

MISUSE OF DRUGS AMENDMENT ACT 2019 POST-IMPLEMENTATION REVIEW

Ministry of Health

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Misuse of Drugs Amendment Act 2019: Post-Implementation Review of S7 Provisions

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EXECUTIVE SUMMARY

Purpose of Report

This report is an interim review of the impact of amendments made in 2019 to MoDA 1975.

The amendment

In August 2019, the Misuse of Drugs Act (MoDA) was amended to:

- enable temporary classification orders to be issued for emerging and potentially harmful substances
- classify synthetic cannabinoids AMB-FUBINACA and 5F-ADB as Class A controlled substances.
- affirm the ability of New Zealand Police (Police) to use discretion when considering whether to prosecute people for personal possession and use of drugs. This includes requiring the Police to consider whether, in addition to other relevant matters, health-based alternatives would be more beneficial to the public interest.

The amendments were made in response to a spike in drug-related harm that was observed in 2017. They made clear the Government's commitment to a health-based approach to preventing drug-related harm by seeking to interrupt supply and consumer cycles, promote awareness of dangers associated with unregulated substances, and reduce exposure to the criminal justice system for possession for personal use, where appropriate.

Changes made in the system

A new national referral pathway to Whakarongorau Aotearoa's Alcohol Drug Helpline was established by the Ministry of Health and Police to support implementation of the health-based approach amendment. Police issued advice to alert officers to the changes and provide guidance on the health-based approach to decision-making and how to make a health referral. Police amended instructions to make low-level methamphetamine offences eligible for non-court proceedings.

These changes were made against a backdrop of existing Police initiatives designed to prevent harm, offending and reoffending and provide alternatives to prosecution, including the ability to refer people to health services. The mental health and addiction system had been the subject of a major government inquiry, and decisions were being made on the recommendations of He Ara Oranga.

In order to be successful, the initiative requires Police and the mental health and addiction system to be actively engaged. Police need to be able to easily refer people to the mental health and addiction system which in turn needs to have a range of support available with capacity and processes in place to support the people who need help.

The review

The Ministers of Finance and Health that the amendments should be reviewed, with an interim review due in two years' time and a full review due in five years' time. The purpose of these reviews is to understand whether the amendment has been successful in supporting a health-based approach to drug-harm reduction and minimising the interaction of people with a drug harm issue with the criminal justice system.

This interim review is also intended to identify opportunities to improve our approach to analysing the impacts of the amendments to ensure the full review scheduled for 2024 is able to provide a comprehensive picture.

The limitations of the information and data means this review has only been able make observations and not be conclusive in several areas. For example, it is unable to draw conclusions on:

- awareness among Police of the 2019 amendment, its intent and the processes established to give effect, or attitudes or beliefs around the referral process
- the relationship between offending types and health referrals
- the relationship between Police proceedings and health referrals
- the AOD sector in terms of national coverage, equity of access and capacity to meet referral demand into the future.

Part one: Health-based Police discretion - Findings

Drug prevalence

To provide context to the findings, the review looked at indicators of drug prevalence. Overall illegal drug supply in New Zealand has remained steady over the last five years, excluding 2019 which was an outlier, skewed by several high-volume seizures of methamphetamine. Cannabis, methamphetamine and methylenedioxymethylamphetamine (MDMA) are the most prevalent illegal drugs in New Zealand. While COVID-19 caused some disruptions to the illegal drug market during 2020, the effects appear to have been temporary for most commodities.

Use of non-Court proceedings by Police

Non-court proceedings include informal warnings, formal warnings and referrals to Te Pae Oranga (an alternative justice model informed by a te ao Māori framework). These are recorded but do not involve any further action.

The use of non-court proceedings for personal drug possession and use has increased from 66 percent of Police interactions in August 2019 to 82 percent in the first quarter of 2021. It is not clear how much of this can be attributed directly to the amendment. Ninety percent of first offences are dealt with by way of non-court proceedings. Police use of non-court proceedings has increased significantly for repeat offences since August 2019 (59 percent in August 2019 to 77 percent in the first quarter of 2021).

It is not known how many of these resulted in health referrals. Where individuals have not been formally referred to a health service, not entering the criminal justice system for personal drug use is still considered a form of harm reduction.

Prosecutions for personal possession and use of cannabis have been declining for a decade. Prosecutions have continued to trend downwards following the 2019 amendments. Use of non-court proceedings, such as warnings, continue to trend upwards.

There has been a significant increase in the use of non-court proceedings for possession and use of methamphetamine since the amendment with no decrease in the prevalence of the drug (eight percent quarter 2 2019 – 49 percent quarter 1 2021). It appears that this has occurred as a result of the updated instructions issued by Police in response to the amendment.

The use of Police discretion around the country appears to be largely consistent with two possible outlier districts. The Eastern Police District appears to use non-Court proceedings less than the regional average while Southland appears to use non-Court proceedings more than the district average. There are, however, challenges in achieving statistically significant trends with the small datasets and the need to account for factors such as the higher incidence of repeat offending in Eastern. There will be a better understanding of trends in the final review in 2024.

Police are providing information to Districts on offending, victimisation and use of supported resolutions, to better inform operational performance and to improve equitable outcomes since

implementing Te Huringa O Te Tai. Te Huringa O Te Tai is a whānau ora crime and crash prevention strategy which focuses on keeping Māori from entering the criminal justice system and addressing the underlying causes of offending. This national and District-specific information includes use of Court and non-Court proceedings for Māori and non-Māori. Inclusion of data specific to personal drug possession and use would enable closer monitoring of outcomes by Districts and will be investigated by Police.

Court actions

Prosecutions overall have declined since 2019 with a sharp decrease in prosecutions for possession or use of methamphetamine. This reflects that there has been a change in Police operational policy and practice in relation to prosecution for offences related to methamphetamine. Overall conviction rates have also declined over the same period.

Diversion is an option for individuals facing court action. It offers the individual the chance to have their charges dismissed once the conditions of the diversion have been met. It has largely been used for personal cannabis possession and use; but is decreasing as fewer prosecutions for possession and use of cannabis are being made. Fewer people facing their first offence for personal drug possession and use are being offered diversion. This could be because most low-level offending is not making it to the courts. This aligns with the Police proceedings findings. Total drug-related diversion numbers have declined over the last decade from 841 in 2010, to 87 in 2016, and 128 in 2020.

Equity

There has been a marked increase in the use of non-court proceedings for Māori for personal possession and use of drugs (84 percent to 91 percent for first time Māori offenders and 56 percent to 70 percent for repeat Māori offenders). The timing is consistent with the amendment's introduction. The increase appears to be less than that for non-Māori but follows the same trend. The drivers for this are likely complex and require further investigation before any conclusions can be made.

The data shows that the trends in non-Court and Court proceedings are similar for Māori and non-Māori indicating that once the decision is made by Police to take proceedings against an individual, they are treated similarly within the Police system in relation to the use of non-court proceedings irrespective of ethnicity.

Conclusions on equity cannot be made as the complexity of the picture is not contained in the Police proceedings data. Demographic and case-level data and interviews with Police officers would be required to more fully understand the full picture.

The Police Prevention First approach and Reframe work programme are expected to improve outcomes for Māori and Pacific communities through the focus on harm prevention and the use of supported resolutions.

Deeper investigation is needed into the equitable application of decision making and use of discretion. Police is working with the University of Waikato on a long-term research programme focussed on examining where bias may exist within Police policies, processes, and practices.

Referrals to health services

Primary health care providers, social sector agencies, Oranga Tamariki, the Courts and Corrections can all offer referrals into alcohol and other drug services. Police has had the ability to refer into health and social services for some time, through various local mechanisms. Individuals can also choose to self-refer at any time.

In response to the health-based discretion amendment a new national referral pathway (the MoDA referral pathway) was established, connected to the Alcohol Drug Helpline provided by the nationwide telehealth provider Whakarongorau Aotearoa (formerly known as Homecare Medical).

If a police officer thinks that someone would benefit from health support, they can refer them to Whakarongorau Aotearoa. This can be done even where no offence has taken place or as part of any Police proceedings. Data is not recorded when the referral offer is declined. Not all referrals will lead to the individual choosing to accept the offer of support. Police encounter a wide cohort of people who use drugs, including many who do not require clinical treatment, as well as those experiencing severe harm.

Since the service started there have been 959 referrals to Whakarongorau Aotearoa, resulting in 181 calls and texts from 147 people. Referral rates through this service are low compared to referrals directly to mental health and addiction services in DHBs.

Police consider a key factor in frontline officer referral rates is confidence that health services are available for individuals referred, particularly from a kaupapa Māori perspective.

Alternative pathways for Health Intervention (AWHI) is a Police-designed local pathway that refers people directly to local agencies who can help them. It was established as a means of early intervention and wrap-around support for people in need and at risk of offending, reoffending or victimisation. AWHI is an offer of support and can be used both when no offending has occurred as well as where there has been an offence. If providers do not have the capacity to respond to a referral within a 48-hour period, they are not available for selection by an officer.

Both initiatives have strengths and there is merit in investigating how to design an integrated pathway that takes advantage of the strengths of both and improves on existing processes.

Health-based referrals were made during 61 percent of all drug-related diversions. Referral percentages reached a peak of 74 percent in 2019 (the year in which the amendment was enacted) but fell to 50 percent in 2020. It is difficult to explain this decline without conducting further research.

This review has found a number of areas for policy and operational improvement to support delivery on the intent of the recommendations which are detailed on the next page.

Health sector capacity to respond

A health-based approach needs the mental health and addiction system to have the capacity to respond to demands for services. The scope of the review has not allowed for a deep examination of the health response, but it is important to understand the complete picture to be able to measure success of the shift to a health-based approach. This will be an important part of the 2024 review.

Currently there is not a consistent range of alcohol and other drug supports in place across the country with capacity to meet all the demand that referrals from Police and other sources (primary health care, Oranga Tamariki, Courts, social services) generate. The investment in Budget 2019 in mental health and addiction services is intended to bolster existing services and establish new initiatives.

Harm reduction

Police are using a range of alternative resolutions, including referring individuals to health services where appropriate, in response to personal possession and use of drugs (and for other reasons). This review has been unable to draw conclusions on the extent of the harms that may have been reduced

in response to the 2019 amendments due to the limited amount of data available at the time of the review and the complicated nature of assessing drug harm reduction. Ways of measuring or estimating the amount of harm reduced will be investigated for the 2024 review when more data will be available.

Part Two: Review of impact of classification of AMB-FUBINACA and 5F-ADB - Findings

Background

Classifying AMB-FUBINACA and 5F-ADB in Schedule 1 (Class A controlled drugs) of MoDA increases the offences and penalties that can be imposed for activities such as importing, manufacturing and supply of the drugs, and Police and Customs have greater search and seizure powers. The Expert Advisory Committee on Drugs recommended to the Minister of Health that they be classified as Class A drugs because of the risk of harm they pose. Once they were classified as Class A controlled drugs, analogues (substances with similar structures) of AMB-FUBINACA and 5F-ADB became controlled drug analogues and subject to penalties under MoDA, providing a deterrent for importers, suppliers and manufacturers to move to similar substances.

Harm reduction

Closed coronial cases involving synthetic cannabinoids showed a surge in deaths in 2017 – 2018 and in the majority of cases AMB-FUBINACA was detected.

Hospital discharges with a synthetic cannabinoid diagnosis returned in 2019 and 2020 to pre-surge levels. This suggests that synthetic cannabinoids in general are still available and causing harm but at greatly reduced levels. The percentage of Māori represented in synthetic cannabinoid hospitalisations is higher than the proportion of Māori in the general population. In 2020 56% of all hospitalisations with a synthetic cannabinoid related principal diagnosis were Māori.

Supply reduction

The Institute for Environmental Science and Research (ESR) testing has found a sharp decline in samples containing AMB-FUBINACA and 5F-ADB since 2019.

There has been a reduction in the quantities of synthetic cannabinoids *powder* seized since 2019 and the quantities of synthetic cannabinoid *plant matter* seized has substantially reduced since 2018. This would suggest that the amount of synthetic cannabinoids being imported has reduced and consequently less synthetic cannabis is being manufactured in New Zealand.

Part Three: Temporary Drug Class Orders - Findings

The amendment allows the Minister of Health to issue a notice in the Gazette that temporarily classifies a substance as a Class C1 drug under MODA where the substance poses, or may pose, a risk of harm to individuals or society. The intent is to enable immediate action to reduce harm from a substance. The effect of temporarily classifying the substance is to provide a mechanism for the immediate search and seizure of the substance and to increase penalties associated with its sale and importation.

The orders are temporary to enable the classification process to happen over the following year. This includes the consideration of the substance by the Expert Advisory Committee.

Being able to quickly classify emerging products under MoDA allows for a fast response to a rapidly adapting synthetic drug market and ensure the continued disruption of the supply of new synthetic drugs.

The process for making a temporary drug classification order (TCDO) is untested. The review team recommends that the existing application process be refined, and more clearly communicated to relevant stakeholders.

On the 29th June 2021 the Ministry received its first request for a TCDO from the National Drug Intelligence Bureau, for the drug Etizolam. This application is being considered and provides an opportunity to test the process.

RECOMMENDATIONS

The following recommendations cover the scope of the review, areas for improvement to deliver on the intent of the amendments, and recommendations to enable a fulsome review in 2024. Findings of the review are noted on page 19.

Recommendations for policy and operational improvements to deliver on the intent of the amendments

1. **Develop** a common understanding of “health-based approaches” to drug harm reduction, reflecting on their development since 2019.
2. **Review** the evidence of effective outreach approaches for people using drugs harmfully to identify areas for service improvement.
3. **Continually improve** the MoDA referral pathways in line with international best practice so they are safe, evidence-based, accessible and maximise engagement by those who need support to reduce drug harm.
4. **Understand and inform** national and local referral pathways to health-based supports for people using illegal drugs, to facilitate easy access for people needing support to the most appropriate service or other support.
5. **Promote** awareness of the national MoDA referral pathway, both with Police and alcohol and other drug service providers.
6. **Consider** developing a cross-sector strategic framework to enhance health-based approaches to drug harm
7. **Consider** whether other referral pathways to mental health and addiction services require best practice improvements for effective outreach.
8. **Note** these recommendations require careful phasing in line with *Kia Manawanui* and *Reframe*.
9. **Continue to explore** opportunities to target support services to Māori and vulnerable populations to address the issues associated with deaths and hospitalisations due to synthetic cannabinoids.
10. **Refine** the existing Temporary Class Drugs Order application process, and clarity about the process be communicated to relevant stakeholders.

