the ESR detected traces of cannabis in 14 out of 25 cases screened. We are concerned that the role of cannabis in youth suicide cases may be greater than currently known, and we note the recent coronial findings on this matter. We believe that further investigation is required to establish a more accurate picture of the role of cannabis in all suicides.

Recommendation

6. We recommend to the Government that it require the ESR to test all suicide referrals for traces of all illegal drugs and alcohol, including cannabinoids, in order to further investigate the extent of the relationship between cannabis use and suicide in New Zealand.

9 CHDS submission (A), p. 18.

Behavioural effects

Sixty-seven submitters had concerns related to adverse behavioural effects of cannabis use. Behaviours most frequently stated as having adverse health effects, particularly on young people, included amotivational syndrome, extreme lack of interest, social dislocation, loss of friends, deterioration in schoolwork, and lack of educational achievement. However, Professor Paul Smith of the School of Medical Sciences (Department of Pharmacology and Toxicology) at the University of Otago stated that there is no definite causal link established between cannabis use and amotivational syndrome. In their 1998 submission to the Health Committee of the 45th Parliament, the police noted that although conduct disorders such as truancy, persistent lying, and non-confrontational stealing were associated with adolescent cannabis use, they believed cannabis use was not the cause of these behaviours. Evidence suggests that cannabis use does not cause behavioural difficulties; instead, it is frequently used by youth who are predisposed to deviant behaviours.[10] Many submitters to this inquiry commented that people are less aggressive, more thoughtful, and calmer under the influence of cannabis. Some submitters talked about being very aggressive and abusive until they gave up alcohol for cannabis.

Violence

There is, and has been for a considerable period of time, a debate over whether cannabis use produces violence. The debate appears to date back to at least 1926, when a New Orleans newspaper exposed the 'menace of marijuana', claiming an association between the drug and crime, especially violent crime. We understand that most currently available research demonstrates that this relationship does not exist, and that human violent behaviour is either decreased or unchanged with cannabis administration. The animal literature suggests the same relationship: cannabis tends to foster submissive behaviours and suppress attack and threat behaviours. Some animal studies have noted heightened aggression with cannabis administration, but there is usually a third variable such as sleep deprivation, social seclusion, or pre-treatment with another drug that might account for this result. In contrast, crime studies repeatedly demonstrate the high and significant involvement of alcohol in general violent behaviour.

Respiratory problems

Sixty-seven submitters stated that cannabis causes physically harmful effects to users. The risk of cancer of the respiratory system and respiratory disease were the most frequently mentioned adverse physical effects related to the most common means of consumption—smoking.

Lung damage

One of the major health problems relating to cannabis is that the majority of users ingest it by smoking cannabis cigarettes either consisting of cannabis alone or in combination with tobacco. Professor Smith observed that pure cannabis cigarettes can induce bronchial tumours when smoked, as a result of carcinogens generated as the cannabis burns. This means that smoking cannabis carries a similar risk of lung cancer and other cancers as

10 Inquiry into the Mental Health Effects of Cannabis, Report of the Health Committee, 1998, *AJHR*, I.6A, p. 15.

tobacco. However, it must also be recognised that, with the exception of extremely heavy users, cannabis users tend to smoke less than tobacco smokers.

The Thoracic Society of Australia and New Zealand and the Asthma and Respiratory Foundation of New Zealand in a joint submission said that the short-term health effects of smoking cannabis are identical to those of tobacco smoke: airway inflammation is provoked, and symptoms of acute bronchitis occur. These two bodies, along with the New Zealand Medical Association, stated that the long-term smoking of cannabis can cause lung damage, and that the effect of smoking cannabis is likely to be just as harmful as tobacco smoking. Resultant harm includes the development of chronic bronchitis and emphysema, and possibly lung cancer. However, adequate data to validate this statement will not be available for another 25 to 30 years, given the very slow rate at which these diseases progress.

The Dunedin Multidisciplinary Health and Development Study lends some support to this statement, but it also identifies the need for carefully designed case control studies. The study states that respiratory symptoms in study members who met strict criteria for cannabis dependence, after controlling for the effects of tobacco, were comparable to the effects from smoking one to 10 cigarettes daily.

One overseas study (Tzu-Chin et al, 1988) that compared the pulmonary hazards of smoking cannabis and tobacco concluded that smoking cannabis, regardless of THC content, results in a substantially greater respiratory burden of carbon monoxide and tar than smoking a similar quantity of tobacco. This 1988 study was based on an all-male cohort of 15 habitual smokers of cannabis and tobacco, and found that smoking a joint of cannabis results in a fivefold increase in carbon monoxide levels in the blood, and a threefold increase in the amount of tar substances which are inhaled.

We have serious concerns about the potential long-term pulmonary consequences of habitual smoking of cannabis cigarettes. Although we recognise that comparisons of cannabis and tobacco-related harm to the respiratory tract and lungs may lead to exaggerations of the degree of danger resulting from cannabis use, there is still widespread debate about the harmfulness of cannabis compared to tobacco.

Given the risks associated with inhaling burnt plant matter, we recognise that the use of high-THC cannabis may have the effect of decreasing harm by reducing the amount of smoke inhaled by the user. We further note that the current practice in New Zealand of users holding smoke in to maximise the effect of the THC has been shown to increase risk of lung damage without increasing the high. We encourage the provision of harm reduction information that makes this clear.

Some submitters commented on the use of devices that steam cannabis and vapourise cannabinoids as an alternative to smoking the dried plant. GW Pharmaceuticals, the company developing cannabis-based products for commercial release in the United Kingdom, submitted that smoking is not an acceptable delivery system for a medicine. This submission identified vaporisers, nebulisers, or dry powder inhalers as potential delivery systems for medicinal use.

In our report on the Smoke-free Environments (Enhanced Protection) Amendment Bill, we recommended widening the definition of 'to smoke' to ensure non-tobacco products were covered by the Smoke-free Environments Act 1990. This change recognised that smoke from non-tobacco products is also a public health risk. We consider further information should be made available to the public about the risks of lung damage from smoking cannabis, as is currently done for tobacco.

Recommendation

7. We recommend to the Government that it ensure provision of harm reduction information designed to minimise lung damage resulting from the smoking of cannabis.

Associated harms

A small number of submissions asserted other harmful effects, including a general risk of cancer, negative impact on brain development, retardation in foetal development, hair loss, cataracts, wrinkling, hearing loss, skin cancer, tooth decay, lung ailments, osteoporosis, heart disease, ulcers, cervical cancer, fertility problems, psoriasis, and vascular disease. A small proportion of submissions did not detail the nature of the negative effects of cannabis, but stated or implied that use was harmful per se and should be either discouraged or eliminated. Comments included that New Zealand already has enough problems with managing public health issues and with the costs associated with alcohol and tobacco use, without having to exacerbate these problems by liberalising another drug for people to use.

Other issues that arose in submissions included the likelihood that passive inhalation of cannabis smoke is harmful, cannabis interferes with short-term memory, and cannabis ingested by the mother may have adverse effects on the foetus—although research suggests this is reversible. Professor Smith also commented that the effects of cannabis on the immune system are poorly understood and it is too early to say whether cannabis affects susceptibility to infectious disease.

Well-being

Forty-five submissions stated that cannabis use is beneficial to well-being. These submissions mentioned the sense of relaxation and euphoric effects obtained from cannabis. Some of these submitters make an explicit choice to use cannabis in preference to drinking alcohol or smoking tobacco. Other submitters, notably young people, stated that they prefer to use cannabis, having developed an aversion to alcohol from watching adults using it, and observing its behavioural effects.

The 'gateway' hypothesis

Research on drug use among American adolescents in the 1970s consistently found a regular sequence of initiation into the use of illicit drugs in which cannabis use typically follows alcohol and tobacco use and precedes the use of stimulants and opioids. However, the National Drug and Alcohol Research Centre (NDARC) of the University of New South Wales noted that the interpretation of this sequence of drug initiation remains controversial. While there is some support for the argument that the pharmacological effects of cannabis increase the likelihood of using more hazardous drugs in the sequence, the NDARC states:

> There is better support for two other hypotheses that are not mutually exclusive: (1) that there is a selective recruitment into cannabis use of nonconforming adolescents who have a propensity to use a range of intoxicating substances, including other illicit drugs, and (2) that once recruited to cannabis use, the social interaction with drug using peers and the illicit drug market increases the likelihood of their using other illicit drugs.[11]

The NDARC noted that on the second hypothesis, the relationship between cannabis use and 'harder' drug use arises from the legal status of cannabis rather than its pharmacological effects.

In its submission, the NDARC cited research (Fergusson and Horwood, 1996 and 2000) that has found that adolescents who start cannabis use early and become daily users of cannabis are at higher risk than their non-using peers of using other illicit drugs 'because of their family backgrounds and poor school performance *before they use cannabis*' [emphasis in original]. They are also more likely to keep company with other drug-using peers. Longitudinal studies of cannabis use by adolescents and young adults also show that heavy cannabis use in adolescence predicts an increased risk of using 'harder' drugs that persists after controlling for pre-existing differences between adolescents who do and do not use cannabis.

Of the smaller group of more frequent users in the 21-year CHDS (used cannabis at least 50 times a year, or approximately weekly, for at least one year), 78 percent did go on to try other illicit drugs. When factors that might influence a young person's decision to experiment with drugs were statistically controlled for, those who used cannabis more than 50 times a year were nearly 60 times more likely to try other illicit drugs than young people who had never tried cannabis. These findings suggest that cannabis, when used frequently, may be a 'gateway drug' to other illicit drug use, although whether this is a result of contact with the illegal market or an effect of cannabis use is uncertain. Clearly, there are attitudinal, genetic, and other factors not measured in this study that are influential.[12]

A discussion document (Monograph No. 3, April 2000) prepared for the Drugs and Crime Prevention Committee of the Parliament of Victoria, Australia, reports the findings of Dutch research that while most hard drug users had also used cannabis, the majority of cannabis users had no experience in the use of other illicit drugs, which could be viewed as evidence against the stepping stone theory of drug use.

A review of cannabis-related literature undertaken by the New Zealand Parliamentary Library (2000) notes that in the Netherlands, where private use of cannabis has been decriminalised since 1976, the number of cannabis users treated in drug outpatient clinics is low: in 1996 there were 2,000 patients, or 0.3 percent of the total estimated number of cannabis users. Of these, 42 percent were also having trouble with alcohol or other drugs. Admissions to addiction clinics for treatment of problematic cannabis use were 5 percent

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11 National Drug and Alcohol Research Centre submission, p. 7.

12 The other factors that were measured were aspects of socio-economic background, family functioning, parental adjustment, gender, cognitive ability, adolescent adjustment, peer affiliations, risk taking, and lifestyle. Other factors statistically linked to use of other illicit drugs, but not as strongly as regular cannabis use, were high use of alcohol, sexual risk taking, and greater exposure to adverse life events.

of total admissions; the majority of the addictions involved alcohol and heroin. Further, the Netherlands has fewer hard drug addicts per capita than Italy, Spain, Switzerland, France, Britain, and the United States of America, and fewer young people in the Netherlands are becoming hard drug addicts. This was a stated aim of the Dutch Government's policy of separating the cannabis market from the market for hard drugs.

Cannabis and alcohol compared

The extent of harm related specifically to cannabis use on a population level is difficult to gauge because of a lack of comprehensive data about the extent and consequences of use, due to its illegal status and because its use is often accompanied by alcohol and/or tobacco use. Multiple use of drugs, particularly in association with alcohol, can cause the most serious harms.

The APHRU's *Drug Use in New Zealand National Surveys Comparison 1998 & 2001* found that one in four respondents had tried a combination of drugs. The most common combination in both surveys was alcohol, tobacco and cannabis (25 percent in 1998 and 23 percent in 2001), followed by alcohol and tobacco (18 percent and 17 percent), and then alcohol, tobacco, cannabis, and at least one of the other drugs (16 percent and 18 percent). The report highlights that those who had used cannabis on 10 or more occasions in the past month were also relatively heavy drinkers. The 2001 survey results indicate that 54 percent of frequent cannabis users drank six (for men) or four (for women) drinks in one sitting at least weekly, compared to 26 percent of all drinkers. A similar disparity occurred when looking at reports of feeling drunk. Three-quarters of frequent cannabis users reported feeling drunk at least monthly, compared to 40 percent of drinkers.

Frequent cannabis users who drank heavily reported harmful effects on energy and vitality, financial position, health, and outlook on life. The proportion reporting such effects did not change between 1998 and 2001. However, there were downward trends in the proportions of frequent cannabis users who reported harm to their friendships from their use of cannabis (21 percent in 1998 and 11 percent in 2001), or harm to their health from their use of alcohol (26 percent and 15 percent).[13]

The NDARC submission stated that on current patterns of use, cannabis has a modest public health impact by comparison with that of alcohol and tobacco. This is explained by the much lower prevalence of cannabis than alcohol and tobacco use in developed societies. It is arguable whether this can be counted as a success of prohibition, and even more contentious is the issue of whether the comparative public health impact of alcohol, cannabis and tobacco would change if the legal status of cannabis were to change. The NORML submission highlighted that the World Health Organization and the United States Institute of Medicine both state that cannabis use is less harmful than alcohol or tobacco.[14]

13 *Drug Use in New Zealand National Surveys Comparison 1998 & 2001*, pp. 39-40, pp. 47-48.

14 NORML is the National Organisation for the Reform of Marijuana Laws.

Driving under the influence of cannabis

Driving under the influence of cannabis can cause decreased appreciation of risk and coordination. The risks associated with cannabis use and driving are further enhanced when alcohol has been consumed.

The safety risks associated with driving while under the influence of cannabis were raised by 24 submitters. Eleven submitters highlighted other safety concerns such as the dangers of operating heavy machinery for both cannabis users and their workplace colleagues. Frequently, submitters stated that the current legal status governing cannabis use impedes the education of users as to what might constitute safe and responsible use. Although small in volume, there is a consensus within these submissions that irrespective of any change to the legal status of cannabis, appropriate policies and practices around the safety issues pertinent to driving and workplace safety should be put in place.

The role of cannabis in serious road accidents

Although there have been many studies of the effects of alcohol on driving, very few studies have looked at the role of cannabis in serious road accidents. In 1995, the ESR commenced a 2-year study with the aim of obtaining estimates of the amounts of cannabis in the blood of fatally injured drivers, using blood samples taken post mortem. The study examined 404 drivers killed in road crashes in New Zealand between June 1995 and May 1997 for whom blood samples were available. Of these, 41 percent had alcohol in their blood. Twenty-two percent of all the drivers had THC, the active ingredient of cannabis, in their blood. In addition, two-thirds of those with cannabis in their blood also had detectable levels of alcohol. The ESR believes that this finding suggests a strong association between cannabis use and excessive use of alcohol. Eight percent of all the drivers had only cannabis in their blood. Fifty-two percent of all the drivers had neither cannabis nor alcohol in their blood. Nearly half the cases in which cannabis was detected were at very low levels not traceable in earlier overseas studies. Comparable overseas studies had lower limits of detection of THC in the blood; applying similar tests in New Zealand would have resulted in THC being detected in only 12 percent of the ESR sample. These people were described in the ESR report as having 'used cannabis fairly recently', or 'being heavy users of cannabis'.

According to the Land Transport Safety Authority (LTSA), the findings do not necessarily indicate that drivers were impaired by cannabis at the time of the crash, because traces of cannabis remain in the body long after use. Cannabis may persist as active metabolites in body fluids for more than a day after use of the drug, and as inactive metabolites for weeks, well after any intoxicating effects have disappeared. Further, it is currently not possible to screen for cannabis intoxication as is done for alcohol, because there is no reliable method of relating cannabis metabolites in body fluids to the level of intoxication at the time of sampling the body fluids. Even if the active metabolites are present, there is a high level of uncertainty that the person whose blood sample contains them was actually intoxicated at the time.

Cannabis has consistently been shown in laboratory behavioural studies to impair psychomotor performance on a range of skills related to driving. Impairment is more noticeable in difficult tasks involving sustained attention and is dependent on the amount of the drug taken. The acute effects on performance of typical recreational doses are similar

to, if not smaller than, those of intoxicating doses of alcohol. However, there is evidence that these effects may be compensated for by changes in other behaviours. For instance, people who are intoxicated with cannabis tend to drive more slowly on laboratory simulators, and engage in less risky behaviour, than those intoxicated by alcohol. The Royal Australian and New Zealand College of Psychiatrists notes research findings that cannabinoids derived from herbal cannabis do cause dose-related impairments of psychomotor performance, with implications for car and train driving, aeroplane piloting, and academic performance. The ESR also notes recent Canadian and Australian studies that suggest that cannabis use does not adversely affect driving. Nevertheless, the ESR remains concerned about the proportion of fatally injured drivers in its study who had cannabis in their blood, and recommends a further study of drugs and driving, not least as a baseline comparison if the legal status of cannabis is changed.

