LAW·COMMISSION
TE·AKA·MATUA·O·TE·TURE

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CONTROLLING AND REGULATING DRUGS

A SUMMARY OF THE LAW COMMISSION'S ISSUES PAPER ON THE REVIEW OF THE MISUSE OF DRUGS ACT 1975

Contents

This summary document is primarily designed for use by individuals and groups wishing to participate in the consultation process and to make submissions on the reform of the Misuse of Drugs Act 1975. It includes the terms of reference given to the Law Commission for the review, a high level summary of the contents of the Issues Paper, and a list of key questions.

Introduction

Substances that affect mood and behaviour ("psychoactive substances") have been used across the world for thousands of years. In New Zealand, the recreational use of illegal psychoactive substances is regulated by the Misuse of Drugs Act 1975.

This Act is now 35 years old. Its main components were developed in the 1970s, when the "hippie" counterculture was at its height and the illegal drugs of choice were cannabis, cocaine, opiates and psychedelics like LSD.

Since that time, a great amount of research has been undertaken into the effects of different drugs. We now know much more about the harms of drug use, and what can be done to reduce that harm. While cannabis use remains relatively high, new drugs have appeared. In the 2000s, party pills like BZP and more harmful drugs like methamphetamine have joined cannabis at the forefront of New Zealand's drug scene. New Zealand's drug landscape is vastly different from that which the Act contemplated in 1975.

Over the years, various amendments have been made to the Act to respond to issues as they arose. These ad hoc amendments have resulted in an Act that has become difficult to understand and navigate. A first principles review of the Act is well overdue.

In 2007 the Associate Minster of Health invited the Law Commission to review the Act. This invitation arose partly in response to the debate over the reclassification of BZP as a Class C controlled drug. The Government decided that, in the light of this debate and other fundamental difficulties with the Act, a broad review of the Act was required.

The Law Commission's issues paper on the Misuse of Drugs Act traces the history of drug policy and regulation in New Zealand, and reviews the current approach to drug regulation. It makes some preliminary proposals for how New Zealand's drug laws can be updated to put in place a modern and evidence-based statute with the ability to respond to the inevitable changes that New Zealand's drug landscape will continue to face.

The Commission's overall approach to its task has been guided and constrained by New Zealand's obligations under the international drugs conventions, which are discussed below in Part 4. At a minimum, these conventions require that the production, manufacture, import, export and supply of drugs listed in the conventions be criminalised. We have not suggested any dilution of New Zealand's prohibition approach in relation to these activities.

Nor would we wish to. In particular, we believe that there must continue to be a vigorous law enforcement focus on large-scale commercial dealing in all convention drugs, backed up by severe penalties.

At the same time, there is room within the conventions to consider more flexible options for responding to small-scale dealing and personal possession and use, particularly where those activities are linked to addiction. We have mooted the possibility that there should in such cases be less emphasis on conviction and punishment, and more emphasis on the delivery of effective treatment.

We have also concluded that our regime for dealing with non-convention drugs is unsatisfactory and needs a major overhaul. Until recently, unless new psychoactive substances were classified as a food or medicine, they were freely available, and could be marketed and used without restriction as a recreational drug until they were proved to be harmful and prohibited. In essence, there was an all-or-nothing approach, in which prohibition was the only form of regulation.

The restricted substances regime introduced in 2005 modified that by allowing new substances to be classified but made available subject to stipulated conditions and restrictions. However, it has only been applied to one substance (BZP, since prohibited). We advocate a new approach, which would prohibit any new psychoactive substance from being manufactured, produced or imported without prior approval. Upon application for approval, a variety of regulatory options would be available; prohibition would be the last resort. This would provide much greater protection for the public.

Our detailed options for reform, upon which we seek feedback, have been developed within this overall framework. The full text of the issues paper can be viewed on the Commission's website www.lawcom.govt.nz. It is also possible to comment on specific questions raised in the paper and to make submissions via the Commission's consultation website www.talklaw.co.nz. We encourage those who wish to make submissions on particular topics to read in full the chapters that relate to those topics, and to consider the questions set out in them.

Terms of reference

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

2 The issues to be considered by the Commission will include:

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

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

Part 1

New Zealand's drug problem and its costs

NEW ZEALAND'S DRUG SCENE

1.1 Chapter 1 of the issues paper outlines what is known about levels of drug use in New Zealand.

1.2 Legal psychoactive substances are the most widely used psychoactive substances. A recent survey on New Zealand drug use in 2007/08 found that approximately 85 % of respondents reported using alcohol and 23 % of respondents reported using tobacco in the last 12 months. The Commission is undertaking a separate review of our alcohol laws.

1.3 Cannabis is the most widely used illegal drug in New Zealand. Approximately 15 % of survey respondents reported using cannabis in the past 12 months, while over 46 % reported using it at some time in their lives. New Zealanders' use of cannabis remains higher than use in the United States, Australia, or any country in Europe.

1.4 BZP was the fourth most widely used drug after alcohol, tobacco and cannabis (used by about 6 % of respondents in the past 12 months) followed by ecstasy (used by about 3 %). Although the use of amphetamines has increased in New Zealand since the late 1990s, use of these substances remains confined to a small proportion of the population. About 2 % of respondents reported using amphetamines in the last 12 months.

1.5 These proportions do not represent discrete populations. Many drug users do not confine their use to one particular drug, but use a number of drugs, often in combination. Nevertheless, it is clear that many New Zealanders engage in recreational drug use at some point in their lives, and the vast majority do so if alcohol is included.