Recommendations for the full review scheduled for 2024

11. **Develop** an evaluation framework by the end of 2021 to guide the final review in 2024, with agencies working together to determine the key datasets and investigate the following factors:
 - engage with front-line Police to explore their understanding, beliefs, confidence and decision-making processes in using health-based approaches to reduce drug-related harm
 - interview people who use drugs on their experiences of the justice system’s use of health-based approaches, and what’s helped them to reduce drug harm

- assess performance against the principles of Te Tiriti o Waitangi including the perspectives of iwi and the community
- data on the AOD sector, the level of referrals pre and post-amendment
- unmet need for Māori including how the sector is taking a kaupapa Māori approach.

INTRODUCTION

Purpose of report

This report is an interim review of the impact of amendments made in 2019 to MoDA 1975. Part one covers amendments to section 7 of the Act, which emphasise health-based approaches for the exercise of Police discretion in prosecution of possession and use of drugs. Part two covers the impact of the classification of AMB-FUBINACA and 5F-ADB. Part three reviews the implementation of the temporary class drug orders.

As interim reports, they draw findings from the limited data available in the two years since the amendments were made. The reports also include recommendations on how gaps could be addressed, and further opportunities to provide a comprehensive picture in a full review of the impact of these amendments, scheduled for 2024.

Background

On 13 August 2019 MoDA amendments came into effect which:

- affirmed the ability of New Zealand Police to use discretion when considering whether to prosecute people for personal possession and use of drugs. This includes requiring the consideration of whether, in addition to other relevant matters, health-based alternatives would be more beneficial to the public interest
- enabled temporary classification orders to be issued for emerging and potentially harmful substances
- classified synthetic cannabinoids AMB-FUBINACA and 5F-ADB as Class A controlled substances.

The MoDA amendments made clear the Government's commitment to a health-based approach to preventing drug-related harm by seeking to interrupt supply and consumer cycles, promote awareness of dangers associated with unregulated substances, and reduce exposure to the criminal justice system for possession for personal use, where appropriate.

The spirit of the amendments is consistent with the Government's broader focus on equitable health and wellbeing outcomes for New Zealanders, their whānau and communities.

Overview of the Misuse of Drugs Act 1975

Under MoDA substances are classified as controlled drugs in three schedules, according to the risk of harm the drug poses to individuals or society by its misuse. The classification of a controlled drug means that there are rules for people producing, supplying, distributing, possessing and using these substances. The schedules are:

- **Schedule 1 (Class A)** are considered to pose a very high risk of harm
- **Schedule 2 (Class B)** a high risk of harm, and
- **Schedule 3 (Class C)** a moderate risk of harm
- There is also **Schedule 4** which includes precursor substances commonly used as ingredients in the manufacture of illegal substances.

Once drugs are classified under MoDA, people may be prosecuted for possessing, using, importing, manufacturing, supplying and administering the controlled drugs. There are more severe penalties for substances in the higher schedules. Once a substance is classified as a controlled drug, Police and the New Zealand Customs Service (Customs) are also able to invoke search and seizure powers under the Search and Surveillance Act 2012 to disrupt supply and reduce the availability of the substances

to people who use or misuse them harmfully. There are some exemptions under MoDA, for example to allow medical and other health practitioners to prescribe, manufacture, supply or administer controlled drugs which are also medicines.

Classification of substances

In the early 2000s new kinds of recreational drugs began arriving in New Zealand. Psychoactive products known as party pills, herbal highs, energy pills and synthetic cannabinoids containing no illegal substances were being sold in dairies and bottle stores. These substances were unregulated and very accessible, sold mostly through retail outlets. This resulted in many products being sold which had a wide variety of active chemicals and concentrations, some of which caused harmful side effects, with reports of serious side effects including aggression, psychosis, and seizures.

At that time, the classification process under MoDA was onerous and unsuited to the rapid emergence of new psychoactive substances. In response to the quickly evolving recreational drug scene and the potential harms associated with it, the Ministry created a 2011 amendment to MoDA that allowed for temporary class drug notices to be issued. These notices prohibited import, manufacture, sale and supply of substances listed by notice in the Gazette. These notices were an interim measure while the substances were assessed by an expert committee and decisions were being made about their appropriate ongoing scheduling. By July 2013, 22 compounds were the subject of notices. Newly introduced substances were frequently found to be more harmful than the products they replaced.

While the intent of the temporary class drug notices was to provide emergency restrictions capable of mitigating suspected safety issues related to new substances, they did not alleviate the procedural issues involved with scheduling under MoDA. As a result, provisions relating to these notices were repealed by the Psychoactive Substances Act 2013 which takes a more proactive approach to psychoactive substances.

The purpose of the Psychoactive Substances Act 2013 is to regulate the availability of psychoactive substances in New Zealand to protect the health of, and minimise harm to, individuals who use psychoactive substances. This Act shifted the burden of proof from the government needing to demonstrate the harms associated with a substance before it could be regulated, to the manufacturer needing to demonstrate the substance poses no more than a low risk of harm before it can be distributed for personal use.

The Psychoactive Substances Act introduced transition arrangements that allowed products that had been on the market for at least three months prior to enactment to be granted an interim licence on application. The interim period was intended to continue until regulations could be made that allowed applications for full licences to be made and described the information and evidence required to support those applications. However, before the interim period of the Act ended, amendments to the Act removed all interim approvals in response to increased harms being associated with the products. The same Psychoactive Substances Act amendment also provided that the Psychoactive Substances Expert Advisory Committee can only consider the evidence from animal testing to ban a product, not to approve it. Therefore, without appropriate alternatives to animal testing, no products can be approved and licensed under the Act. Currently, there are no approved products and no applications for a product have been received.

Further information on the Psychoactive Substances Act is in Appendix 1 (glossary).

Key drivers for the 2019 MoDA amendments

The 2019 amendments were initiated in response to a high degree of health-related harm being experienced by people who were using synthetic cannabinoids new to the New Zealand market.

At the time Government considered policy changes, there had been 42 deaths provisionally linked to synthetic drug use, 25 of whom were Māori, in the period June 2017 to June 2018. At that time, these were active cases under consideration by the Coroner and no conclusions had been drawn about the cause of death. Immediately prior, there had been 13 confirmed deaths linked to synthetic drug use between July 2016 and May 2017.

Two substances of concern were of particular concern: AMB-FUBINACA and 5F-ADB. These drugs were readily available, relatively cheap to produce and buy, and had a strong ‘come down’ which resulted in increased compulsion to use again. Anecdotal reports tell us that people used synthetic cannabinoids to avoid returning a positive workplace drug test.

The 2019 amendments to MoDA reclassified AMB-FUBINACA and 5F-ADB from unapproved psychoactive substances to Class A controlled drugs. This was done to indicate to the public their potential level of harm. The change increased Customs and Police staff powers to search for and seize these substances, with the intention of interrupting the supply chain. MoDA also contains analogue provisions which mean that many other synthetic cannabinoids, although not specifically scheduled in MoDA, are captured as class C controlled drugs on the basis of their structural similarity to AMB-FUBINACA or 5F-ADB.

The amendment also allowed for temporary class drug orders to be issued in relation to substances that poses or may pose a risk of harm. Temporary class drug orders make a new substance a class C controlled drug for a period of up to 24 months. This provides protection for the public while further work is undertaken to assess whether the substance should be permanently scheduled under MoDA and in which class.

The Government’s intention in making these changes was to minimise health-related harm, and to interrupt supply chain. It was not to create additional harm to people who use drugs through entry into or progression through the criminal justice system. The Minister of Health stated:

*“We want to balance controlling supply, and thus ensuring public health and safety, with protecting those who use these dangerous synthetic drugs from criminalisation. In doing so we can shift people towards **the health and social support services they need**. This aligns with the Government’s intent to treat drug use as a health issue”. [Cab-18-MIN-0620 “Synthetic drugs response”, emphasis added]*

It was identified that one potential problem with simply reclassifying these substances was the potential to overly impact vulnerable people through further enforcement. In view of this, MoDA was further amended to affirm Police use of discretion with respect to personal possession and use of controlled drugs, as outlined above in the review scope section. However, Police continue to have the ability to prosecute for personal possession and use in appropriate cases.

Taking a health-based approach

Some people who take drugs experience mild to moderate drug-related harm, and a smaller proportion experience severe drug-related harms and will need intensive support.

New Zealand’s approach is consistent with many modern jurisdictions’ approaches to drug harm in that we balance a harm reduction approach to people who use drugs, while taking a strong approach to disrupt drug suppliers, manufacturers and importers.

Health-based approaches apply to people using alcohol and other drugs, local communities and the general public. In broad terms, a health-based approach to drug use includes:

- providing harm reduction or treatment support, as opposed to arrest or criminal justice/court processes
- non-judgemental approaches that destigmatise people that seek help
- approaches that prevent harm and intervene earlier in the development and/or experience of drug harm
- population-level health promotion that supports positive social and cultural norms around drug use and harm.

“Health” in this context is holistic, taking into consideration not only the physical and mental state of individuals, but their social, environmental and economic factors. Health-based approaches are therefore not limited to health services but involve a wide range of actors across government and in communities. Policies and interventions will look different across the spectrum of use or harm, and should be based on the setting, population, and the type of substance.

Mental health and addiction system

There are long-standing regional and local variations in the funding and types of arrangements for addiction treatment services.

Variations in funding and types of services can have positive or negative impacts. While some variations are necessary to effectively cater to the differing needs of the regions that they serve, others reduce the quality of the service for individuals. For example, some regions have highly developed models of care across the region, and others less so. Most district health boards (DHBs) fund residential treatment within their region, while others fund services outside of the region meaning that people must travel away from their regions to access these services. For example, there is currently no DHB alcohol and other drug provider in the Lakes and Wairarapa DHBs. Some DHBs also contract non-governmental organisations to provide specialist services.

There are also differences in the types of services available for priority populations. For example, young people may be assessed and receive services for alcohol and other drug issues via Child, Adolescent Mental Health Services. Other young people may be seen in specialist youth services such as Altered High in Auckland, Rubicon Rehabilitation services in Northland, Mirror Counselling in Dunedin, and Sorted in the Bay of Plenty.

[He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction](#)

In 2017, the incoming Government commissioned an independent inquiry into mental health and addiction in New Zealand. The inquiry was mandated to look at mental wellbeing from mental distress to enduring psychiatric illness, and to take account of the determinants of mental health, many of which lie outside the health system.

The final report, *He Ara Oranga*, was released in December 2018. Among other things, it highlighted the need for an approach to mental health and wellbeing that addresses the determinants of mental health and wellbeing. It noted that New Zealand did not have a complete continuum of care, with components of the system missing for New Zealanders with mild to moderate mental health and addiction needs who do not meet the threshold for specialist services. Key recommendations were to support access and choice, build this ‘missing middle’, and to transform primary care so that people can get mental health support in their communities.

A number of recommendations relate to alcohol and other drug services (AOD). The key recommendations specific to drug use made within the report included:

- Recommendation 27: 'Replace criminal sanctions for the possession for personal use of controlled drugs with civil responses (for example, a fine, a referral to a drug awareness session run by a public health body or a referral to a drug treatment programme)
- Recommendation 28: 'Support the replacement of criminal sanctions for the possession for personal use of controlled drugs with a full range of treatment and detox services.' The 2019 MoDA amendments align with these recommendations and, through their focus on harm-minimisation and health-promotion, contribute to ongoing progress
- Recommendation 29: 'Establish clear cross-sector leadership and coordination within central government for policy in relation to alcohol and other drugs'. There are a range of existing forums and arrangements for cross-sector activity relating to alcohol and other drugs.

Police has implemented the intent of recommendation 27 to the extent that they can within the existing legal framework when using their discretion not to prosecute for possession and personal use of controlled drug offences. Police avoid criminal sanctions where suitable and consider whether to refer people to health-based services but also consider the public interest as provided for in legislation where this is necessary and appropriate. In addition, substantial progress has been made to provide a broad, accessible and sustainable range of services for people who use illegal drugs harmfully.

More recently, the Ministry of Health has been progressing *Kia Manawanui: Long term pathway to mental wellbeing 2021*. *Kia Manawanui* contains a series of actions to be implemented over a ten-year horizon and include commitments in support of the intent of recommendations 27 and 28 of *He Ara Oranga*.

[Budget 2019 – sustaining existing services and establishing some new initiatives.](#)

Government's response to *He Ara Oranga* to date includes Budget 2019 investment of \$69 million over four years in AOD treatment services. This is a mix of spending to update investment in established services, and to introduce new initiatives. Investment includes:

- specialist AOD services (\$42m over four years for Vote Health, \$2m for Vote Corrections)
- primary and community alcohol and other drugs AOD services (\$14m over four years)
- the expansion of Pregnancy and Parenting Services to two new sites (\$7m over four years)
- sustainable funding for Te Ara Oranga, the Northland methamphetamine harm reduction pilot (\$4m over four years).

There has also been large-scale investment in mental health and addiction support for people experiencing mild to moderate mental health and/or alcohol and other drug concerns. Budget 2019 provided \$455 million over four years as a direct response to the concerns raised in *He Ara Oranga* about a 'missing middle' of people who experience mental health and addiction issues but whose needs do not currently require specialist support. As part of this funding, new integrated primary mental health and addiction (IPMHA) services through general practice are being rolled out over a five-year period.

As at 30 April 2021, IPMHA services are being offered in 197 general practice locations in 16 DHB areas, 15 contracted youth services, 9 Pacific services and six kaupapa Māori services. These numbers will continue to grow as more services are established throughout the roll out. To date these services combined have provided over 130,000 sessions overall to people, and now deliver approximately 10,000 sessions each month.

Further detail of *He Ara Oranga*, recent Government investment in the mental health and addiction system and *Kia Manawanui* is included in Appendix 3.

Policing policy and operations

Police has been changing its operating model for the last decade or more, with a greater focus on prevention and victims of crime. In relation to personal possession and use of drugs, this has been evidenced in a steady decline of cannabis related prosecutions, well in advance of the 2019 amendments.

The following initiatives by NZ Police were in place in the lead-up to the 2019 amendments to MoDA:

- Prevention First operating model - an operating model that encourages prevention of harm and reduction of risk of reoffending
- Te Huringa o Te Tai - A whānau ora crime and crash prevention strategy which focuses on keeping Māori from entering the criminal justice system and addressing the underlying causes of offending
- Te Pae Oranga iwi community panels – an iwi/Māori-led, restorative principled approach as an alternative to Court that holds people to account and enables them to put right the harm caused by their offending. Te Pae Oranga is not yet available in every District.
- AWHI – a tool to allow Police Officers to refer people in need of support directly to agencies who can help.

These initiatives are set out in more detail in Appendix 4.

PART ONE- HEALTH-BASED APPROACHES FOR THE EXERCISE OF POLICE DISCRETION

Review scope and objectives

Review scope

This report is specific to the section 7 amendments to MoDA (the “health-based approach amendment”) and considers the implementation and impact of the exercise of Police discretion and accompanying Health response.

As amended, the relevant subsections of section 7 are:

(5) To avoid doubt, it is affirmed that there is a discretion to prosecute for an offence against subsection (1)(a), and a prosecution should not be brought unless it is required in the public interest.