The LTSA has advised that the only method currently available to the police for detecting drugged drivers, including drivers affected by cannabis, is the observation of impaired driving behaviour. Once the behavioural signs are observed, samples of body fluids need to be collected and analysed to provide supporting evidence. In general, the enforcement methods involving behavioural observation used to detect alcohol-impaired drivers will also be effective against those who have used cannabis and other recreational drugs. Individual cases of poor quality driving by cannabis users continue to cause concern to police around the world. However, both body fluid analysis and the training of police officers to effectively observe and record behaviour are expensive and time-consuming.

Recommendations

8. We recommend to the Government that the ESR develop a mechanism by which impairment by cannabis could be detected.

9. We recommend to the Government that the ESR test all people killed in road accidents for traces of all illegal drugs and alcohol, including cannabinoids.

Cannabis and Māori

Available research

The Health Committee of the 45th Parliament recognised the lack of robust research into the effects of cannabis on Māori, and recommended that the Government fund research to this end.[15] The Ministry of Health has launched the New Zealand Health Monitor, a 10-year cycle of regular surveys designed to provide information on all aspects of New Zealanders' health. One module of the monitor is the National Drug Survey, which will be conducted at 2-yearly intervals and will provide comprehensive information on all aspects of drug use, including ethnicity data. The most up-to-date data on Māori and cannabis available to the current committee is from the 1998 survey *Te Ao Taru Kino – Drug Use Among Māori*. A more current analysis is expected now that APHRU's national surveys comparison has been published.

15 Inquiry into the Mental Health Effects of Cannabis, Report of the Health Committee, 1998, *AJHR*, I.6A, p. 23.

Estimated use among Māori

Te Ao Taru Kino – Drug Use Among Māori was based on a national telephone survey of a sample of 1,593 Māori aged 15 to 45, which found that:

- 60 percent of Māori surveyed had tried cannabis
- 69 percent of Māori surveyed who had ever tried cannabis had since given up
- 26 percent reported trying cannabis in the 12-month period prior to being interviewed
- 18 percent regarded themselves as current users
- 4 percent could be regarded as heavy users (had used cannabis 10 or more times in the 1-month period prior to being interviewed)
- 41 percent of those who had used cannabis stated they tried it for the first time between the ages of 15 and 17; the younger people in the sample reported trying it at slightly younger ages than the older people
- 76 percent of cannabis users did not drive while under the influence of cannabis; however, 19 percent of males said they did some, most, or all of their driving while under the influence of cannabis, compared to 9 percent of females
- 51 percent of cannabis users stated that they used at least some of their cannabis with alcohol. Twenty-one percent of females reported smoking all their cannabis while drinking, compared with 12 percent of males.

The 21-year CHDS found that reported cannabis use by Māori aged 14 to 21 years was high: 83 percent of Māori in the cohort reported cannabis use compared to 67 percent of non-Māori.

Effects of cannabis on Māori

The APHRU's 1998 survey results indicated that approximately half of those who admitted using cannabis in the previous 12 months were not concerned about the amount of cannabis they were using, but 34 percent felt they were using more than they were happy with. When asked to identify what problems, if any, they had experienced as a result of using cannabis, 69 percent of those who admitted using cannabis in the previous 12 months reported experiencing no problems. Heavier cannabis users (used on 10 or more occasions in the previous 30 days) were more likely to report memory loss as a problem. Respondents who admitted using cannabis in the previous 12 months were asked how cannabis had affected a range of specified life areas. Forty-six percent of respondents reported a problem in at least one of these areas, and 28 percent of respondents stated that it had adversely affected their levels of energy and vitality. Other areas adversely affected by cannabis use included outlook on life, finances, friendships, and health.

Most of those who admitted having used cannabis stated that they did not need any help to reduce their level of cannabis use. Very few felt they needed at least some help, while a small group stated that they needed help at some stage in their life but did not get it. The main reasons cited for not being able to get help were:

- fear of the law

- fear of losing friends
- having no local services
- not knowing where to go
- social pressure.

Although most felt that cannabis use around children, before driving, and before work or study was unacceptable, some felt that cannabis use in social situations such as at a party or at the beach was acceptable. Respondents generally felt that the level of risk associated with cannabis use increased as cannabis use became heavier. There were considered to be fairly low levels of risk associated with non-regular use.

A small proportion of people who had smoked cannabis in the previous 12 months tried to ensure that they had a regular supply of the drug. While almost all received cannabis free at times, almost half bought at least some of their cannabis. Very few grew their own supply.

The CHDS found that symptoms of cannabis dependence among Māori were higher than among non-Māori: 15 percent of Māori in the cohort compared with 8 percent of non-Māori.

Case study

Research into public health issues related to smoking cannabis in the Bay of Plenty by Toi Te Ora Public Health identified the main public health issues as:

- road traffic crashes due, in particular, to a combination of alcohol and cannabis
- respiratory disorders linked to heavy use
- cannabis dependence
- cannabis being a trigger for mental illness
- adverse social and educational effects on young people, leading to reduced employment opportunities
- adverse effects on the foetus.[16]

Increased cultural alienation and the role of socio-economic status and racism in relation to public perceptions of cannabis use was also identified. In its assessment of community realities in the Bay of Plenty region, Toi Te Ora found that factors contributing to public health risks of cannabis use include:

- the cannabis black market
- cannabis being a key economic source in many Bay of Plenty communities, especially for rural Māori and the eastern Bay of Plenty (including communities west of Opotiki)
- accessibility and affordability of cannabis

16 Toi Te Ora is the Health Promotion and Health Protection department within Pacific Health, the operational arm of the Bay of Plenty District Health Board.

- acceptability (viewed in cannabis-prevalent areas as less harmful or medicinal when compared to tobacco, and in communities where there is a sense of rebellion against the system).

Māori conviction rates for cannabis offences

In New Zealand, Māori would appear to be at greater risk of harm resulting from the criminalisation of cannabis. Māori convictions for cannabis offences are disproportionate to the Māori percentage of the population and Māori cannabis use rates. The 1998 APHRU survey results estimate that cannabis use rates for Māori are similar to those in the population as a whole for recent use (used in the last year): 24 percent compared to 20 percent for all ethnicities. While more Māori report having tried cannabis, 60 percent compared to 50 percent for all ethnicities, current-use rates for youth are similar.

In New Zealand, crime figures generally are dominated by young men. Young Māori men aged 18 to 24 years have the highest 'used in the last 12 months' rate, but this is not markedly higher than for young men for that age group in all ethnicities (48 percent of Māori compared with 43 percent of all males aged 18 to 24 years). The five percentage points of difference between Māori and all male use rates are not sufficient to explain the 10.7 to 13 percentage point difference in possession and dealing conviction rates. One hypothetical explanation for the remaining disparity could be that people in low socio-economic groups have more incentive to engage in lucrative criminal activity, although incentive does not necessarily translate to action. Official data demonstrates that Māori are more likely to have lower incomes, higher rates of unemployment, and poorer educational outcomes. Another explanation could be that Māori receive disproportionate attention from law enforcement personnel.

In 2001, Māori made up 14.5 percent of the New Zealand population, but received 43 percent of the convictions for using cannabis and 55 percent of the convictions for dealing in cannabis. By comparison, European New Zealanders form the majority of the population but did not receive a majority of convictions. Europeans received a greater share of use convictions, and a lesser share of dealing convictions. Similar disparities have been documented in the United States of America for people of black and Hispanic ethnicity, in relation to illicit drug use in general.

> According to the Federal Household Survey, 'most current illicit drug users are white. There were an estimated 9.9 million whites (72 percent of all users), 2.0 million blacks (15 percent), and 1.4 million Hispanics (10 percent) who were current illicit drug users in 1998.' And yet, blacks constitute 36.8% of those arrested for drug violations, over 42% of those in federal prisons for drug violations. African-Americans comprise almost 58% of those in state prisons for drug felonies; Hispanics account for 20.7%.[17]

Enforcement and Māori

The Police have advised that a recent independent review of Police Youth Diversion undertaken by the Crime and Justice Research Centre at Victoria University of Wellington

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17 Substance Abuse and Mental Health Services Administration (National Household Survey on Drug Abuse) and Bureau of Justice Statistics (Sourcebook of Criminal Justice Statistics 1998 and Prisoners in 1998), cited in 'Cannabis: information to supplement the April 2000 report', Parliamentary Library, November 2001, p. 5.

(January 2002) found that patterns of offending and outcomes were very similar for Māori and Pākehā, and that Māori were not receiving different or more severe responses. However, Police figures would appear to bear out the idea that Māori are disproportionately apprehended both in general and for cannabis-related offences in relation to the total population (see Table 2).

Table 2: Māori and non-Māori apprehensions for the year ended 31 December 2001

Ethnicity	All recorded apprehensions		Recorded cannabis apprehensions	
Māori	81,392	(41.44%)	8,502	(39.35%)
Non-Māori	115,008	(58.56%)	13,102	(60.65%)
Total	*196,400*		*21,604*	

The 21-year CHDS concludes that current cannabis laws are administered in a discriminatory way, with males, Māori, and those with a police record being more likely to be arrested or convicted for cannabis use than female users, non-Māori users, and users without a criminal record. We are particularly concerned with the suggestion that a high level of police bias is leading to the disproportionate arrest and conviction rates of Māori for cannabis offences, based on the irrelevant attribute of ethnicity rather than the actual extent of offending. The submission from Te Rūnanga o Te Rarawa appears to support this finding. The submitters believe that diversion is inconsistently applied throughout New Zealand in a way that discriminates against Māori. The findings of the CHDS are shown in Table 3.

Table 3: Factors associated with arrest/conviction for cannabis-related offences amongst cannabis users (N = 662)

Ethnicity	% Arrested	p[18]	% Convicted	p
Māori	17.1		13.1	
Non-Māori	3.3	<.0001	2.2	<.0001

Police comment

Police dispute the claim of bias, and state that ethnicity is only one of several risk factors associated with arrest or conviction for cannabis offences. Although the Police agreed with the CHDS that males and Māori are disproportionately represented in cannabis arrests and convictions, they commented 'this situation is not unique to offences under the Misuse of Drugs Act 1975, but characteristic of almost all offences.'[19] The independent review of Police Youth Diversion (January 2002) mentioned above would appear to support the Police position.

Recommendation

10. We recommend to the Government that it follow up the allegations that the Police discriminate against Māori as highlighted in the Christchurch Health and Development Study (CHDS).

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18 Based on chi squared test.

19 New Zealand Police briefing, 27 May 2002.

Cannabis economy

A significant 'green' economy (or black market) for cannabis is known to exist in New Zealand, in particular, on the East Coast and in the far north of the North Island. Both regions are characterised by high unemployment, rural isolation, a majority or high Māori population, and widespread use of cannabis. Cannabis use is deeply entrenched in the lives of young people. The cannabis economy provides seasonal employment and ready cash, but it also causes widespread social harm, including cannabis dependence, truancy, youth exposure to cannabis, contact with criminal gangs, and the consequences of criminalisation, with many of the people in these communities imprisoned for minor cannabis-related offences.

Experience in the Bay of Plenty and the far north

In their oral presentations to the previous committee, community representatives from Opotiki emphasised that the cannabis black market supports the entire Opotiki community. When the cannabis crop is harvested, there is more disposable income, people are able to buy new cars, and serious social problems are averted. However, submitters stated that the problem is symptomatic of economic change in New Zealand in general, and that dependence on cannabis cultivation needs to be considered within the context of poverty, unemployment, and other issues related to public health; self-determination; Māori cultural identity; physical, sexual, and emotional abuse; and low youth self-esteem.

It is generally acknowledged that there is third-generation use of cannabis in Opotiki. Cannabis use provides relief from the stresses of poverty, unemployment, and the resultant lack of opportunity. However, the purchase of cannabis means there is less money for basic needs such as food and housing, and schools experience an increase in truancy during the harvest period.

The far north, sometimes known as 'cannabis country', also experiences huge problems relating to cannabis. Community representatives from Te Rūnanga o Te Rarawa reported cases of children as young as 6 years old selling cannabis in schools, unemployed parents using cannabis heavily at home, children finding their parents' 'stash', school suspensions, and exposure to criminal gangs. As in the Bay of Plenty, cannabis use and associated behaviour in families in the far north has entered the third generation; in some cases entire families are trapped in a cycle of dependency, and consequently cannabis-related problems have become normalised.

Proposed solutions

Submitters from community-based organisations from both the far north and eastern Bay of Plenty argued that alternative economic opportunities are urgently needed to break the dependence on the cannabis economy. Many growers would prefer to be earning 'clean money' rather than 'dirty money', and do not enjoy the stigma associated with cannabis cultivation and the resultant fear of the law. One group from Whangarei stressed that young people who receive criminal convictions arising from minor cannabis offences often end up in jail where they become victims of physical and sexual assault.

Some submitters argued that regulation of the cannabis market would enable cannabis growers to transfer their experience and expertise from growing cannabis illegally for people to smoke, to growing and developing hemp products legally for the commercial

market. This would also impact positively on the whole community through the creation of job opportunities and responsible role models. An example of local entrepreneurship in this regard is the hemp and harakeke shop at the Whangarei Railway Station.

Trial crops of industrial hemp in New Zealand are currently in their second year of cultivation, with the aim of establishing the potential for the production of hemp fibre and hemp seed oil. The Misuse of Drugs (Industrial Hemp) Amendment Bill, in the name of Nandor Tanczos, is currently before the Primary Production Committee.

Estimates of profit

There have been no studies of the profit from selling cannabis on the black market in New Zealand. However, estimates derived from data collected in the 1998 New Zealand National Drug Survey suggest that profits are significant: the total quantity of cannabis purchased from the black market was calculated at 7,308,820 grams (almost 15 million joints) at an estimated wholesale value of $52.2 million and estimated retail value of $84.3 million.[20] Other estimates of the value of the cannabis market vary wildly from $140 million to $900 million a year for Northland alone.[21]

Studies in the United States of America have found that selling illicit drugs is often considered to be a lucrative activity that attracts people into criminal careers, particularly those from disadvantaged backgrounds. However, there is some evidence from US studies that drug dealers generally earn only very modest amounts from drug dealing, and are faced with high risks of victimisation and imprisonment. This may also be the case in the far north and on the East Coast.

The previous committee heard that many of the proceeds from the Northland cannabis economy actually go to Auckland, which implies that illegal commercial interests profit from cannabis production while the local people who are involved in, or dependent upon, the cannabis economy do not.

We believe that cannabis use, cultivation, and black market activity exacerbate deprivation in areas like Opotiki and the far north. The degree to which cannabis alone causes broader social harms is an issue that is dependent on a number of variables, with the one emphasised by submitters being the lack of employment opportunities. However, we would be concerned if cannabis use was being used as an excuse for the social problems facing these communities. Further, we are concerned that the economic imperatives for engaging in the cannabis economy are being used in precisely this way.

Enforcement of prohibition in New Zealand

Police resourcing

Cannabis law enforcement accounted for $19 million of the total Police budget of $790 million in 2000–01, or approximately 2 percent of total police activities.[22] From 1992–93 to 1999–2000, a similar proportion of the annual Police budget was spent on possession and

20 APHRU submission, p. 36.

21 'Cannabis: information relating to the debate on law reform', Parliamentary Library, April 2000, p. 30.

22 APHRU submission, pp. 7-8.

more serious cannabis offences, covering all police activities including diversion and prosecution. Table 4 indicates that the police spent more of their time policing minor—rather than serious—cannabis offences.