DRUG-RELATED HARM IN NEW ZEALAND

The nature of drug-related harm

1.6 It is unarguable that drug use causes substantial harm to and imposes major costs on the community. This is the case whether the drug used is a legal drug like alcohol or an illegal drug like cannabis or methamphetamine.

1.7 Chapter 2 reviews the available evidence about the particular harms caused by cannabis and methamphetamine. These two drugs are at the forefront of public debate in New Zealand.

1.8 A significant amount of research has been undertaken on the harms of cannabis use. Most cannabis-related harms are caused when use is regular and long-term. These harms include the risk of dependence, harm to respiratory and other functions particularly from the effects of smoking, and mental health disorders. Cannabis use in adolescence can be especially harmful, with an increased risk of cannabis dependence and an unexplained link between cannabis use and use of other illegal drugs. Research also suggests that cannabis use increases the risk of a motor vehicle accident by two to three times.

1.9 There is less research available on methamphetamine, which has come more recently onto the drug scene. This means that some key questions about the effect of methamphetamine (for example, its link to violence) remain unresolved. Nevertheless, research demonstrates that methamphetamine use is potentially life-threatening, can lead to a number of psychological harms including psychotic symptoms, suicidal thoughts, and anxiety disorders, and puts users' physical health at risk. Much more so than cannabis, it is clear that methamphetamine can cause serious harm at the time of use and over the longer term.

Identifying and measuring drug-related harm

1.10 However, while the harms and costs associated with alcohol are typically understated and misunderstood, those associated with illegal drugs are often generalised and overblown. It is currently difficult, if not impossible, to accurately identify and measure drug-related harm. There is a lack of robust evidence about the full range of harms, short-term and long-term, that each illegal drug causes. Drug-related harm also varies significantly depending on the drug concerned and the individual who uses it. Some drugs primarily cause harm to a small subset of users who use repeatedly or excessively, while other drugs cause harm even after modest levels of use.

1.11 In addition, while discussions about alcohol regulation acknowledge the benefits arising from its use, discussions about the harms arising from using other drugs tend to ignore the benefits that may arise, including therapeutic benefits. There is also a tendency to conflate the harm arising from drug use with the harm arising from drug prohibition. The development of a criminal black market in a prohibited drug (and the crime that goes with it), the cost to the State of enforcing drug prohibition, and the impact on a drug user of a criminal conviction are harms of drug prohibition, not of drug use.

Part 2

The overall approach to drug regulation and drug policy

DRUG REGULATION

2.1 The main justifications that tend to be put forward for regulation of any activity are broadly:

- to reflect, enforce, and shape moral values;
- to prevent harm to those who might engage in that activity;
- to prevent harm to others from an individual's choice to engage in that activity.

2.2 We discuss how these justifications might apply to drug use in chapter 7. In our view, regulation to prevent people from harming themselves is justified only in limited circumstances. In the drugs context, we think these circumstances are only to protect the young and those whose mental faculties are impaired. That is the approach we have taken in chapter 16 to developing options for reform of the Alcoholism and Drug Addiction Act 1966.

2.3 Beyond those limited exceptions, we think that regulation of drug use is justified only to prevent harm to others, and where the benefits arising from that reduction in harm outweigh the costs arising from regulation itself. That is, in essence, the approach taken in our issues paper on the regulation of alcohol.

2.4 However, we should emphasise that the harm people cause to themselves is not irrelevant to the discussion about whether or not to regulate. That harm almost inevitably causes harm to others as well. Moreover, it may erode social cohesion and undermine fundamental values, thus causing harm to society as a whole.

DRUG POLICY

2.5 If drug regulation is to be based on the objective of reducing harm to others, so too must drug policy.

2.6 Chapter 3 discusses the Government's drug policy, which is contained in the National Drug Policy 2007–2012. The overarching goal of the Policy is to prevent and reduce the health, social, and economic harms that are linked to tobacco, alcohol, illegal, and other drug use. This reflects the principle of harm minimisation.

2.7 The Policy supports a broad and integrated approach to minimising the harm of drug use under the three pillars of:

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

2.8 The Policy's approach is supported by the United Nations, which most recently has stressed the need for drug policy to achieve a balance between strategies and measures aimed at eliminating drugs and those aimed at reducing demand through prevention and treatment.

2.9 We note some difficulties with the concept of harm minimisation in chapter 3. In particular, the concept has too often been seen as a proxy for the legalisation of a particular drug or of drugs in general. For that reason, it has been the focal point of competing ideologies in drug control policy. This is unfortunate and illustrates how easily semantics can divert attention from the real issues.

2.10 Notwithstanding these difficulties, we consider that harm minimisation remains an appropriate policy platform for the future. The question is how to ensure that the regulatory approach provides adequate support for that platform.

Part 3

Problems with the current approach to drug regulation

MISUSE OF DRUGS ACT 1975

3.1 Chapter 4 outlines some of the difficulties that have emerged with the Misuse of Drugs Act since its enactment. The Act is now 35 years old. It has been amended numerous times and is supported by two free-standing but closely linked amendment Acts. As a result, the Act has become difficult to understand and navigate. It is questionable whether it now provides a coherent or effective legislative framework.

3.2 Particular difficulties with the Act include:

- how the Act deals with new and unregulated psychoactive substances;
- concern that the current classification of some drugs does not accurately reflect available evidence about their relative harm;
- the use of regulations, rather than the Act itself, to deal with significant matters of policy;
- the Act's interaction with other relevant legislation such as the Medicines Act 1981 and the Hazardous Substances and New Organisms Act 1996, which may also apply to psychoactive substances (discussed further in chapter 5).

