April 2019

Committee Secretariat
Health Committee
Parliament Buildings
Wellington
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Misuse of Drugs Amendment Bill

SUBMISSION

This submission is being made by Family First NZ, a registered charitable organisation that researches and advocates on family issues in the public domain.

We wish to appear before the Committee

Executive Summary:

- we **SUPPORT** the intent of the bill to allow consideration (but not requirement) of a health-based approach for certain cases of low-level and/or first-time drug use & possession *(see supporting evidence from page 2 onwards)*

- we **OPPOSE** any change to the legal status of marijuana and other drugs (separate from the Class A drugs proposed in this bill) because of the significant health and addiction issues around recreational drug use, and the need for the law to reflect those and to protect society *(see supporting evidence from page 13 onwards)*

- we **CALL FOR** increases in resources and funding for both
  - drug prevention programmes, and
  - addiction and mental health services *(see page 6 for the policy)*

- **INCREASED HARM** - liberalising the laws around marijuana and other harmful drugs will *increase* harm - *not* reduce it *(see supporting evidence at page 13 onwards & page 22 onwards)*

- **CHILD CENTRED DRUG POLICY IS AN IMPERATIVE** - protecting children from illicit drug use is not an option for States / Parties to the United Nations Human Rights Convention on the Rights of the Child, it is an obligation. Therefore, drug policy in NZ must be child-centred, not user-centred *(see supporting evidence at page 19 onwards)*

- we **CALL ON** the Labour and Green parties to withdraw the 2020 Referendum to legalise marijuana.

INTRODUCTION

The Hon Dr David Clark, when introducing this bill, said[1]

> *The bill will ensure that enforcement powers and penalties are focused on those who import, manufacture, and supply dangerous drugs, and not the people who use the drugs themselves. We want to make sure that those who are in the web of addiction are supported to give up the drugs that they are dependent upon. The report of the Government Inquiry into Mental Health and Addiction has recommended reforming drug policy and laws with a focus on minimising harm and promoting health while increasing addiction services. Our response is consistent with these recommendations, ensuring that people aren't unnecessarily criminalised for using drugs and instead can access the health and social support services that they need. We've seen too many drug-related deaths and hospitalisations over the last few years. Action is needed to prevent and reduce further drug-related harm.*

We support this underlying intent of the bill, as long as this doesn't mean weakening the legal framework around drugs in general.

We are concerned that it applies to <u>all</u> harmful drugs, and does not clearly delineate between occasional users, and dealers and drug abusers.

We also agree with the comments of Green MP Chloe Swarbrick who said:

> *Drugs aren't <u>just</u> a justice issue; drugs are a social issue, they're an education issue, they are a mental health issue, they are a housing issue, and they are a well-being issue. <u>We know that police are using their discretion at the moment</u> when they're choosing whether or not to prosecute people who they find using drugs.*

This statement highlights two things. **The role of the law has an equal part to play in a holistic approach to drug use, drug abuse, and drug dealing. It also acknowledges that the police are *already* using discretion and a smart arrest policy** (*see further discussion below*).

Hon Michael Woodhouse was correct when he said:

> *It would be hard to find a particular user of illicit substances that would not in some way benefit from a therapeutic approach or a health-centred approach. There's no reference here to <u>recidivism</u>, to the <u>seriousness of the crime</u>, to the fact that there may be <u>other crimes committed</u> around the possession offence—perhaps <u>burglaries</u>, perhaps <u>disorderly conduct</u>.*

And Greg O'Connor highlights the exact model that we have raised in this drugs debate:

> *….the good use, the sensible use of sentencing—the sensible use of imprisonment, even—can actually be a very good tool, because <u>what it does is gives leverage</u>. So*

[1] https://www.parliament.nz/en/pb/hansard-debates/rhr/combined/HansDeb_20190312_20190312_24

> *where the warnings haven't worked, where someone has gone through a system where they have been not prosecuted and continue to do so, if they then end up in court, the effect of that is the court will understand that we've got a case that we can deal with seriously, that it has gone through some sort of threshold system on its way to where we are. Now, you may say that in other systems that have been introduced, there have been pre-charge warnings, diversions, and various other things. These are, actually, simply other versions of the same thing. What it does, particularly with drugs, those that we're dealing with—so, often, having an encounter with the police, having an encounter with the authorities, is enough to deter people from what they will do.*

BOTH LAW *AND* HEALTH

Pro-drug groups make two erroneous claims.

- *"It's a health issue, not a criminal issue."*
- *"The war on drugs has failed."*

Theodore Dalrymple is blunt when he says in his book *Romancing Opiates: Pharmacological Lies and the Addiction Bureaucracy*:[2]

> *… [The War on Drugs is Lost is an] unimaginative and fundamentally stupid …metaphor [which] exerts a baleful effect on proper thought … If the war against drugs is lost, then so are the wars against theft, speeding, incest, fraud, rape, murder, arson, and illegal parking. Few, if any, such wars are winnable.*

Australian ethicist Dr Greg Pike says that the assertion that addiction is a medical problem and not a criminal one is a simplistic and unrealistic dichotomy. If those with addictions commit serious offences, as does happen, the criminal law cannot simply turn a blind eye. The community still needs to be protected.[3]

Nobody would claim that we apprehend too many drunk drivers or thieves – even though we spend money and effort on roadside checks. **The government has a responsibility to keep the public safe from harm**, including from dangerous substances.

The law has an important deterrent effect.

Most people don't want to break the law. It sends an important societal message.

Part of the 'health' argument is based on the myth that 'petty' marijuana users are filling our prisons. But statistics obtained from the Ministry of Justice by Family First NZ under the Official Information Act show that less than 10 people have been given a prison *or home detention* sentence for cannabis possession offences in each of the last three years, and that even these sentences may be 'influenced by their previous offending history'.[4]

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[2] https://www.amazon.com/Romancing-Opiates-Pharmacological-Addiction-Bureaucracy/dp/1594032254
[3] https://www.drugfree.org.au/images/pdf-files/library/Policies_Legislation_and_law/TheDebateOnDrugLawReform_DrGregPike.pdf
[4] https://www.familyfirst.org.nz/wp-content/uploads/2017/02/Marijuana-imprisonments.pdf

In the 20 years to 2014, the number of arrests for cannabis per 100,000 head of population dropped by 70%.[5]

It will be difficult to meet somebody who says they've been behind bars for smoking a joint, and that's their only crime. International studies have shown that most are imprisoned for *drug related offences*, that is, crimes committed while on drugs (murder, armed robbery, theft, assault, child abuse, etc.) or crimes committed in order to obtain drugs. The statistics from the Ministry of Justice appear to confirm that. This is also the case in Australia and the US.

Erroneous claims that we are wasting time and resources focusing on the criminal aspect fail to understand (or perhaps, want to ignore) that there has been a substantial decline in arrests for cannabis use in New Zealand over the past decade, and that police diversion and Alcohol and Other Drug Treatment (AODT) Courts have been increasingly used.[6] Diversion and pre-charge warnings are being used sensibly and effectively. The Substance Addiction Act passed into law in 2017 simplifies the process for police, health services and loved ones to force those locked in a cycle of substance abuse into compulsory treatment.[7]

Rather than focusing on 'health' at the centre of drug policy, the focus should be on 'well-being'.

A smart arrest policy can both provide a societal stamp of disapproval *and* provide an opportunity to intervene and stop the progression of use.

Keeping marijuana and other drugs illegal through an appropriate application of the laws that cater for "youthful indiscretions" and which focus on supply / dealers is as much a public safety policy as it is a public health policy.

Sending a message that carrying a small amount of heroin or cocaine or 'P' is okay is a dangerous and foolish message.

COERCION OF THE LAW

NZ researcher Gerald Waters says that international research and best practice evaluations around alcohol and drug courts show they are probably the most effective in stopping recidivist. Participants in the courts must undergo intense rehabilitative programmes, alongside community work, to address substance addiction and the related criminal behaviour – thereby interrupting the cycle of addiction-driven offending.[8]

> "*It looks at the underlying causes, not just punishing people… It is non-adversarial, so you have defence and prosecution working together – for the betterment of those who would perhaps react positively to treatment.*"

[5] https://www.radionz.co.nz/news/national/368483/arrests-for-cannabis-possession-fall-70-percent-in-20-years
[6] http://saynopetodope.org.nz/petty-marijuana-users-not-filling-our-prisons/
[7] http://www.stuff.co.nz/national/health/89673029/new-law-could-force-more-drug-and-alcohol-addicts-into-compulsory-rehabilitation
[8] https://www.newsroom.co.nz/2018/09/10/231051/the-logic-behind-drink-driving?preview=1

It is also significant to note that Portugal (trumpeted as the model of drug laws by drug supporters in NZ) coerces treatment and rehabilitation. We should reject the notion that coerced treatment (aided by legal sanction) is unworkable or acceptable for drug users.