(6) When considering whether a prosecution is required in the public interest, in addition to any other relevant matters, consideration should be given to whether a health-centred or therapeutic approach would be more beneficial to the public interest

The review does not investigate broader policy or operational issues, such as the decriminalisation of drugs for personal use. It also does not provide a performance audit of individual agencies or service providers.

Review objectives

The overarching objective of the review is to understand the amendment’s impact on supporting a health-based approach to drug-harm reduction and whether the intent of minimising harm associated with entry into or progression through the criminal justice system is being realised. The review team has therefore sought to understand how the amendments have been implemented, including systems and processes to support the intent of the amendment. In this review we seek to:

- understand the impact of the health-based approach amendment on relevant groups: Police; mental health and addiction service providers; the court system and Judiciary; and people and communities who are affected by illegal drug use
- identify the relationships between referrals to health services from Police and the implementation of the amendment
- capture any geographic or demographic differences in how the amendment is being implemented
- identify any implementation barriers, their causes and opportunities for improvement. Further information on the scope, objectives, approach, methodology and limitations of the review are included in appendix 2.

To do this we have looked at both quantitative and qualitative data, systems and processes to understand outcomes.

PART ONE REVIEW FINDINGS

Implementation

The following outlines what was established in the initial months of implementation.

A new system for health-based referrals

A new referral pathway was established by the Ministry of Health and Police to support implementation of the health-based approach amendment. This is a nationally consistent referral mechanism to the Alcohol Drug Helpline provided by the existing national telehealth service provider, Whakarongorau Aotearoa (then known as Homecare Medical).

The referral pathway is referred to in this report as the MoDA Referral Pathway and discussed in the Referrals to Health Services section of this report.

Police guidance and training

On 13 August 2019, Police advised its staff that the Amendment Act had come into effect and updated its operational guidance. The advice included:

- the amendments to MoDA;
- the introduction of the MoDA Referral Pathway;
- that there was guidance in the Police CheckPoint App on making a health referral, and an online referral form;
- amending Police instructions to allow low-level methamphetamine offences to receive a pre-charge warning (now replaced by a formal warning); and
- answers to frequently asked questions about the changes.

These updates alerted officers to the changes and provided guidance on the health-based approach to decision making and how to make a health referral.

The Solicitor-General's Prosecution Guidelines provide the framework for the public interest test for all offences. Police are experienced in weighing up different criteria to determine whether the public interest test is met across a range of offences, including personal possession and use of drugs. Specific guidance for police officers on use of the public interest test for personal drug possession and use was developed by Police and was accessible to staff across different channels.

Police Māori Responsive Managers and their teams in Supported Resolutions also have a role in helping frontline to use and understand the supported resolutions pathways.

Key finding(s):

Immediately following the introduction of the amendments:

- A new nationally consistent system for health-based referrals was established, and Police advised its staff of the amendments and implications for operations
- Changes were made to Policing instructions to allow a health-based approach for methamphetamine offences.

Drug prevalence in New Zealand

Overall illegal drug supply in New Zealand has remained steady over the last five years, excluding 2019 which was an outlier that was skewed by several high-volume seizures of methamphetamine. Cannabis, methamphetamine and MDMA are the most prevalent commodities in the New Zealand illegal drug landscape. While COVID-19 caused some disruptions to the illegal drug market during 2020, the effects appear to have been temporary for most commodities.

In line with overall drug trends, methamphetamine seizure volumes have remained steady over the last five years, excluding 2019 which was an outlier that was skewed by high volume seizures. While there were temporary disruptions in supply due to COVID-19, wastewater consumption levels remain stable indicating methamphetamine is available throughout New Zealand. Enduring demand for methamphetamine will almost certainly continue to drive supply and a market for organised crime.

Cannabis remains the most seized illegal drug in New Zealand. The cannabis market remained largely unaffected by COVID-19 as cannabis is mainly grown and supplied domestically. While an increase in the quantity seized was observed in 2020, cannabis seizure quantities have been relatively stable over the last five years.

Synthetic cannabinoid seizures continue to decline overall, however these substances are likely to remain available across the New Zealand market, due to high accessibility and a low price point. The synthetic cannabinoid market is continuously shifting as offshore manufacturers develop new products to circumvent legislation in jurisdictions with comprehensive analogue laws, such as New Zealand. This is evidenced by a steady increase in the diversity of synthetic cannabinoids seized, and the detection of new synthetic cannabinoids throughout 2020.

MDMA seizure volumes steadily increased between 2017 and 2020, then dropped significantly in 2021, likely due to disruptions in MDMA supply into New Zealand. This trend is reflected in levels of MDMA detected in wastewater. The reduction in MDMA supply coincided with, and likely led to, an increase in synthetic cathinones being sold as MDMA to meet demand. This highlights the unpredictability of the drug market and the degree to which prevalence is affected by supply and availability.

Details of Police and Customs seizures of these substances is included in Appendix 5.

Key finding(s):

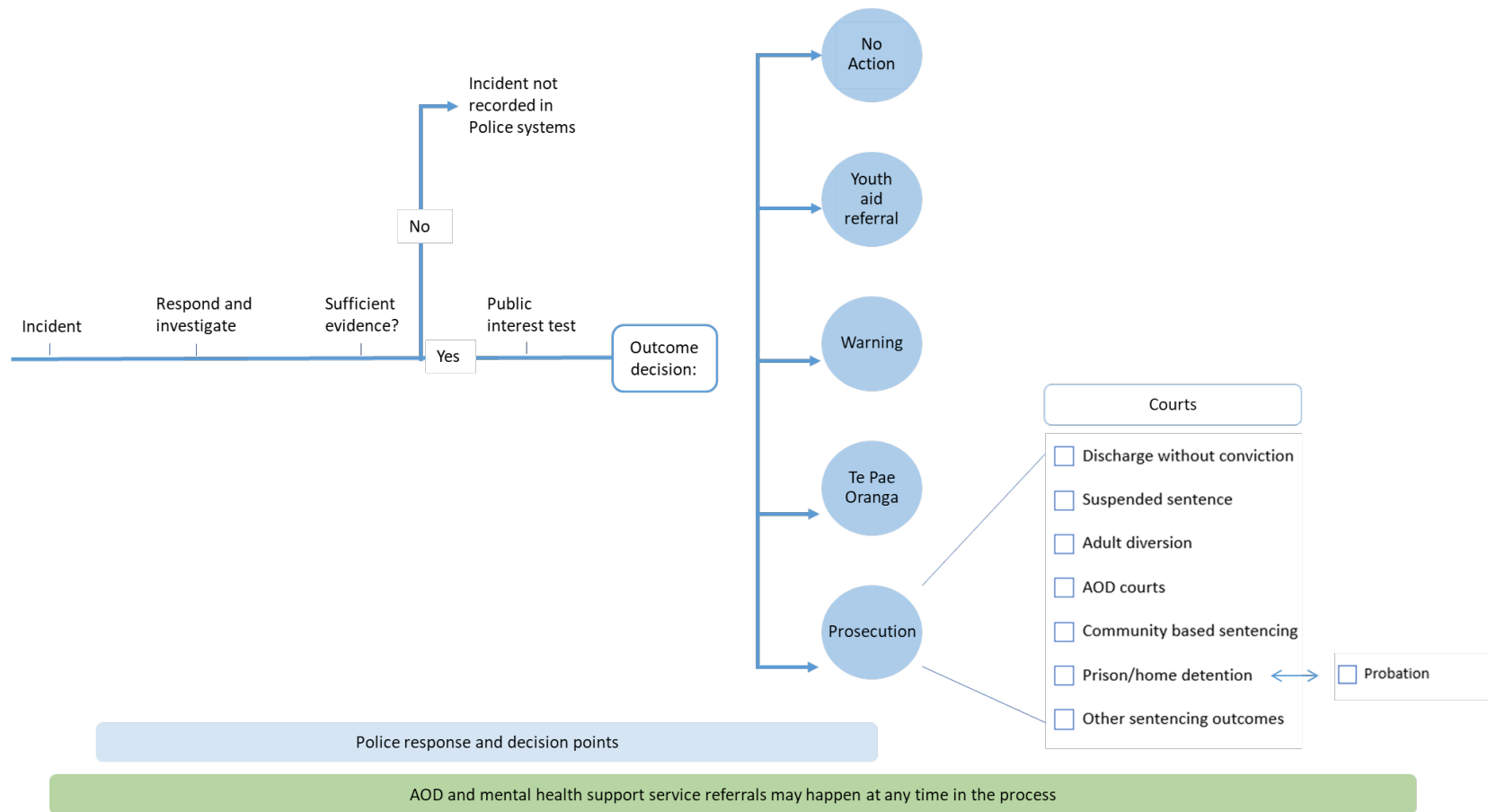
Police and Customs drug seizure data and wastewater testing indicate that:

- overall illegal drug supply in New Zealand has remained steady over the last five years
- cannabis, methamphetamine and MDMA are the most prevalent commodities in the New Zealand illegal drug landscape.

Resolution proceedings

The following diagram illustrates the potential outcomes for an individual suspected or confirmed to have been in possession or have used illegal drugs. This diagram includes the investigative and decision-making stages and options for Police and multiple prosecution outcomes. Alcohol and other drug, and mental health support referrals may occur at any stage.

FIGURE 1 RESOLUTION OUTCOMES



Police proceedings

Individual police officers apply discretion in dealing with a range of matters, which include personal possession and use of drugs. They are guided by the Policing Act 2008, the Solicitor-General's Prosecution Guidelines and Prevention First. When police officers exercise the use of discretion on whether to prosecute or not, they are increasingly using supported resolution options. These include formal warnings, informal warnings and Te Pae Oranga (Iwi Community Panels). Referrals to health and other support services can be made as part of any of these interactions.

Actions that Police officers may take include:

- *Informal warnings*: This is the most informal of the Police warning thresholds and does not involve any further action. Informal warnings, often known as verbal warnings, are usually recorded in the National Intelligence Application.
- *Formal warnings*: This is a written warning issued to an individual. The warning is recorded (and may be shared during Police vetting if relevant) but is not a charge and subsequently does not result in prosecution. Individuals can dispute a warning. This warning is usually applied in instances where the offence is punishable by less than six months' imprisonment
- *Referral to Te Pae Oranga*: an alternative justice model informed by a te ao Māori framework. It is not yet available in every Police District
- *Youth Referral*: Can include a youth warning, Te Pae Oranga, Youth Court, Family Group Conference and other interventions
- *Court action (prosecution and diversion)*: in-court proceedings precipitated by prosecution (diversion is accessed following the laying of charges for prosecution).

The term 'proceedings' is not limited to court action and is an umbrella term for all response options available to Police when addressing possession of drugs for personal use. A proceeding counts each separate occasion when Police deal with a person for one or more offences. Proceedings for official statistics are classified according to the "most serious offence" that the person is dealt with on that occasion.

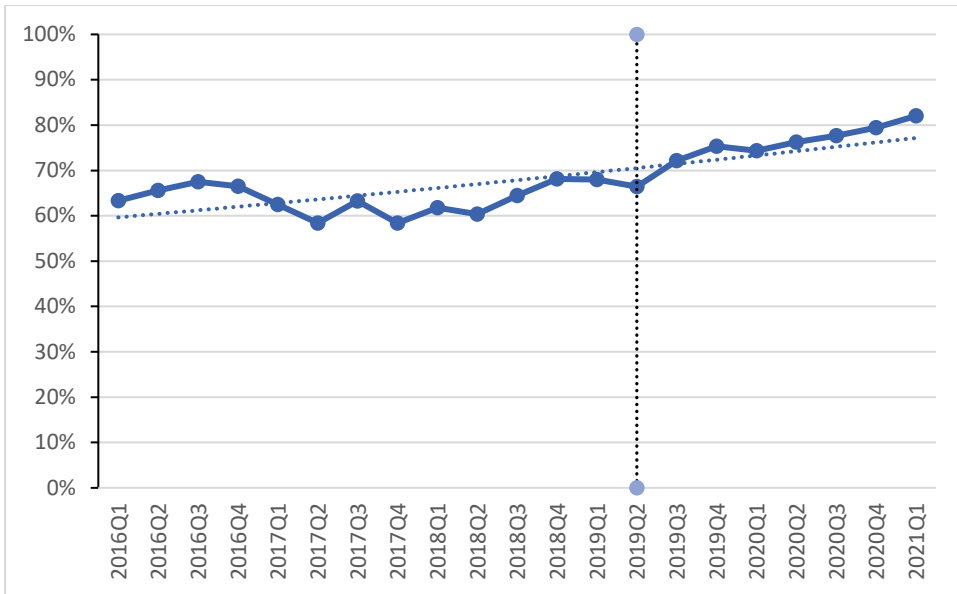
All non-court proceedings (verbal warnings, formal warnings and referral to Te Pae Oranga) have been aggregated in the following tables. Everyone else will have had court action taken. We have analysed the data to show what change in the use of non-court proceedings has happened after the 2019 amendment. The graphs in the following section are drawn from Police proceedings data.

Non-court proceedings for personal possession and use charges

Graph 2 shows the percentage of non-court proceedings for personal possession and or use, where that was the most serious charge. It includes all drugs and all ethnicities

This graph shows an increase in the use of non-court proceedings by Police since August 2019 to the first quarter 2021 (66 percent to 82 percent) and therefore a decrease in the use of court proceedings (34 percent - 18 percent). This is the continuation of a trend started before 2019 but it has increased since 2019.

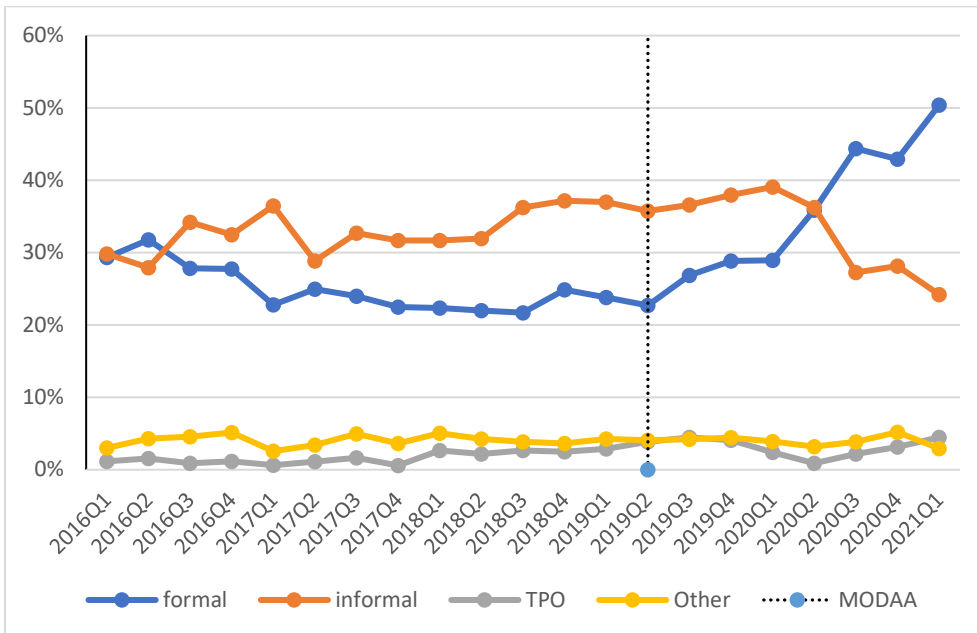
GRAPH 2. PERCENTAGE OF NON-COURT PROCEEDINGS WHERE PERSONAL POSSESSION AND USE IS THE MOST SERIOUS OFFENCE



Graph 3 shows the breakdown of the proceedings described in graph 2. It shows a significant increase in the use of formal warnings (36–50 percent) and a decrease in the use of informal warnings (36–24 percent) since quarter 2 2020. This is when formal warnings became easier to make.