3.3 Most fundamentally, however, the Act seems poorly aligned with the policy platform of harm minimisation. The Act is a criminal justice statute. Its focus is on controlling the supply of drugs by eliminating their illegal importation, production and supply. The use of drugs, even by those who are dependent on them, is largely treated as a matter solely of criminal policy rather than health policy. It should, however, be the concern of both.

3.4 Of course, legislation inevitably has a particular focus on law enforcement, because this is how offences are created and law enforcement powers are provided. In contrast, legislation may not be necessary, or even particularly appropriate, for establishing education programmes, voluntary treatment options, or programmes to reduce harm.

3.5 The 1973 report of the Blake-Palmer Committee, on which much of the Act is based, included recommendations for improved treatment and support for those dependent on drugs and for high quality preventive community education. These recommendations did not require legislation to implement, and do not therefore feature in the Act. Perhaps as a result, these aspects of the Committee's recommendations have not received the attention they deserved.

3.6 New Zealand's approach to drug regulation has also been heavily influenced by international developments, particularly the worldwide focus on the "war on drugs". The armoury of this war is predominantly an armoury of supply control. This has been at the expense of measures to reduce demand for, and limit problems caused by, drug use.

3.7 If there is to be some rebalancing to ensure that strategies and resources match the objectives of the National Drug Policy, greater legislative recognition of demand reduction and problem limitation strategies is required.

Part 4

New Zealand's international obligations

THE REQUIREMENTS OF THE INTERNATIONAL DRUG CONVENTIONS

4.1 New Zealand is a party to three long-standing United Nations drug conventions:

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

4.2 The conventions apply to over 100 narcotic drugs and psychotropic substances. These substances have historically been the most widely used psychoactive substances for medicinal, scientific and recreational purposes.

4.3 Chapter 6 outlines the obligations these conventions impose. Broadly, they require parties to limit the production, manufacture, import, export, trade, distribution, possession and use of particular drugs to legitimate medical and scientific purposes. The conventions have led to prohibition becoming the dominant global approach to controlling the use of illegal drugs for recreational purposes.

4.4 There is a significant debate internationally about the effectiveness of prohibition. Some argue that prohibition has not deterred drug use and itself causes very substantial harm. In contrast, the United Nations considers that, at the least, prohibition has led to drug use being contained.

4.5 Whatever the merits of that debate, which is discussed in chapter 7, parties are bound under international law to the obligations the conventions impose. The only alternative is for a state to denounce one or more of the conventions, an action no state has ever taken.

4.6 We consider that New Zealand must continue to comply with its obligations under the conventions. This is consistent with New Zealand's role as a member of the international community. A very high proportion of countries are signatories to the conventions and, despite the increasing disquiet over the effectiveness of prohibition, there still remains a high level of international consensus on the broad parameters of drug policy. Moreover, it is not feasible for one party to the conventions to legislate in this area in isolation from others. To do so risks compromising the effectiveness of international efforts towards drug control.

4.7 However, this does not preclude changes to New Zealand's approach to the control of convention drugs. There is considerable debate about whether the conventions require criminalisation of possession and personal use. On a less conservative interpretation of them, they do not. However, even within a framework that continues to criminalise possession and personal use, there is substantial room for movement in the treatment of personal drug use and lower-order offending in general. In addition, the conventions do not apply to new psychoactive substances that come onto the drugs market.

Part 5

Proposed approach to convention drugs

CLASSIFICATION OF PROHIBITED DRUGS

5.1 Chapter 9 discusses the ABC drug classification system, which is fundamental to drug regulation in New Zealand. Under this system, the restrictiveness of controls imposed on a particular drug, and the severity of penalties attached to breaches of those controls, depends upon whether a drug is classified as falling into Class A, B or C. Which class a drug falls into depends on the harm it causes. Since 2000, there has been an Expert Advisory Committee on Drugs, which provides advice to the Government on classification decisions.

5.2 There has been no systematic review of the individual drug classification decisions made before 2000. It is generally accepted that some of the current classifications are anomalous, and do not reflect available scientific evidence about drug harm.

5.3 A number of other criticisms have been levelled at classification systems like ours. These include:

(a) Their potential vulnerability to media and political pressure. However, this pressure will inevitably play a part in decisions about penalties for drug offences no matter how these penalties are set.

(b) The way in which harm is assessed. There is much debate about how to measure drug harm. But while the available evidence varies from drug to drug, scientists are generally agreed on the relative seriousness of the harm caused by most commonly used drugs.

The approach to classification

5.4 There are a range of options for reforming the approach to classification:

(a) *Abolish classification altogether in favour of a single maximum penalty for all drugs:* This would mean, broadly, that an offence involving cannabis or BZP would attract the same maximum penalty as an offence involving heroin or methamphetamine. The relative culpability of each substance would be reflected in the offender's sentence, perhaps guided by statutory guidance or guidance issued through the courts. This option would leave a lot of discretion with sentencing judges to decide the seriousness of a wide range of conduct. There would also be no systematic way of informing judges, for sentencing purposes, about the different harms associated with different drugs.

(b) *Establish a two-tier classification system:* This would make a clear distinction between very harmful and less harmful drugs. It might provide clearer and more easily understood categories than a three-tier system but may be too simple a system to deal with the wide range of harms posed by different drugs.