Again, Hon Michael Woodhouse was correct during the First Reading when he said:[9]

> *There is no diversion here. There is no requirement for that person to actually be sent to a therapeutic community or a health-centred approach or an addiction service—no reference to that—and the Prime Minister admitted today that there were going to be no more resources put into the health system as a consequence of this bill when it's passed. So a heavily, heavily, under stress health sector is not going to be able to respond to drug possession referrals that don't go before the courts but go before the health service. So we simply don't prosecute.*

The currently illegal status of drugs is an inhibitor that deters people from participating. While there will be some who are enticed by the illegality, most people do not like engagement with criminal behaviour or with criminal distribution networks.

A 2001 study of 18-29 year olds by the *NSW Bureau of Crime Statistics and Research* revealed that 29% of those who had never used cannabis cited its illegality as the reason. Furthermore, 91% of those currently using cannabis weekly or more said they would consider using more if it were legal.[10]

Broadcaster and commentator Mike Yardley argues:

> *"The NZ Drug Foundation argues it's a complete waste of "hundreds of thousands of police hours" trying to enforce the law, criminalising and imprisoning Kiwis for low-level possession. Just because tens of thousands of Kiwis choose to smoke dope in defiance of the law, is not a compelling reason to legitimatise their lifestyle. 42% of front-line police officer hours are consumed on dealing to family violence. If you apply the extreme, absurd and self-serving logic of the legalise lobby, the police should surrender to family violence too, because so many Kiwis are indulging in this sick and twisted national sport. Ditto for child abuse, tax evasion, drink-driving, shop-lifting, or any other social scourge you care to name."* [11]

Apart from the fact that *"hundreds of thousands of police hours"* is a completely made-up mythical claim by the Drug Foundation, it is also ironic that researchers say that the alleged reduction in law enforcement and justice expenditure have not been realised overseas, with crime increasing and an increase in the costs of added regulation for non-compliance.

Furthermore, the budget estimates do not cover the additional health and education on cannabis harms and the fact that the illegal drug trade will inevitably continue to thrive under more regulation and taxation. **Drug dealers and other criminals who derive huge profits from the drug trade will not cease criminal activity in the face of a "health-approach".**

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[9] https://www.parliament.nz/en/pb/hansard-debates/rhr/combined/HansDeb_20190312_20190312_24
[10] https://www.bocsar.nsw.gov.au/Documents/CJB/cjb58.pdf
[11] http://www.stuff.co.nz/the-press/opinion/83410482/Mike-Yardley-Legalising-cannabis-not-in-the-public-interest

PREVENTION MATTERS

The United Nations Office on Drugs and Crime (UNODC) said in its 2012 report:

> *"Cannabis prevention efforts are critical because cannabis is often the first illegal drug used by youth. Preventing substance use before it begins not only makes common sense, it is also cost-effective. For every dollar invested in prevention, a savings of up to $10 in treatment can be realised."* [12]

They went on to recommend that cannabis possession should remain a punishable offence, while **its use should be prevented and its continued use treated**.

> *"There are several evidence-based prevention and treatment strategies that governments can implement to effectively reduce marijuana use, abuse and addiction and prevent much of the consequences and costs to society with regard to health care, social support, security and development."*

We should continue *fighting* drugs and the devastation its use causes on both the users, their families, and society in general.

A SENSIBLE DRUG POLICY FOR NEW ZEALAND

A sensible drug policy should recognise three pillars of drug policy - which are similar pillars to how we have approached a *SmokeFree* target:

- **SUPPLY REDUCTION – target the dealers and suppliers**
- **DEMAND REDUCTION – promote a drug-free culture**
- **HARM REDUCTION – ensure addiction services & support are available for those who genuinely want to quit. The primary purpose is *not* to keep users using, but reduce and help them *exit* drug use!**

It's not about a 'war'. We don't need an army, machine guns, informants, patrols. We need a "*Stay Drug-Free*" message. It's about enforcing drug laws to protect families.

It's working for tobacco.

IF WE CAN BE SMOKEFREE 2025, WHY NOT DRUGFREE 2025 ALSO?

In your consideration of how to deal with the misuse of drugs, it is vital that we are aspirational and target best outcomes. In that respect, it is significant to see how the law and public policy serves an important role in the use and abuse of different drugs.

[12] https://www.unodc.org/documents/drug-prevention-and-treatment/cannabis_review.pdf

Tobacco:15%

The great news is that smoking rates in New Zealand continue to reduce, with 15% of adults currently smoking (this has dropped from 25% in 1996/97).[13] [14] Although 605,000 New Zealand adults still smoke, over 700,000 have given up smoking. The number of Year 10 pupils who said they were regular or daily cigarette smokers has dropped from about 15 percent in 2001, to 1.9 per cent in 2018 – 2018 ASH Year 10 Snapshot.[15]

Though smoking is down, around 5000 people die each year in New Zealand because of smoking or second-hand smoke exposure.[16] That's 13 people a day.

A report published the Ministry of Health in 2016 estimated that the total cost of smoking to New Zealand's health and welfare systems was $2.5 billion in 2014.[17] Tobacco excise tax currently raises approximately $1.5 billion gross per year.

> *"New Zealand only has seven years left to achieve the Smokefree 2025 goal."*
> Helen Clark, patron of Action for Smokefree 2025 (ASH)[18]

Alcohol: 8.4% – 20%

Latest stats indicate that 20% of New Zealanders aged 15 years or more who drink alcohol has a potentially hazardous drinking pattern (79% of New Zealanders aged 15+ drank alcohol in the past year).[19]

8.4% of the past-year drinkers consumed a large amount of alcohol (more than six standard drinks for males or four for females on a drinking occasion), at least once a week. 20% women who had been pregnant in the past 12 months reported that they had consumed alcohol while pregnant (*Ministry of Health, 2015).*[20]

Marijuana: 3.7%

Just 3.7% use cannabis on a *weekly* basis.[21] 11% have used it in the last 12 months (*Ministry of Health 2013*)

Illicit Drugs

One in six (16.6%) adults had used any drug for recreational purposes in the last 12 months, equating to 438,200 people. The prevalence of having used drugs for recreational purposes in the last 12 months was highest for the following drugs:

- cannabis (14.6%) (*2010*)
- BZP party pills (5.6%)
- ecstasy (2.6%)
- amphetamines (2.1%)
- LSD and other synthetic hallucinogens (1.3%). *(Ministry of Health 2010)* [22]