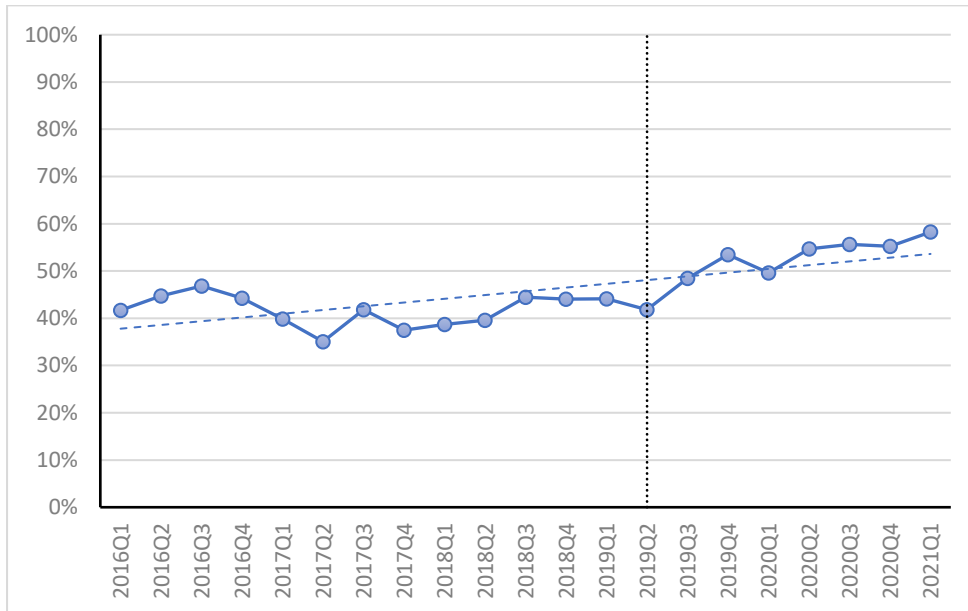
This means that more people are now receiving a formal warning than previously. This will be reflected in the information Police have for any further interactions.

GRAPH 3 NON - COURT PROCEEDINGS AS A PERCENTAGE OF ALL PROCEEDINGS WHERE PERSONAL POSSESSION AND USE IS THE MOST SERIOUS OFFENCE



Graph 4 shows the use of non-court proceedings where possession or use was one of multiple offences. The use of non-court proceedings by Police has also increased for these people since August 2019 to the first quarter 2021 (42 percent-58 percent).

GRAPH 4. PERCENT NON - COURT PROCEEDINGS WHERE PERSONAL POSSESSION AND USE IS ONE OF MULTIPLE OFFENCES



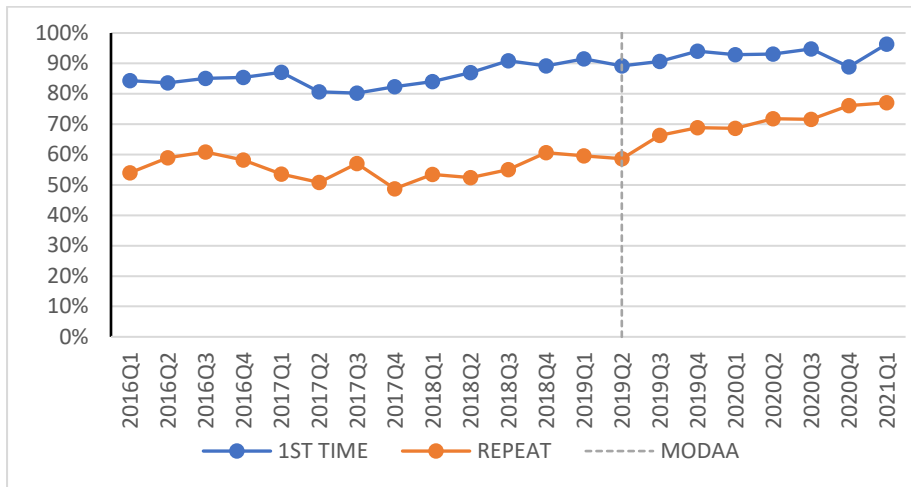
The data shows that Police has increased use of non-court proceedings when dealing with personal possession and use of drugs offence. We do not know if this is a long-term trend or, due to limitations in the data, if it correlates with an increase in health-referrals for these individuals.

Non-court proceedings first and repeat offences

Graph 4 shows the percentage of non-court proceedings for first and repeat offences for possession and use of illegal drugs. It includes all drugs and ethnicities.

The data shows that Police use of non-court proceedings is almost 100 percent for first time offenders and has increased for repeat offences. The increase in the use of these proceedings for repeat offences since August 2019 is significant (59 percent in August 2019 to 77 percent in the first quarter of 2021).

Graph 5 Percentage non-Court by first time and repeat offences where personal possession and use is the most serious offence



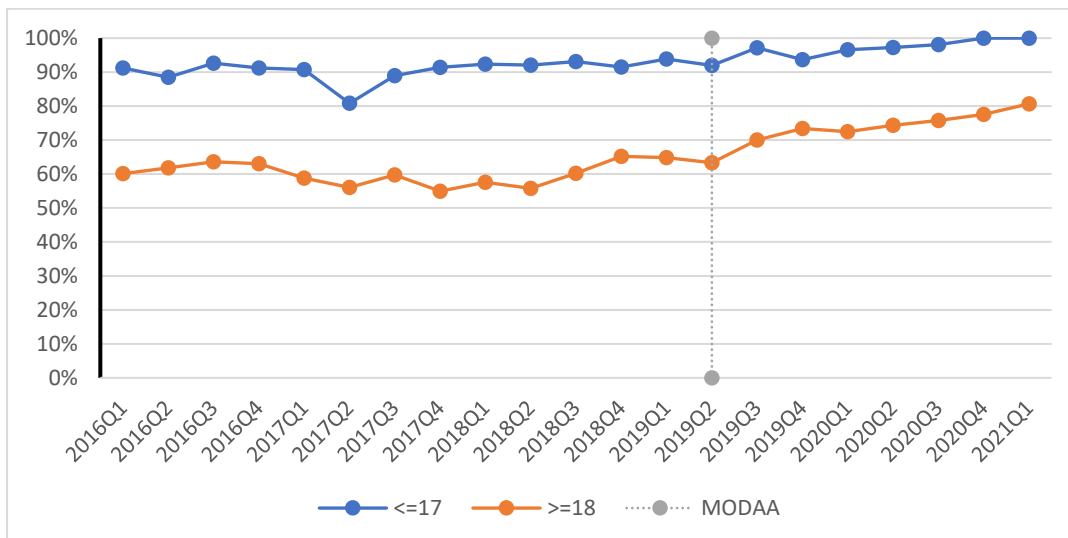
Non-court proceeding for youth and adults

Graph 6 shows the percentage of non-court proceedings for those under and over 18 years of age where personal possession and use of illegal drugs is the most serious charge. It includes all drugs and ethnicities.

The percentage of youth who do not have court-based proceedings was high before the amendment and has continued to increase (Q4 2019 92 percent to Q1 2021 100 percent). Almost all youth go through the youth justice system. They are referred to Police Youth Aid and, where action is warranted, it is through the Oranga Tamariki led Family Conference process.

For people over 18 years of age there has been an increase in the use of non-court proceedings (Q 4 2019 63 percent to Q1 2021 81 percent).

GRAPH 6. PERCENTAGE OF NON-COURT PROCEEDINGS FOR PERSONAL USE AND POSSESSION OFFENCES FOR YOUTH AND ADULTS WHERE PERSONAL POSSESSION AND USE IS THE MOST SERIOUS OFFENCE



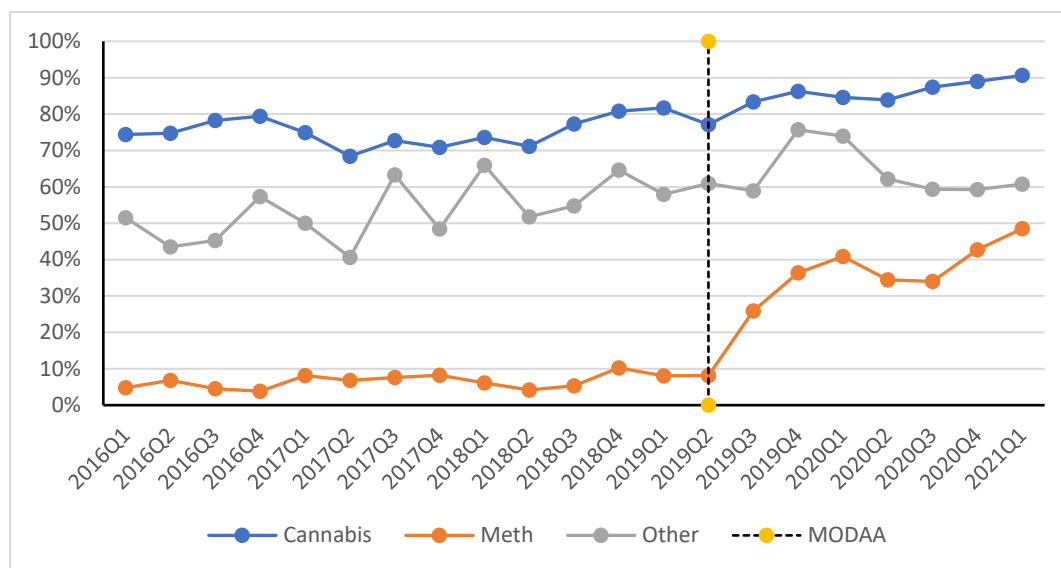
Proceedings by drug type

Graph 7 shows the percentage of non-court proceedings for personal possession and use charges that are non-court versus court by drug. It includes all ethnicities.

This graph shows a significant increase in the use of non-court proceedings for personal possession and use of methamphetamine (8 percent quarter 2 2019 – 49 percent quarter 1 2021). This change appears to be the result of the change in Police instructions following the health-based amendment. Methamphetamine seizure volumes have remained steady over the last five years and wastewater levels of methamphetamine remain stable indicating methamphetamine is readily available throughout New Zealand.

A high percentage of proceedings for personal possession and use of cannabis were already non-court. This has also increased since the amendment (77 percent quarter 2 2019 – 91 percent quarter 1 2021).

GRAPH 7. PERCENTAGE OF NON-COURT PROCEEDINGS BY DRUG TYPE WHERE PERSONAL POSSESSION AND USE IS THE MOST SERIOUS OFFENCE



Proceedings by Police District

Graph 8 shows the percentages of non-court actions for personal possession and use by Police district. The data shows that the use of Police discretion between regions over time is largely similar with three possible outliers. The regions differ in the use of Police discretion. For example, Eastern Police District appears to use non-court proceedings less than the regional average while Southland appears to use non-court proceedings more than the regional average. This could be due to the small numbers involved and the short length of time since the amendment.

The data does not show why there are differences in the use of non-court proceedings in different Police districts, which could be due to many factors, such as the number of repeat offences, age profile in the District, drug prevalence, etc. National consistency may not be desirable, but fairness and consistency in decision making would be. Without understanding what drives these differences we cannot be sure whether this is being achieved. This issue should be considered more fully in the final review in 2024.

Police have determined that until this review commenced, Districts have not been receiving data that would support them to consider how effectively they have implemented the health-based approach to personal possession or use. Police will give consideration to how this can be remedied.