(c) *Retain the current classification system with some changes:* If this option was progressed, a necessary change would be a requirement to keep the classification system under regular review to ensure it remains up-to-date with developing scientific knowledge and relevant changes in the drug landscape. Current classifications would also need to be reviewed.

(d) *Establish a more nuanced classification system:* Further tiers could be added to the classification system with maximum penalties based on the score a drug type receives on a scientifically based drug harm index. The main problem with this option is its reliance on accurate identification and measurement of drug harms. As noted above, there are real problems in this area. In addition, a multi-tier system may distort the sentencing process because it would create a large number of offences with little between them in terms of culpability.

The process of classification

5.5 If a classification system is retained, as it would be under options (b) to (d), there needs to be a process for making classification decisions. We propose the following changes to the current process:

(a) *Criteria used for classification decisions:* We think that, unlike now, the criteria used to decide whether to prohibit a drug should be different from the criteria used to decide the class in which a prohibited drug should fall. The costs and benefits of prohibition need to be taken into account when deciding whether or not to prohibit a drug. Harm to others is the most important consideration when it comes to classification, categorised according to the substance's physical harms, dependence potential and social harms.

(b) *Body that makes classification decisions:* There remains a need for a statutory committee of experts, like the Expert Advisory Committee on Drugs, to advise the Government on the regulation and classification of drugs but in a modified form. We propose a committee of eight people who between them have appropriate expertise in one or more of the following: pharmacology, toxicology, drug and alcohol treatment, psychology, community medicine, neuroscience, emergency medicine, psychiatry and expertise in drug policy, research and evaluation.

(c) *Classification process:* We have some serious doubts about the current Order in Council process used to give effect to classification decisions. It is a truncated parliamentary procedure that restricts public participation and full parliamentary scrutiny of drug classifications. It may be better that classification is effected by the Act itself. If the truncated procedure remains, we think it should be available not only for increasing the levels of classification (as it is now) but also for reducing them.

DEALING

5.6 The overall thrust of our review proposals is to ensure that the approach to drug regulation takes account of the relative harm that particular drug-related activities cause. We consider that drug dealing, particularly on a large commercial scale, is the most harmful of all drug-related activities. It is important that offences and penalties are in place that adequately reflect the criminality of that behaviour.

5.7 We propose a number of changes to the dealing offences. These are discussed in chapter 10.

Sale and supply

5.8 The Act currently distinguishes between the "sale" (a transaction for profit) and the "supply" (a transaction without profit) of Class C drugs. We do not think that this is necessary. The extent of profit an offender makes from dealing will normally be relevant to the sentence he or she receives. But it is not so important that it should be a core element of the offence, while other equally relevant factors (such as the quantity of drugs) are not. There is also no reason why the approach to sale and supply should be different for Class C drugs than for Class A and B drugs. We therefore propose that the distinction between sale and supply be abolished.

"Social dealing"

5.9 The 1975 Act treats the supply of Class C drugs to adults as equivalent in seriousness to a possession offence. Where the quantities are small, we agree with this approach. Supply of small amounts, to friends and acquaintances, without profit or with a very small profit, and with no significant element of commerciality, is entirely different from commercial supply.

5.10 Supply should always be a criminal offence. However, we do not think that separate offences are necessary to reflect the difference between social supply and commercial supply. We instead think it should be dealt with as part of sentencing. In particular, we suggest that on sentence there should be a presumption against imprisonment when the judge is satisfied that the following circumstances indicating social supply exist:

(a) the supply involved small quantities of a drug;
(b) the offender was also using the drugs;
(c) the supply was to friends or acquaintances;
(d) the supply was not motivated by profit.

5.11 There is no reason to draw a distinction between classes of drugs in this respect. Nor is there any reason why the presumption should not apply to other dealing activities like import and export. We therefore propose that the presumption should apply to any social dealing of any drug (regardless of the dealing activity and class of drug involved).

5.12 We also think that the presumption should apply to an offender who has imported, exported, produced, manufactured, or cultivated drugs for his or her own use.

5.13 Such a presumption does not preclude imprisonment. Depending upon the circumstances, it would still be available, along with a range of other sanctions.

Presumption of possession for supply and reverse onus

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

5.15 Some argue that, without a presumption, the prosecution would face difficulties proving that the defendant possessed a drug for the purposes of supply. This is particularly so when the only evidence is the quantity of the drug in the defendant's possession. Expert evidence may need to be called in every case about ordinary patterns of use of the particular drug. This would be time-consuming and expensive.

5.16 Some also argue that the presumption is appropriate because the purpose of use is a fact that is peculiarly within the defendant's knowledge. However, this is an overly simplistic approach. The defendant may sometimes be the only person able to provide evidence on the point, but this will not invariably be so. Other evidence, like any unexplained profits or tick lists, will also enable an intent to supply to be inferred. In this respect, possession for supply is no different from an offence like burglary, which requires proof of entry with intent to commit a crime.

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

5.18 We have identified four options for addressing the practical problems of proof that the presumption seeks to remedy, while respecting the fundamental protection conferred by section 25(c). These are:

(a) *Retain an offence of possession for supply but with no presumption:* This option would be consistent with the Bill of Rights Act, but would be problematic in practice. There would be likely to be inconsistencies in charging practice, because individual police officers would have to determine whether or not a quantity was sufficient to charge as possession for supply. The prosecution would probably need to call expert witnesses in every case to establish that a person in possession of the same amount as the defendant would not possess that quantity for his or her own use.