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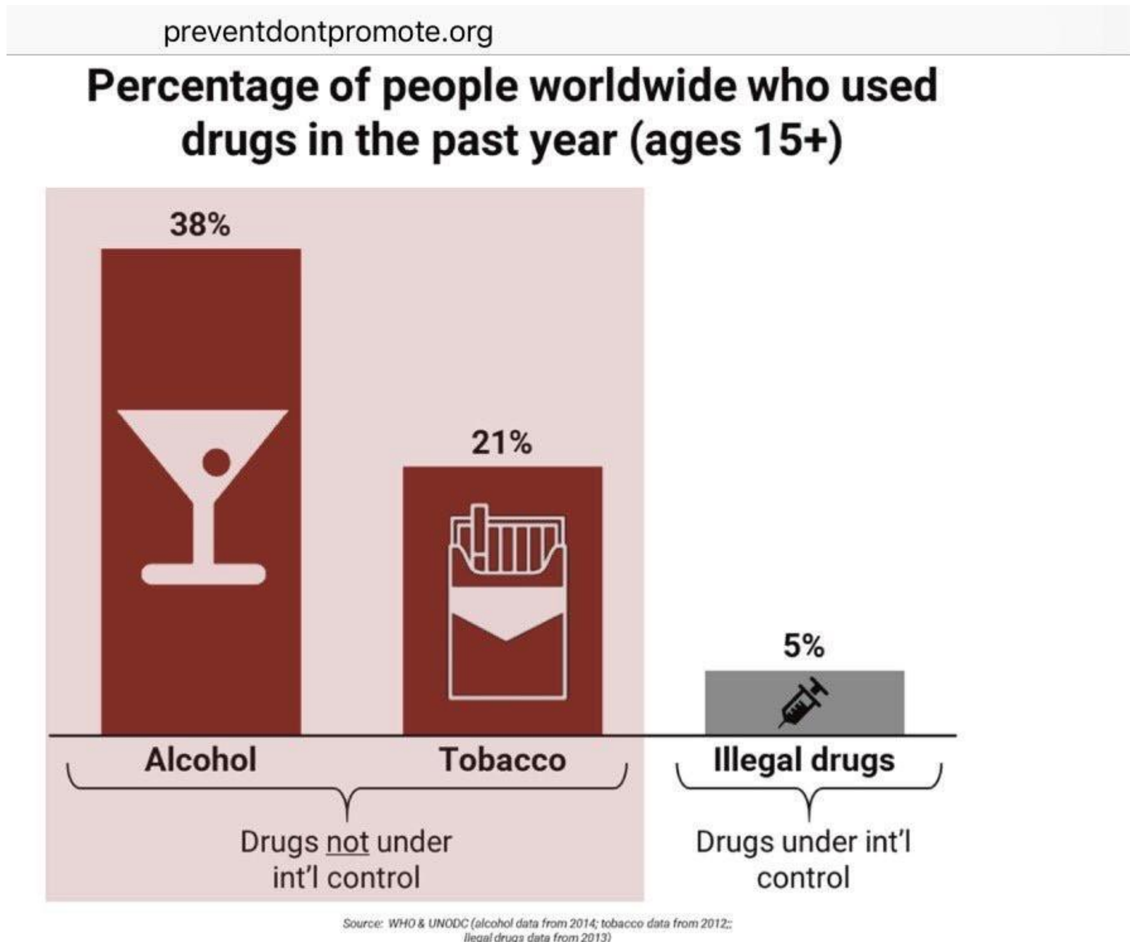
[13] https://www.smokefree.org.nz/smoking-its-effects/facts-figures
[14] https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/_w_ce2401c3/#!/key-indicators
[15] http://www.scoop.co.nz/stories/PA1904/S00039/teen-smoking-at-lowest-level.htm
[16] https://www.health.govt.nz/your-health/healthy-living/addictions/smoking/health-effects-smoking
[17] https://www.health.govt.nz/system/files/documents/pages/appendix-8-april-background-info-tobacco-control-programme.pdf
[18] https://www.stuff.co.nz/national/102608415/no-room-for-complacency-if-were-to-reach-kick-smoking-by-2025-helen-clark-says
[19] https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/_w_ce2401c3/#!/key-indicators
[20] https://www.alcohol.org.nz/resources-research/facts-and-statistics/nz-statistics/new-zealand-drinking-patterns
[21] https://www.health.govt.nz/publication/cannabis-use-2012-13-new-zealand-health-survey
[22] https://www.health.govt.nz/system/files/documents/publications/drug-use-in-nz-v2-jan2010.pdf

Illegality keeps prices high and use relatively low.



There is no adequate reason why government can persistently and successfully target smoking and not do likewise with drugs.

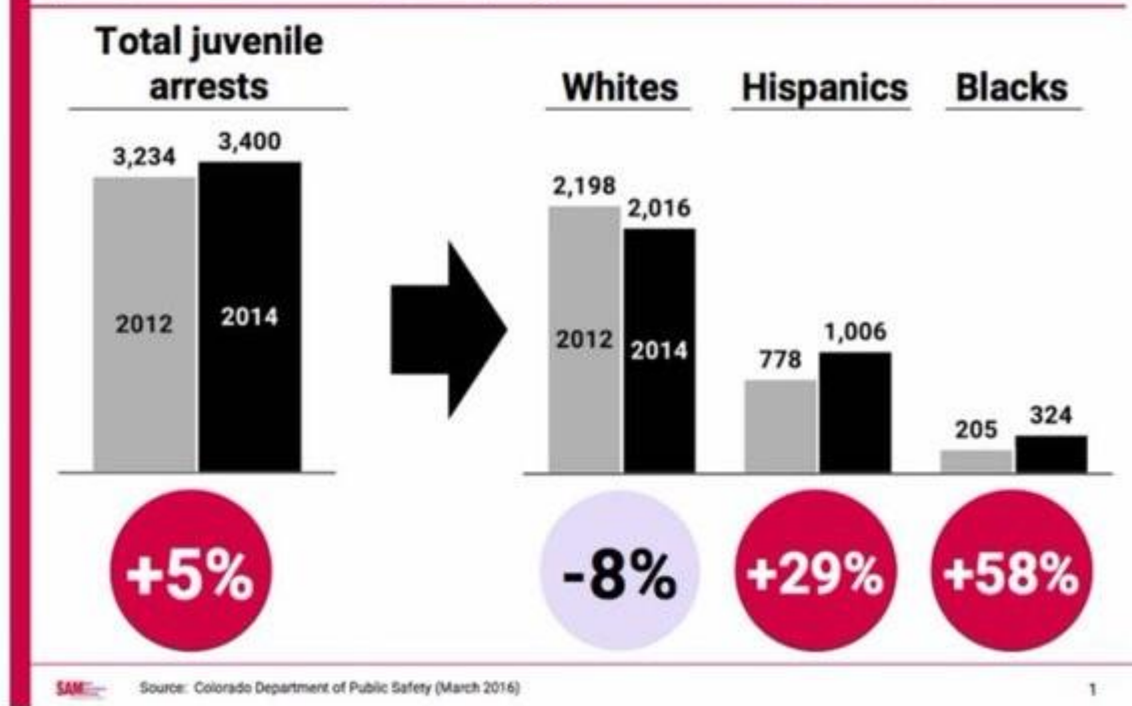
The end goal of the anti-smoking campaign is not 'slow down' or 'moderate' but 'QUIT', and a realistic understanding about the effort required to reach that end, with numerous strategies and support agencies assisting on the journey. And the numbers overwhelmingly suggest that it is working.

SOCIAL JUSTICE

Criminal Offence Rates

As pro-marijuana lobbyists argue that drug liberalisation will increase social justice, disparities among use and criminal offense rates continue among race, ethnicity, and income levels in US states that have legalised marijuana. The **District of Columbia** saw public consumption and distribution arrests nearly triple between the years 2015 and 2016, and a disproportionate number of those marijuana-related arrests occur among African-Americans.[23] **Colorado** has seen a similar trend.[24] Colorado marijuana arrests for young African-American and Hispanic youth have increased since legalisation.[25]

[23] https://www.washingtonpost.com/local/public-safety/dcarrests-for-public-use-of-marijuana-nearly-tripled-last-year/2017/07/11/906bea50-627d11e7-8b2b-b6c8c99c3bea_story.html?utm_term=.6f023f47928c
[24] https://cdpsdocs.state.co.us/ors/docs/reports/2016-SB13-283-Rpt.pdf
[25]



[26]

The reason? According to a 2013 survey conducted by the Colorado Department of Public Health and Environment, black and Hispanic youth are slightly more likely to use marijuana than their white counterparts: About 17% of white high school students reportedly used pot in the previous 30 days, while 25.9% of black students and 23.6% of Hispanic students did.[27] [28]

Poverty

In a similar trend to alcohol outlets and pokie machine venues in New Zealand, communities of colour are being subjected to disproportionate targeting by marijuana facilities and dealers in the US. In **Los Angeles**, the majority of dispensaries have opened primarily in African-American communities.[29]

An overlay of socioeconomic data with the geographic location of pot shops in Denver, **Colorado** shows marijuana stores are located primarily in disadvantaged neighbourhoods.[30] Those with a household income below $25,000 had a 20% current-use rate compared to a 11% rate among households with income levels of $50,000 or greater.[31]

The National Survey on Drug Use and Health found that 28% of women living in low-income areas tested positive for marijuana use during pregnancy.[32] Another study by the American College of Obstetricians and Gynecologists reported that young women from lower income levels have a 15–28%

[26] http://www.vox.com/2016/5/11/11656582/colorado-marijuana-arrests-race
[27] https://cdn1.vox-cdn.com/uploads/chorus_asset/file/6470709/2013_Colorado_marijuana_students.0.pdf
[28] https://www.vox.com/2016/5/11/11656582/colorado-marijuana-arrests-race
[29] https://link.springer.com/article/10.1007/s10935-017-0479-2
[30] https://learnaboutsam.org/wp-content/uploads/2018/07/SAM-Lessons-Learned-From-Marijuana-Legalization-Digital-1.pd
[31] https://cdpsdocs.state.co.us/ors/docs/reports/2016-SB13-283-Rpt.pdf
[32] https://www.ncbi.nlm.nih.gov/pubmed/28498631

rate of marijuana use during pregnancy.[33] Up to 60% of these young women continue marijuana use throughout pregnancy due to a decreased perception of risk and stigma.[34]