GRAPH 8. PERCENTAGE OF NON-COURT ACTION WHERE PERSONAL POSSESSION AND USE IS THE MOST SERIOUS OFFENCE BY POLICE DISTRICT

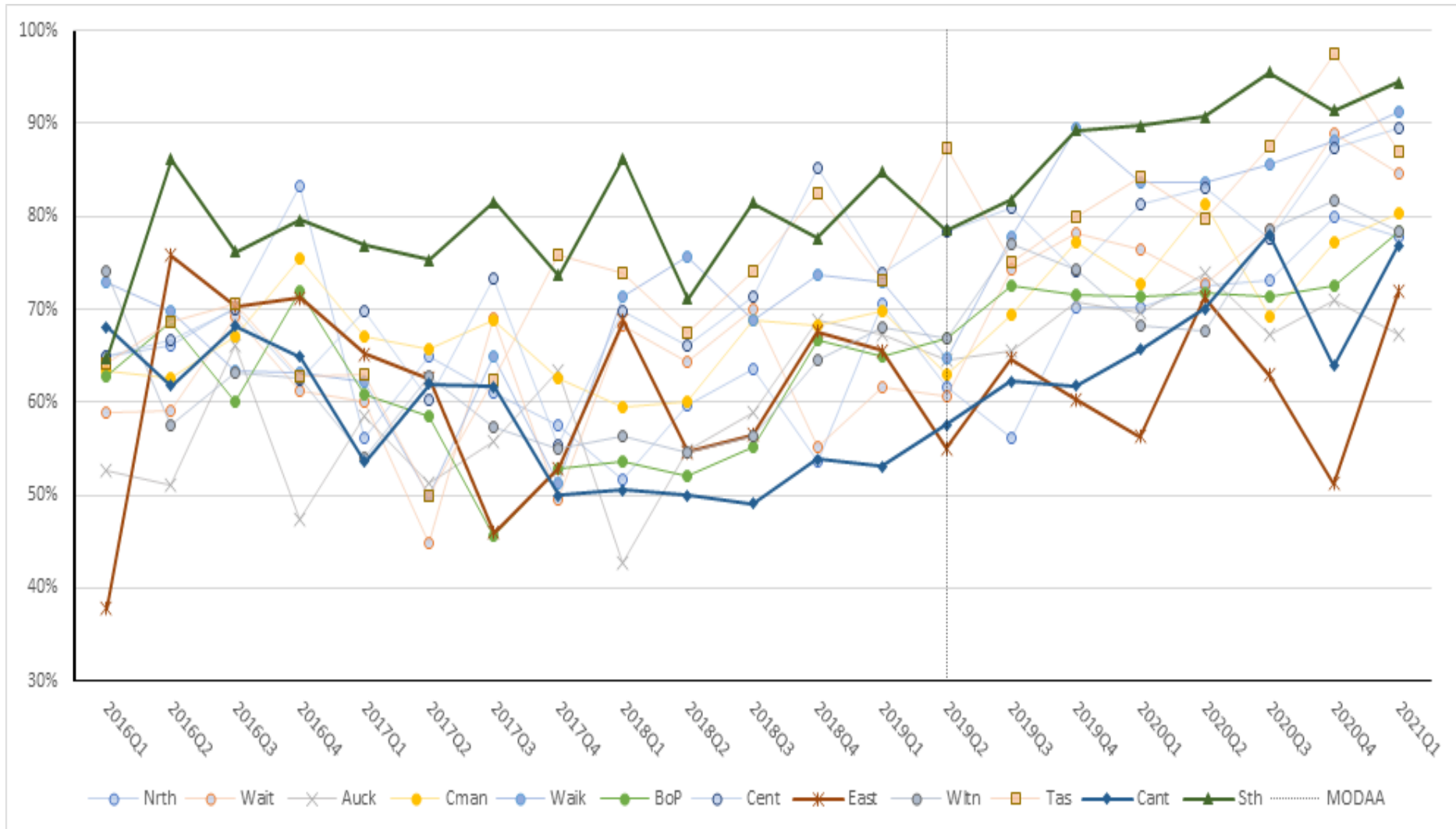
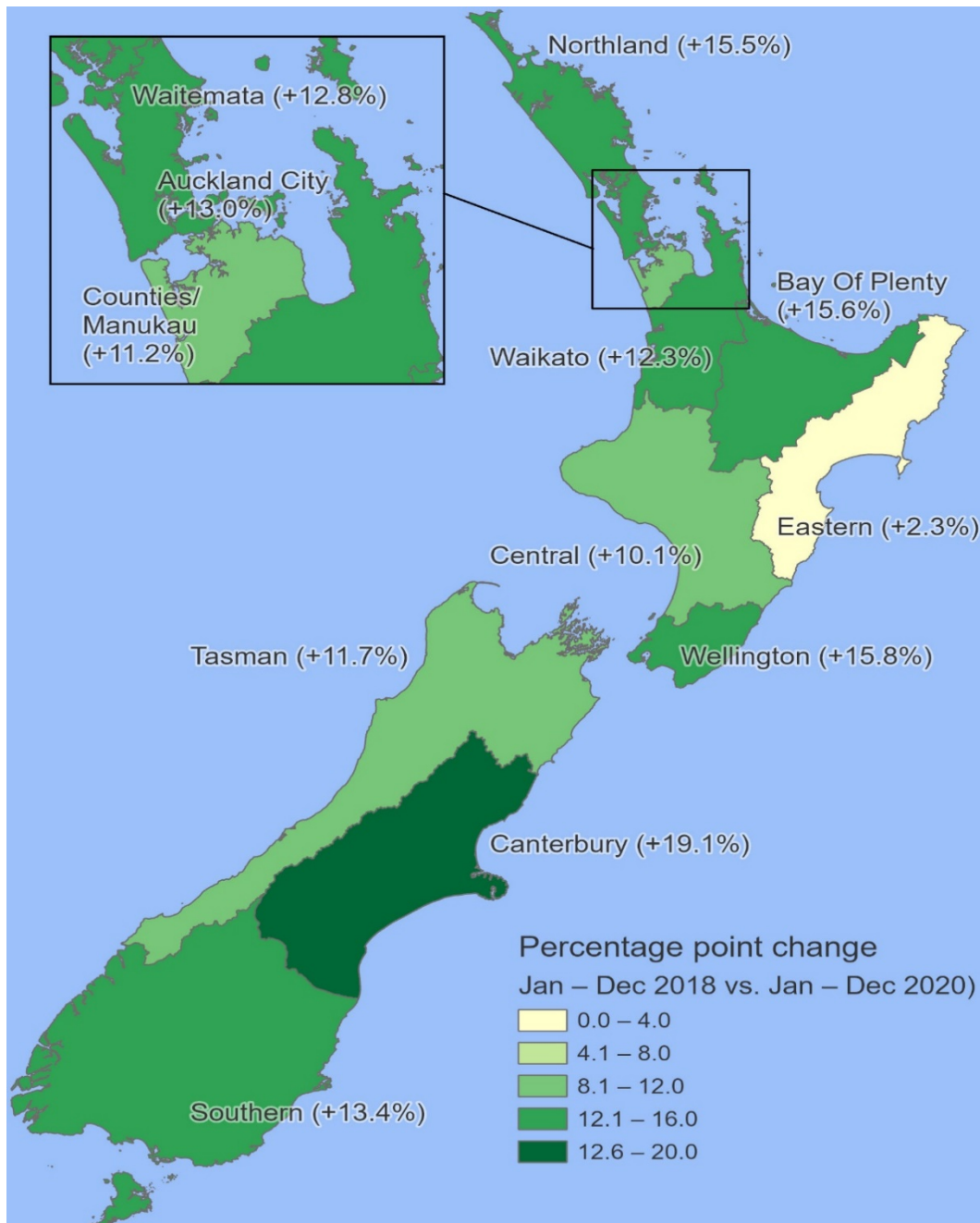


Figure 9 is a map of the Police districts that shows the difference in each district in the average use of non-court proceedings (where drug possession and or use is the most serious charge) in the year before the change and after. The Eastern Police District has only increased the average use of non-court proceedings by 2.3 percent.

FIGURE 9. USE OF NON-COURT PROCEEDINGS WHERE PERSONAL POSSESSION AND OR USE IS THE MOST SERIOUS CHARGE DIFFERENCES BY POLICE DISTRICT ANNUAL AVERAGE CALENDAR YEAR BEFORE AMENDMENT AND AFTER AMENDMENT



Key finding(s):

- There has been a general downward trend in proceedings for the personal possession and use of drugs, and especially in relation to cannabis
- Since 2019 Police has increased the use of non-court proceedings compared to court proceedings when dealing with all personal possession and use of drugs offences.
- Since 2019 there has been a sharp increase in the use of non-court proceedings for personal possession and use of methamphetamine.
- The data shows that all Police districts have increased their use of non-court proceedings compared to court proceedings in situations where personal possession and use is the most serious offence, and the rate of increase varies across the districts.

Court actions

As the intent of the amendment was to divert people away from the criminal justice system, as appropriate, the review has considered Court-based as well as alternative resolution pathways.

Courts have a range of options at their disposal for cases involving illegal drugs for personal possession and use. While cases in front of Court all involve charges and will be considered for prosecution, there are still alternatives to prosecution through the adult diversion pathway.

Health-based approaches that address health and social needs apply to the Court system as well as frontline policing.

Adult diversion

Adult diversion is a Police-managed, post-charge resolution pathway. It enables certain offences to be dealt with in an alternative manner to prosecution. Conditions may be attached to diversion, and will vary from case to case, but may include:

- making an apology to the victim or victims
- reparation of expenses incurred by the victim as a result of the offending
- restoration of harm caused through work in the community
- a Restorative Justice conference (often) involving the victim
- referral to support services (eg, educational programmes, counselling and addiction treatment).

A Prosecutor will make a request to the court to dismiss the charges in situations where diversion conditions are successfully completed.

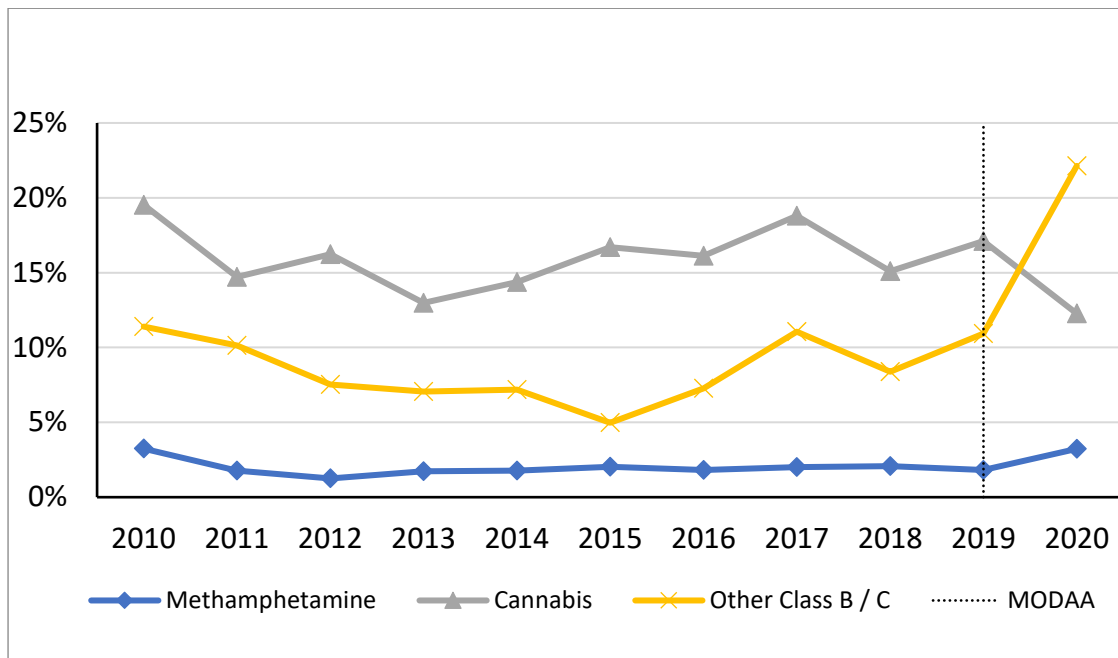
Appendix 4 contains a description of the purpose, criteria and considerations for adult diversion, and information on the Diversion Scheme managed by the Police Prosecution Service.

The following graphs show the use of adult diversion for cases involving personal use and possession of illegal drugs, by drug type and by first time offenders. The data used in these graphs has been provided by the Ministry of Justice.

Note adult diversion data differs to other non-Court action data. Other non-Court actions are measured at the time the offence occurs, whereas adult diversion can be weeks or months later, at the point the Court agrees to the use of adult diversion. If the conditions are not met, adult diversion may be subject to prosecution. The different timestamps and potential for double counting mean that we are unable to show adult diversion as a proportion of all non-Court action or in comparison to Court actions.

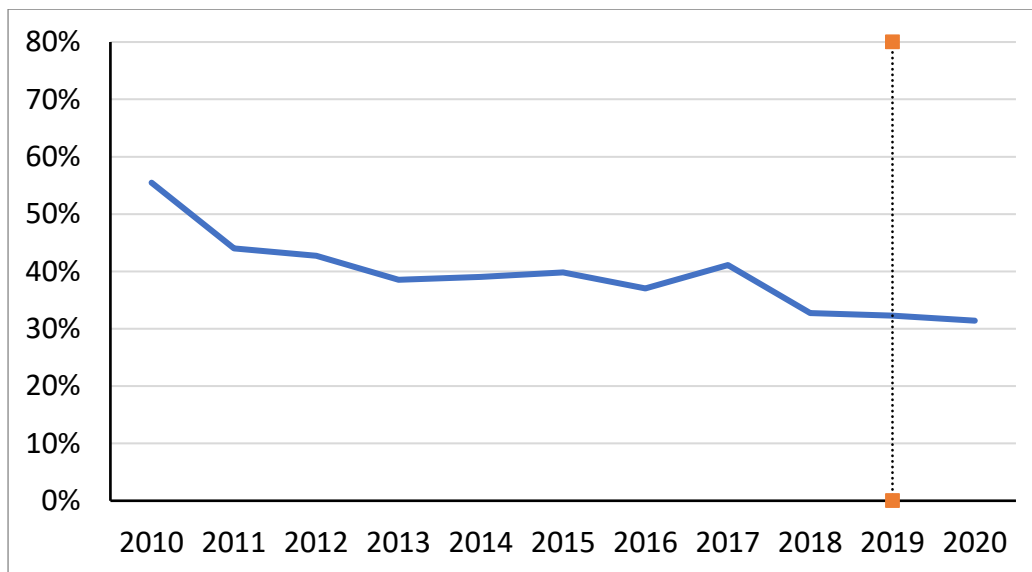
Graph 10 shows instances of adult diversion for personal possession and use by drug type. It shows that since 2010 adult diversion has largely been used for personal cannabis possession and use, though this has declined significantly over the decade to a point where it is almost on par with adult diversion for other drug types. This corresponds with a decrease in the number of prosecutions being taken for personal possession or use of cannabis and may be indicative of fewer overall proceedings being taken for personal possession or use of cannabis.

GRAPH 10. ADULT DIVERSION FOR POSSESSION AND USE OF PERSONAL DRUGS, BY DRUG TYPE



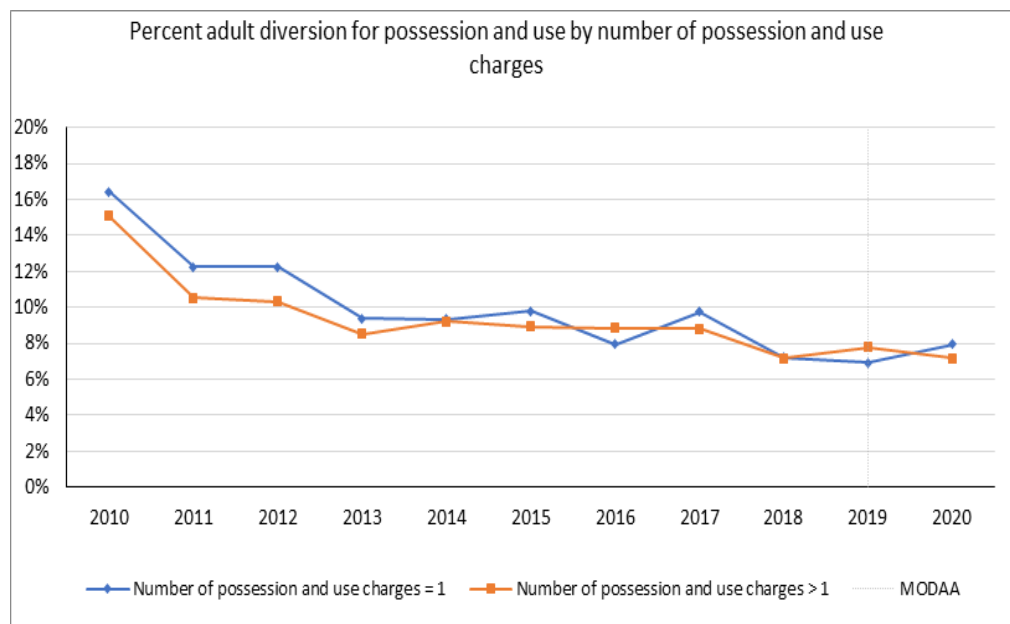
Graph 11 shows that, between January 2010 and December 2020, there has been a general downward trend of cases of adult diversion for possession and use of all drugs where this was their first offence.