The police definition of 'minor' offences includes possession, procurement, smoking/use, conspiring and 'miscellaneous'. The definition of 'serious' offences includes importing and exporting, producing, dealing, and cultivating cannabis. The majority of police time spent on cannabis-related offences over this period was for procurement (35 percent of total police time) and cultivation (32 percent) offences, followed by possession (14 percent), dealing (10 percent), producing cannabis (4 percent), importing or exporting offences (2 percent), 'miscellaneous' (2 percent), use (1 percent), and conspiring offences (0.1 percent). Fifty-three percent of the total enforcement costs for cannabis offences over this period were for minor cannabis offences.[23]

On average about 22,000 people were arrested for all cannabis offences each year in New Zealand between 1994 and 2000. In 1999, there were 9,399 prosecutions for the use of cannabis, 5,657 prosecutions for dealing in cannabis, and 3,512 prosecutions for 'other cannabis' offences. Of the 9,399 prosecutions for the use of cannabis, 6,761 resulted in convictions, and 52 custodial sentences were imposed. The most common sentence imposed for the use of cannabis was a fine (70 percent). Periodic detention was imposed in 15 percent of cases, and community service in 6 percent. The use of police diversion, rather than a criminal conviction, for cannabis use offences remains very rare. In 1999, only about 300 prosecutions (3 percent) for cannabis use were dealt with through diversion rather than a criminal conviction. However, the figure could be higher due to the number of unproved prosecutions.[24] The APHRU states that there is roughly a 4 percent chance each year of arrest for a minor cannabis offence in New Zealand, compared with a 1.25 percent chance in Australia and a 2 percent chance in the United States of America.[25]

The Police record huge numbers of offences involving cannabis. During the past 10 years, cannabis offences have accounted for an average of 4.6 percent of all recorded offences. The number of cannabis offences recorded by the Police increased from 17,229 in 1988–89 to 24,899 in 1997–98, an increase of 45 percent, compared with a 4 percent increase for non-cannabis drug offences. On average, 94 percent of recorded drug offences in New Zealand over the past decade have involved cannabis.[26]

The 21-year CHDS found that the administration of current cannabis laws is inefficient, with only 6 percent of cohort members who used cannabis coming to police attention. It is also discriminatory against males, Māori, and former offenders, and is ineffective in deterring users from cannabis use. Ninety-five percent of the cohort arrested or convicted for cannabis use continued with or increased their use of cannabis. The study recognises

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23 Figures rounded to provide full dollar estimates. Police response to committee questions, June 2003.

24 The Ministry of Justice commented that from the beginning of the diversion scheme in 1988–89, there was a large increase in the number of 'not proved' cases, many of which will be 'diverted'. In the year 2000, 2,299 of the 8,699 prosecutions for possessing or using cannabis (26 percent) were not proved, which suggests that the diversion figures are likely to be higher than indicated by Police figures.

25 The Ministry of Justice commented that the APHRU calculation is based on police statistics, which record 'offences' rather than people. As some people can be arrested for multiple offences or on multiple occasions within a year, the ministry believes that 4 percent is almost certainly an over-estimate.

26 Office of the Commissioner, New Zealand Police, background paper, March 2001.

the adverse health effects of cannabis use, but also emphasises the extent to which the law itself has harmful effects.

National crime statistics for 2002 show that non cannabis-related drug crimes such as those involving amphetamine-type stimulants rose by 28.4 percent, from 2,212 to 2,841 offences. There was also a 7.5 percent decrease in cannabis-related offences in 2002. While possession offences went down there was an increase in the number of dealing offences. The Police do not draw a direct correlation between these trends.[27]

Table 4: Average yearly costs incurred by police enforcing cannabis law 1992–93 to 1999–2000

	Enforcement time (hours)	Average cost per hour	Average yearly cost of enforcement
Minor cannabis offences	142,082 hours	$70	$9,945,770
Serious cannabis offences	126,835 hours	$70	$8,878,466
Total	*268,917 hours*		*$18,824,236*

Apprehension rates

We are very concerned about the rate of youth apprehensions by the police for cannabis offences. Although these under-16-year-olds account for only approximately 10 percent of total cannabis offence apprehensions, their numbers do appear to be increasing (see Table 5). We also note that while the number of 17 to 24-year-olds apprehended for cannabis offences has declined both in actual terms and as a proportion of the total, this group continues to record the majority of apprehensions. Notably, the number of apprehensions in the over-35 age group has increased both annually and as a proportion of the total over the past few years.

Table 5: All recorded cannabis offence apprehensions by age group for year ended 31 December 2001

Age	1997	%	1998	%	1999	%	2000	%	2001	%
0-16	2144	9.42	1993	8.28	2102	9.12	2251	10.17	2214	10.25
17-24	9876	43.40	10340	42.95	9700	42.08	9158	41.39	8779	40.63
25-34	7272	31.56	7758	32.29	6972	30.24	6541	29.56	6055	28.02
35+	3459	15.20	3980	16.53	4276	18.55	4176	18.87	4556	21.08
Total	*22751*		*24071*		*23050*		*22126*		*21604*	

Prosecution rates

Averaged out since the start of the 1990s, 55 percent of cannabis charges taken through to prosecution relate to possession or use charges, compared with 31 percent for dealing or cultivation, and 14 percent for miscellaneous cannabis-related charges. The proportion of

27 National Crime Statistics for 2002, http://www.police.govt.nz/news/release/841.php, accessed 7 July 2003.

possession or use cases brought before the courts has dropped from 58 percent in 1990, to 46 percent in 1998, and 41.7 percent in 1999. This would seem to indicate that proportionately fewer cannabis possession and use cases are being brought through the court system, although the raw data has changed little over time.[28]

Police state that officers generally detect the majority of possession offences at the street level in association with other matters such as disorder and other behavioural offences, or through vehicle searches directly related to road safety issues. We remain unconvinced by this, noting that 42 percent of convictions for cannabis do not include other offences. These offences usually involve very small amounts of cannabis. In most cases, the police deal with these offences by way of arrest and prosecution. Of the 13,000 offences (procurement, possession, smoking, using cannabis) during the 2000–01 financial year, a total of 8,143 were dealt with by way of prosecution. Only 399 were dealt with by way of diversion. Police state that there has been a slight increase over the past few years in this class of offence with little change in the numbers either warned or dealt with by diversion.[29] However, we note that the number of diversions increased by 33 percent between 1999 and 2000–01.

Police comment

The Police recognise that although the present law is difficult to enforce and most cannabis use is unlikely to be reported or come to police attention, this does not equate to poor administration. Further, the Police dispute the claims of inequitable application of the law or bias, and state that it is the circumstances surrounding cannabis use that are most likely to determine the legal outcome. Only conspicuous activities such as public cannabis use, the use and possession of cannabis in relation to other offending, or prolonged or heavy cannabis use are likely to result in apprehension.

Police highlight that gender, ethnicity, and previous arrest, which the CHDS focuses on, are only some of the risk factors associated with the arrest or conviction of cannabis users. Police state that conduct disorders and the lack of school qualifications, which may be interpreted as a proxy for socio-economic status, are also significant risk factors associated with arrest or conviction. In 2001–02, conduct disorders were evident in 23.7 percent of arrests for cannabis, which is higher than the other risk factors listed above. As stated previously, Police agree with the CHDS that males and Māori are disproportionately represented in cannabis arrests and convictions, but comment that 'this situation is not unique to offences under the Misuse of Drugs Act 1975, but characteristic of almost all offences'.[30]

Search and seizure without warrant

Under section 18 of the Misuse of Drugs Act 1975, the police have the power to search for and seize controlled drugs in Class A, B1 and C1 without warrant, provided there is probable cause. Cannabis resin (hashish) and cannabis oil (hash oil) are classified Class B1 within the Second Schedule of the Misuse of Drugs Act, and cannabis leaf, fruit or seed is

28 Office of the Commissioner, New Zealand Police, background paper, March 2001.

29 ibid; New Zealand Police briefing paper, tabled 15 May 2002.

30 New Zealand Police briefing, 27 May 2002.

classified as Class C1 within the Third Schedule. This provision allows for situations where a warrant may not be able to be obtained quickly enough for the police to respond to offences under the Misuse of Drugs Act. This was intended by Parliament to be used primarily for serious trafficking and supply offences, not for personal possession charges. Those powers were curtailed by requiring each search to be notified to the Commissioner of Police within 3 days. Today these powers are used as part of routine activities or street patrols. The president of the New Zealand Police Association commented in his oral submission that the police are becoming increasingly aware of the need to be more discerning in the exercise of section 18 powers (to search people for drugs without a warrant, provided there is reasonable cause). The Police Association president admitted that the police have targeted people on the basis of their dress.

We would be concerned if appearance alone, rather than 'conspicuous behaviour', is a key determinant in police deciding to search someone for possession of drugs under section 18 of the Misuse of Drugs Act.

Table 6: Search and seizure without warrant

Calendar year	Number of searches without warrant
1992	2026
1993	3161
1994	3553
1995	3072
1996	3517
1997	3068
1998	4010
1999	2478*
2000	3869
2001	4994

*Only partial data is available for 1999 due to the integration of data systems.

The frequency with which the police are invoking these powers appears to be increasing. In 2001, the police invoked section 18 powers 4,978 times, compared with 3,870 times in 2000 and 2,478 times in 1999. In 2001, 83 percent or approximately 4,130 of these cases were related to cannabis offences. We note that some submitters considered that most searches do not involve invoking section 18 powers, but rely on the consent of the suspect.

Some submitters commented on police search powers under the Misuse of Drugs Act. The Auckland Council for Civil Liberties, for example, commented that criminalisation has resulted in police resources being tied up 'persecuting cannabis users' through random searches, with a negative impact on people's civil liberties.

Questions have been asked about the balance between section 18 powers and the New Zealand Bill of Rights Act 1990 (section 21 unreasonable search and seizure), and this has recently been the subject of a Law Commission discussion paper *Entry, Search and Seizure*, April 2002. Police note that defendants are able to contest the admissibility of evidence

obtained in every police search. This allows the 'reasonableness' of section 18 searches to be tested by the courts on an individual basis.

Judge Gittos tested the reasonableness of the section 18 search of CW Fowlie by Auckland police on 17 June 2001. The judge was highly critical of police practice in this regard, stating that the police search breached Mr Fowlie's Bill of Rights protections. He gave his opinion that the search was unreasonable, and dismissed the charges. The police have advised that on the morning of Mr Fowlie's arrest, the Auckland City Team Policing Unit was active in Auckland's Karangahape Road. The police stated that Mr Fowlie was not approached because of any conduct issue, but as part of a police exercise to engage people and make them aware of the police presence and as a crime prevention initiative. Having approached Mr Fowlie, the police said they smelt cannabis, invoked their section 18 powers, and found 0.7 grams of cannabis in his possession.

We consider the right to challenge the admissibility of a search under section 18 in court to be inadequate protection. Most members of the public have little understanding of their legal rights with regard to search powers of the police, or their rights under the New Zealand Bill of Rights Act. Legal costs also mean that most people will not challenge these powers, in particular because of the practice of the Legal Services Agency to not give legal aid where imprisonment is unlikely. Some of us are concerned about evidence that police misuse these powers to search without warrant, while others of us consider there is no need to investigate the search and seizure powers under the Misuse of Drugs Act.

Recommendations

11. We recommend to the House that the Justice and Electoral Committee consider the use of search without warrant powers by police under the Misuse of Drugs Act 1975.

12. We recommend to the Government that the Ministry of Justice consider the content of this report as part of its review of the eligibility criteria for legal aid as set out in the Legal Services Act 2000 and the Legal Services Regulations 2000.

Part 2 Public health and health promotion strategies to minimise the use of, and harm associated with, cannabis

Submitters consistently told us that not enough is known about what constitutes an effective drug education strategy. We are concerned that information is fragmented and difficult to obtain. The Ministry of Youth Affairs is currently leading and coordinating the Effective Drug Education Project, in consultation with the Ministry of Education, the Ministry of Health, the Ministry of Justice, and the Alcohol Advisory Council of New Zealand (ALAC), following an approach to the Government in 2002 by the Green Party. The project will survey all drug education programmes, and identify and encourage best practice alcohol and drug education. The review will be peer-reviewed by a panel of experts, and a set of recommendations on effective drug education will be developed. The review aims to:

- reduce alcohol and drug use, particularly by young people
- increase understanding about what constitutes effective drug education
- increase uptake of effective drug education by schools and communities
- increase understanding about drugs and their economic and social costs
- identify gaps in service delivery and research.

The Ministry of Health recommends that we consider supporting key public health strategies to minimise cannabis-related harm, all of which focus on community-based approaches. These strategies include:

- community action programmes
- Māori-controlled initiatives
- a range of school-based responses.

We support the public health strategies recommended by the Ministry of Health, and urge the ministry to adequately resource a variety of complementary health strategies to minimise the harms related to cannabis.

Submitters' views of public health strategies

The expert submissions highlighted that health promotion strategies should address broad social harms in the community. Given that vulnerable cannabis users tend to come from socially disadvantaged communities, with problematic cannabis use adding to other pre-existing problems such as educational failure, unemployment, and mental health problems, a broad-based approach to reducing cannabis-related harm is necessary. Strategies should be inter-sectoral, collaborative, and multi-layered, with a strong community action focus.

Comments made by submitters supporting possible public health programmes for cannabis fit into five categories and are shown in Table 7 below.

Table 7: Comments on possible public health programmes for cannabis

Comment	No. of submissions making this comment[31]	% of submissions making this comment[32]
Harm minimisation (unspecified programme or strategy)	235	44.2
Wider education (such as mass media campaigns)	227	42.7
Factual, unbiased information	226	42.5
Community development[33]	135	25.4
School-based education	110	20.7

Harm minimisation

The philosophy that public health policy and programmes should be planned, funded and delivered within a harm minimisation strategy was supported by the highest proportion of submissions.[34] There was minimal comment providing clear definitions of what people mean by harm minimisation, although the implication is a package of public health policies encompassing legislation, regulation and community development, and targeted health promotion and education programmes. Strategies to minimise harm were suggested, ranging from credible education programmes to the legalising of bongs and appliances perceived to reduce the physical damage caused by smoking, health warnings on packages of cannabis, and licensing growers and suppliers.[35] Application of the Smoke-free Environments Act 1990 to cannabis and proactive media campaigns such as the campaign to promote safe driving were also suggested.

Although there was general support for a harm minimisation philosophy, there was also general acknowledgement of the problems inherent in advocating harm minimisation strategies for an illegal drug. For example, some submitters recognised the extent of youth exposure to cannabis, but favoured a harm minimisation approach despite their strong opposition to cannabis use. Many submitters expressed the view that it is impossible to develop effective public health programmes while cannabis retains its current illegal classification and its cultivation, supply, and use is a criminal offence. Two hundred and sixteen submitters who supported a change to the legal status argued that it is hard to educate, offer treatment, or do research when the drug is illegal. Conversely, a few submissions explicitly rejected a 'harm minimisation' approach, in favour of a 'harm prevention' approach.

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31 The total number of comments adds to more than 405 as some submissions made more than one comment in this section.

32 This percentage is calculated from the total number of submissions received (532), as opposed to the total number of submissions that made a comment in this section (405), or the total number of comments made in this section (933). Therefore, these percentages can only be used to indicate the proportion of submissions that did, or did not, make each individual comment. They cannot be added to give the proportion of submissions that made groups of comments.

33 A range of activities, such as economic development, community-based education, and alternative activities for youth.

34 The Ministry of Health defines harm minimisation as an approach to drug policy focused on reducing the net overall impact of any adverse health, social, and economic consequences of drug use to the individual or society, without necessarily eliminating drug use.

35 There is research evidence available indicating that use of bongs (commonly water pipes for smoking cannabis) may increase risk of respiratory harm.

The New Zealand Medical Association (NZMA) supported a harm minimisation approach aimed at reducing the incidence and severity of drug problems. The NZMA focused on discouraging adolescents from starting smoking cannabis, or at least delaying the time when they start; reducing heavy usage; and persuading pregnant women to quit smoking cannabis. The NZMA stated that it does not oppose partial decriminalisation of the possession or use of small amounts of cannabis, provided it can be shown that increased harm would not result. The NZMA commented that under partial decriminalisation, health authorities would be able to offer more organised preventative and quitting interventions.

Wider education

Wider education as opposed to school-based education was advocated by many of those making submissions, with 227 submissions expressing this preference. Education was perceived as a key strategy consistent with a harm minimisation philosophy, but the approach favoured varied.

Advocates for cannabis law reform tended to express the need for wide public education campaigns to communicate factual information about cannabis. These messages include encouraging young people to delay using cannabis; information about its effects, both harmful and positive; advocacy of light or moderate use; non-smoking options; how to minimise harm from smoking through, for example, the use of appliances; and, finally, where and how to seek help and advice. Repeatedly, the point was made that wider education and health promotion activity can be effective only if it is seen to communicate credible, factual information. Consistency with the public health programmes developed for other recreational drugs, such as the drink driving and smoke-free campaigns, was also emphasised.

In contrast, those against cannabis law reform advocated wider education focusing on the harm of cannabis use, the dangers of being led into harder drug use, the impact of a criminal conviction on one's life and family, and promotion of methods to eliminate the substance.

There was minimal comment on any preferred means to undertake broad education campaigns. Public advertising, mass media campaigns, and targeted education campaigns were suggested. Analogies were frequently drawn between the range of initiatives developed to promote moderate and safe alcohol and tobacco consumption, including smoke-free environments. Some argued that targeted community initiatives, including marae-based education, are more effective than mass media campaigns, which can be counter-productive.