Homelessness

A new study examining why people become homeless has found that daily marijuana use significantly increases men's likelihood of becoming homeless. The Melbourne University research found that for men, using cannabis daily increases their likelihood of becoming homeless by age 30 by 7-14 percentage points.[35] Almost 50% of the sample had used drugs regularly (cannabis daily and/or hard drugs weekly) by the age of 30. The researchers say;

> *"Our research suggests that early interventions to reduce cannabis use may be effective in reducing the number of boys and young men who become homeless."*

It is argued that the easy availability of marijuana after legalisation also appears to have a possible link to Colorado's growing homeless population. While overall U.S. homelessness decreased between 2013 and 2014 as the country moved out of the recession, Colorado was one of 17 states that saw homeless numbers increase during that time. Perhaps not coincidentally, it was also when Colorado legalised "recreational-use" marijuana and allowed retail sales to begin. The U.S. Department of Housing and Urban Development reported a 13% increase in Colorado's homeless population from 2015 and 2016.[36] The rate of homelessness among Colorado children has increased 50%.[37]

Business owners and officials in Durango, Colorado, testify that the resort town "*suddenly became a haven for recreational pot users, drawing in transients, panhandlers, and a large number of homeless drug addicts.*" [38] [39]

MORE THAN 'WOODSTOCK WEED'

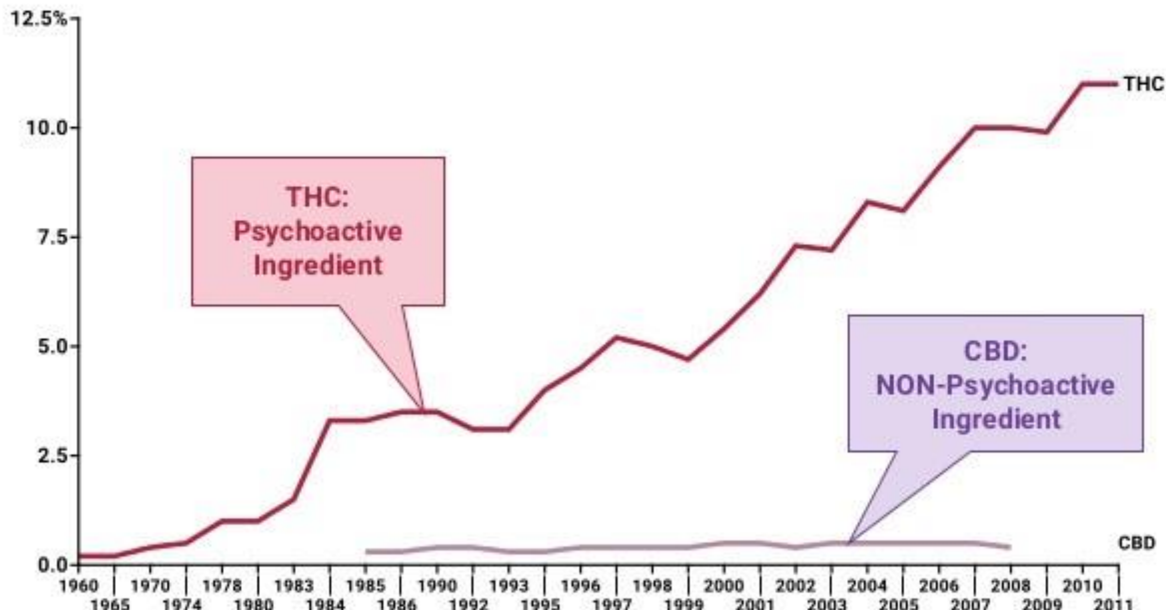
The 1-2% THC weed of Woodstock era has been replaced by popping a handful of gummy bears containing 10 times the legal limit of THC per serving, or a 90% THC dab. It *was* just a plant – but it isn't today. This marijuana debate - especially - is about commercialised THC and the next Big Tobacco. **It is a fundamentally different, harder drug.**

This Is Not Your Parent's Pot

Drug growers increase the potency of marijuana in order to raise prices – and therefore profits. By experimenting with breeding practices and cultivation techniques over many years, growers have been able to greatly elevate the THC level found in the oily resin of the plant's leaves and flowers.

[33] https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-onObstetric-Practice/Marijuana-Use-During-Pregnancy-and-Lactation
[34] https://learnaboutsam.org/wp-content/uploads/2018/07/SAM-Lessons-Learned-From-Marijuana-Legalization-Digital-1.pdf
[35] https://pursuit.unimelb.edu.au/articles/why-do-people-really-become-homeless
[36] http://www.foxnews.com/us/2017/07/10/colorado-tries-to-fight-homeless-problem-that-may-have-beentriggered-by-pot-law.html
[37] http://www.coloradotrust.org/content/story/colorado-sees-surge-child-homelessness
[38] http://www.foxnews.com/us/2017/05/17/legalized-marijuana-turns-colorado-resort-town-into-homeless-magnet.html
[39] https://learnaboutsam.org/wp-content/uploads/2018/07/SAM-Lessons-Learned-From-Marijuana-Legalization-Digital-1.pdf

While dope shops do see forms of cannabis plants, much of the business is in concentrates, edibles, and THC that can be vaporised, based on the extraction of highly potent THC from the plant, manufactured in to every possible way to consume that THC.[40]



In Colorado;

- the average THC content of all tested flower in 2017 was 19.6% statewide compared to 16.4% in 2014.
- the average potency of concentrated extract products increased steadily from 56.6% THC content by weight in 2014 to 68.6% at the end of 2017.[41]

In Colorado, "Ditch Weed" refers to weak weed. It used to mean under 3% THC. Today, ditch in Colorado is anything 15% or less!

Most cannabis being sold illegally in the UK is super-strength skunk linked to a higher risk of psychotic mental health episodes. In 2016, 94% of police seizures were high-potency marijuana, compared to 85% in 2008 and 51% in 2005.[42]

Potency rates of up to 95% have been recorded.[43] [44]

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[40] https://www.ncbi.nlm.nih.gov/pubmed/20487147
[41] https://rmhidta.org/files/D2DF/FINAL-%20Volume%205%20UPDATE%202018.pdf
[42] http://www.bbc.com/news/health-43196566
[43] https://www.colorado.gov/pacific/sites/default/files/MED%20Equivalency_Final%2008102015.pdf
[44] http://www.canpotkill.me/take-a-look-at-the-facts

The United Nations Office on Drugs and Crime (UNODC) summed up the issue in their 2012 report, saying that **THC content and the potency of cannabis have been increasing over the past 30 years.[45] Higher THC content can increase anxiety, depression, and psychotic symptoms, and can increase the risk of psychotic symptoms, dependence, and increase adverse effects on the respiratory and cardiovascular systems in regular users.** The increase in THC content is attributed to indoor cultivation and improved breeding.

Smart Colorado – a lobby group focusing on marijuana harm to children says;

> *"In Colorado, highly potent concentrates and edibles have been tied to a spike in hospitalizations – including many children — and even deaths. Edibles come in innocuous forms like candies, sodas and cookies that can be deceiving and attractive to kids while highly potent liquids and waxes can be consumed in new dangerous ways. Although the industry likes to compare marijuana to alcohol, these new products and potencies are nothing like a beer or a glass of wine. These genetically modified strains and concentrates also bear no resemblance to the "Woodstock weed" of yesteryear. The marijuana industry has fought back efforts to limit THC potencies in Colorado."* [46]

And,

> *". . . when we create a licit industry selling an abusable drug, the resulting businesses will have a strong profit incentive to create and sustain abusive consumption patterns, because people with substance-abuse disorders consume most of the product. Supplying moderate or controlled use is merely a side business. So if we create a licit cannabis or cocaine industry, we should expect the industry's product design, pricing, and marketing to be devoted to creating as much addiction as possible."*
>
> Source**:** Drugs and Drug Policy: What Everyone Needs to Know (Oxford Press, 2011)[47]

'WRECKREATIONAL' DRUGS

> *"Recreational" drug use is a misnomer – put a 'w' on the front and you'd be closer to the truth*
>
> Former Wellington coroner Garry Evans[48]

As liberalisation and commercialisation has increased in US states, false advertising of marijuana products as being "*natural*" and "*healthier than alcohol and tobacco*" have greatly decreased the perceived risk of harm related to marijuana use. The main psychoactive ingredient in marijuana, THC, has now been observed to cause many different types of mental and physiological health problems—especially in children and youth.