(b) *Repeal the offence of possession for supply:* Two alternative approaches could be taken under this option. First, there could be two possession offences categorised by quantity, with the offence relating to the higher quantity having a higher maximum penalty. Secondly, there could be one possession offence with a high maximum penalty, with the scale of offending taken into account at sentencing.

(c) *Establish an evidential onus:* In the absence of any evidence to the contrary, the defendant would be presumed to possess a certain quantity of drugs for the purposes of supply. The defendant would be required to point to evidence that the drugs were not possessed for supply. The prosecution would then need to disprove the defendant's contention beyond a reasonable doubt.

(d) *Retain the presumption and the reverse onus:* Under this option, the Supreme Court's concerns could perhaps be addressed by more clearly articulating the basis on which presumption levels are set. In addition, current levels would need to be reviewed to ensure they were up-to-date, and there would need to be a robust process of regular review after that.

5.19 Our tentative preference is to repeal the possession for supply offence in favour of two possession offences (option (b)). The aggravated possession offence would be defined solely with reference to the possession of a quantity of drugs that is generally inconsistent with personal use. The applicable quantity would need to be specified for each drug. The purpose of possession (whether for supply or for personal use) would become relevant at sentencing.

5.20 We do not consider any of the other options to be workable. Option (a) creates the practical difficulties outlined above. Option (c) is likely to lead to the defendant raising the onus in every case. Its practical advantages are therefore minimal. It is far from certain that the Supreme Court would consider option (d) to be consistent with the Bill of Rights Act.

PERSONAL USE OFFENCES

5.21 In New Zealand, there is some limited distinction in law and in practice between the approach taken to personal drug use offences (including possession) and that taken to more serious drug offences such as commercial production and supply. Chapter 11 considers whether anything more is required.

5.22 There is significant scope within the framework provided by the conventions to put in place a more effective regulatory approach for dealing with personal use offences. This approach would:

- enable law enforcement resources and activity to focus on more harmful drug-related offending like commercial dealing;
- provide a more proportionate response to the harm that drug use causes;
- address or mitigate some of the harms and costs that inevitably result from drug prohibition;
- provide greater opportunities in the criminal justice system to divert drug users into drug education, assessment and treatment.

5.23 Our proposed options for how this may be achieved, both at the time an offence is detected and if a prosecution commences, are identified below and discussed in chapter 11.

5.24 There is nothing novel in any of the options we propose. All Australian states and territories, the United Kingdom, and many European countries have made similar changes.

5.25 We are aware of concern that options like these may increase drug use. However, most studies in this area have concluded that changes in use levels are independent of the regulatory approach in place – that is, the regulatory approach itself neither increases or decreases drug use. This conclusion is supported by comparisons of actual use levels and rates of increase in jurisdictions with different regulatory approaches. In any event, the primary objective of these options is to reduce drug-related harm, rather than to reduce drug use per se.

5.26 It is clear that drug use, on its own or in combination with other factors, can cause significant harm to the user, his or her family, and the wider community. We think that the criminal justice system has a key role to play in identifying individuals whose drug use is causing harm and diverting them into drug education, assessment and treatment. Simply punishing a drug user, without taking steps to address their drug use, is a wasted opportunity.

Proposed options

When a personal use offence is detected

5.27 Our proposed options are:

(a) *Formal cautioning scheme for all drugs:* The police would be able to issue up to three caution notices rather than prosecute the user. A user receiving a third caution notice would be required to attend a brief intervention session and be assessed with a view to receiving drug treatment. A user on his or her first or second caution could be escalated to the level of a third caution and be required to attend a brief intervention session in appropriate cases. A user who had exhausted his or her caution options would be prosecuted.

(b) *Infringement offence regime for less serious drugs:* The police would issue an infringement notice, which would require the user to pay a fixed monetary penalty or, possibly, attend a drug education session. Prosecution and conviction for a personal use offence would not be possible.

(c) *A menu of options:* A number of responses would be open to police depending on the circumstances of the offence and the offender. These responses would range from issuing a caution or infringement notice, to referral to drug assessment with a view to treatment, to prosecution.

When a prosecution commences

5.28 Our proposed options are:

(a) *Greater use of the Police Adult Diversion Scheme:* The Scheme's application could extend to other personal use offences beyond its current application to possession or use of a Class C drug, cultivation of cannabis, and possession of needles or other utensils.

(b) *Less severe penalties:* The current statutory presumption against imprisonment following a conviction for possession or use of a Class C drug could extend to all personal use offences. Alternatively, personal use offences could be non-imprisonable offences.

(c) *Court-based diversion into assessment and treatment:* Greater use could be made of the court system to provide the defendant with assessment and treatment where alcohol or drug abuse and dependence are identified.

Other issues

5.29 We also question whether it remains necessary to retain a separate criminal offence of use (because the same behaviour is caught by the offence of possession), and whether the possession of utensils for the purpose of using drugs should continue to be a criminal offence.

ENFORCEMENT AND THE CRIMINAL LAW

Criminal law and procedure

5.30 In addition to offences of dealing and personal use, the Misuse of Drugs Act contains a range of offences targeting other drug-related activities. These include offences related to precursor substances used to produce, manufacture, or cultivate a controlled drug.