GRAPH 11. ADULT DIVERSION FOR PERSONAL POSSESSION AND USE OF DRUGS, WHERE THIS IS THE FIRST OFFENCE



Graph 12 compares cases where personal possession and use of drugs is the only offence with cases where it is one of a number of offences. Between January 2010 and December 2020, there have been consistently fewer cases of adult diversion being used for multiple offences compared with where possession and use of drugs is the only offence. Both show a decrease in the early part of the decade but are relatively similar and flat for the second half of the decade.

GRAPH 12. ADULT DIVERSION FOR PERSONAL POSSESSION AND USE OF ILLEGAL DRUGS BY NUMBER OF CHARGES



Adult diversion data provides no indication of the health-based approach to Police discretion amendment having affected the rate of prosecutions resulting in diversion, as these numbers were already trending downwards.

Total drug-related diversion numbers have declined over the last decade, from 841 in 2010, to 87 in 2016, and 128 in 2020. Adult diversions slightly increased in 2017.

The majority of all drug-related diversions are cannabis-related personal possession and consumption charges.

Referrals to health services through adult diversion are discussed in the Referrals to Health Services section.

Prosecutions

Once Police have prosecuted a person there are a range of case outcomes that may result. If the prosecution is proved, outcomes include: a conviction where a person is found to be, or pleads guilty, a youth court referral and conviction, a discharge without conviction, an adult diversion or a youth court discharge. If the prosecution is not proved, outcomes include a person being found not guilty or charges are withdrawn or dismissed. If a person is convicted, the Court will proceed to sentencing which can include imprisonment, community sentences, monetary sentences, or deferment.

The review team analysed Ministry of Justice data on prosecution outcome, court volume and health referral data. This data showed that most drug prosecutions and convictions relate to cannabis and methamphetamine.

There has been a clear downward trend in Police prosecution for personal possession and use of all substances over the past decade. The trend was most noticeable between 2010 and 2012 and had flattened in the three years leading to the 2019 amendment. We can see another noticeable decrease in Police prosecutions in 2019. This is a strong indicator there has been an operational shift in that time.

Prosecution for methamphetamine was trending upward until 2019, when it took a sharp decline (895 prosecutions for possession and use of methamphetamine in 2010, 1,204 in 2019, and in 2020). This is likely due to changes in Police prosecution decisions rather than changes in the use of methamphetamine. Methamphetamine seizure volumes have remained steady over the last five years and wastewater levels remain stable indicating methamphetamine is readily available throughout New Zealand.

Prosecution for cannabis, on the other hand, has been trending downward for the past decade and the amendment appears to have had little if any impact on this trend (2010 3887 prosecutions for possession and use of cannabis, 2019 649 prosecutions for possession and use of cannabis, 2020 530 prosecutions for possession and use of cannabis).

The Court volumes of cases for personal possession and use of all substances has decreased between 2018 and 2020 by 24 percent compared with a three percent increase between 2016 and 2018 indicating an operational shift in Police prosecution behaviour prior to the amendment.

Prosecution outcomes reflect this shift with conviction numbers also trending down. Conviction numbers for personal use and possession of all drugs decreased between 2018 and 2020 by 30 percent indicating a sentencing shift by the courts.

The decrease in prosecution for personal use and possession for all drugs has not been applied evenly with Māori seeing a decrease of 21 percent compared with a decrease of 26 percent for non-Māori.

TABLE 1. PROSECUTIONS FOR METHAMPHETAMINE AND CANNABIS POSSESSION AND USE

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total Prosecutions											
Methamphetamine	895	732	799	696	735	835	996	1,098	1,154	1,204	990
Cannabis	3887	2698	2137	1509	1224	1000	875	872	762	649	530
First court appearance											
Methamphetamine	784	649	712	625	650	691	800	921	990	998	808
Cannabis	3,382	2,313	1,865	1,321	1,032	879	784	750	665	567	467

Key finding(s):

- For all drugs, adult diversion prosecutions show a continued downward trend that began prior to the 2019 amendment.
- The majority of drug-related adult diversions are cannabis-related personal possession and consumption charges. An investigation into individual cases might identify there is still some progress to be made in helping people using other substances to access the scheme.
- There has been a significant drop from 2010 to 2020 in the percentage of cases subject to adult diversion where personal possession and use was their first offence.
- There has been a steady and significant decrease in Police prosecutions for first time offences for personal possession and use of cannabis since 2010 to 2020.
- Prosecutions for first time offences for personal possession and use of methamphetamine rose slightly between 2010 and 2019 but has been decreasing steadily since 2019.

Equity: proceedings and prosecutions by ethnicity

We consider that the amendment would be delivering equitable outcomes if people are being treated fairly, and all groups of people get the same access to health services they need, and all avoid the harm from the entering the justice system at the same levels. It would also mean that there are options for non-Court action that best suit the needs of the individual and are culturally appropriate.

Police officers apply discretion in dealing with a wide range of matters, including whether to prosecute for personal possession and use of drugs. The use of discretion is central to promoting just outcomes as it allows an officer flexibility to consider the circumstances of the person they are in contact with, including aggravating and mitigating factors, when deciding whether to use non-court action or to prosecute. Discretion is supported by Police instructions and guidelines.

Police have been investing in new approaches to policing for some time. The Prevention First approach and Reframe work programme are expected to improve outcomes for Māori and Pacific communities through the focus on harm prevention and the use of supported resolutions.

The data only picks up recorded interactions with Police, and we understand that most individuals are not asked for their ethnicity when records are made.

The data shows that, once identified by Police, the outcomes for Māori and non-Māori are closely aligned.

TABLE 2 COURT ACTION MĀORI AND NON-MĀORI BEFORE AND AFTER THE AMENDMENT

Pre-amendment (Q1 2016 to Q2 2019)	Post-amendment (Q3 2019 to Q1 2021)
Māori first time offence - 16% court action	Māori first time offence - 9% court action
Māori repeat offence - 44% court action	Māori repeat offence - 30% court action
Non-Māori first time offence - 17% court action	Non-Māori first time offence - 11% court action
Non-Māori repeat offence - 44% court action	Non-Māori repeat offence - 29% court action

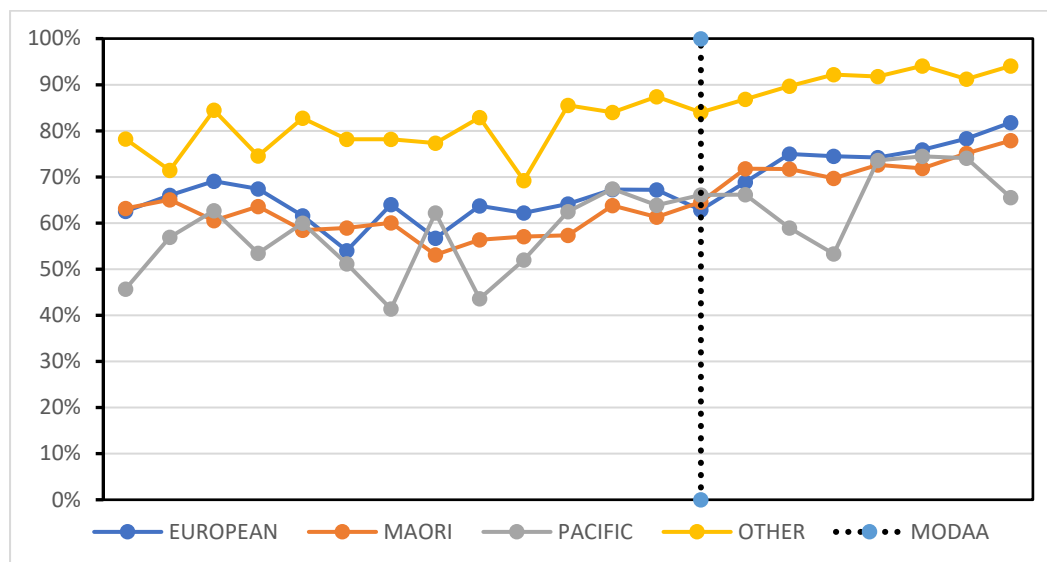
Non-Court proceedings by ethnicity

Graph 13 shows the percentage of proceedings for personal possession and use charges that are non-Court versus Court where they are the most serious charge for different ethnic groups. It includes all drugs and is drawn from Police proceedings data.

This graph shows an upward trend in the use of non-Court proceedings as a response to these offences for Māori. There is a marked increase in the third quarter of 2019, consistent with the timing of the amendment’s introduction, and this increase has been maintained. The change observed for Māori appears to be less than has been observed for Europeans but is following the same trend.

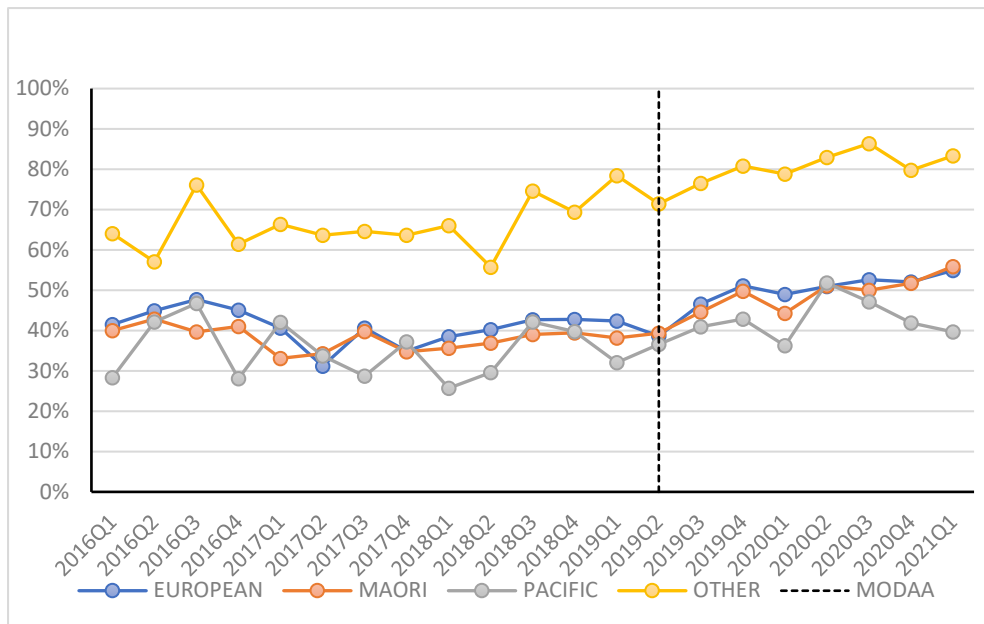
The numbers of Pacific people in this dataset are too small to find a meaningful data trend.

Graph 13 Non – court proceedings by ethnicity personal possession and or use most serious charge



Graph 14 shows the percentage of proceedings for personal possession and use charges that are non-court versus court for different for all charges by ethnic groups. It includes all drugs and is drawn from Police proceedings data. The graph shows that there has been an increase in the use of non-court proceedings at the same level for both Māori and Europeans since the amendment (39 percent Q2 2019 – 56 percent Q1 2021).

GRAPH 14. ALL NON – COURT PROCEEDINGS BY ETHNICITY PERSONAL POSSESSION AND OR USE NOT MOST SERIOUS CHARGE



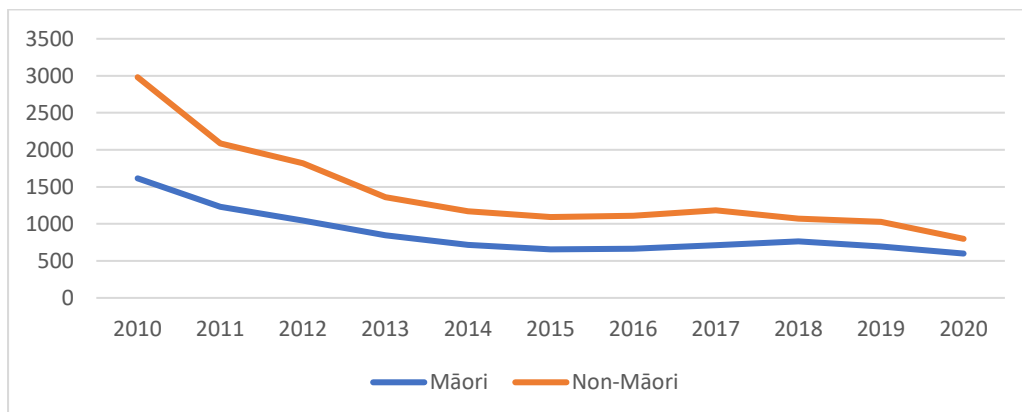
Prosecution of Māori and non-Māori for all drugs

Based on the raw data, the proportion of Māori who have had proceedings taken against them (35 percent) is higher than the proportion of Māori in the wider population (16 percent). However, the data does not control for age, self-reported drug use rates or any other variable, which impacts on the proportion of Māori.

Police is working with the University of Waikato on a major piece of work looking at how Police can ensure it delivers policing that is fair and equitable for all our communities. “Understanding Policing Delivery” will be a long-term research programme focussed on examining where bias may exist within Police policies, processes, and practices. The findings will inform Police work programmes and help it deliver on our commitment to Māori, and the Treaty, by ensuring Police actions are fair, reasonable and proportionate for all New Zealanders.

Prosecutions for both Māori and non- Māori have been decreasing since 2010 but the general downward trend appears to have been less pronounced for Māori than non-Māori. Since 2019 the trend has continued but there is insufficient data to conclude it is the result of the health-based amendment.

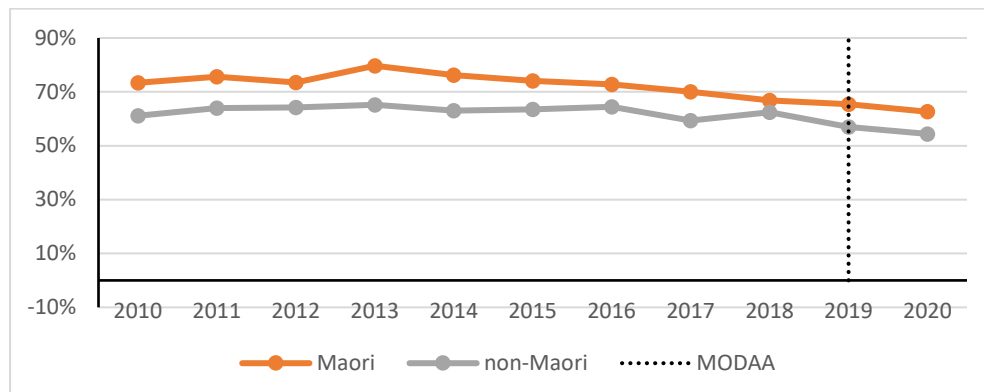
GRAPH 15. PROSECUTION OF MĀORI AND NON-MĀORI FOR PERSONAL POSSESSION AND USE OF ALL DRUGS



Conviction rate of Māori and non-Māori for all drugs

The trend in conviction numbers for personal possession and use of all drugs reflects a similar pattern to prosecution numbers. This may reflect a similar shift, which has been occurring in sentencing practices. The numbers are too small to determine significance at this stage.