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[45] https://www.unodc.org/documents/drug-prevention-and-treatment/cannabis_review.pdf
[46] http://smartcolorado.org/wp-content/uploads/2016/10/Lessons-Learned-Smart-Colorado-Handout.pdf
[47] https://www.forbes.com/sites/richdanker/2011/10/19/its-time-for-a-new-approach-to-policies-involving-illegal-drugs/
[48] https://www.stuff.co.nz/dominion-post/news/73738804/wellington-coroner-garry-evans-reflects-on-18-years-of-sad-deaths

While public opinion has been moving toward the liberalisation and even legalisation of marijuana, science and medicine has been moving toward broad agreement on marijuana's harms and dangers!

According to virtually every scientific review, including a 2016 World Health Organisation (WHO) report and a 2017 National Academy of Sciences study, marijuana is addictive and harmful – despite rhetoric from the marijuana industry. According to the WHO, regular cannabis users can develop dependence on the drug. The risk may be around **1 in 10 among those who ever use cannabis, 1 in 6 among adolescent users, and 1 in 3 among daily users.**[49] **Withdrawal syndrome is well documented in cannabis dependence**

There are currently in circulation over 26,000 evidence-based research articles, papers and other literature covering the inherent physical, psychological, environmental, social, familial and community harms of cannabis. This includes the detailed and renowned 2016 cannabis report from the *World Health Organisation*.[50]

> *"Why do nations schedule drugs? …… Nations schedule psychoactive drugs because we revere this three-pound organ (of our brain) differently than any other part of our body. It is the repository of our humanity. It is the place that enables us to write poetry and to do theatre, to conjure up calculus and send rockets to Pluto three billion miles away, and to create iPhones and 3D computer printing. And that is the magnificence of the human brain. Drugs can influence [the brain] adversely. So, this is not a war on drugs – this is a defence of our brains, the ultimate source of humanity."*
>
> Dr Bertha Madras, Professor of Addiction Psychiatry at Harvard Medical School[51]

HOW DOES MARIJUANA AFFECT THE BRAIN?

Source: National Institute On Drug Abuse (June 2018) [52]

Short-Term Effects

When a person smokes marijuana, THC quickly passes from the lungs into the bloodstream. The blood carries the chemical to the brain and other organs throughout the body. The body absorbs THC more slowly when the person eats or drinks it. In that case, they generally feel the effects after 30 minutes to 1 hour.

THC acts on specific brain cell receptors that ordinarily react to natural THC-like chemicals. These natural chemicals play a role in normal brain development and function.

Marijuana over-activates parts of the brain that contain the highest number of these receptors. This causes the "high" that people feel. Other effects include:

[49] http://apps.who.int/iris/bitstream/handle/10665/251056/9789241510240-eng.pdf;jsessionid=CE26AD9FCB9F8DB8D1B2AA28810841F8?sequence=1
[50] http://apps.who.int/iris/bitstream/handle/10665/251056/9789241510240-eng.pdf;jsessionid=BBEFE64635DD884F670EC080FF30A1E7?sequence=1
[51] https://www.brookings.edu/wp-content/uploads/2016/03/20160414_marijuana_debate_transcript.pdf
[52] https://www.drugabuse.gov/publications/drugfacts/marijuana

- altered senses (for example, seeing brighter colours)
- altered sense of time
- changes in mood
- impaired body movement
- difficulty with thinking and problem-solving
- impaired memory
- hallucinations (when taken in high doses)
- delusions (when taken in high doses)
- psychosis (when taken in high doses)

Long-Term Effects

Marijuana also affects brain development. When people begin using marijuana as teenagers, the drug may impair thinking, memory, and learning functions and affect how the brain builds connections between the areas necessary for these functions. Researchers are still studying how long marijuana's effects last and whether some changes may be permanent.

For example, a study from New Zealand conducted in part by researchers at Duke University showed that people who started smoking marijuana heavily in their teens and had an ongoing marijuana use disorder lost an average of 8 IQ points between ages 13 and 38. The lost mental abilities didn't fully return in those who quit marijuana as adults. Those who started smoking marijuana as adults didn't show notable IQ declines.[53]

In another recent study on twins, those who used marijuana showed a significant decline in general knowledge and in verbal ability (equivalent to 4 IQ points) between the preteen years and early adulthood, but no predictable difference was found between twins when one used marijuana and the other didn't. This suggests that the IQ decline in marijuana users may be caused by something other than marijuana, such as shared familial factors (e.g., genetics, family environment). NIDA's Adolescent Brain Cognitive Development (ABCD) study, a major longitudinal study, is tracking a large sample of young Americans from late childhood to early adulthood to help clarify how and to what extent marijuana and other substances, alone and in combination, affect adolescent brain development.[54]

Marijuana use may have a wide range of effects, both physical and mental.

Physical Effects

- **Breathing problems.** Marijuana smoke irritates the lungs, and people who smoke marijuana frequently can have the same breathing problems as those who smoke tobacco. These problems include daily cough and phlegm, more frequent lung illness, and a higher risk of lung infections. Researchers so far haven't found a higher risk for lung cancer in people who smoke marijuana.
- **Increased heart rate.** Marijuana raises heart rate for up to 3 hours after smoking. This effect may increase the chance of heart attack. Older people and those with heart problems may be at higher risk.
- **Problems with child development during and after pregnancy.** One study found that about 20% of pregnant women 24-years-old and younger screened positive for marijuana. However, this study also found that women were about twice as likely to screen positive for marijuana use

[53] http://www.pnas.org/content/109/40/E2657
[54] https://www.drugabuse.gov/related-topics/adolescent-brain/longitudinal-study-adolescent-brain-cognitive-development-abcd-study

via a drug test than they state in self-reported measures. This suggests that self-reported rates of marijuana use in pregnant females is not an accurate measure of marijuana use and may be underreporting their use. Additionally, in one study of dispensaries, nonmedical personnel at marijuana dispensaries were recommending marijuana to pregnant women for nausea, but medical experts warn against it. This concerns medical experts because marijuana use during pregnancy is linked to lower birth weight and increased risk of both brain and behavioral problems in babies. If a pregnant woman uses marijuana, the drug may affect certain developing parts of the fetus's brain. Children exposed to marijuana in the womb have an increased risk of problems with attention, memory, and problem-solving compared to unexposed children. Some research also suggests that moderate amounts of THC are excreted into the breast milk of nursing mothers. With regular use, THC can reach amounts in breast milk that could affect the baby's developing brain. More research is needed. Read the *Marijuana Research Report* for more information about marijuana and pregnancy.[55]

- **Intense Nausea and Vomiting.** Regular, long-term marijuana use can lead to some people to develop Cannabinoid Hyperemesis Syndrome. This causes users to experience regular cycles of severe nausea, vomiting, and dehydration, sometimes requiring emergency medical attention.

Mental Effects

Long-term marijuana use has been linked to mental illness in some people, such as:

- temporary hallucinations
- temporary paranoia
- worsening symptoms in patients with *schizophrenia*—a severe mental disorder with symptoms such as hallucinations, paranoia, and disorganized thinking

Marijuana use has also been linked to other mental health problems, such as depression, anxiety, and suicidal thoughts among teens. However, study findings have been mixed.