Some submitters offered to distribute information about the harms and risks related to cannabis use, for example through cannabis paraphernalia outlets. We suggest they contact the Ministry of Health, which will be able to provide them with the appropriate information.

Factual information

An urgent need for factual information on both positive and negative effects of cannabis was highlighted in 226 submissions. This view is separate from the commentary about wider education initiatives. The vast majority of these submissions were also in favour of a

change to the legal status of cannabis—73 percent favoured legalisation and regulation and 17 percent decriminalisation. Related to the preference for easy access to factual information about cannabis is the source of that information. Explicit references were made to the relationship between lack of factual credible information from neutral official agencies and the ignorance, fear and 'hype' associated with access, supply, and use of cannabis.

Community development

The importance of 'developing the community' was highlighted by 135 submissions, but few were explicit about what they meant by this. Relevant suggestions included investment for the economic benefit of the community; development of social and cultural opportunities; employment options; recreational facilities and programmes; alternative educational options and the need for community-provided positive youth activities; and parenting programmes. Professionally managed and appropriately funded drug education and treatment programmes for those needing them were also seen as mandatory and an integral part of a community's health and education services.

Generally, those in favour of cannabis law reform advocated for cannabis and issues related to its use to be addressed from a health perspective rather than as a legal issue. They believe only then can the issues central to cannabis use and abuse be openly debated and the reasons underpinning New Zealand's high rates of cannabis consumption be identified.

There were repeated calls for youth activities and the creation of supportive social and cultural environments where young people feel safe and nurtured in their efforts to learn effective decision-making and life skills. Boredom, peer pressure, a 'cool image', and lack of basic factual information on which to base decisions about use, were perceived to be contributing reasons behind high cannabis usage rates in youth. Some suggested that the glamour of an illegal substance to young people is one reason some try it. If this is the case, some argued, decriminalising cannabis might result in adolescents trying other illegal drugs or gangs pushing 'harder' drugs. Other submitters argued that law reform would have the effect of separating the cannabis market from hard drugs, making it less likely that cannabis users would come into contact with them.

School-based education

Support for school-based education was cited in only 21 percent of submissions. The majority of comments about school-based education focused on drugs and their use in the wider sense. For example, one submission stated that school-based education should be aligned with health promotion messages so that young people were not sent mixed messages. Suggestions included that drug education needs to begin in year six or seven, should be part of a general programme about drugs, and should be integrated into the health or life-skills curriculum. The urgent need for education to be based on credible factual information, presented professionally without bias, and using culturally appropriate media, was repeatedly emphasised.

Those who prefer cannabis law reform believed school-based education programmes should focus on teaching adolescents life skills that will support them to make decisions about use of all drugs and minimising harm related to participation in such risky behaviour. Conversely, those who oppose any change in the law considered that school-based drug

education programmes should focus on teaching about the dangers, risks, and harmful effects of the drugs. A number of submissions were received from recent school leavers who had participated in school-based drug education programmes. Their comments suggested that participants in current drug education activities do not perceive this kind of education to be effective. One school leaver stated that some school-based educators used 'scare tactics', and information that was false or 'blatantly exaggerated', which undermined the credibility of both the educators and the information they used. Overall, there were few complimentary comments about the general standard of drug education programmes and providers currently available for school education. Inadequate funding, inconsistent approaches, few resources, lack of factual information about cannabis, and local community sensitivities were perceived as the factors underpinning this problem.

Some submitters considered that there could be a lack of credibility when some organisations receive funding from the tobacco and alcohol industry to conduct such education.

Community action programmes

The Ministry of Health recommends that community action programmes be one of the Government's key public health strategies. Community action programmes focus on building community capacity to deal with cannabis and other drug issues. Community action projects are designed, developed, and delivered in partnership with communities to meet their own needs. The Ministry of Health has recommended that they should be of at least 3 to 5 years' duration and also include formative evaluation components. Community action projects are also multi-sectoral and can involve any mix of targeted initiatives such as health promotion messages, family-based strategies, school-based strategies or peer-based strategies.

There has been a developing base of community action research programmes in New Zealand addressing alcohol and drug issues since the first Community Action on Alcohol Project in the 1980s. Further community action research projects such as the Liquor Liaison Project, the Māori Drink-Drive Project, the Rural Drink-Drive Project, the Youth and Alcohol Project and the Community Action on Youth and Drugs (CAYAD) have all developed successful strategies in addressing their respective issues and documented positive impacts within their communities, working intersectorally on structural, environmental, and climate-setting change with key groups such as health, local government, police, and community stakeholders.

The CAYAD project was a 2½ year community action project with a focus on addressing drug-related harm to youth. It was originally set up in late 1997 by the APHRU and the Whariki Māori Health Research Group to tackle an apparent increase in school suspensions for cannabis infringements. The project was expanded after feedback from schools that they were really dealing with the broader societal issue of cannabis use in the community, as well as wider social problems and diminishing support for students and their families. Proposals were requested for innovative projects, particularly targeting low socio-economic areas with high drug suspension rates.

APHRU and Whariki brokered and coordinated the CAYAD project with six community partners, operating in six rural, urban, and provincial localities, most of which have high youth and Māori populations and high unemployment. Five of the six community

organisations involved were funded by a Ministry of Education and Alcohol Advisory Council of New Zealand joint venture, and the sixth was funded by the Health Funding Authority. The project involved schools, local organisations, and young people in planning, priority setting, and developing a range of culturally appropriate activities and resources to address drug-related harm in their locality.

The CAYAD objectives and strategies were to:

- increase informed discussion and debate through community consultation hui, development of local media advocacy, and advocacy on national alcohol and drug issues
- promote, implement, and support policies and safe behaviours through encouraging clubs and marae to formulate manaaki tangata policies and practices, and support for youth-organised recreational events
- identify 'best practice' for addressing the needs of schools, young people, and whānau, by developing proactive policies and practices that build on the new school health education curriculum, using teacher training, Student Assistance Programmes, peer support, youth leadership approaches, and whānau and hapū education and support programmes
- build alliances between organisations and agencies through collaboration on health, recreation, and employment initiatives
- develop appropriate local resources and support young people's voices and messages on reducing alcohol and other drug related harm through murals, poster competitions, waiata, and safe party pamphlets.

Features of this project included increased collaboration between different sectors and organisations that had never previously worked together, increased parent and community involvement with schools, increased participation in community activities by young people, and increased workforce development for community workers.

The Ministry of Health currently funds five CAYAD projects in Opotiki, Nelson, Hokianga, Whangaruru, and Kaitaia. The Nelson and Opotiki projects work closely with their local councils. The Nelson project has focused on alcohol and youth issues and promoting collaborative youth events and activities, and has directly involved young people in the organisation of these events. The Opotiki project has continued to work with marginalised groups of young Māori and their whānau or hapū, by taking them on cultural journeys of discovery and change, which has included addressing the place of alcohol and drugs in their lives.

During 2001, the APHRU research team undertook impact evaluation work with the community action projects in the Hokianga, Whangaruru, and Kaitaia.[36] Overall, the CAYAD initiative was viewed by key informants as making an important contribution to promoting social change in the three Northland communities. Broad impact measures included decreases in drug-related school suspensions and stand-downs in these areas,

36 APHRU produced a comprehensive review of the effectiveness of approaches to reduce drug-related harm, for the former Health Funding Authority in August 1999.

decreases in reported incidence of youth crime, changes in attitudes and behaviour related to excessive drug use, and greater coordination of services for young people and their families.

We strongly support initiatives such as the Nelson and Opotiki CAYAD projects. However, we consider that ongoing funding certainty is required, and the programmes should be allowed to run for long enough to establish self-sufficiency. We agree that any funding increase should be based on considered performance measures. We believe that the CAYAD model should be rolled out elsewhere, conditional on good evaluation of these projects' stated outcomes. The Associate Minister of Health has recently announced a commitment of $2.55 million from the 2003–04 Budget for 15 community action programmes, to be allocated over 4 years. We understand the commitment is a result of the successful piloting of CAYAD projects in Kaitaia, Hokianga, Whangaruru, Opotiki, and Nelson. This announcement should bring some funding certainty to submitters from the pilot areas such as the far north, who expressed frustration at having only pilot programmes to address the huge social issues facing their communities, to which cannabis use by young people is one contributing factor. We understand that the expanded initiative will run in six rural and nine urban areas where use of drugs is highest.

Recommendations

13. We recommend to the Government that it undertake research into the effectiveness of community action programmes in New Zealand.

14. We recommend to the Government that it commit to ongoing funding for the community action programmes and community-based education programmes, on the basis of evidence-based outcomes.

Māori-controlled initiatives

As outlined in Part 1 of this report, considerable concern has been expressed about the perceived levels of cannabis use by Māori, and its detrimental impact, including the social and cultural impacts of drug-related harm. In 1998 the Mental Health Commission identified mental health as the number one health concern for Māori, and cited drug and alcohol abuse and psychosis as the main reasons for admission to psychiatric care for Māori. Māori experience disproportionate cannabis-related harm, and strategies designed for the general population have often had limited effect in reducing harm to Māori. The Ministry of Health recommends, as one of five key public health strategies, Māori-controlled approaches, with Māori being able to access appropriate support as necessary.

We understand that problems associated with Māori communities are addressed more effectively when targeted approaches are developed specifically by and for Māori. There is a need for in-depth knowledge of the Māori community, and of acceptable and effective approaches to use when advocating changes in behaviour and lifestyle. Te Rūnanga o Te Rarawa and other researchers have argued the need for New Zealand drug education programmes to be well coordinated, community driven, bicultural, and based on the principles of community development, tikanga Māori, and Treaty of Waitangi concepts such as tino rangatiratanga. The Community Action Project of Whangaruru (CAPOW) submission, for example, emphasised a holistic approach that seeks to restore knowledge

of the community's shared whakapapa using tikanga Māori, to restore the identity and connectedness of the community's members.

Toi Te Ora Public Health has identified two goals to reduce the public health risks related to smoking cannabis in the Bay of Plenty: impacting on individual behaviours, and changing community attitudes that cannabis is 'cool', or 'counter-cultural'.

The Opotiki Safer Communities Council's innovative He Rangihou New Day Project was part of the wider CAYAD initiative. The project initially targeted youth aged 10 to 14 years, particularly Māori, and people who most influence them on drug-related issues, and expanded to youth aged 10 to 25 years, particularly Māori, in 2000–01. The project initially ran from January 1998 to June 2001, and was funded largely by the Ministry of Education, with small grants from Toi Te Ora Public Health. A new funding contract for He Rangihou New Day Project was successfully negotiated with the Ministry of Health in December 2000 for 3 years from January 2001.

We recognise the importance of local community research and strategies in the reduction of cannabis-related harm. We are encouraged by the initiatives of the Opotiki Safer Communities Council project, which include a holistic education and motivation programme that places drug issues in the context of personal, whānau, hapū and community development, is tailored to local needs, and is bicultural and bilingual, with a Māori focus where appropriate.

We understand that He Rangihou New Day Project is expected to produce most of its benefits in the long term, but short-term positive impacts that have been identified include an improvement in attitudes and behaviour among some school children and other young people—including some young people not appearing in court or being sentenced as was likely—and reductions in suspensions and exclusions from school. Other impacts already identified include an increase in the capacity of some local communities and whānau, hapū, and iwi organisations to deal more effectively with drug-related issues; an increase in drug-related awareness through discussion and debate; and an increased awareness of the value of comprehensive and holistic approaches that focus on harm reduction rather than prohibition, are bicultural, and are tailored to local sub-cultures and conditions.

Interviews with 21 stakeholders in the Opotiki district in 1999 and 2000 found that the project has had a profound impact on the community. Most people interviewed praised the community development worker's skills as a facilitator and motivator who worked effectively in both Māori and Pākehā worlds and with families, had effective links to iwi groups, and made good use of tikanga in teaching and building rapport with young people.

There is little documentation of Māori community-based drug prevention strategies. However, we support the continued delivery of programmes that are based on Māori cultural contexts and are controlled and delivered by Māori, because they are more likely to contribute to Māori development goals. We commend community action projects in high-risk areas such as Whangaruru, Kaitaia, and Opotiki. In particular, we support the focus on promoting tikanga Māori and identity among young people, such as the waka ama and kapahaka groups, to minimise cannabis and alcohol use.

Recommendations

15. We recommend to the Government that there be continued delivery of effective programmes that take into account cultural perspectives to minimise cannabis and alcohol-related harm, on the basis of evidence-based outcomes and conditional on successful project evaluations.

16. We recommend to the Government that programmes with a specific cultural orientation be expanded to encompass other cultural groups in New Zealand.

Drug education: school-based programmes

Preventing early onset of cannabis use

Preventing early onset of cannabis use is one of the Government's key policy goals. Considerable research exists indicating that early drug use is associated with psychosocial developmental problems, when young people move from experimental to frequent use. Schools are an important environment where drug-related harm minimisation messages can be delivered at an early age.

However, consistent results over two decades indicate that school-based drug education alone is ineffective in delaying or reducing drug use. Studies that ask young people what they want from drug education programmes do show that they want more detailed and accurate information for informed choice. In particular, they want more information about the effects of legal and illegal drugs on the body and about the appearances of illegal drugs, and they want the information to be non-judgmental.

We believe that for school-based programmes to be effective, information on drug-related harm must be integrated into the health and physical education curriculum and linked with comprehensive community programmes. The health and physical education curriculum recognises that health education programmes in schools need to be more than a composite of information, values, skills, and social competency training. Emphasis is needed on strengthening links with the community to address the consistency of messages with those received from the media and other community sources, and to provide support for school-based strategies. Information-based programmes may be popular but knowledge alone is unlikely to change behaviour. The Australian Life Education and American Project DARE (Drug Abuse Resistance) programmes both continued to receive extensive public funding in their countries of origin until recently, despite research evaluation indicating no preventative effects and higher drug use in their areas compared with similar areas that did not use these programmes.

New Zealand has its own version of the DARE programme. The New Zealand version is connected to the Australian DARE, which was initiated independently of the US programme, and significantly altered to address the mistakes learned from the experience in the United States.

We believe that the health and physical education curriculum should also be supported by approaches such as Health Promoting Schools and Student Assistance Programmes. The Health Promoting Schools Programme, using schools as settings for health promotion, has been adopted by many schools in Australia and New Zealand. This approach provides a

framework for integrating positive health initiatives into the school environment and increasing community interaction. Efforts could be made to more strongly integrate drug-related initiatives into this approach.

Student Assistance Programmes (SAPs) have been steadily introduced into American schools, and are regarded as an 'umbrella', covering any activities helping schools deal with students' problems, particularly those related to alcohol and other drugs. The school owns the programme and a representative school committee takes responsibility for implementation, operation, and maintenance of school policies and staff training, and for introducing various appropriate skills-based courses for referred students.

An evaluation of SAPs in three American states indicated that they play a significant role in helping students with alcohol, drug, family, and school behaviour problems, and also impact positively on the school and community. In 1999 the SAP concept was introduced into New Zealand by public health units and health promotion organisations in Palmerston North, Nelson, and the Hokianga. This was to provide a proactive and constructive alternative to the punitive disciplinary practices that are sometimes used by New Zealand schools to deal with alcohol and drug problems. Student Assistance Programmes complement the Health Promoting Schools Programme approach.

The Ministry of Health recommends that the SAP approach be expanded, with two key areas being psychological services to schools and greater access to family-based interventions.

We are concerned that the number of school suspensions for cannabis-related incidents exceeds stand-downs alone among all offences including violence, which indicates that schools treat cannabis more seriously than violent incidents, including those involving weapons. We believe that schools need to receive support so that they can respond to cannabis use in a way that preserves educational opportunities. An environment more conducive to youth drug education is required.

Some of us respect the right of schools to have zero-tolerance policies regarding drug use but would like to see the quality of school-based drug education improve.

Police-led school drug education programmes

The New Zealand Police also delivers drug education programmes in consultation with schools. Most YES (Youth Education Services) programmes contain social competencies and skills that would relate to drug usage. The two primary school programmes Dare to Make a Choice and Tena Kowhiria, and the secondary programme, Dare to Drive to Survive, are the programmes specifically operated with police officers. Choice and Tena Kowhiria are designed to integrate into a classroom over an extended period of time. Dare to Make a Choice has been evaluated for more than a decade, and the results appear to have been positive. Research (Livingstone, 1997) suggests that attitudinal shifts occur among parents and other adults in the community as much as with the school students. In 1999–2000, police resources dedicated to drug-related education included 34,924 police hours at a cost of $2.4 million, which accounted for 10 percent of police personnel costs

related to drug-related outputs.[37] We are not convinced that this is the best use of police resources and would prefer to see drug education being funded through, and provided by, a more relevant ministry.