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

5.32 Some of the more significant matters discussed in chapter 12 are whether:

(a) precursor substances should only be able to be classified as controlled drugs or precursor substances and not both;

(b) an offence is required to penalise those who expose others, particularly children, to the dangers associated with methamphetamine manufacture;

(c) there is any justification for retaining specific time periods for when charges under the Act may be laid;

(d) the reverse legal onuses contained in other parts of the Act should remain in light of the Supreme Court's concern about the reverse onus for the presumption for supply;

(e) there remains a need for a specific forfeiture regime for misuse of drugs, in light of the new Criminal Proceeds (Recovery) Act 2009.

Search and surveillance

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

5.34 The Law Commission gave extensive consideration to the Misuse of Drugs Act powers when it prepared its search and surveillance report. We do not propose to make any further changes to these powers beyond those recommended in that report and reflected in the Bill.

5.35 However, there is one issue outstanding. This is whether any changes are required to the Act's internal concealment powers. These powers enable police or customs officers to detain a person for up to 21 days if there is reasonable cause to believe that the person has any Class A or Class B drugs secreted within his or her body for any unlawful purpose.

5.36 As discussed in chapter 14, we propose two changes to these powers. The first is to limit the powers to situations where the person is suspected of concealing for the purposes of a dealing offence. The second is to enable the use of a wider range of medical imaging techniques and technologies if an examination is carried out to determine whether or not drugs are secreted. Currently, these examinations are limited to a physical examination, an x-ray, or an ultrasound scan.

EXEMPTIONS TO PROHIBITION

5.37 Many prohibited drugs have important uses in medicine, science, and industry. The Misuse of Drugs Act and its regulations contain a number of exemptions from the overall prohibition framework to enable controlled drugs to be used for these legitimate purposes. These exemptions are discussed in detail in chapter 5. Chapter 13 discusses our proposed changes to them.

Licensing scheme

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

- establishing the main components of the licensing scheme in primary legislation, rather than leaving them to be dealt with in regulations as currently;
- appointing, in primary legislation, the Director-General of Health as the licensing authority;
- abolishing the Minister of Health's role in approving and revoking licences, because decisions like these should be the sole responsibility of the licensing authority and are not political decisions.

Prohibited drugs as medicines

5.39 In the main, we do not propose much substantive change to the current exemptions that allow the supply and use of controlled drugs as medicines. In practice, these appear to be working relatively well. However, identifying what the exemptions are requires a detailed consideration of both the Misuse of Drugs Act and the Medicines Act as well as the regulations made under them. A number of important exemptions are also in the regulations rather than in primary legislation. This lack of transparency and accessibility is unsatisfactory. We propose that the exemptions instead be clearly set out in one Act.

5.40 There are two areas where we think more substantive reform may be required.

Controls to prevent "drug seeking"

5.41 It is clear that there is some diversion and misuse of prescription drugs in New Zealand. This is particularly in relation to opioids, benzodiazepines and stimulants. International experience suggests this is likely to increase.

5.42 Most of the drug-related harm arising from this misuse is similar to that for other types of drugs. However, because most diverted drugs are publicly funded, it also imposes a significant cost on New Zealand's health budget.

5.43 The Misuse of Drugs Act already contains a number of statutory measures to address drug seeking. We propose a number of minor changes to these measures, to ensure their scope is clearly defined and targeted. There may also be other controls that could be imposed.

Use of cannabis for medicinal purposes

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

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

5.46 Provided that the potential for diversion and misuse can be controlled, we see no reason why cannabis should not be able to be used for medicinal purposes in limited circumstances. We therefore propose the establishment of a scheme for that purpose. Under our proposed scheme, those suffering from chronic or debilitating illnesses would be able to use cannabis under medical supervision to obtain relief from their symptoms, particularly where conventional treatment options have proven ineffective.

5.47 At this stage, we think that cultivators of cannabis should be licensed in the same way as other legitimate dealers in controlled drugs. This would minimise the risk that the cannabis would be diverted into illegal activity, and would ensure the cultivation of a limited supply of cannabis in a controlled and standardised way. We also favour the establishment of a central register of authorised users of cannabis for medicinal purposes who, once registered, would be able to obtain prescriptions for cannabis from their medical practitioner or another authorised prescriber.

Part 6

Proposed approach to non-convention drugs

LEGALISATION WITH REGULATORY RESTRICTIONS

6.1 Goods, services, and activities are generally only prohibited when the harm they cause is so great that no lesser regulatory approach provides a safe alternative, or when the costs of that lesser approach exceed the benefits of not prohibiting at all. This is entirely appropriate. In a free and democratic society, full prohibition of any good, service, or activity should always be the last resort.

6.2 As discussed in chapter 8, we see no reason to take a different approach to the use of psychoactive substances that are not covered by the conventions. This includes new substances, like different variants of party pills, which regularly come onto the drugs market.

6.3 We therefore propose that:

(a) a model of legalisation with regulatory restrictions should be the starting point for a non-convention drug;

(b) the regulatory restrictions should:

- be the minimum necessary to prevent or reduce harm;
- reflect the nature of the risks that drug poses;
- not cause more harm than they prevent;

(c) full prohibition of a non-convention drug should only be considered when legalisation with regulatory restrictions has proven ineffective in reducing the harm associated with that particular drug's use.

6.4 One of the factors that will need to be considered when determining how a new drug should be regulated is the impact this decision could have on the decisions people make about substituting one drug for another. Prohibition might be appropriate, for example, if a new psychoactive substance is found to be more harmful than a prohibited drug and might be more widely used because of its legal status.

REGULATING RECREATIONAL SUBSTANCES

6.5 Legalisation with regulatory restrictions is the approach taken in the Hazardous Substances and New Organisms Act 1996 (HSNO). Technically, HSNO already applies to psychoactive substances, although it has never been used for this purpose.