GRAPH 16. CONVICTION NUMBERS OF MĀORI AND NON-MĀORI FOR PERSONAL POSSESSION AND USE OF ALL DRUGS



We cannot draw conclusions on the level of any inequity as the data we have only shows the ethnicity of the person not the other demographic information that contribute to understanding why decisions were made. We do not have case-level data to inform our understanding and have not interviewed Police officers to understand their decision-making framework. We understand ethnicity is determined by the Police officer, rather than being self-reported.

Key finding(s):

- The proportion of Māori identified by Police for personal possession and use of illicit drugs is larger than the proportion of Māori in the general population.
- Māori and non-Māori cases are similarly distributed across non-Court and Court actions (suggesting that once people are in the Justice system, they are treated similarly).
- Conviction rates are declining for both Māori and non-Māori, but the decline for non-Māori is steeper than for Māori.

Referrals to health services

People use drugs for many reasons. Whilst harms are associated with illegal drug use, many people who use substances do not experience long-lasting negative effects or develop addiction. However, some people do, and the harms experienced can be wide-ranging, from injury and disease, through to social, financial and legal problems.

Similarly, not everyone who uses drugs will need treatment, although education and early intervention is often a useful approach to minimise future risk of harm. Of those for whom treatment and support would be beneficial, access to this support is not always obvious or known to be necessary.

A 2006 study¹ of help-seeking behaviour found the key reasons that people don't seek help early is that they don't recognise they have a problem, or they think they can deal with it themselves. Where someone is 'at', in terms of the awareness of impacts of their use, associated harms and 'stage of change' matters to both the acceptance to seek or accept support and the kind of help that best practice evidence suggests could be received. 'Precontemplation' is common and is characterised by a lack of awareness, as opposed to a lack of willingness. Encouraging someone to a stage of 'contemplation' and through ambivalence is an important feature of the recovery journey, prior to stages of 'determination, action and maintenance'. Lapses in this cycle may occur at any time. Stigma is a significant barrier to help seeking and combined with the often-illegal nature of drug use, it can take time and encouragement from many sources before a person recognises they need help and have the motivation and resources to make contact.

The range of help and support people benefit from can take many forms. Some will benefit from brief intervention and harm minimisation education, and some will need more formal treatment services, including peer support, outpatient counselling, residential treatment, ongoing continuing care and outreach or other specialist services. Measures such as drug checking and needle exchange programmes are also part of a broader harm reduction approach.

Supports need to be available, accessible, appropriate and accommodating of individuals' needs and circumstances. While this review did not set out to assess the adequacy of mental health and addiction supports in general, the following does note issues raised by those we interviewed for consideration elsewhere.

Primary health care providers, social sector agencies, Oranga Tamariki, the Courts, and Corrections all have the ability to offer referrals into alcohol and other drug services. Police has had the ability to refer into health and social services for some time, through various local mechanisms. The two studied in this review are the National MoDA Drug Referral pathway established for the implementation of the 2019 amendments, and AWHI, a local referral pathway set up in the Bay of Plenty Police District in 2018.

Police referrals to the National MoDA Referral Pathway

A new national referral mechanism for those found in possession of small quantities of illegal drugs was set up to ensure a consistent approach to assessing health needs by a health professional (referred to in this document as the 'MoDA Referral Pathway'), recognising that frontline Police are not health or social workers. This takes the form of an app on Police's phones.

¹ Oakley Browne MA, Wells JE, Scott KM. 2006. Executive summary. In: MA Oakley Browne, JE Wells, KM Scott (eds). Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Ministry of Health.

Should frontline Police determine that a person found with an illegal substance may benefit from assessment as to their need for health support, they can offer to refer the individual to the Alcohol Drug Helpline. If the person agrees, personal information entered through a standalone app will initiate a series of text messages to the person's mobile phone over a seven-day period. These messages will:

- congratulate them for taking the first steps towards making a change in their lives
- let them know that help is available
- provide text and phone details for the Alcohol Drug Helpline.

These text messages cease when the person makes contact, opts out, or when a week since has passed since referral.

Should the person make contact, their call goes through to the Alcohol Drug helpline. Between 8am and 10pm on weekdays, staff on the Alcohol Drug helpline are 'ringfenced' – i.e. staff will not pick up any calls that come through 1737, Depression, Gambling or any other helpline. The call is triaged and taken by the person with the highest degree of experience and expertise in drug counselling. A screening conversation takes place. The conversation may point people to useful information, strategies and resources to help reduce harm, and a referral to face to face services (occasionally occurring through a 'warm' (in-person) handover).

When considering Police referrals to health services, there are a few important factors to take into consideration:

- there does not need to have been an offence for a referral to be made, and referrals can be used as preventive measures
- there are a range of agencies and providers who can offer AOD referrals, these include general practitioners, the Courts, social services and Police
- frontline officers need to be confident in making health referrals, including that alcohol and other drug and mental health services have capacity to support, particularly from a kaupapa Māori perspective, to individuals who are referred
- Police are not trained in needs assessments, triaging or drug counselling, but do have general training in conversations with people with high and complex needs, behavioural issues. These conversations need to be carefully managed and are often highly emotive
- as Police do not record all contacts, and do not record offers of referrals that individuals do not consent to, we do not have total numbers where Police consider a referral to health services would be beneficial
- Police referrals to the MoDA referral pathway are only recorded when the individual consents to being referred. Data is not recorded on the number of referrals offered by Police which are declined
- Police referrals are voluntary, and a person using drugs harmfully needs to be ready and able to access drug counselling or other supports, we do not expect every referral to materialise into contact
- the right kind of supports are not always available.

The table below shows the numbers of referrals made through to the Alcohol Drug helpline provided by Whakarongorau Aotearoa, all of whom will have received text messages through the service. It also shows total contacts representing calls through to the Alcohol Drug helpline, and the number of people who have been in contact. This information is recorded by the Alcohol Drug helpline service provider, Whakarongorau Aotearoa.

Since the Drug Referral Pathway's launch in August 2019, Whakarongorau Aotearoa's Alcohol Drug Helpline has:

- received 959 total referrals, ranging from 28 to 65 a month, and an average of 43.6 per month
- received 181 calls and texts from 147 unique individuals.

As is illustrated by table 3, referral and contact numbers do fluctuate, but are often small in number.

TABLE 3: POLICE REFERRALS TO THE MODA REFERRAL PATHWAY

Month	Total Referrals	Total Contacts	Unique Service Users
Aug-19	16	2	2
Sep-19	61	8	8
Oct-19	49	15	9
Nov-19	55	6	6
Dec-19	65	7	6
Jan-20	61	12	12
Feb-20	39	0	0
Mar-20	37	3	3
Apr-20	46	8	7
May-20	45	4	4
Jun-20	44	16	12
Jul-20	44	6	5
Aug-20	48	8	4
Sep-20	36	19	14
Oct-20	44	12	7
Nov-20	35	18	18
Dec-20	41	5	5
Jan-21	28	3	2
Feb-21	31	4	4
Mar-21	50	14	10
Apr-21	49	8	7
May-21	35	3	2

Note that referrals do not include those referred to health services via other supported resolution pathways, such as Te Pae Oranga and AWHI.²

All Alcohol Drug Counsellors are DAAPANZ registered and are among the most experienced staff employed by the telehealth service.

Conversations take the form of motivational counselling. Counsellors tailor calls to the individual's state including where they are in the addiction cycle. From time to time, counsellors will arrange a call back from the Alcohol Drug line. Whakarongarou Aotearoa advises that calls last ten minutes on average, and five minutes following for the counsellor to write up the notes.

The review team was advised that, on occasion, conversations include a referral to face-to-face services, and in recent months, staff have been actively trying to refer people on to the most accessible services. Staff will send people the numbers and addresses for services, and some

² Contact numbers do not include where individuals have terminated calls early.

referrals are done via a three-way conversation (warm handovers) so that the phone counsellor can relay the person's story.

Counsellors always choose DHB-funded services, whether they are attached to a DHB or are provided by an NGO, on the expectation that these services that would be maintained. They use Healthpoint (New Zealand's national service directory) and Family Services Database (an internal directory) for these referrals. We were advised that, as a default, a large volume are referred on to DHB Community Alcohol and other Drug Services, and would note there are regional differences in the eligibility criteria for those services, with some limiting their client-base to moderate to severe issues. We noted there are no guidelines for staff to support referrals on to other services, or information on eligibility criteria or the capacity of services to receive referrals.

MoDA referral pathway improvements

Since 2019 Whakarongorau Aotearoa has implemented the following enhancements to maximise engagement:

- a reminder text service to encourage initial engagement with the provider, with follow-up messages on days 3, 5 and 7
- re-wording of the initial text message to be more direct about inviting engagement with the service
- ringfencing staff 8am to 10pm and prioritising those with higher qualifications.

Across all phone lines, Whakarongorau Aotearoa carries out user feedback surveys, but this appears limited to people who have engaged. The service could benefit from consumer design workshops, for example, to test if the language used in their text messages could be improved.

Whakarongorau Aotearoa noted they were occasionally contacted by Police staff who are not aware of the MoDA Referral Pathway, and that regional awareness of the service was still building. They were not aware of what communications had been provided to frontline staff on the service, but were interested in assisting with efforts to build awareness of the service's existence, processes, capacity and expertise.

While their most experienced staff are assigned to the Alcohol Drug Helpline, and on the job training is provided, Whakarongorau Aotearoa noted there is no national qualification for telehealth addiction counselling. Yet the job takes a special set of skills. With more local services offering telehealth, particularly following COVID-19, there is an opportunity for the national telehealth provider, DAPAANZ and the Ministry of Health to collaborate on national alcohol and other drug phone counselling qualifications.

Direct, local referrals through Alternative Pathways for Help Intervention (AWHI)

AWHI is an interactive pdf which allows Police officers to refer people in need of support directly to local agencies who can help them.

Developed at the request of the Western Bay of Plenty Local Area Commander in December 2018, AWHI quickly spread across the Bay of Plenty district, and is now in the Northland, Waitematā, Counties Manukau, Waikato, Bay of Plenty, Eastern, Central, Wellington, and Canterbury Police Districts. Auckland City, West Coast, Nelson and Southern Districts have all indicated they wish to join.

The te reo Māori word "awhi", in this context, means "help". As was relayed to us by one of its originators, Police "can't arrest our way out of problems." AWHI was established as a means of early intervention and wrap-around support for people in need and at risk of offending, reoffending or

victimisation. AWHI is an offer of support, and can be used both when no offending has occurred as well as where there has been an offence.

Providers specialise in young people, addiction, mental health, family wellbeing (family harm prevention) and road policing and licensing. They are selected by the local areas themselves, in a spirit of *kāwanatanga* and *rangatiratanga*, and based on community needs.

Police give the selected provider information on the individual’s circumstances and what they need help with. The individual’s name, preferred method of contact, gender and date of birth are provided, and the referral includes a request for the person to be enrolled with the provider, and progress reports to an AWHI email address for that district.

If providers do not have the capacity to respond to a referral within a 48-hour period, they are not available for selection by an officer. The pdf is updated monthly, and any referrals to providers with full books can be reassigned, and Police may look for more partners for that service.

TABLE 4: REFERRALS FROM POLICE TO ADDICTION SERVICES THROUGH AWHI

The table below shows that between 5.1 and 7.4 percent of referrals by Police to health and social services are to addiction services, as recorded by AWHI. It should be noted that the highest referral numbers are in the Bay of Plenty, where AWHI has been in place longer than any other district, and that referrals to addiction services include referrals for alcohol and gambling services as well as illegal drugs.

Timeframe	Total referrals to addiction services*	Total referrals to all health and social services
2018	221	2979
2019	395	7718
2020	433	7609
January – April 2021	165	2856
TOTAL	1214	21,161

AWHI expansion

For local referrals, NZ Police National Headquarters is now developing AWHI into an online platform. Work is currently underway on a six-week proof of concept and evaluation.

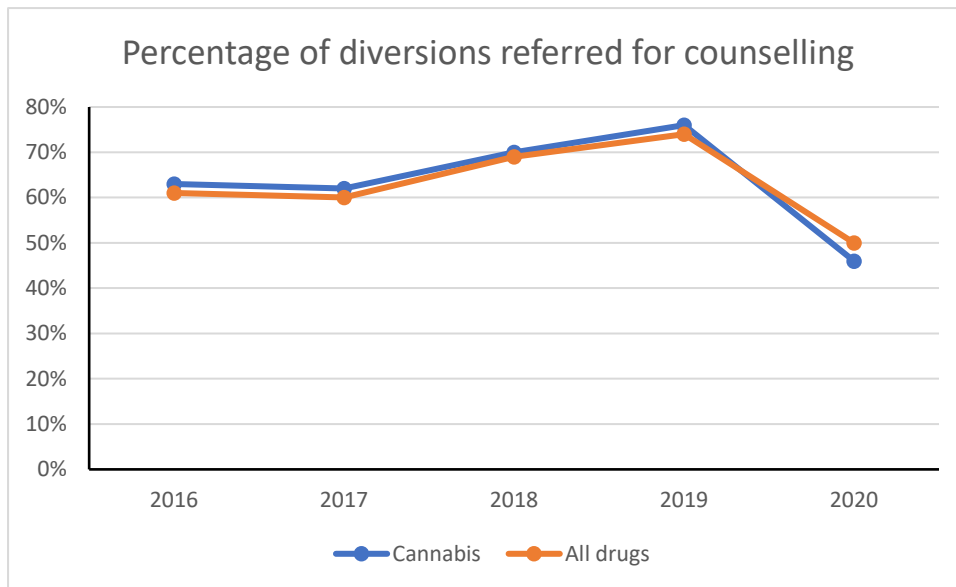
Referrals to health services through Adult Diversion

As shown in Figure 1 Health referrals can be made at any time during the resolution process. This review has not sought data on referrals through the Court or probation process. We have provided information on the diversion process as it is a hybrid Police- Court process initiated by Police. Graph 16 shows the percentage of adult diversion outcomes involving a referral to drug counselling.

In 2016, health-based referrals were made during 61 percent of all drug-related diversions. Referral percentages reached a peak of 74 percent in 2019 (the year in which the amendment was enacted) but fell to 50 percent in 2020. It is difficult to explain this decline without conducting further research.