Recommendations

17. We recommend to the Government that it note our concern that most young people who use cannabis do so in an environment that is not conducive to well-informed decision-making, and ensure that useful information is readily available.

18. We recommend to the Government that drug and alcohol education be an integral and ongoing part of the health curriculum.

19. We recommend to the Government that the Ministry of Education conduct research into school stand-downs, suspensions, and expulsions as a result of incidents involving cannabis.

20. We recommend to the Government that the Ministry of Education examine how best to support schools and students in responding to cannabis use in a way that preserves educational opportunities.

37 Office of the Commissioner, New Zealand Police, background paper, March 2001.

Part 3 Legal status of cannabis in New Zealand

Scale of harm

The Misuse of Drugs Act 1975 prescribes penalties for dealing, possessing, using, cultivating, or stealing controlled drugs. The Act is administered by the Ministry of Health but is enforced by the Police and the Customs Service.

As a result of the Misuse of Drugs Amendment Act 2000, New Zealand's classification framework is now based solely on the risk of harm that the misuse of the drug poses to individuals or to society. This basis is applied to all drugs classified under the Act. That is, our Act does not have different processes for 'narcotic' or 'psychotropics' as the United Nations conventions do. The Act uses a three-pronged classification of 'very high risk', 'high risk', and 'moderate risk' of harm. To assess the risk of harm the Act provides a list of relevant factors, including the potential therapeutic advantage of the drug or the risk to public health. Accordingly, drugs posing a:

- very high risk of harm should be scheduled as 'Class A' and listed in the First Schedule to the Act
- high risk of harm should be scheduled as 'Class B' and listed in one of the Parts in the Second Schedule to the Act
- moderate risk of harm should be scheduled as 'Class C' and listed in one of the Parts in the Third Schedule to the Act.

New Zealand cannabis classifications

In New Zealand, cannabis resin (hashish) and cannabis oil (hash oil) are classified as Class B1 within the Second Schedule of the Misuse of Drugs Act 1975, and cannabis leaf, fruit and seed is classified as Class C1 within the Third Schedule. Both B1 and C1 classifications are subject to police powers of search and seizure without warrant under section 18 of the Act.

Table 8: Summary of the classification framework for cannabis as a controlled drug within the Misuse of Drugs Act 1975

Part of Schedule	Examples	Penalties
Second Schedule, Part 1 (Class B controlled drugs)—includes refined or concentrated forms of cannabis (higher potency than natural plant leaf) Minister's approval required for use of cannabis oil/resin	Cannabis resin and oil (ie hashish and hashish oil)	Up to **14 years** imprisonment for importation, manufacture or supply Up to **10 years** imprisonment for conspiracy to commit an offence Up to **3 months** imprisonment or **$500** fine **or both** for possession
Third Schedule, Part 1 (Class C controlled drugs)—includes natural forms of cannabis Generally substances used illicitly rather than medically Minister's approval required	Cannabis leaf, fruit, and seed	Up to **8 years** imprisonment for importation, manufacture or supply Up to **7 years** imprisonment for conspiracy to commit an offence Up to **3 months** imprisonment or **$500** fine **or both** for possession

As summarised in Table 8, Part 2 lists controlled drugs that have moderate abuse potential, but also have therapeutic uses. Part 2 classifications allow for a controlled drug to be readily prescribed by medical practitioners. Section 18 powers are not applicable to controlled drugs classified under Part 2 of the Third Schedule, but the penalties are the same as for all controlled drugs listed in the Third Schedule. Part 3 listed controlled drugs include similar products to Part 2, that is, therapeutic substances, but with generally lesser dependence potential than Part 2 substances. This includes partially exempted drugs that can be supplied without prescription in certain circumstances. The Third Schedule contains six further parts (listed in Appendix D).

The process for classifying controlled drugs

The process for a controlled drug to be considered for reclassification in New Zealand is summarised below:

- The Expert Advisory Committee on Drugs (EACD) provides its expert advice on the classification of a particular drug to the Associate Minister of Health
- The Associate Minister of Health will consider the advice, and may recommend that the Governor-General issue an Order in Council classifying the substance accordingly in the Act.

However, before such an Order in Council can come into force, the House of Representatives must approve the Order in Council by resolution, as specified in sections 4 and 4A of the Act and in Sessional Orders. The Order in Council must be notified in the *New Zealand Gazette,* and the House then has between 28 days and 1 year to approve or reject it. However, Sessional Orders also require that before the House considers any motion to approve the Order in Council, it must be referred to the Health Committee. Once Parliament has approved the Order in Council, a commencement order is prepared for the Governor-General's authorisation, which comes into force 28 days after the Governor-General's signature. The drug is then added to the appropriate schedule in the Act and relevant provisions of the Act (for example, enforcement provisions) come into force.

We note that the EACD is tasked with reconsidering the classification of all controlled drugs, and will therefore reconsider the classification of cannabis at some stage. Most of us consider it would be helpful for the EACD to make its reconsideration of this classification a priority. Others of us consider that the existing arrangement is adequate, and do not agree that any higher priority be placed on the reconsideration of cannabis.

Recommendation

21. We recommend to the Government that the Expert Advisory Committee on Drugs give a high priority to its reconsideration of the classification of cannabis.

International comparisons

Internationally, there is no universal classification for cannabis. As summarised in Table 9, the United States considers all cannabis to be the equivalent of a class A drug (listed in Schedule 1), while cocaine is listed in Schedule 2. Cannabis is also listed under Schedule 1 of the United Nations' classification regime. The United Kingdom currently distinguishes between cannabis oil (class A) and resin (class B), though all forms of cannabis are expected to be reclassified class C. Canada lists cannabis as a Schedule 2 drug, though legislation has recently been introduced to decriminalise minor cannabis possession and use offences. A table showing the maximum fines or custodial sentences for cannabis offences in the countries discussed in this report are included as Appendix E.

Table 9: Cannabis classifications in other jurisdictions

United States (Federal)	Marijuana and hash oil	Schedule 1	DEA #7360
United Kingdom	Cannabis oil derived from herbal cannabis	Class A	Misuse of Drugs Act 1971
	Cannabis and cannabis resin (hash)	Class B	
Canada	Marijuana and cannabis resin (hash)	Schedule 2	Controlled Drugs and Substances Act 1996
Australia	Varies per state		
Sweden	No distinction is made between narcotic preparations and psychotropic substances		Narcotic Drugs Punishment Act 1964
Netherlands	Cannabis oil	List 1a	Opium Act 1976
	Cannabis	List 2b	

United Nations drug conventions

New Zealand is a signatory to three United Nations drug conventions: the 1961 Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention Against Illicit Traffic in Narcotics and Psychotropic Substances (the Vienna Convention). Article 3 of the Vienna Convention requires signatories to make the production, possession, purchase, cultivation, and sale of illicit drugs including cannabis a criminal offence under domestic law. Signatories do, however, have some discretion in terms of how they deal with people committing these offences, and are able, for example, to opt for treatment or education as opposed to conviction or punishment.

Legislative options for cannabis

The Government has undertaken not to introduce legislation to change the legal status of cannabis, in accordance with the Agreement for Confidence and Supply with the United Future parliamentary caucus.

Submitters' views

The majority of submissions to this inquiry supported legalisation of cannabis, with 52.3 percent favouring legalisation and regulation. Combined with the 20.8 percent of submissions that supported decriminalisation in some form, approximately 75 percent of submissions favoured some change to the legal status of cannabis. Twenty-one percent of submissions supported maintaining the status quo, and the majority of this group favoured the current prohibition regime.

The majority of submissions were completely opposed to any change in the law that would allow under-18-year-olds to use cannabis. Submitters who favoured either partial prohibition or legalisation still want to see an age limit for the legal use, possession, cultivation, and supply of cannabis. These submitters' favoured age limit is determined by their concept of an adult, or a desire for consistency with other similar legislation: for the majority of submitters, this means 18 years of age, but a few prefer 16 years.

Generally, those supporting a change to the legal status of cannabis believe that many of the harms associated with its current status, such as an uncontrolled black market and the stigma of a criminal conviction, need to be removed if public health initiatives are to be effective.

As discussed previously, some submissions considered cannabis health policy and public health programmes need to be developed in conjunction with any legal or police policy programme. Any change to the legal status of cannabis should be accompanied by a range of public health strategies. Some health promotion strategies, for example mass health education campaigns, may be more appropriately implemented prior to any law change. Those who support a law change believe that resources currently spent on policing and enforcement of cannabis law should be redirected to fund effective drug education and treatment programmes.

Others argue that specific public health policies, programmes, and funding are required for some communities and target groups. These are required to support the development of healthier communities and to manage the high risk of exacerbating current complex public health problems, should the legal status of cannabis be changed.

One of the themes emerging from the expert submissions was the view that policies should avoid criminalising non-problematic cannabis users. Various social harms result from giving criminal convictions to occasional cannabis users who do not pose a risk to themselves or others. Submitters considered that the law should therefore contain options for dealing with minor cannabis use that avoid criminalisation. Several mechanisms were recommended, including:

- cautioning for first offenders
- diversion to education programmes or health treatment
- fines for repeat offences, with flexible payment options, or compulsory education.

We are advised that very strict prohibition of cannabis, where even minor personal use is criminalised, could contribute to a range of problems, including creation of a large-scale black market; causing disrespect for a widely broken law; hampering provision of effective

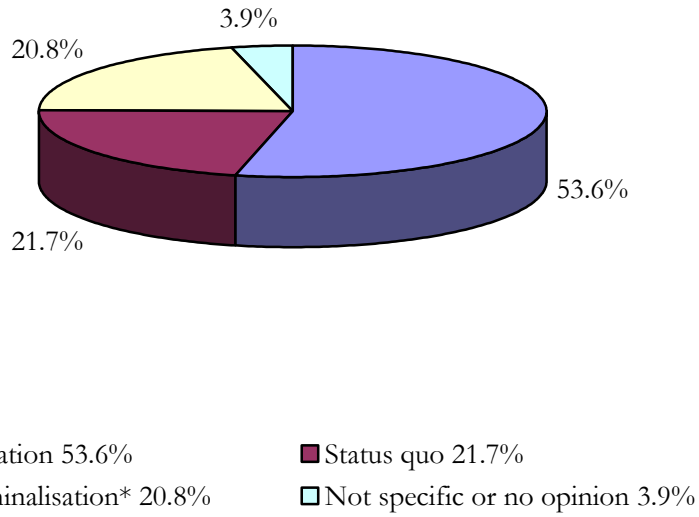
health promotion information and provision of, and access to, best treatment services; hampering access to cannabis for medicinal purposes; and encouraging punitive, harmful policies in schools. Removing the criminal penalties for cannabis offences to some extent may alleviate these problems by providing more options for dealing with cannabis.

The various alternative options for dealing with cannabis from a legislative and operational standpoint in the New Zealand context are shown in table 10.

Table 10: The legislative options

Status quo	Option A: Prohibition
(No change to the law, but may involve a change to enforcement practice)	Option B: Prohibition with an exception for medicinal purposes
	Option C: Prohibition with expediency principle
	Option D: Prohibition with formal caution and/or referral
Decriminalisation	Option E: Prohibition with civil/administrative penalties
	Option F: Partial prohibition
Legalisation	Option G: Legalisation and regulation
	Option H: Free trade

Figure 1: Submitters' views on the overall status of cannabis



* Includes 57 non-specific submissions supporting decriminalisation without specifying a model

Table 11: Submitters' views on the legal status of cannabis

OPTIONS	No.	%	GENERAL CATEGORY	No.	%
OPTION A Prohibition	93	17.5%	STATUS QUO	115	21.7%
OPTION B Prohibition with an exemption for medicinal purposes	10	1.9%			
OPTION C Prohibition with expediency principle	0	0%			
OPTION D Prohibition with formal caution and/or referral	12	2.3%			
OPTION E Prohibition with civil/administrative penalties	16	3.0%	DECRIMINALISATION (includes a third category of submissions that supported decriminalisation without specifying a model)	111 (57 non-specific)	20.8%
OPTION F Partial Prohibition	38	7.1%			
OPTION G Legalisation and regulation	278	52.3%	LEGALISATION	285	53.6%
OPTION H Free Trade	7	1.3%			
Not specific or no opinion	21	3.9%		21	3.9%
TOTAL	*475**	*89.3%**		*532*	*100%*

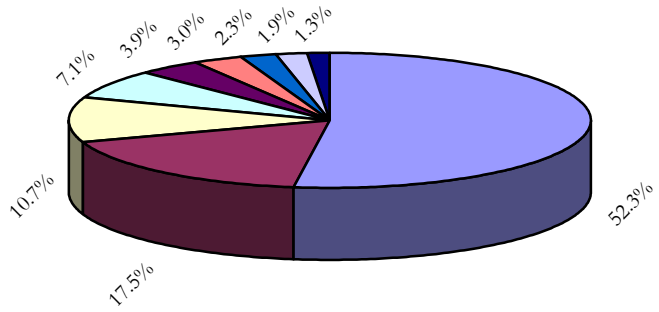
* This figure and percentage exclude the 57 submissions that supported decriminalisation without specifying a model.

Submitters' views

The majority of submitters favour some form of legalisation (52.3 percent), while similar proportions of submitters favour the status quo (21.7 percent), or decriminalisation (20.8 percent). A small proportion of submitters were not specific or did not state an opinion on the legal status of cannabis (3.9 percent). Table 11 shows submitters' views arranged according to the various legislative options.

Figures 1 and 2 show submitters' overall views of the legislative options for cannabis, as well as their preferred options.

Figure 2: Submitters' preferred legal status for cannabis



- Legalisation and regulation (option G) 52.3%
- Prohibition (option A) 17.5%
- Non-specific support for decriminalisation 10.7%
- Partial prohibition (option F) 7.1%
- Not specific or no opinion 3.9%
- Prohibition with civil/administrative penalties (option E) 3.0%
- Prohibition with formal caution and/or referral (option D) 2.3%
- Prohibition with an exemption for medicinal purposes (option B) 1.9%
- Free trade (option H) 1.3%

Prohibition with an exemption for medicinal purposes

We believe that the issue of medicinal use should be dealt with independently from the legislation regulating general use, so have chosen to separate this section in the report.

Overseas experience

Interest in the therapeutic use of cannabis has been rekindled by recent legislative changes in some US states (including Alaska, Arizona, California, Nevada, Oregon, and Washington), which enable doctors to prescribe cannabis for medicinal purposes. This policy allows for people with certain illnesses who may benefit from cannabis use to be prescribed or to use the drug without prosecution. In these jurisdictions, a clear distinction is made between therapeutic applications and the recreational use of cannabis.

Policies of this type may specify illnesses that may be legally treated with cannabis, require certification of medical need and a register of legal users, and may protect prescribing doctors from criminal charges. This option could also be a component of other options shown in Table 11, for example, Option D and Option E.

Cannabis has been shown to be effective in providing relief for some medical disorders, and this option is consistent with the United Nations drug conventions. However, the issues surrounding cannabis use for other users, such as targeting education, prevention, harm minimisation, and treatment measures, remain difficult. This option does not change the rate of convictions for general use and possession of cannabis, and it may create an

incentive to deceive or to put pressure on those licensed to prescribe cannabis for medicinal purposes.

It has been claimed that one of the alleged costs of cannabis prohibition is that it prevents patients with life-threatening and chronic illnesses, such as AIDS and cancer, from using cannabis for therapeutic purposes. There is evidence that cannabinoids may be useful as anti-nausea agents, as appetite stimulants in patients with AIDS-related wasting, as anti-spasmodic agents in neurological disorders such as multiple sclerosis, and as analgesics for pain that is unrelieved by existing analgesics.

GW Pharmaceuticals

There has been some progress in pharmacological research into the potential of cannabinoids for medicinal use. In the United Kingdom, GW Pharmaceutical trials of cannabis and cannabinoids have successfully passed Phase III clinical trials (the last tests before marketing) and the company is beginning to enter commercialisation deals to get the product on to the market. GW Pharmaceutical lists a range of potential therapeutic applications for cannabis-based medicines, including AIDS Wasting Syndrome, arthritis, multiple sclerosis, chemotherapy, pain, asthma, depression and mental illness, epilepsy, and schizophrenia.

Submitters' views

Only 10 submitters stated their preference for cannabis prohibition with an exemption for medicinal purposes. This may be explained by the relatively small proportion of submitters who suffer from a chronic illness, and who could potentially benefit from an exemption under the existing law. However, the overall analysis of submissions reflected a reasonably high level of recognition of the potential or real medicinal effects of cannabis—105 submitters stated that cannabis could have medicinal benefits, with about half specifically commenting on a legal exemption for medicinal use.