Respiratory

In 2007, NZ scientists studied 339 marijuana and cigarette smokers, and determined that smoking ONE joint of marijuana was comparable to the effects on airflow obstruction of between 2.5 – 5 tobacco cigarettes, "*Adverse effects [of marijuana] on lung function is of major public health significance*," the study authors warned.[56]

A 2007 review of 34 studies on marijuana use and lung function found short-term exposure to marijuana is associated with bronchodilation, and long-term marijuana smoking is associated with increased respiratory symptoms suggestive of obstructive lung disease.[57]

Psychosis

> *"The link between cannabis and psychosis is quite clear now; it wasn't 10 years ago."*
> Professor Colin Blakemore, chief of the Medical Research Council (UK) (2007)[58]

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[55] https://www.drugabuse.gov/publications/research-reports/marijuana/can-marijuana-use-during-pregnancy-harm-baby
[56] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2094297/
[57] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2720277/
[58] https://www.independent.co.uk/life-style/health-and-families/health-news/cannabis-an-apology-5332409.html

In 2011, Australian researchers did a large systematic review (meta-analysis) using 83 studies for the *Archives of General Psychiatry.* They said;

> "*The results of meta-analysis provide evidence for a relationship between cannabis use and earlier onset of psychotic illness, and they support the hypothesis that cannabis use plays a causal role in the development of psychosis in some patients. The results suggest the need for renewed warnings about the potentially harmful effects of cannabis."* [59]

Lung Cancer

Nine scientists from the Medical Research Institute of New Zealand examined 79 cases of lung cancer and 324 control patients and concluded: "*long-term cannabis use increases the risk of lung cancer in young adults."* [60]

According to the British Lung Foundation, *"smoking three or four marijuana joints is as bad for your lungs as smoking twenty tobacco cigarettes.*" THC, the primary psychoactive ingredient of cannabis, decreases the function of immune system cells that help protect the lungs from infection.[61]

Heart Health

People who use marijuana may be three times more likely to die from high blood pressure than non-users of the drug, a new study finds. The researchers say that their findings indicate that marijuana use is a greater risk factor for poor cardiovascular health than cigarette smoking.[62]

Hospitalisation

Colorado – The yearly rate of emergency department visits related to marijuana increased 52% after the legalisation of recreational marijuana. (2012 compared to 2016). The yearly rate of marijuana-related hospitalisations increased 148%.[63]

In **Colorado**, calls to **poison control centers** have risen 210% between the four-year averages before and after recreational legalisation.[64] [65] **Washington** has seen a 70% increase in calls between the three-year averages before and after legalisation.[66] The Washington Poison Control reported 378 cases of toxic exposure to marijuana in 2017.[67]

Central **Oregon** hospitals saw a nearly 2,000% increase in emergency room visits due to marijuana poisoning, with 434 marijuana-related emergency visits in January 2016 alone, compared to a maximum of 32 visits per month prior to legalisation.[68]

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[59] https://www.ncbi.nlm.nih.gov/pubmed/21300939
[60] https://www.ncbi.nlm.nih.gov/pubmed/18238947
[61] https://www.newscientist.com/article/dn3039-cannabis-smoking-more-harmful-than-tobacco/
[62] http://www.medicalnewstoday.com/articles/318854.php
[63] https://rmhidta.org/files/D2DF/FINAL-%20Volume%205%20UPDATE%202018.pdf
[64] http://www.rmhidta.org/html/FINAL%202017%20Legalization%20of%20Marijuana%20in%20Colorado%20The%20Impact.pdf
[65] https://www.ncbi.nlm.nih.gov/pubmed/28365373
[66] https://www.ofm.wa.gov/sites/default/files/public/legacy/reports/marijuana_impacts_update_2016.pdf
[67] https://www.wapc.org/wp-content/uploads/2017-Cannabis-TTR-Updated-6-27-2018-1.pdf
[68] http://www.ktvz.com/news/bend/c-o-hospitalssee-dramatic-spike-in-pot-related-illnesses/69167250

The increase in marijuana-related emergency room visits in Oregon includes a growing number of Butane Hash Oil (BHO) burn victims.[69] [70] BHO is a marijuana concentrate that yields a THC potency of 70–99% and is highly lucrative. Production involves forcing raw marijuana and butane into a reaction chamber, which creates a highly combustible liquid that easily explodes when introduced to an ignition source.(similar to a P-Lab). According to publicly available information from the Oregon Poison Control Center, calls regarding cannabis exposure grew most dramatically in the 21 years and older population – representing 60% of all calls.[71]

CANNABIS AS A GATEWAY DRUG

> "*Consistent evidence[72] has shown that cannabis use almost always precedes the use of other illicit drugs, including cocaine, methamphetamine, hallucinogens (including LSD and ecstasy), illegally obtained prescription drugs, and opiates, such as heroin or morphine. Cannabis users are significantly more likely than non-users to use other illicit drugs, and more frequent use of cannabis and younger age of initiation to the drug strengthen this relationship, even after controlling for potential confounding variables and studying twins. This use pattern is strongest in adolescents and declines with age, possibly because of increased social maturity on the ability to resist illicit drug use."*
>
> UNODC (United Nations Office on Drugs and Crime):
> Cannabis A Short Review (2012)[73]

Direct associations have been made between the frequency of marijuana use and higher THC potency with the development of mental health issues (psychosis, depression, anxiety, suicidality, reshaping of brain matter, and addiction).[74] [75] Links to lung damage and serious cardiovascular problems have also been found (hypertension, myocardial infarction, cardiomyopathy, arrhythmias, stroke, and cardiac arrest).[76] Marijuana use during pregnancy has also been shown to negatively affect the cognitive development of children by increasing their risk of hyperactivity, impulsivity, and inability to focus.[77] [78]

Chronic adolescent marijuana use has been correlated with cognitive impairment and a decreased ability to do well in work or school.[79] [80] [81] [82]

Marijuana has a variety of other interactions with mental health. While the popular view holds that marijuana is not addictive, brain scans of marijuana users show changes in the structure of the brain's

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69 https://learnaboutsam.org/wp-content/uploads/2018/07/SAM-Lessons-Learned-From-Marijuana-Legalization-Digital-1.pd
70 https://learnaboutsam.org/wp-content/uploads/2017/04/Oregon-State-Police-reportJanuary-2017.pdf
71 https://static1.squarespace.com/static/579bd717c534a564c72ea7bf/t/5b69d694f950b7f0399c4bfe/1533662876506/An+Initial+Assessment+of+Cannabis+Production+Distribution+and+Consumption+in+Oregon+2018_OR-ID+HIDTA_8-6-18.pdf
72 https://www.ncbi.nlm.nih.gov/pubmed/16548935
73 https://www.unodc.org/documents/drug-prevention-and-treatment/cannabis_review.pdf
74 https://www.ncbi.nlm.nih.gov/pubmed/28644037
75 https://global.oup.com/academic/product/contemporary-health-issues-on-marijuana-9780190263072?cc=nz&lang=en&
76 https://www.ncbi.nlm.nih.gov/pubmed/28905873
77 https://www.ncbi.nlm.nih.gov/pubmed/28365373
78 https://www.sciencedirect.com/science/article/pii/S0149763405000953?via%3Dihub
79 https://www.researchgate.net/publication/314140400_The_Hidden_Costs_of_Marijuana_Use_in_Colorado_One_Emergency_Department's_Experience
80 https://www.ncbi.nlm.nih.gov/pubmed/26409752
81 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4586361/
82 http://www.pnas.org/content/109/40/E2657

reward center to be consistent with addiction.[83] Heavy users have also been clearly observed to have withdrawal symptoms.[84] In Colorado, marijuana is the second drug most often implicated in addiction treatment admissions, after alcohol.[85]

Furthermore, a number of studies have identified marijuana's role in the pathway to other substance abuse. For example, a ground-breaking study of over 30,000 Americans showed that participants who reported marijuana use in the previous year were 2.6 times more likely to abuse prescription opioids.[86] Colorado toxicology reports show the percentage of adolescent suicide victims testing positive for marijuana has increased.[87] This is not terribly surprising, as daily marijuana use among youth who begin before the age of 17 significantly increases the risk of suicide attempts.[88]

"SCROMITING"

Cannabis withdrawal was included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). According to researchers in San Diego, "*Long-term and very heavy marijuana use may cause severe stomach pain and vomiting in a very small percentage of users. Cannabinoid Hyperemesis Syndrome (CHS) causes symptoms ranging from severe stomach pain, nausea, vomiting and the impulse to take hot showers… the condition has become so common, ER staff have coined a new term that helps identify it: "scromiting," for "screaming" and "vomiting."*[89]

In a case report published in the British Medical Journal Case Reports, researchers said a 27-year-old, from Minnesota, was brought to the Mayo Clinic six times over the course of a year complaining of nausea, vomiting and abdominal pain.[90] The cannabinoid hyperemesis syndrome (CHS) occurs in heavy marijuana users, those who smoke at least 20 times a month, who have recurrent and severe bouts of nausea, vomiting and abdominal pain. The number of people affected by CHS is unclear, although its prevalence could be in the millions.