6.6 The restricted substances regime in the Misuse of Drugs Act is also relevant. That regime was established to deal with new recreational psychoactive substances that were not harmful enough to justify prohibition. It is discussed in detail in chapter 5. BZP is the only drug ever to be brought within that regime, and then only briefly. It is now a Class C controlled drug. Problems with the definitions used to determine the scope of the regime mean legislative change is required before it could be used again.

6.7 The current lack of active regulation of new psychoactive substances creates risks for the public. It makes it possible for potentially unsafe substances to be marketed and sold without restriction. We think that the approach to regulating new psychoactive substances needs a major overhaul.

6.8 We propose that a new regime be implemented, designed specifically for psychoactive substances. This regime would bring together the best features of HSNO and the restricted substances regime. It would replace the latter. Chapter 8 identifies what the proposed features of this new regime are.

6.9 Like HSNO, the regime would require manufacturers and importers of a new substance to obtain an approval for it before it could be released onto the market. This effectively reverses what happens now in practice, where a substance can be manufactured, imported and sold without restriction until it is proven to be harmful.

6.10 Like the restricted substances regime, we think there should be some minimum requirements on all approved substances. These may include, for example, restrictions on their sale or supply to people under 18, advertising restrictions like those imposed on tobacco products under the Smoke-free Environments Act 1990, and a prohibition on where these substances may be sold. The regulating body could also impose additional conditions on individual substances, depending on the particular harms they posed.

6.11 If an approval to manufacture or import a substance were declined, the appropriate course would be to bring it within the regime that applies to prohibited drugs. Similarly, if the regulatory regime proved to be ineffective in minimising the harm of a regulated drug, prohibition could then be considered.

Part 7

A greater focus on treatment, prevention, and education

ACHIEVING A BALANCE IN DRUG POLICY

7.1 Chapter 15 proposes ways to achieve a better balance between strategies of supply control, demand reduction, and problem limitation.

Drug treatment

7.2 We think that there needs to be a much greater emphasis on drug treatment.

7.3 A 2006 New Zealand survey indicated that in the preceding 12 months 2.6% of the population experienced alcohol abuse, 1.3% alcohol dependence, 1.2% other drug abuse and 0.7% other drug dependence. In crude terms, these figures represent the proportion of the population that potentially might benefit from alcohol and drug treatment.

7.4 There is clear evidence that specialist alcohol and drug treatment can be cost-effective. The National Committee for Addiction Treatment cites studies which estimate that for every $1 spent on addiction treatment there is a $4 to $7 reduction in the cost associated with drug-related crimes. Total savings for some non-residential programmes can exceed costs by a ratio of 12:1.

7.5 The number of treatment services does not appear to be sufficient to meet demand. There are particular problems in some geographical areas, for some service types such as residential programmes, and for some population groups, particularly youth. Treatment services available to the court system are also insufficient.

Problem limitation

7.6 Problem limitation measures aim to reduce the specific harms that result from existing drug use. There are two main problem limitation programmes operating in New Zealand:

(a) Opioid substitution treatment – a safer legal drug like methadone is substituted for illegal street opiates. Approximately 4500 people currently receive methadone treatment in New Zealand.

(b) Needle and syringe exchange – injecting drug users can buy clean needles and syringes from specified exchange outlets and can exchange used injecting equipment on a one-for-one basis. Needle exchange is now well established across the country.

7.7 Some other jurisdictions have put in place other problem limitation measures. These include the limited state provision of heroin to addicts where other opioid substitution treatment is not effective, drug consumption rooms, and the use of early warning systems and pill testing kits to reduce the risk of overdose and poisoning.

7.8 At this stage, we do not consider any of these other measures are appropriate or necessary in New Zealand. However, this is a developing area. We therefore think the legislation should be flexible enough to enable measures like these to be adopted if required. This could be done by regulation, when specified statutory criteria are met.

Demand reduction

7.9 Demand reduction strategies encompassing drug education, health promotion, social marketing programmes and the Community Action on Youth and Drugs (CAYAD) programmes are discussed in chapter 15.

Support for drug treatment and demand reduction

7.10 We have considered whether there should be increased statutory recognition and support for drug treatment and demand reduction, and how this could be done. On balance, we do not think any of the available options are satisfactory.

7.11 However, we do think it would be useful to develop a blueprint for drug and alcohol and other addiction service delivery for the next five years. The Mental Health Commission seems best-placed to do this work.

ALCOHOLISM AND DRUG ADDICTION ACT 1966

7.12 The Alcoholism and Drug Addiction Act 1966 allows drug addicts to be compulsorily detained to undergo assessment, detoxification and treatment. The Ministry of Health is currently reviewing the Act. The Act is out-of-date, and there are difficulties in reconciling its broad powers of detention with the rights and protections in the New Zealand Bill of Rights Act 1990.

7.13 We think that there is a place for a limited compulsory civil detention and treatment regime containing appropriate safeguards. People who are drug dependent are often incapable of making rational decisions over their substance use and personal welfare. Short-term compulsory intervention may get them to a position where they are able to more readily help themselves. If there was no compulsory regime, their access to treatment might be significantly eroded.