Professor Paul Smith from the University of Otago referred to the large volume of research that demonstrates that THC and other cannabinoids have many therapeutic effects in the treatment of human disease. In addition to the therapeutic advantages noted above, Professor Smith added the reduction of nausea and vomiting and the prevention of wasting by appetite stimulation in diseases such as cancer and AIDS; the reduction of intraocular pressure in glaucoma; the reduction of spasticity in multiple sclerosis; potent analgesic effects; and, increasingly, evidence that some cannabinoids may protect against brain damage following stroke. The NZMA supports research into the benefits of cannabis for medicinal use, and into alternative delivery systems, but emphasises that such research should be evidence-based and carried out using standard scientific methodology.

One submitter who suffers from HIV talked about the relief gained from smoking cannabis. The nausea, diarrhoea, insomnia, headaches, and severe lack of appetite that resulted from taking the prescribed medicine (halcyon) led to an unusual loss of weight, as well as halcyon addiction and a feeling of losing control. In this case, the adverse side effects of both HIV and the prescription medication are relieved through the daily use of cannabis. However, the submitter, who is on a benefit, stated that he is unable to procure a constant supply of cannabis for medicinal use due to cannabis being an illicit substance.

Legal provision for use of cannabis for medicinal purposes

The Minister of Health has the power to authorise medicinal use of cannabis products. This power relates to:

- approved cannabis products for research or study
- cannabis products approved by overseas regulatory authorities
- the use of unapproved raw cannabis plant for medicinal use.

Medicinal cannabis use is controlled under the Medicines Act 1981, the Misuse of Drugs Act 1975, and the Misuse of Drugs Regulations 1977. The Minister's powers of approval are currently delegated to the manager of Medsafe, the therapeutics arm of the Ministry of Health.

Unapproved raw cannabis cigarettes and other illicit cannabis products do not fit the criteria of approved products under the Medicines Act 1981, as they are not manufactured to standardised processes. There is a difference between a pharmaceutical form of cannabis preparation and raw cannabis plant material. A standardised cannabis cigarette or other cannabis plant product might theoretically be able to be approved for prescription for research or study, if it is manufactured to the standards required under the Medicines Act. The Ministry of Health does not support the use of raw cannabis plant for medicinal purposes, as there are no controls over its quality, dose or effectiveness.

The National Drug Intelligence Bureau (NDIB), comprising staff from the New Zealand Police and New Zealand Customs Service, advises the Ministry of Health on applications for medicinal use of unapproved raw cannabis plant. To date, most applications to use cannabis for medical reasons have sought approval to smoke raw cannabis plant. The NDIB has not previously supported medicinal use of raw cannabis plant, and this advice has been provided to successive Ministers of Health. The former Associate Minister of Health, Hon Maurice Williamson, accepted this advice in responding to an applicant in 1994.

Provision exists in the legislation for prescription of cannabis products approved by regulatory authorities overseas, or approval of clinical trials of approved cannabis products. The manager of Medsafe has offered to approve the prescribing of a synthetic cannabis product called Marinol (dronabinol), provided the required licences are obtained. However, this has never been acceptable to applicants, due to the costs involved for clients. Pharmac would not fund these products because no cannabis preparation has consent to be distributed in New Zealand. There is also resistance to Marinol because it is not seen as being as effective as plant matter, and because it causes side effects such as uncontrollable highs.

The Medicines Act and the Misuse of Drugs Act both contain exemptions that would enable a doctor to lawfully prescribe or administer cannabis, a controlled drug, to a patient, provided ministerial approval is given. There is provision in the law for medical practitioners to prescribe cannabis for their patients without the need for cannabis being gazetted as an approved medicine. Theoretically, a medical practitioner could procure a supply of cannabis for this purpose under sections 25 and 29 of the Medicines Act, and directly import the cannabis product currently under trial in the United Kingdom for a

particular patient. Again, ministerial approval is required for the licensing of cannabis supply to a medical practitioner, but once this is secured and the medicinal cannabis prescribed, there is nothing stopping the patient from lawfully consuming the prescribed drug.

We are aware that natural and synthetic cannabinoids are being developed and trialled overseas as medicinal products. We think that this development has potentially useful implications for people suffering from a range of both acute and chronic illnesses. We believe these products should be made available in New Zealand if MedSafe is satisfied through the usual processes that they have some therapeutic benefit.

Some of us believe that if this research demonstrates that cannabinoids have medicinal properties superior to other currently available pharmaceuticals, they should be considered, as any other medicine would be, through the usual channels for classification and prescription availability in New Zealand. Some of us do not want the medicinal use of cannabis to have the potential to be a back door to legalisation.

The Green Party member, mindful of the suffering of many seriously unwell people that might be relieved by the use of cannabis, and mindful of the risks endured by people because they do self-medicate with cannabis, supports ministerial approval to allow doctors to prescribe medicinal cannabis in appropriate circumstances, pending the completion of clinical trials and MedSafe approval.

Recommendation

22. We recommend to the Government that it pursue the possibility of supporting the prescription of clinically tested cannabis products for medicinal purposes.

Legislative options for general use

Option A: Prohibition

The use, possession, cultivation, importation, sale, and distribution of any amount of cannabis is treated as a criminal offence. Prohibition operates in most US states, Sweden, France, England and Wales, although in England and France, alternatives to prosecution, such as cautions or referral, are possible.

Advantages and disadvantages of option A

Prohibition arguably limits use, limits supply and availability, and is consistent with the United Nations drug conventions, to which New Zealand is a signatory. However, the current high levels of use and the level of black market activity indicate that the current prohibition regime is not effective in limiting cannabis use. Prohibition results in high conviction rates for a relatively minor offence, which inhibits people's education, travel and employment opportunities. Prohibition makes targeting education, prevention, harm minimisation, and treatment measures difficult because users fear prosecution. It also facilitates the black market and potentially exposes cannabis users to harder drugs.

Submitters' views

Ninety-three submissions supported no change to the legal status of cannabis. Eight of these specifically favoured increased penalties for drug suppliers, and four commented on stricter police enforcement or more police to enforce existing laws. The 93 submissions supporting the status quo did so because they think cannabis is harmful to health and that changing the legal status would result in increased use, and 'send the wrong message'. A few submissions suggested that more research is needed to enable policy makers and the public to fully understand the physical, social, and economic impact of cannabis use upon individuals and communities.

Option B: Prohibition with an exemption for medicinal purposes

We have considered option B, which does not require a change to the legal status of cannabis. We recommend that this option be applied for medicinal purposes where appropriate, conditional on a doctor's approval being given (see pages 54 to 57).

Option C: Prohibition with expediency principle

No submissions were in favour of a prohibition model with an expediency principle. This is the situation that currently exists in the Netherlands, and has resulted in very low levels of cannabis use amongst youth and some of the lowest rates of hard drug addiction in the Western world. In practice, the policy allows for licensed premises to sell cannabis over the counter, and users are never prosecuted for simple possession or use. The lack of support for this model among submitters may be because few recognise that this is the actual legal position in Holland, although it could also be because submitters believe that proper regulation above board is required. It is notable that some 1,500 submitters signed a form letter calling for 'Dutch style coffee shops'.

Option D: Prohibition with formal caution and/or referral

The option of prohibition with formal cautioning and/or referral is intended to provide an alternative to court proceedings and the stigma associated with a criminal record. With this option, offenders are given a caution, and in some jurisdictions education or treatment, instead of being convicted. It also provides an opportunity to target offenders and give them information about cannabis and the consequences of future prosecutions.

Jurisdictions with cautioning policies

A number of Australian states have already implemented cautioning policies including New South Wales, Victoria, Western Australia, and Tasmania. All Australian states, with the support of the federal Government, are implementing a formal policy of diversion, giving police and courts the option to direct minor drug offenders into compulsory assessment for treatment or education. England, Wales, France, and Sweden operate under total prohibition policies, but also make some use of cautioning or referral. The majority of the 43 police forces in England and Wales have now adopted a specific cautioning policy in dealing with minor drug possession offences. An evaluation of the Western Australian pilot that included education sessions suggested clear shifts in participants' knowledge of cannabis and the potentially harmful consequence of use, and some evidence of change in attitudes and behaviour. However, the study had a limited sample. The option is consistent with the United Nations drug conventions.

The Swedish experience

The previous committee heard from Dr Per Johanssen, director of the Swedish National Institute for Public Health, about the Swedish experience. This is a prohibition regime that has been successful in dramatically reducing the Swedish level of cannabis use. Sweden decriminalised cannabis use in the early 1960s, and then recriminalised it in 1969 after a significant increase in youth drug use. Sweden progressively tightened its drug laws during the 1970s and 1980s and now has some of the strictest drug laws and lowest levels of drug use in the Western world. Swedish drug laws are characterised by the 'coercive care' model, which, by directing offenders to assessment, focuses more on treatment than incarceration as a method of stopping drug use. No legal distinction is made between serious offences related to soft or hard drugs, so that the penalties for dealing or trafficking in cannabis or heroin, for example, are equally harsh.

We understand there is no published work that shows the effectiveness of the Swedish coercive care programme. The costs associated with this policy may be high, but expenditure on social welfare in Sweden is also relatively high. According to the Australian Drug Foundation, survey data indicates that Swedish drug use rates are very similar to those of the Netherlands, a nation with a different drug policy approach but similar levels of social organisation. In the Netherlands, which operates a more laissez-faire approach to cannabis, there has not been a high incidence of cannabis use. In the United Kingdom, cannabis use is higher, despite the penalties being stricter than in the Netherlands.

Submitters' views

Twelve submissions favoured prohibition with a formal caution and/or referral. Most of these preferred more consistent use of police diversion practices, and advocated a compulsory component of drug education or treatment assessment for minor cannabis offences. Mostly, submitters wanted this approach taken for first, and sometimes second, offenders or youth offenders. The New Zealand Drug Foundation Board favours an improved diversion policy, through increased transparency in warning and diversion procedures, backed by the development of education, counselling, and treatment capacity. A formal warning with provision of health information is suggested as a first formal police intervention, with the second formal intervention for cannabis possession being diversion to an education programme or to a treatment assessment. The APHRU submission supports a similar approach to cannabis enforcement policy, which includes a formal police policy of cautioning or formal warnings for first-time minor cannabis offences, followed by diversion for subsequent minor cannabis offences.

Disadvantages of option D

The Ministry of Justice advised that one disadvantage of this option is that it does not change the way those offences that are prosecuted are handled. This is because the staff and judge time that would be freed is spread across a large number of locations, meaning that the capacity to redirect any of this resource is limited. In addition, 58 percent of prosecutions for cannabis possession or use also involve charges for other offences. If it is assumed that these other offences would continue to be prosecuted, this option may result in approximately 3,500 fewer prosecutions a year. This was approximately 1.3 percent of total prosecutions in 1999. Further, it will not affect the cannabis black market. The discretion itself would be determined by the police rather than Parliament, and could be changed by the police without referral to Parliament. Finally, the use of police discretion

may be selective or arbitrary, and applied inequitably. We would like to see the development of formal criteria and protocols to ensure consistency. It is possible that those receiving a caution may have increased subsequent attention from police, leading to a growing involvement in the criminal justice system. However, cautioning in the United Kingdom suggests the reconviction rates following cautions are low.

Australian state programmes

The submission of the APHRU argued that this option can result in savings in drug law enforcement and other costs, and has the potential to enhance knowledge of the effects of use, and change attitudes and behaviours. In Australia, state programmes were brought about by policy initiatives rather than legislative changes. The cautioning of an offender is at the discretion of the police officer, but strict criteria apply. Most jurisdictions have a separate cautioning system for juvenile offenders, who are also dealt with separately in the rest of the judicial system. Table 12 summarises the cautioning systems that are currently in operation in Australia.

Table 12: Cannabis cautioning programmes in Australia

State	Name of programme	Date introduced
New South Wales	Cannabis Cautioning Scheme	3 April 2000: began 12-month trial
Victoria	Cannabis Cautioning Programme	1 Sept 1998: implemented state wide after a 6-month trial
Western Australia	Cannabis Cautioning and Mandatory Education System	1 March 2000: implemented after a 12-month trial
Tasmania	Cannabis Cautioning Programme	July 1998

The main conditions and criteria for the issue of a caution in the Australian cannabis cautioning programmes are as follows. Cautions are issued for possession of up to 50 grams of cannabis (15 grams in New South Wales and 25 grams in Western Australia) for personal use only and possession of equipment for consumption. Adult offenders must be aged 18 or over (17 years in Victoria), the identity of offenders is confirmed, and the consent of the offender to the caution is required. Offenders are not to have any other prior drug offences, and the offender must admit to the offence. A maximum of two cautions can be issued to one offender (except for Western Australia). No other offences or drugs are to be involved at the time of the caution, and information on the health and legal ramifications and referrals for counselling are to be included with the caution notice. A caution cannot be issued for possession of hashish or hash oil.

Police diversion in New Zealand

In New Zealand, the Police Adult Diversion scheme allows a first-time offender to be 'diverted' into a variety of avenues, such as community work, counselling, referral to agencies, or a donation to charity, instead of receiving a conviction. The New Zealand Police has been instrumental in the development of the diversion scheme, which is used to redress offending with an emphasis on restorative justice. Diversion also allows for the individual merits of each situation to be considered and an appropriate response delivered.

For an offender to qualify for diversion:

- the offence must be a first offence, unless special conditions apply
- the offence must not be serious, or the circumstances must be such that a conviction would be out of all proportion to the gravity of the offence
- the offender must admit guilt, show remorse, and be prepared to pay full reparation
- the offender must agree to diversion
- it is important that the victim and the officer in charge are consulted and their views taken into account.

Police offer diversion for drug offences on a case-by-case basis, considering the merits of the incident. For example, the Auckland Diversion Coordinator generally uses the following framework for minor drug offences:

- payment of an agreed sum based on the fine the court would normally hand down
- restoration to address any damages or loss to family
- curative and educative interventions to warn of drug-related harm and to address any issues of dependence
- acknowledgment that drug use is illegal, and that if arrested again, there is unlikely to be an opportunity for diversion.

Over the past 5 years, approximately 65 percent of recorded cannabis offences were resolved by prosecution, with an average of 26 percent of offences resolved by means of a police warning or caution. However, cannabis offences recorded in the past 2 to 3 years appear to indicate that fewer cannabis possession and use cases are being processed through the court system.

The APHRU submission suggested that expansion of the police diversion programme to include both first-time and subsequent cannabis offences may meet some concerns regarding the economic and social costs of cannabis convictions. Australian jurisdictions agree that the use of written formal cautions and identified harm reduction action—including referral to treatment services—as a part of any diversion by police has improved outcomes wider than those associated with just a justice response. Canadian research (Single, 1999) shows that convictions for some minor cannabis offences do have wider social and economic implications for people who would be unlikely to offend in any other way. That research also identifies that around 92 percent of social users continue to use cannabis despite a conviction.

Police comment

Police have indicated that they will be examining the current diversion guidelines and practice, with a view to ensuring that practice is consistent across the country. The project ran in 2002–03 and it took into account the need for police to exercise discretion in each case.

We think there may be some merit in the police expanding the diversion scheme to further reduce the number of prosecutions and convictions for minor cannabis use offences. We

would expect this to free up police resources for more serious crime. We recognise the need for police to be able to act with some discretion in relation to the diversion scheme, but we are concerned that the application of diversion on a case-by-case basis may have at times resulted in the disproportionate prosecution and conviction, rather than diversion, of the socio-economically disadvantaged and Māori.

We note that concern was raised during hearings about the potentially inconsistent application of diversion. We are concerned about the claim that arbitrary or discriminatory application of diversion occurs in different areas; it is alleged, for example, that diversion is never applied in Porirua, where there is a large Māori and Pacific Island constituency, but it is granted in Wellington Central and Palmerston North. In particular we note the potential for police to become effective judge and jury, deciding who gets diversion and what the effective 'sentence' will be. We also note a potential source of conflict of interest where individual officers can decide on the appropriate recipient of diversion money.

Option E: Prohibition with civil/administrative penalties

With option E, minor cannabis offences become civil rather than criminal offences, and incur on-the-spot fines. Such offences may include cultivation of a limited number of cannabis plants. Such systems have been in place in three Australian states since the late 1980s (South Australia, Northern Territory and Australian Capital Territory), 11 US states from the 1970s (although one state, Alaska, recriminalised in 1990), and also Italy since 1992.

Advantages of option E

This option would reduce the number of offences for minor cannabis use and possession being processed through the court system. Sending infringement notices provides an opportunity for sending information and educational material to users. There is also potential for savings in drug law enforcement costs. This option is consistent with the UN drug conventions.