A 2015 study found that the incidence of cyclic vomiting doubled in Colorado after weed was legalized, as well as incidence of CHS rising in other states where the drug is legal.[91] The first study to report on the phenomenon was led by Mount Barker Hospital in Australia, where researchers realized patients who had repeat attacks of vomiting had one thing in common: chronic cannabis use.[92] [93]

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[83] https://www.ncbi.nlm.nih.gov/pubmed/24741043
[84] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2777674/
[85] http://www.rmhidta.org/html/FINAL%202017%20Legalization%20of%20Marijuana%20in%20Colorado%20The%20Impact.pdf
[86] https://www.ncbi.nlm.nih.gov/pubmed/28946762
[87] https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/CoVDRS_12_1_17/Story1?:embed=y&:showAppBanner=false&:showShareOptions=true&:display_count=no&:showVizHome=no#4
[88] https://www.ncbi.nlm.nih.gov/pubmed/26360862
[89]
[90] http://casereports.bmj.com/content/2018/bcr-2018-226524.short?g=w_casereports_current_tab
[91] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4469074/
[92] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1774264/
[93] https://www.dailymail.co.uk/health/article-6283063/Marijuana-left-woman-27-hospitalized-six-times-intense-vomiting-syndrome.html

AS A SIGNATORY TO THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD THE BEST INTEREST OF THE CHILD OBLIGATES OUR DRUG POLICY TO BE CHILD CENTRED – NOT A USER CENTRED DRUG POLICY

Despite the claims of pot-industry lobbyists that liberalisation (and legalisation) will not affect young adult and youth use, the data show that with legalisation and normalisation, people are radically increasing their rate of consumption.[94] As commercialisation increases in legalised states, false advertising of marijuana products as being "natural" and "healthier than alcohol and tobacco" have greatly decreased the perceived risk of harm related to marijuana use. The main psychoactive ingredient in marijuana, THC, has now been observed to cause many different types of mental and physiological health problems— especially in children and youth.

Their hopes and dreams literally go up in marijuana smoke.

The problem with liberal drug policies like legalisation is that they centre upon the **rights of the *user***, at the expense of the most vulnerable party in the community, the *child*. Article 33 of the ***Convention on the Rights of the Child*** reads as follows:

> ***States Parties shall take all appropriate measures, including legislative, administrative, and educational measures to protect children from the illicit use of narcotic drugs and psychotropic substances, as defined in relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.***

Stephan Dahlgren, a Swedish lawyer who has been working for international organizations including UNICEF on human rights, children's rights, and home affairs since 1994, says "*This means that human rights law is requesting from all states that the protection of the child from ever getting in contact with drugs shall be the prism through which national and international drug policy shall be crafted*." [95]

We wish to quote from his significant paper "*THE RIGHT OF CHILDREN TO BE PROTECTED FROM NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES A HUMAN RIGHT/INTERNATIONAL LAW PERSPECTIVE"* by Stephan Dahlgren and Roxana Stere (May 2010)[96] and the associated policy Document.[97]

> *The only explicit statement about narcotic and psychotropic drugs (henceforth drugs) in any core United Nations Human Rights Convention is Article 33 in the 1989 Convention on the Rights of the Child (CRC). Protection against drugs is hence unquestionably a human rights issue. Protecting children from illicit use/production/trafficking of drugs is not an option for States Parties to the CRC. It is an obligation. Since CRC is more or less universally ratified the obligation is universal.*

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[94] https://www.ibhinc.org/drug-legalization/

[95] http://www.dontdecriminalize.org/files/images/pages/Protectionfromdrugs2012.pdf

[96] https://iogt.org/wp-content/uploads/2015/03/rights-of-the-child-to-be-protected-from-drugs.pdf

[97] https://www.unodc.org/documents/ungass2016/Contributions/Civil/World_Federation_Against_Drugs/Protectionfromdrugs2012-1.pdf

shall be read and understood alongside the overarching principle in CRC Article 3:

*CRC Article 3 states that ˝**In all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration**. ˝*

Therefore, not only is the obligation of States Parties to protect children from drugs a human rights imperative; it is a human rights imperative that should be given primary consideration. The child's interest to protection from illicit use / production / trafficking of drugs shall always be the starting point for discussing drug policy. The perspective shall be child centred, as opposed to adult centred, or user centred.

…. CRC has 54 Articles. Of these 11 are Special Protection Articles, covering children in especially difficult situations where special protection measures are called for.[98] Children and drugs are one of those 11 situations… Overall the ambition shall be to eradicate these situations. Children shall not be recruited into armed forces. Children shall not be involved in pornography. Children shall not be illicitly using drugs, or involved with production and trafficking thereof. Prevention is the frontline for child protection.[99]

***Whenever the society is deciding on legislation, or other policy the best interest of the child shall be considered, and not only on an equal footing with other interest, but it shall be a primary consideration**… An assumed right to take illegal drugs as a matter of self-expression or privacy would by comparison have almost zero civic interest, and would lose in a contest with any child rights provision….*

*Application of Article 33 shall also be permeated by the key principle in the above-mentioned Article 3 ˝The best interest of the child˝. The primacy of children's interests means that **general drug policy making shall be child centred**. Authorities shall primarily ask the question ˝how will this impact on children's right to protection from drugs ".*

The wording of Article 33 allows for a scope of protection that also covers the situation where the drug user is not the child, but e.g. his/her parent.[100] States Parties should strongly prevent that such situations emerge.

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[98] Special Protection Articles defined as per Guidelines for States Parties Reporting to the Committee on the Rights of the Child http://www2.ohchr.org/english/bodies/crc/workingmethods.htm#a2

[99] UNICEF 2009 Child Protection Strategy states in Para. 3 that "Successful child protection begins with prevention." Para. 2 states that the approach shall be human rights based.

[100] UNICEF's Implementation Handbook for the CRC (2002) is noting that ˝Parents dependent on drugs may have babies with consequent physical or intellectual disabilities, or have babies born with a drug addiction (p.498). In this respect the CRC provides that ˝the child by reason of his physical or mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth". Drug abuse by parents or other family members may also result in children being neglected or harmed. The Committee on the Rights of the Child have in their Concluding Observations on Swedens fourth State Party Report (2009) stated that they are concerned about the big quantity of children who are suffering the consequences of drug usage among their parents (para. 48).

Since Colorado, Washington, Oregon, Alaska, and the District of Columbia (Washington, DC) legalised marijuana, past-month use of the drug has continued to rise above the national average among youth aged 12–17 in all five jurisdictions.[101] The average rate of regular teen marijuana use in the legalized states of Alaska, Colorado, Oregon, and Washington is 30% higher than the U.S. rate as a whole (NSDUH, 2006-2017). Almost a third of all 18–25 year olds in legal states used marijuana in the past month, up from around one-fifth 10 years ago.[102]

In conclusion, and again quoting from Dahlgren and Stere;

> *The best interest principle has far reaching implications since it goes beyond the child-only realm. The best interest of the child shall be a primary consideration in all policy making that affects children, even in areas which at first might seem to have nothing to do with children.* ***In the field of drugs policy the question "how does this affect children's right to protection from drugs" shall be mainstreamed. It shall be the starting point for all drug related discussions****. Before stipulating e.g. that "Health is the priority for drug policy" decision makers shall ask themselves****: Is this the best way to ensure that children are protected against illicit use / production / trafficking of drugs? If the answer is no the policy has to be re-thought….***
>
> *From a human rights point of view even a society that good-faithedly works to be drug free is likely to have needs for treatment, and should respond to these. However, it deserves again to be underlined, in context of what has been said about the first priority for drug policy and victimisation above, that* ***a policy that puts reactive health before prevention seems to be user centred and out of step with Article 33.***

And once again, it's not just around 'smoking a joint'. One recent study showed increased use by 14–18 year olds with newer forms of consumption—vaping and edibles.[103] Another study conducted in Oregon found that as medical marijuana users and growers increased in a community, marijuana use among youth also increased, in part because of social acceptance of the drug.[104] [105]

We repeat the significant statement above - ***a policy that puts reactive health before prevention seems to be user centred and out of step with Article 33 when considering the best interests of children and young people.***

CHILDREN ARE ALREADY BEING HOSPITALISED FOR MARIJUANA POISONING IN NEW ZEALAND

Here in New Zealand, **Ministry of Health figures gained under the Official Information Act in November 2018 show that 73 children have been hospitalised in the past five years either for poisoning or for mental and behavioural disorders due to the use of cannabis.** This is over four

[101] https://learnaboutsam.org/wp-content/uploads/2018/07/SAM-Lessons-Learned-From-Marijuana-Legalization-Digital-1.pdf
[102] https://www.samhsa.gov/data/population-data-nsduh
[103] https://www.ncbi.nlm.nih.gov/pubmed/28662974
[104] https://www.ncbi.nlm.nih.gov/pubmed/28484894
[105] https://learnaboutsam.org/wp-content/uploads/2018/07/SAM-Lessons-Learned-From-Marijuana-Legalization-Digital-1.pdf

times the number of hospitalisations compared to synthetic cannabis for the same age group. For all ages, more than 2,200 have been hospitalised for cannabis alone.[106]

EFFECT ON YOUNG PEOPLE

New Zealand has some of the richest data on the adverse consequences of cannabis use coming from two major studies: the Christchurch Health and Development Study (CHDS)[107] and the Dunedin Multidisciplinary Health and Development Study (DMHDS).[108]

The CHDS is a study of a cohort of 1265 children born in 1977 who have been studied to the age of 35.