Key features of our proposed civil detention regime

7.14 Chapter 16 outlines what the key features of a civil detention and treatment regime could be. In summary, these are that:

- The regime should provide for detention and involuntary treatment of alcohol and drug dependence only as a last resort.
- Only the degree of intervention necessary to address the risk of harm or danger posed to the detained person should be authorised.
- There should be a clear threshold that must be met before a person may be detained for treatment (as proposed below).
- An assessment to determine whether a person meets the threshold for detention should always require a personal examination and should only be performed by a medical practitioner who has expertise in drug and alcohol dependence and has been accredited to undertake such assessments under the Act.
- The accredited medical practitioner should be empowered to authorise the detention of a person who meets all the criteria for detention on an interim basis (for example, for five days).
- Any person subject to the Act, and other people with an interest in the person's welfare (such as family members), should be able to apply to the Family Court for a review of the decision to detain that person.
- Inspectors similar to those provided under the Mental Health (Compulsory Assessment and Treatment) Act 1992 should be appointed, both to ensure that any person being detained has access to advocacy and support from an independent lawyer and to provide more general oversight of the operation of the Act.
- The accredited medical practitioner responsible for the person's treatment during the interim period should be required to apply to the Court if he or she believes that the person still meets the criteria and further compulsion is necessary at the end of the interim period. The Court would review the decision to detain and treat the person and determine the maximum period of detention. The Court would also have the power to immediately discharge the person where there is no ongoing basis to detain him or her.

- Provision should be made in the Act for a leave of absence from the treatment facility or institution.
- Subject to an order for extension, the maximum period of detention should be 28 days.
- The accredited medical practitioner responsible for the person's treatment should be able to apply to the Court in some exceptional circumstances for an extension of the period of court-ordered detention and treatment.
- The accredited medical practitioner responsible for the person's treatment should be required to release the detained person at any time if satisfied that the person no longer meets the criteria for detention for treatment.

7.15 We think this regime should only be available when:

(a) the person has a dependence on alcohol or other drugs; and

(b) detention and treatment is necessary to protect the person from significant harm to himself or herself; and

(c) the person is likely to benefit from treatment for his or her alcohol or drug dependence but has refused treatment; and

(d) no other appropriate and less restrictive means are reasonably available for dealing with the person.

Questions for the public

The full issues paper includes a number of questions relating to the detail outlined above. For those people who do not wish to work through the issues paper itself, responses to the following questions would be useful.

You should feel free to respond only to those questions that are relevant to you. It would help us if you could indicate in your feedback which questions you are responding to.

PROPOSED APPROACH TO CONVENTION DRUGS

Classification of prohibited drugs

1 Should the ABC classification system be retained? If so, are changes to it required?

2 If classifications are retained, are any changes required to the way in which classification decisions are made? If so, what?

Dealing

3 Should the current distinction in the Act between the sale of Class C drugs and the supply of Class C drugs be removed, so that supply for profit would not be a separate offence but a factor to consider during sentencing (together with other factors such as the scale of supply)?

4 Should social dealing be treated differently from other forms of dealing? If so, how?

5 Should there continue to be an offence of possession for supply? If not, should there be two possession offences categorised by quantity, with the offence relating to the higher quantity having a higher maximum penalty?

Personal use offences

6 What approach should be taken to personal use offences (including possession)? In particular, what alternatives (if any) to prosecution should be used?

7 If a personal use offence is prosecuted in the courts, what approach should be taken?

8 Should there continue to be a criminal offence for drug use or does it suffice to rely on the offence of possession for personal use?

9 Should the possession of utensils for the purpose of using drugs remain a criminal offence?

Enforcement and the criminal law

10 In addition to dealing and personal use offences, what other offences are required to regulate drug-related activities?

11 Are changes required to the provisions in the Act that specify the process for proving particular matters in court when a charge is being laid? If so, what?

12 Are any changes required to the powers in the Act that allow police and customs officers to detain someone they suspect of secreting drugs in his or her body (the "internal concealment powers")?

Exemptions to prohibition

13 Are all the current exemptions (contained in the Misuse of Drugs Act and regulations made under it) still needed or are some obsolete? Are any new exemptions needed?

14 Are the legislative controls currently in place adequate to address the diversion and misuse of prescription drugs? What further controls do you think are needed?

15 Should the law authorise the medicinal use of cannabis by people suffering from chronic or debilitating illness? If so, how should any new regime work?

PROPOSED APPROACH TO NON-CONVENTION DRUGS

16 Should new recreational drugs that are not covered by the international drug conventions be regulated rather than prohibited, with prohibition only used as a last resort?

17 Should such drugs require approval before they can be manufactured or imported for recreational use?

18 Where they are approved for manufacture or import, should minimum standards covering distribution and supply (e.g. age restrictions, place of sale restrictions, advertising restrictions) be imposed? What should the main minimum standards be?

A GREATER FOCUS ON TREATMENT, PREVENTION AND EDUCATION

Achieving balance in drug policy

19 Would the development of a blueprint for drug and alcohol and other addiction services be a practical way of giving more emphasis to treatment? What else might be done?

20 Should more use be made of treatment for alcohol and drug dependence when people come before the courts? If so, how?

Alcoholism and Drug Addiction Act 1966

21 Should a regime allowing civil committal for the detention and treatment of alcohol and drug dependence be retained? If so, what should its key features be?

22 Should a person only be able to be detained under this regime when all of the following conditions are met:

(a) the person has a dependence on alcohol or other drugs; and

(b) detention and treatment is necessary to protect the person from significant harm to himself or herself; and

(c) the person is likely to benefit from treatment for his or her alcohol or drug dependence but has refused treatment; and

(d) no other appropriate and less restrictive means are reasonably available for dealing with the person?

Official Information Act 1982

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

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