Disadvantages of option E

On the downside, this option can be misunderstood by the public. Two analyses (Chaloupka et al 1999, Saffer and Chaloupka 1999) have suggested a link between decriminalisation and increased use. The studies found higher numbers of use among people—including young people—living in decriminalised states than in prohibition states. However, more recent research has found no discernible impact on the rates of cannabis use. This option is likely to maintain the cannabis black market, but it is possible that the black market could be undermined somewhat if limited domestic growing were permitted.

Another detraction from this option is that potential savings in drug law enforcement costs could be offset by non-payment of fines. In South Australia, for example, the issuing of fines under the Cannabis Expiation Notice scheme has not resulted in fewer criminal convictions for minor cannabis offences, as expected. The rate of payment of fines has been consistently low in South Australia, and those who do not pay (often those least able to pay) are liable for criminal prosecution. A related problem of 'net-widening', through fines being issued to people who previously would only have been warned, has also occurred in South Australia, where the number of minor cannabis offences detected under the scheme increased by about 2½ times between 1987 and 1996. This increase appears to

be mainly due to the greater ease with which a Cannabis Expiation Notice can be issued under the scheme, compared to the procedures of an arrest and charge that would be required for a prosecution. Finally, a high rate of non-payment of infringement fines may have also led to clogging up the courts. To counter these problems, the South Australian Government in 1997 introduced payment of fines by instalment.

Submitters' views

Sixteen submissions were in favour of prohibition with civil penalties for personal use. Two submissions favoured community service instead of instant fines, because the imposition of fines would unfairly burden the less well-off and favour the wealthy. One submission proposed that the Misuse of Drugs Act 1975 be amended so that minor cannabis offences, such as possession of small amounts and small scale growing for personal purposes, should be expiated through payment of a fine that is targeted for mental health and drug use education, rather than through a criminal conviction. The National Drug Research Institute of Curtin University, Western Australia, recommends an infringement fee model involving cautioning for first offenders; expiation of subsequent offences for possession of small amounts of cannabis, with differing fines depending on the quantity in a person's possession; and flexibility so that the means of expiation could be either payment of the fine or attending a specified cannabis education session. This model provides that failure to respond to an infringement notice would not result in automatic conviction on the cannabis charge, and penalties for driving under the influence of cannabis should be commensurate with those for driving under the influence of alcohol. The joint submission by the Thoracic Society of Australia and New Zealand and the Asthma and Respiratory Foundation of New Zealand supported the continued prohibition of cannabis possession and continued convictions for cultivation, supply, and sale of cannabis, but favoured civil penalties for its use by individuals rather than a criminal conviction.

Option F: Partial prohibition

Under partial prohibition, use, possession, and cultivation of small amounts of cannabis for personal use are legal, but the cultivation and possession of large amounts, and the sale of any amount, are illegal.

Advantages of option F

Partial prohibition would reduce convictions for minor cannabis use and possession. It would free up resources to apply to more intensive enforcement on suppliers to ensure users switch from black market purchasing to home cultivation, thereby reducing the black market demand and its supply and associated harms. However, it would require finding solutions to the difficulties in estimating the amount of savings, ensuring that succeeding Parliaments maintained those funding flows, and calculating whether or not users actually switch to domestic use. Targeted and general education, prevention, harm minimisation and treatment measures, and safe practices in using cannabis would be promulgated in an environment that is more conducive to education about cannabis harms.

This option has been recommended by official Government inquiries in Canada (1972), the USA (1972) and Australia (1996), but has not been implemented in any of these countries. Until recently, such a policy operated to a limited degree in Spain, but the current system in Spain is closer to a civil/administrative penalties framework.

Disadvantages of option F

Disadvantages of this option are that it may be interpreted as symbolising a position in favour of cannabis use, access to cannabis might be enhanced, and it may give rise to increased use. However, there is no evidence that it would increase use. In fact, evidence suggests it would make no difference.

Submitters' views

Thirty-eight submissions supported a partial prohibition option, although it is likely that this figure would be larger, given that some of the 57 submissions that were not specific about their preferred decriminalisation model expressed support for allowing home cultivation for personal use. Most of the submissions supporting partial prohibition favoured an age limit for the legal use, possession, or cultivation of cannabis. The submitters' preferred age limit was generally based on their conception of when an individual reached adulthood. Most submitters favoured an age limit of 18 years of age; however, a few preferred 16 years. Of the submissions specifying plant numbers for home cultivation for personal use, seven submitters supported up to five plants, three wanted between five and 10 plants, and two thought more than 10 plants would fall under this category. The NZMA, which is opposed to any change to legislation that would result in increase use of cannabis, noted that health authorities would be able to offer more organised preventative and quitting interventions under partial decriminalisation.

Option G: Legalisation and regulation

This option would see cannabis become a drug on the open market, in a similar way to how tobacco and alcohol are available. It would be subject to regulation, in the same way that alcohol and tobacco are, as appropriate for a psychoactive drug.

Advantages of option G

Information about the quality and effects of cannabis would be readily available, and the costs of providing that information would be imposed upon the regulated suppliers. Education, prevention, harm minimisation, and treatment measures would be easier to promulgate, as would the promotion of safe cannabis use practices. This option would eliminate convictions for cannabis use and personal possession cases. However, unregulated suppliers and suppliers who act in breach of the regulations would still be prosecuted. This option could free up police resources. Over-the-counter sales could substantially reduce the cannabis black market. Legislation would provide the opportunity to tax what is reportedly a thriving cannabis business and to direct the additional revenue toward treatment and education. However, tax levels would have to be calculated to ensure that price levels discouraged use without being so high as to preserve an incentive for an illegal market.

Disadvantages of option G

Disadvantages of this option are that it might result in increased availability, which could result in increased use and increased risk of harm from the drug. This policy has not been adopted in any industrialised country, although the Dutch model can be called a 'de facto' as opposed to 'de jure' legalisation regime, since it regulates the cannabis market in reality although not in legislation.

Submitters' views

Two hundred and eighty-five submissions favoured legalisation. The vast majority of these favoured legalising with regulation. Only seven appeared to favour no regulation for adults. Approximately 95 of the 285 were based on a standard letter that favoured Dutch-style cannabis cafés and cultivation for personal use. They also wanted criminal records for non-violent cannabis offences to be wiped. As with submitters who supported partial prohibition, those supporting legalisation favoured an age limit for the legal use, possession, cultivation and supply of cannabis. Again, the submitters' favoured age limit was determined by their concept of an adult: the majority favoured 18 years of age, but a few preferred 16 years.

Legalisation can encompass a range of options and the submissions reflected this. There were submitters who favoured regulations similar to those for alcohol or tobacco, and who favoured including cannabis in the smoke-free legislation. Some mentioned the tax revenue the Government could receive and the tourism benefits from legalisation. Some submissions favoured licensing growers under certain conditions; for example, approval would be granted to applicants of a responsible age and would be based on that person's criminal record. The proceeds from application fees would be used for education and administration. One submission claimed that further benefits would be gained by regulating growers in geographical areas where people currently depend on illicit cannabis incomes.

A number of submissions supported licensing sellers in cafés or bars, where cannabis could be sold under regulations limiting trading hours, and restricting sales to minors and intoxicated persons, which alcohol sales are subject to. Others proposed regulating suppliers to ensure that individuals would be able to purchase cannabis in a safe and healthy environment. One submitter argued that a regulated cannabis market would control both the quantity and quality of cannabis available to consumers, and therefore reduce the health risks associated with cannabis use.

One or two submissions proposed some form of licensing for users; one submission suggested potential licensees would undergo physical and psychological testing to be registered, with periodic follow-up tests to monitor well-being and also provide the Government with data to better understand the long-term effects of cannabis use. Others stated their opposition to large-scale production by companies, or to the taxation or advertising of cannabis. Of the submitters who supported option G, 12 percent of submitters who specified plant numbers for home cultivation for personal use favoured up to five plants, six submissions favoured five to ten plants, and two favoured more than ten plants. A few submitters suggested a trial legalisation first, before moving to full decriminalisation.

A number of other categories of comments arise from submissions, including removing criminal convictions for cannabis offenders (114 submissions made this comment, of which 95 submissions were in the form of a standard letter), supporting hemp cultivation (67 submissions), and reversing prohibition on pipes and water bongs.

Option H: Free trade

Advantages and disadvantages of option H

This option would see cannabis become a product on the open market, like bananas, subject to minimal regulation. This option would see some or all cannabis-related offences removed from the Act. It would make cannabis a freely available, uncontrolled substance. Such an approach could reduce the number of police-recorded offences by as many as 24,000 per year, and the number of convicted cases by about 7,000 per year, depending on whether all or only some cannabis-related offences were removed from the Act. Clearly, this option would free up some resources throughout the justice sector and largely remove a black market. However, this policy would be inconsistent with international conventions. It may tarnish New Zealand's image in the international community, and may encourage cannabis tourists to New Zealand.

Recommendations

23. We recommend to the Government that it consider diverting minor cannabis offenders into compulsory health assessment for first possession and use offences, rather than a criminal conviction.

24. We recommend to the Government that the Police expand the diversion scheme for cannabis offences, and apply diversion consistently in all parts of New Zealand so that fewer minor cannabis offences are prosecuted through the courts.

25. We recommend to the Government that the Police examine procedures relating to diversion for cannabis offences in order to determine how greater consistency and fairness might be achieved.

Petitions

1999/37 Petition of Chris Fowlie and others

The above petition is before the committee. It requests that the Government repeal the impending ban on the importation and sale of certain classifications of pipes, waterpipes, bongs and clips. We are not making any recommendations regarding the importation or sale of items associated with the smoking of cannabis.

The Green Party member acknowledges the petition of Chris Fowlie and others calling for an end to the ban on importation and sale of paraphernalia such as water filter pipes and bongs. The Green Party member believes such regulation makes a harm reduction approach more difficult, and notes that the Minister of Health could issue a Gazette Notice to repeal that ban.

1999/114 Petition of Susan Dawn Peacock and 6 others, 1999/122 Petition of Fa'agolo Tualima WongKee and 20 others, 1999/157 Petition of Pastor Adam White and 157 others, 1999/173 Petition of Owen Edgerton and 35,516 others

The above petitions are before the committee. They request that Parliament abandon any move to decriminalise cannabis. We are not recommending such a course of action.

New Zealand National minority view

The New Zealand National Party believes that there should be no softening of the law as it relates to cannabis use. This illegal drug has been shown to be harmful to the physical and mental health of individuals, and especially our youth.

While we support the select committee recommendations on the health aspects as they relate to youth, research, health programmes, and education, we respect the rights of schools to take a zero-tolerance approach to drugs.

We do not believe the Expert Advisory Committee on Drugs should give a high priority to reconsidering the classification of cannabis.

We do not believe the Ministry of Justice should review the eligibility criteria for legal aid.

The cannabis inquiry examined the most appropriate health strategies related to cannabis use and the most appropriate legal status. The National Party believes the issues have been fully canvassed and there are no grounds for now passing the issue to the Justice and Electoral Committee to consider the use of search without warrant powers by the police, or the appropriate legal status.

The legal status of cannabis should remain unchanged.

United Future minority view

United Future does not support the ideology that public health policy and programmes should be planned, funded and delivered within a harm minimisation strategy. We believe that harm minimisation as a strategy does not address the issues and needs of those most at risk from substance abuse and addiction. Instead we would promote an approach that sees New Zealanders maximise their health potential.

We do not support committee recommendations to standardise school-based responses to cannabis offences. We believe that schools with a zero-tolerance approach should be free to do so if this is the will of the community they serve.

United Future wants to register concern about the fact that the inquiry was limited to cannabis, because cannabis is frequently used in conjunction with alcohol and other drugs, and so it is usually not possible to examine its effects separately.

United Future believes it is possible to offer diversionary options to young and first time offenders, for those in possession of amounts reflecting personal use rather than supply, without changing the legal status of cannabis.

United Future, as part of our supply and confidence agreement with the Labour/Progressive Government, has an undertaking from the Government that there will be no government-led move to change the legal status of cannabis during this term of government. Therefore we see no benefit in having the cannabis issue referred to the Justice and Electoral Committee for consideration.

Green Party minority view

The Green member believes that a rational and evidence based drug policy is essential to a healthy society. Like most people, he is concerned about the abuse of cannabis, alcohol and other drugs and the problems of underage use. Clearly heavy, chronic use of cannabis is associated with health problems, and underage use is more likely to be associated with cannabis dependency and harm.

The Green Party believes that it is also clear from the evidence heard by the committee, that moderate use by adults is unlikely to be harmful. One of the problems with the current law surrounding cannabis is that it criminalises non-problematic moderate use while doing nothing to reduce underage use or the abuse of cannabis in general. In fact cannabis abuse and use in general has increased significantly under prohibition.

Prohibition is also associated with a significant illegal economy, the lowering of respect for the law in general and the creation of a more difficult environment within which to educate people about the harm that can result from cannabis abuse.

The Green Party believes the evidence heard by the committee was very clear that the law must change.

In this context, the Green member believes that the United Future party's demand that the Government not introduce legislation to change the legal status of cannabis undermines the select committee process and shows a lack of regard for the evidence.

The Green member supports the removal of all penalties for simple personal use and possession of cannabis by adults, and in addition supports the recommendations of this inquiry.

ACT New Zealand minority view

ACT New Zealand does not support the recommendations made by the health select committee in the report on the cannabis inquiry. Although many parts of the body of the report are sound and well researched we find the recommendations to be vague, unrealistic and if enacted would be of little value but costly to implement. An example of this is the recommendation 'that the ESR test all people killed in road accidents for traces of all illegal drugs and alcohol, including cannabinoids' which is a task involving a large screening laboratory process, it would be costly and the purpose of such a measure has not been outlined. We support the use of clinically tested cannabis products for medicinal purposes.

The recommendations, many of which ACT considers politically correct rhetoric will allow the Government to hide behind the real problem which needs to be addressed, that of the most appropriate legal status of cannabis. This was included in the terms of reference of the inquiry but has not been dealt with.

New Zealand First minority view

New Zealand First opposes extending the availability of cannabis but recognises that there is considerable divergence of opinion that exists within the community. New Zealand First believes the evidence presented to date suggests that consistent marijuana use has harmful

effects on individuals, particularly young people and that it can lead to dependency and/or use of harder drugs. It can also be associated with criminal offending.

New Zealand First will continue to campaign against legalising cannabis and to support the retention of its present status.

Appendix A

Committee procedure

The previous committee called for public submissions on the inquiry. The closing date for submissions was 7 February 2001. The previous committee received 552 submissions from the organisations and individuals listed in Appendix B. The committee heard evidence at Wellington, Auckland, Christchurch, Dunedin, Hamilton and Paihia. The previous committee met between 6 September 2000 and 12 June 2002 to consider the inquiry. Hearing evidence took 56 hours and 21 minutes and the previous committee spent a further 8 hours and 25 minutes in consideration.

We met on 13 November 2002, 26 March, 16 and 30 April, 11, 18 and 25 June, and 9, 23 and 30 July 2003 to consider the inquiry. We spent 6 hours and 28 minutes in consideration. A subcommittee of Steve Chadwick, Dr Lynda Scott and Sue Kedgley (replaced by Nandor Tanczos) met on 6, 14 and 22 May 2003, and spent 2 hours and 15 minutes considering the inquiry.

Committee members

Steve Chadwick (Chairperson)
Judith Collins
Ann Hartley
Dave Hereora
Sue Kedgley
Nanaia Mahuta
Pita Paraone
Heather Roy
Dr Lynda Scott
Judy Turner
Dianne Yates

Nandor Tanczos replaced Sue Kedgley for this item of business.

Advisers

Ministry of Health
Ministry of Justice

Appendix B

List of submitters

Of the 552 submissions on the inquiry, 60 were anonymous submissions and one was received as secret evidence.