The study has now published 30 scientific papers on the issue of cannabis. This research shows that:
* Cannabis use by cohort members was common, with over 75 per cent reporting use, and in the region of 15 per cent developing a pattern of heavy use and dependence at some point.
* The use of cannabis was associated with increased risks of a number of adverse outcomes including: educational delay; welfare dependence; increased risks of psychotic symptoms; major depression; increased risks of motor vehicle accidents; increased risks of tobacco use; increased risks of other illicit drug use; and respiratory impairment. These effects were most evident for young (under 18-year-old) users and could not be explained by social demographic and contextual factors associated with cannabis use.

It's called 'dope' for a reason.

The United Nations Office on Drugs and Crime (UNODC) reported on the New Zealand study which found that cannabis is linked with dropping out of school, and subsequent unemployment, social welfare dependence, and an overall feeling of inferior life satisfaction compared to non-cannabis using teens. These results remained significant even after controlling for family socio-economic background; family functioning; exposure to child abuse; childhood and adolescent adjustment; early adolescent academic achievement; and comorbid mental disorders and substance use.[109] [110]

Mental Health

Direct associations have been made between the frequency of marijuana use and higher THC potency with the development of mental health issues (psychosis, depression, anxiety, suicidality, reshaping of brain matter, and addiction).[111]

Daily marijuana use among youth who begin before the age of 17 significantly increases the risk of suicide attempts. Researchers led by the National Drug and Alcohol Research Centre at the University of New South Wales (and including New Zealand researchers) analysed results of three large, long-running studies from Australia and New Zealand involving nearly 3,800 people.[112] Teenagers who start

[106] http://www.scoop.co.nz/stories/PO1811/S00279/children-hospitalised-for-marijuana-poisoning-mental-harm.htm
[107] http://www.otago.ac.nz/christchurch/research/healthdevelopment/publications/
[108] http://dunedinstudy.otago.ac.nz/publications
[109] https://www.unodc.org/documents/drug-prevention-and-treatment/cannabis_review.pdf
[110] https://www.ncbi.nlm.nih.gov/pubmed/18482420
[111] https://www.ncbi.nlm.nih.gov/pubmed/28644037
[112] https://www.sciencedirect.com/science/article/pii/S2215036614703074

smoking cannabis daily before the age of 17 are seven times more likely to commit suicide, a study has found.[113]

"The link between cannabis and psychosis is quite clear now; it wasn't 10 years ago."
Professor Colin Blakemore, chief of the Medical Research Council (UK) (2007)[114]

Colorado toxicology reports show the percentage of adolescent suicide victims testing positive for marijuana has increased. *(Colorado Department of Public Health & Environment [CDPHE], 2017).*[115]

Hospitalisation

The number of teenagers sent to emergency rooms more than quadrupled after marijuana was legalised in Colorado — mostly for mental health symptoms, researchers reported in 2017.[116]

"There is no question marijuana can be addictive; that argument is over. The most important thing right now is to understand the vulnerability of young, developing brains to these increased concentrations of cannabis."
Nora Volkow, director of the National Institute on Drug Abuse[117]

In the UK, more than 125,000 hospital admissions have taken place over the past five years as a result of taking cannabis – including 15,000 teenagers – some of whom were rushed to hospital suffering from serious psychosis. The levels of admissions in England have jumped by more than 50% since 2013.[118]

Effect On Teen Attitudes To Drugs

A 2017 survey found that one in four U.S. high school seniors would try marijuana or use it more often if it was legal – the highest in the 43-year history of the Monitoring the Future survey.[119] Broken down, about 15% of 12th graders said they would try marijuana if it was legal. And about 10% of current users said they would use it more often.[120]

Hidden Big Marijuana Products

Students say vaping is everywhere and 'it's easy to hide'.[121] Researchers at the Centers for Disease Control and Prevention (CDC) surveyed some 20,000 students in grades 6-12 about their marijuana use in e-cigarettes.[122] They found that nearly 1 in 11, or 2.1 million middle and high school students used marijuana in e-cigarette devices. In legal states people can buy cartridges of high - potency

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[113] https://learnaboutsam.org/wp-content/uploads/2018/07/SAM-Lessons-Learned-From-Marijuana-Legalization-Digital-1.pdf
[114] https://www.independent.co.uk/life-style/health-and-families/health-news/cannabis-an-apology-5332409.html
[115] https://learnaboutsam.org/wp-content/uploads/2018/07/SAM-Lessons-Learned-From-Marijuana-Legalization-Digital-1.pdf
[116] https://www.nbcnews.com/health/health-news/er-visits-kids-rise-significantly-after-pot-legalized-colorado-n754781
[117] https://www.washingtonpost.com/archive/opinions/2005/05/17/the-right-drug-to-target/1d763036-8215-4724-8f97-ffeecd91df16/?noredirect=on&utm_term=.e652bd453250
[118] https://www.dailymail.co.uk/news/article-6273159/UK-hospitals-treat-125-000-cannabis-users-past-five-years.html
[119] http://monitoringthefuture.org/pubs/monographs/mtf-vol1_2017.pdf
[120] https://www.webmd.com/mental-health/addiction/news/20180606/more-teens-than-ever-would-try-marijuana#1
[121] https://denver.cbslocal.com/2017/03/07/its-easy-to-hide-students-say-vaping-is-everywhere/
[122] http://themarijuanareport.org/wp-content/uploads/2018/09/2018-JAMA-Youth-Vaping-MJ.pdf

cannabis oil that fit into many e-cigarette devices. The popular Juul does not make marijuana pods, but users can refill Juul's nicotine cartridges with cannabis oil.

A US study this year found that teens who used e-cigarettes and hookah were up to four times more likely to use marijuana later, according to a study published in the journal *Pediatrics*.[123]

A RAND Corporation study just published by the journal *Drug and Alcohol Dependence* found that adolescents who view more advertising for medical marijuana are more likely to use marijuana, express intentions to use the drug and have more-positive expectations about the substance, providing the best evidence to date that an increasing amount of advertising about marijuana may prompt young people to increase their use of the drug.[124]

New Zealand teens are aware of the risks. Rajshan Featonby (16) is checking himself into a drug rehab clinic after being on various drugs for four-years.

> "*I was about 10-years-old when I ended up with CYFS, I was about 12 when I had my first toke of marijuana and I was 13 when I had my first toke of synthetic cannabis*." [125]

Pathway To Other Drugs

In 2017 researchers examined data from 17,000 youth aged 12-17 who participated in the 2014 National Survey on Drug Use and Health.[126] Compared with youth *without* past-month marijuana use, youth *with* past-month marijuana use were 9.9 times more likely to report past-month use of other illicit drugs.

CONCLUSION

- we **SUPPORT** the intent of the bill to allow consideration (but not requirement) of a health-based approach for certain cases of low-level and/or first-time drug use & possession

- we **OPPOSE** any change to the legal status of marijuana and other drugs *(separate from the Class A drugs proposed in this bill)* because of the significant health and addiction issues around recreational drug use, and the need for the law to reflect those and to protect society

- we **CALL FOR** increases in resources and funding for both
  - drug prevention programmes, and
  - addiction and mental health services

- **INCREASED HARM** - liberalising the laws around marijuana and other harmful drugs will *increase* harm - *not* reduce it

[123] https://edition.cnn.com/2018/08/06/health/vape-hookah-marijuana-teens-study/index.html
[124] https://www.rand.org/news/press/2018/05/17.html
[125] https://www.tvnz.co.nz/one-news/new-zealand/watch-new-plymouth-teen-putting-drugs-behind-him-and-turning-his-life-around
[126] https://www.ncbi.nlm.nih.gov/pubmed/29758306

- **CHILD CENTRED DRUG POLICY IS AN IMPERATIVE -** protecting children from illicit drug use is not an option for States / Parties to the United Nations Human Rights Convention on the Rights of the Child, it is an obligation. Therefore, drug policy in NZ must be child-centred, not user-centred

- we **CALL ON** the Labour and Green parties to withdraw the 2020 Referendum to legalise marijuana.

Thank you for consideration of this important social issue.

Bob McCoskrie
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