Expert submissions

Institute of Environmental Science and Research
Christchurch Health and Development Study
Simon Lenton
National Drug and Alcohol Research Centre
New Zealand Drug Foundation
Paul F Smith
Alcohol and Public Health Research Unit
Drug and Alcohol Services Council
National Centre for Treatment Development

Submissions from organisations

198 Youth Health Centre
Alcohol and Public Health Research Unit, University of Auckland
Alcohol Drug Association New Zealand
Aotearoa Legalise Cannabis Party
Art Department
Ashburton District Council
Association of Proprietors of Integrated Schools
Asthma and Respiratory Foundation of New Zealand
Auckland Council for Civil Liberties
Auckland University NORML
Australian Committee for Medical Cannabis
Australian Drug Law Reform Foundation
Awhitu Peninsula Fellowship
California NORML
Cannabis Corporation Limited
Catholic Women's League of New Zealand
Central King Country Rural Education Activities Programme
Christian Heritage Party
Coalition for Cannabis Law Reform
Community Action Project of Whangaruru
Crown Public Health
Drug Abuse Prevention Alliance
Drug-Arm New Zealand Foundation
Dunedin Multidisciplinary Health and Development Research Unit
Family and Caregiver Support
Gain New Zealand
Green ELM Institute
Green Party of Aotearoa New Zealand
Greenlane Christian Centre
Growth Through Moderation Society
GW Pharmaceuticals
Health Action Te Mana Taki Hauora
Independent Schools Council
Invercargill Safer Community Council
Kelburn Club
Legalise Cannabis Alliance
LibertariaNZ
Life Education Trust (NZ)
Marlborough Health Promotion Public Health Unit
Massey University Students Association

Mayors Opposed to Marijuana Decriminalisation
Mental Health Collective
Mental Health Commission
Mild Greens
Mount Maunganui Baptist
National Council of Women of New Zealand
National Organisation for the Reform of Marijuana Laws (NORML)
New Mexicans for Compassionate Use
New Zealand Automobile Association
New Zealand Medical Association
New Zealand Medicinal Cannabis Club
New Zealand Police Association
New Zealand School Trustees Association
New Zealand Women's Christian Temperance Union
North New Zealand Conference Seventh-day Adventist Church
NSAD Care Ltd
Opotiki Community Issues Steering Group
Opotiki Safer Communities Council
Otago University NORML
Otumoetai College Parent Teacher Association
Patients Rights Advocacy Waikato
Pharmaceutical Society of New Zealand
Planetary Healing Foundation
Presbyterian Church of Aotearoa New Zealand Caversham Parish
Public Health South Te Waka Hauora
Regional Public Health, Hutt Valley
Royal Australian and New Zealand College of Psychiatrists
Rural Women New Zealand
Salvation Army
Schizophrenia Fellowship New Zealand
St Peter's College, Auckland
Students from Hamilton Boys High School
Te Rūnanga o Te Rarawa
Te Ruunanga A Iwi O Ngati Tamatera
Thoracic Society of Australia and New Zealand
Toi Te Ora Public Health
Wellington and Victoria branch of NORML
Wellington Community Law Centre
Wellington People's Centre
WellTrust
Westminster Christian School
Youth Trust
Zoe Evangelistic Ministries

Submissions from individuals

Aaron Neumann
Adrian Holloway
Adrian Picot
Alan Anderson
Alan Millar
Alexander Hull
Alexander Montgomery
Alexis Hilton Hope
Alistair Newman
Allan Harris
Alma Dillon
AM Berkhoff
Aman Pilgrim
Amanda Reilly
Andrew
Andrew
Andrew Boyd
Andrew Hoy
Andrew McClure
Andrew Te Ua
Andrew Tustin
Andy
Andy Maloney
Angela Black
Angus Jones
Ann Te Ua
Anna McKnight
Anthony Bremner
Anthony Cox
Anthony NW Ryder
AP Winnington
Arthur Baysting
AS Gibbons
B Brosnan
Barbara Groundwater
Barry Kenneth Stone
Belinda J Murphy
Ben Hall

Ben Mayes
Ben Thell
Benjamin James Moore
Benjamin Parsons
Bernard Smith
Bill Barnes
Billy McKee
Bradley James Schmidt
Brandon Hutchison
Brandon Lynn
Brendan Torelle
Brent Royds
Brodie John Andrews
Bruce Royal Gurnick
BS Carruthers
C McDonald
C Withers
Caleb Armstrong
Callum Malcolm
Cameron Forbes
Carol Ann Bradford
Caroline Allison
Carolyn Searle
Carsten Zoff
Cassia Simeon
Che Riley
Chris Comely
Chris Heffernan
Chris Lawry
Christine Frew
Christine Mitchell
Christopher Holmes
Colin Douglas Grayling
Coral Hammer
Corina Drumm
Craig Hart
Curtis Antony Nixon
D Gales
Dale McKinley
Damian Moran
Daniel Savage
Daniel Taylor
Danna Glendining
Darryl White
Dave Burkhart
Dave Whitaker
David Crowther
David Dwyer
David G Meikle
David Hadorn
David Hay
David MacClement
David Moore
David R Currie
David Ross
David S Gilgen
David Wheatley
Dawn Bowen
Dean Isherwood
Dean Pearce
Deidre Parkes
Denis Shuker
Dennis and Norma Walker
Dennis Walker and others
DJ Simpson
Dr Alex Wodak
Dr KNP Mickleson
Duncan Langley Eddy
Duncan Robertson
EA Evans
Ed
Edward-Jay Robin Belanger
Eileen Jacoba Puharich
Elizabeth Anne Franks
Emily Sandford-May
Emmet Maloney
Emmiline Hawthorne
Eric Messick
Esther Robb
Frederick Noel Fastier
Gabrielle McVeigh
Garth Bishop
Gary Stuart Clarkson
Genevieve de Spa
George Ridley
Glenis Schomburg
Glenn Kelly
Glenn McIntosh
Graeme White
Graham French
Grant Nicholson
Greg Harris
Greg Soar
Greg Walter
Gregory John Henderson
Hamish Bannister

Hamish MacEwan
Hannah Pearce
Harry Cording
Harry Rain
Harry Stottle
Haydn Flower
Heath Nola
Heather McDonald
Helen Shaw
Hon Peter Dunne
Hubert Peeters
Hugh Robb
Ian Holmes
Ian Holten
Ingrid O'Connor
Irene Atkinson
Irinka Britnell
Isabel Pasch
JA Matangi
J Rendille
Jack Callinan
Jakh Heremia
James McNee
James Muir
Jamie Hargroves
Jamie Kearney
Jamie Kerr
Jane Hutchison
Janine Robinson
Jason
Jason Baker-Sherman
Jean Jackson
Jeanette Saxby
Jeffrey Douglas Law
Jenine Clift
Jenness Rouche
Jenny George
Jeremy Robert Evans
Jesse Attreau
Jessee Swaney
Jill Young
Jim Hughes
Jim Rankin
Jo Blanchfield and Mike Swanson
Joe Citizen
Joe Wein
John B Westbrooke
John Creser
John De Bonnaire
John Dolan
John Marks
John Riddell
John Salter
Johnny Theisen
Jonathan McMahon
Jonathan Rennie
Joseph Clay Roehl
Judith Hyndman
Julian Maxwell
Julie Hamilton
Justin Moore
Karen Blacklock
Karl Suntinger
Kate Turner
Katherine Dewar
Kathryn Liddell
Kelly Needham
Kenneth John Haydock
Kent Deitemeyer
Kerry Baird
Kerryn Pollock
Kerylee Jan Anaru
Kevin Myers
Kevin O'Connell
Kirstie McAllum
KM Smith
Kristine Ford
Kristy Robinson
Laura Elliott
Lauren Somerhayes
Laurie and Trevor Griffiths
Leane Pragert
LeeAnn E Illminen
Leonard Mills
Les Gray
Leslie Yates
Lew Dangerfield
Lloyd David Jones
Lois Ford
Luke Millard
Luke Nieuwenhuizen
Lynden Wallis
Lynley and Philip Lake
M A M B
M and GW Parker
Maarten Nieuwland

Marama Tate
Margaret A Malin
Margaretha Antje Norder
Marie Gunn
Marie Summers
Marion Barnes
Mark Cubey
Mark Feldman
Mark Richards
Martin McCarron
Martin Smith
Mary F Holden and Susan Moore
Mary Woodward
Mathew Jenkins
Mathew Watson
Matthew Hughes
Matthew Jeyes
Matthew King
Matthew O'Byrne
ME Brosnaham
Meagan Moller
Megan McDonald
Melanie Sannum
Meliors Simms
Melissa Rose Andrew
Metiria Turei
Michael Britnell
Michael Craig Hobbs
Michael Falvey
Michael Foreman
Michael J Morel
Michael Killick
Michael McMullan
Michael Ross
Michael Sands
Michael Sheehan
Michael Smith
Michel D'Hondt
Michele Poore
Mike Finlayson
Mike Scott
Misa Matyr
Mischele Rhodes
Monica Haar
Mrs J Leota
Murray Tingey
NM Wardlaw
Nancy Eisenberg
Nathan Kennerley
Neil Hunt
Neville Yates
Ngaire Pryde
Ngawai Greenwood
Nick Henry
Nick Taylor
Nicola Harvey
Nigel Little
Nik Mildenhall
Nik Warrensson
Ohomauri Ripia
Oliver Hoffmann
Oliver Rankin
Patricia Bellaney
Patrick Stowers
Paul Bradley
Paul Briggs
Paul Elwell-Sutton
Paul John Robinson
Paul McMullan
Paul Taylor
Paul Watson Paton
Paul Winstanley
Paula Lambert
Paula van Beek
Pauline Gardiner
Pema Hegan
Peter and Marie Stafford
Peter Beaumont
Peter Hitchcock
Peter MF Smith
Peter Noanoa
Peter W Butcher
Peter Wakeman
Phil Deere
Phil Mackie
Phil Saxby
Phil Taylor
Pip Harker
PJ Truscott
Quanah Hudson
RA and LJ Upton
Ray Hunt
Regan Andrew
Renne Murison
Rhys Wilson

Richard Ernest Wilson and Gail Clarke Wilson
Richard Jeffrey
Richard Selinkoff
Rick Cranston
Rick Williment
Rob Hawes
Robert J Gregory
Robin Chadwick
Robin Martin
Rodger McCaw
Roger Douglas Keen
Rohan Wittmer
Ronald Hamilton Reid
Rosalie Duke
Rosalie Steward
Roseanne Hay
Russell Masters
Russell W Gilmer
Ryan Kopp
Ryan Oliver
Sam Wilson
Samantha
Sandy Hay
Sarah Duckworth
Sarah Pavis
Schannel van Dijken
Sean Priest
Shari French
Sheila Malcharek
Sian Northfield
Simon Chisnall
Simon Field
Simon Monckton
Simon Vale
Simon Wood
SL English
Slaven Kljucanin
Sonja Graetz
Stephanie McCulloch
Stephen Anderson
Stephen Guntrip
Stephen Lwee
Stephen McIntyre
Stephen Munro
Stephen Straver
Steve Burnett
Steve Esson
Stuart Harwood
Stuart Young
Sue Bagshaw
Sue Heap
Sue Worth
Sugra Morley
Susan Travan
TH Parker
Tai Lockie
Teresa Aporo
Terry Sheppard
Tess Pickering
Tessa Burrows
Tim Minehan
Tim Wyborn
TND Anderson
Tony Brown
Tony Player
Trystan Swain
Valerie Morse
Veslemoy Guise
Vickie Gosling-Walker
Vincent Mark Williams
WH Thomson-Prosser
WAH and JS Williams
Walter Richards
Warren Bryson
Warren Watson
Wendy Vivienne Crane
William J Keir
William Jon Mervyn Howell
WM Moore
Worik Macky Turei Stanton
Yani Johanson
Yuval Kravitz

Appendix C

Form submissions

The previous committee received 1771 postcard type form submissions, which state the following:

Form submissions

> Public health and health promotion strategies to minimise the use and harm associated with cannabis should be based on harm reduction. The best way to prevent cannabis abuse is with honest, credible and factual drug education. Only in a climate where cannabis is viewed from a public health perspective instead of a criminal justice perspective can prevention efforts by [sic] effective. Hundreds of thousands of New Zealanders choose to use cannabis, and very few abuse it. Arresting these otherwise law-abiding citizens serves no legitimate purpose, extends government into inappropriate areas of our lives, and causes enormous harm to the lives, careers and families of the thousands of cannabis smokers arrested every year. Far more harm is caused by cannabis prohibition than by the use of cannabis itself. We need more compassionate drug policies that help people rather than punish them. Other countries that have reformed their cannabis laws have not experienced any significant increase in cannabis use, and have achieved huge savings in law enforcement as well as improving the effectiveness of drug education and treatment. I call for the immediate removal of all penalties for the use possession and cultivation of cannabis by adults for personal use, and the non-profit transfer of small amounts. Criminal records for non-violent cannabis offences should be wiped. I support the introduction of Dutch-style cannabis cafes. Regulating the sale of cannabis would most effectively control access by minors, and minimise harms to cannabis users and to society.

The committee received a further 193 form submissions of a similar nature, and another 14 form submissions with similar recommendations.

Appendix D

Cannabis as a controlled drug in New Zealand

Summary of the classification framework for cannabis as a controlled drug (CD) within the Second Schedule of the Misuse of Drugs Act 1975

Second Schedule Class B controlled drugs
Part 1—includes refined or concentrated forms of cannabis (higher potency than natural plant leaf). For example, cannabis resin (hashish) and oil (hashish oil)
Substances have generally been processed
Includes opiates with both therapeutic and abuse potential
Minister's approval only required for use of cannabis oil/resin (ie not for morphine or opium)
Part 2—mainly stimulants
Includes amphetamines with medical uses (for example, methylphenidate). Lesser dependence potential than substances in Part 1
Minister's approval required for prescribing, dispensing, and administration.
Part 3—commonly used for medical purposes
Lesser dependence potential than Parts 1 and 2. Includes drugs not yet used in New Zealand, but have been used and classified internationally. For example, New Zealand asked to classify by the United Nations
Minister's approval not required

Section 18 police powers of search and seizure without warrant apply only to controlled drugs listed under Part 1 of the Second Schedule.

Penalties for all controlled drugs listed in the Second Schedule are: up to 14 years' imprisonment for importation, manufacture or supply; up to 10 years' imprisonment for conspiracy to commit an offence; up to 3 months' imprisonment or $500 fine or both for possession.

Summary of the classification framework for cannabis as a controlled drug (CD) within the Third Schedule of the Misuse of Drugs Act 1975

Third Schedule Class C controlled drugs (cannabis leaf, fruit, and seed)
Part 1—natural forms of cannabis
Generally substances used illicitly rather than medically
Minister's approval required
Part 2—moderate abuse potential, but also have therapeutic uses
Readily prescribed by medical practitioners
Part 3—similar products to Part 2, ie therapeutic substances, but generally lesser dependence potential than Part 2 substances
Partially exempted drugs that can be supplied without prescription in certain circumstances
Part 4—includes barbiturates with medical uses, for example, sedative effects. Some no longer used
Moderate dependence/abuse potential, although barbiturates probably have more dependence/abuse potential than the benzodiazepines in Part 5 (which is why they are no longer really used)
Part 5—includes benzodiazepines and some barbiturates. Medical uses (for example sedatives). Moderate risk of abuse/dependence potential. Probably less risk than Part 4 substances
Part 6—includes pharmacy only medicines. Some over the counter.
CDs exempted from the prohibition on export/import, supply, administer—for example when prescribed by medical practitioners
Part 7—CD analogues

Section 18 police powers of search and seizure without warrant apply only to controlled drugs listed under Part 1 of the Third Schedule.

Penalties for all controlled drugs listed in the Third Schedule are: up to 8 years' imprisonment for importation, manufacture or supply; up to 7 years' imprisonment for conspiracy to commit an offence; up to 3 months' imprisonment or $500 fine or both for possession.

Appendix E

Penalties for cannabis offences: some international comparisons

Country	Maximum fines or custodial sentences for cannabis offences (trafficking offences compared with possession offences for personal use)
United States (Federal)	**Life imprisonment** for Federal trafficking offences
	Civil penalty of up to **US$10,000** per violation for possession of marihuana for personal use
United Kingdom	**14 years** plus **unlimited fine** for trafficking (Crown Court)
	6 months and fine of **Stg£2,000** for trafficking (Magistrates Court)
	Caution or **fine** to **5 years** (Class B drugs), or **2 years** (Class C drugs) for possession of small amounts for personal use
Canada	**Life imprisonment** for importing/exporting or possession for purposes of exporting, or trafficking
	Up to **Can$1,000** fine or imprisonment for up to **6 months (or both)**, for possession of 1 gram of cannabis resin, or 30 grams of cannabis
Australia (varies per state)	South Australia:
	Up to **25 years** and **A$500,000** for trafficking; but double this penalty for sale or supply to a person under 18 years, or within a school zone
	Between **A$50** and **A$150** for possession, use, or growing of small amounts
	ACT:
	Up to **life imprisonment** for cultivating for sale or supply (for more than 1,000 plants)
	Up to **A$100** for cultivation of not more than 25 grams of cannabis
Sweden	Up to **18 years** for multiple offences of recidivism
	2 to 10 years for 'grave narcotic drugs offences'
	Up to **3 years** for 'narcotic drugs offences'
	Up to **1 year** for 'gross negligence'
	Up to **6 months** or a fine if offence judged to be 'petty'
Netherlands	Up to **4 years** and a fine of **Euro$45,000** for imports and exports or professional cultivation
	1 month and/or fine of **Euro$2,300** for possession or sale of no more than 30 grams of hemp