Out of a total of 793 drug-related diversions across the four years, 63 percent (499) have received a health referral within the diversion process.

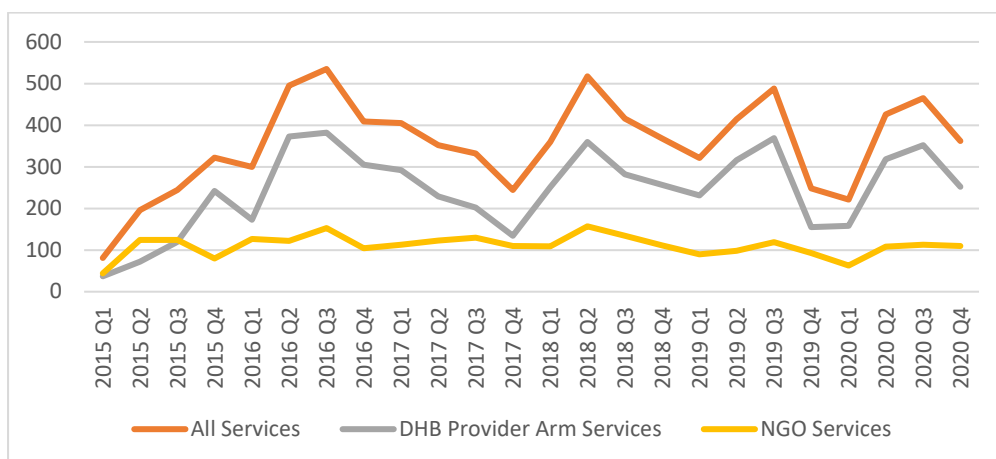
Graph 17. Percentage of diversions referred for counselling – cannabis and other drugs



Direct Police referrals to DHB Alcohol and Drug and Co-Existing Problems teams

Referral rates through the MoDA Referral Pathway are low when we compare these with national referral numbers by Police to DHB Alcohol and Drug (AOD) and Co-existing Problems (CEP) teams (included both DHB provided services and services provided by non-governmental organisations). It needs to be noted, however, that these referrals include mental health, alcohol and gambling referrals. Some of these will overlap with the referrals in AWHI and so are not comparable. While these datasets are not the same they provide another view on referrals. The data in the following two tables has been extracted from the Ministry of Health national mental health and addiction information collection (PRIMHD)

GRAPH 18. NUMBER OF REFERRALS BY POLICE TO AOD AND CEP TEAMS

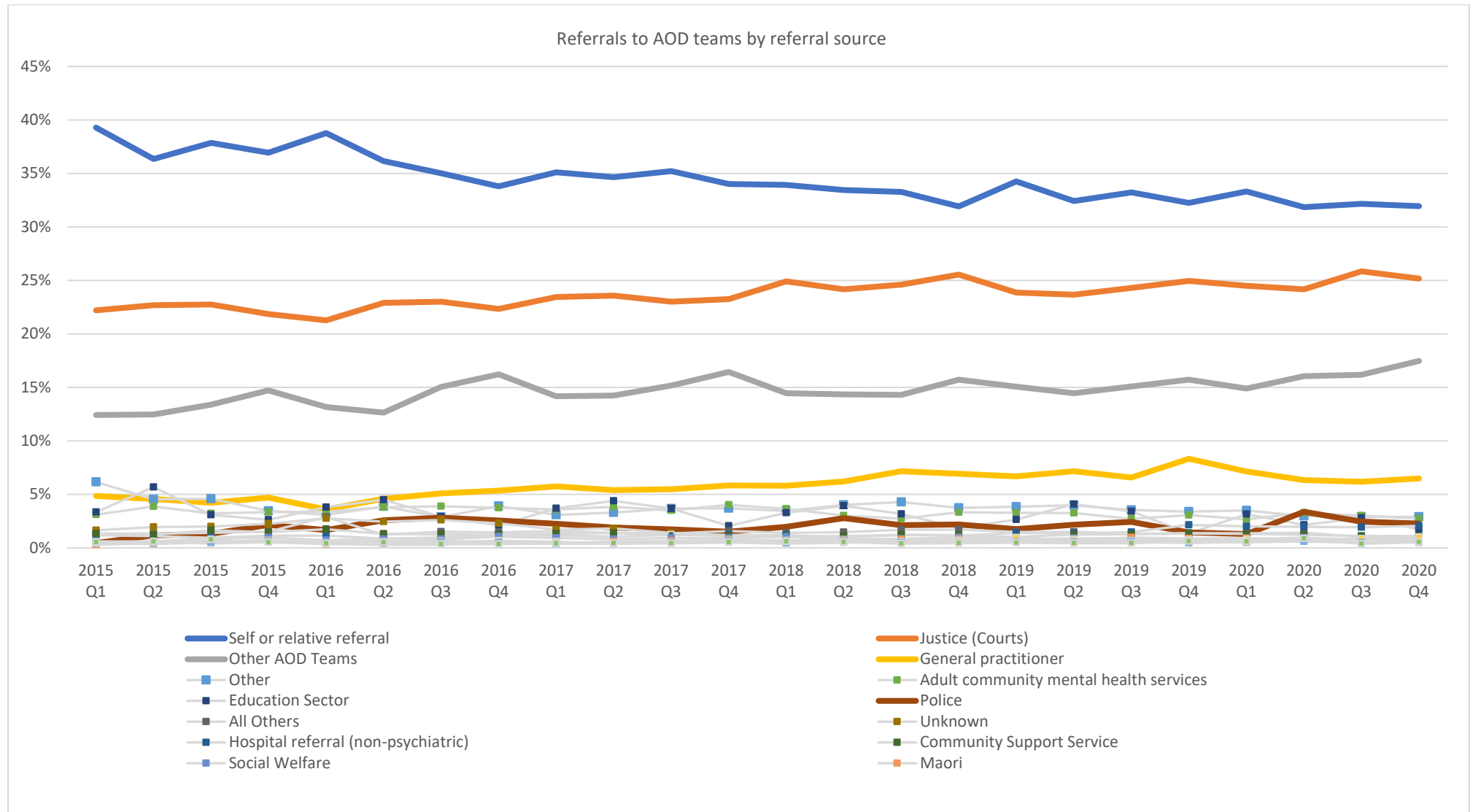


Some people are referred to services more than once, meaning that the total sum of people referred to AOD and CEP teams is greater than the total number of clients.

Police has raised a concern that mental health and addiction services do not have sufficient capacity to accept further referrals to alcohol and other drug services.

Police referrals form a small proportion of overall referrals. As illustrated by the graph 18 and noting this includes referrals for alcohol and gambling issues, self-referrals (including by whānau) are the most common type of referrals to alcohol and other drug teams in both DHB and non-governmental organisations. This is followed by referrals from Courts and referrals between alcohol and other drug services and then referrals from general practitioners. This data was extracted from the PRIMHD database by the Ministry of Health. It does not include referrals to national telehealth lines.

GRAPH 19. POLICE REFERRALS TO AOD AND CEP TEAMS AS A PROPORTION OF ALL REFERRALS



Te Pae Oranga

The review team was not able to interview frontline police about their experiences implementing the health-based approach for the interim review due to the short timeframes for the review. Police were able to provide useful insights via an existing qualitative work programme on Te Pae Oranga. We have, however, been given information from a 2020 Police study that interviewed frontline officers on their experience and opinions of Te Pae Oranga panel referrals.

Some of the following key findings from the Te Pae Oranga review are applicable to this review.

Participants who attended Te Pae Oranga had statistically significant better results on all four reconviction outcomes:

- fewer were reconvicted for a new offence
- they committed less harm to their communities
- they had fewer convictions overall
- they took longer to reoffend than their matched controls.

Key insights from frontline officers include:

- Te Pae Oranga integrates community-based partnerships to address the root causes of crimes
- an officer's decision making is influenced by the amount of time and paperwork involved
- the perception of local, district and national priorities have an impact on referrals.

Insights from mental health and addiction service providers

Survey results

The review team carried out a survey of mental health and addiction service providers, focused on alcohol and other drug services. A survey was sent to 48 providers. Eleven responses were received.

The responses represented a reasonable but not full geographic spread and included DHB provider arm, NGO and kaupapa Māori providers. Most were contracted by a government agency for their services, with two being funded by charity and fundraising. Alcohol was the most common substance reason for presentation by clients, followed by cannabis and methamphetamine, opioids and then synthetic cannabinoids.

Seven of the eleven respondents identified they received Police specific referrals and noted an increase in those referrals since August 2019. We expect this increase to include referrals for alcohol and gambling issues. We found that the identified referral numbers were generally low (2- 50), with the exception of Waitemata DHB, which reported 5260 referrals. Both Community Alcohol and Drug Services indicated they had no capacity to take on new cases.

Responses from providers suggested referrals come from a variety of pathways, including arrest, but that no provider noted receiving referrals from the National MoDA Drug Referral Pathway provided by Whakarongorau specifically. The answers we received suggested that courts and lawyers may make more referrals to their services than police (noting that Police also make referrals via the Helpline).

Respondents reported that the main barrier to engagement for people who use drugs, was due to unwillingness by the person to engage. Providers said that where people were unwilling to engage, this was because they did not think they had a problem or were unwilling to reduce their current level of drug use. Providers also suggested a low success rate in engagement was due to the way in

which calls are passed on to providers, and that individuals might feel compelled, which is not the best way to create ongoing engagement.

Providers also commented on their perspectives on the most effective enablers of a health-based approach to personal drug use. While outside the scope of this review, several providers commented that further amendment to MoDA to decriminalise the use of drugs was seen as necessary to deliver a truly health-based approach. Several providers commented that they supported the diversion of people from the justice system where appropriate.

Providers also commented on:

- the need for holistic, wrap-around services to target the underlying drivers of addiction (specifically poverty, inequities, racism)
- using public health and wellbeing approaches
- a need to address geographical inequities in access to services, including a need for increased resourcing to support shorter wait times
- more treatment options including addiction-specific services for the general community and those on probation (funded by Corrections)
- a need for more funding for more residential beds
- a need to relax of the criteria for residential rehabilitation
- a need for more kaupapa Māori, strength-based approaches, and approaches that emphasis whanau engagement and reconnection to iwi and hapū.

Interviews with mental health and addiction service providers

The review team interviewed five mental health and addiction service providers, including one kaupapa Māori service provider. The following provides a summary of key points from those interviews.

Māori service provider perspective

The review team interviewed staff from Hāpai te Hauora to get the Māori service provider perspective. They noted the importance of relationships in delivering a successful health-based approach. In their view, a strong relationship between Police, Health, Ministry of Social Development, and Oranga Tamariki is required when discretion is being exercised. They suggested that these agencies should be connected and supporting the frontline police officers at that initial point of contact.

They felt that the options and choices available for a health-based approach for Māori do not go far enough. Funding goes to Primary Health Organisations who they see as not always well connected with communities. Iwi liaison officers play an important role in connecting individuals with the right services. They report immense stress on existing Māori providers, and a disconnect between mainstream services and Māori. For example, if someone identifies as Māori then these providers feel it is left to Māori providers to provide them with support and they may feel they are under resourced and underfunded.

Drug taking among providers' client base

As with the survey results, alcohol use was the main issue among clients, followed by methamphetamine. The providers see few people using synthetic cannabinoids but noted that this group is a very marginalised group of people with complex issues, who they did not expect would engage with a telehealth service. There has been a significant increase in gamma-hydroxybutyrate (GBH)/gamma butyrolactone (GBL) use among clients.

Direct referrals from Police and referrals through the MoDA Referral Pathway

At a managerial level, some were unaware of the MoDA Referral Pathway associated with the Alcohol Drug helpline, or of the Alcohol Drug helpline itself. This does not necessarily mean the providers are not receiving referrals from the helpline, as they received referrals for individuals who had been in contact with Police and others in the Justice system.

One service received a large number of referrals from Police. A large proportion of these referrals comes from the family violence-focused roundtables. These are direct referrals from Police, but involve the provider making cold calls, where only 10 percent of people agree to service follow-up. Providers noted that evidence base is in favour of warm handovers with peer support and finds cold calling to be ineffective.

Providers observed that people would often agree to get help when Police are asking them to, but then later decline help as they don't remember the original conversation, or no longer feel compelled. Providers observed a much higher success rate when the person's partner or whānau was involved in the referral.

One provider questioned whether the system was designed well enough to maximise the chances of referrals turning into an ongoing connection and uptake of services. Early engagement is key to preventing severe harm, and providers questioned whether staff on the Alcohol Drug Helpline, even if they are well qualified, felt equipped to carry out the motivational interviewing.

Effectiveness of referrals by Police

Providers commented on the sensitivity of conversations with people who use drugs, they need to be carefully held in order to motivate or not dispel any motivation a person might have to seek help and engage with services. One provider suggested community outreach services staffed by people with motivational interviewing skills would be better able to reach vulnerable people.

They noted it would be unrealistic to expect every Police referral to turn into a successful engagement with services, and that a person might need to be told multiple times that a substance was causing harm, and that support was available to them, before seeking help. Conversations and interventions need to be well-timed.

One provider was concerned that the association of mental health and addiction providers with Police might be a disincentive for people who use drugs to engage, they might be mistrustful of authority.

Providers agreed that the best approach for some people might not be referral to a brief intervention or drug treatment service, but that addressed other social issues, such as housing or domestic violence.

Service availability

Providers reported long wait times for their services. More simple cases can be dealt with quickly, but individuals requiring a more holistic response, or a detoxification intervention could be waiting several weeks.

Despite this, the providers we spoke to do try to address all level of need, and not turn people away if their drug use is not serious enough. One provider channelled around 70 percent of their clients into group programmes until 1:1 services were available, and prioritised people with complex or acute needs for those services.

Providers noted difficulties reaching people in rural areas, and people with access issues such as a lack of transport or juggling more than one job. After hours programmes and probation groups go some way, and there are community outreach teams in place.

Māori and Pacific people engage less with managed withdrawal programmes, and there are likely better models, potentially kaupapa Māori-run home detox services.

NZ Drug Foundation

The review team interviewed the NZ Drug Foundation about health-based approaches to drug harm and received a document subsequently that outlined the organisations views of an effective model for health interventions by Police.

The NZ Drug Foundation considers an effective model should follow a set of basic principles:

- non-stigmatising and non-judgemental conversations
- informative and helpful
- non-punitive in nature (ie, not accompanied by a threat of prosecution)
- presenting treatment or support as optional rather than obligatory
- offering the right amount of information to the individual, and written information
- proactive follow-up.

On the last point, the NZ Drug Foundation noted that only a small proportion of those found in possession of drugs will need treatment or other support.

They also noted that a referral model such as this “stands or falls on the services and supports that are available to back it up. Referring someone to a service that doesn’t exist or that has a very long waiting list is pointless. It is important that a Police model be designed well, but it can only be as good as the services that sit behind it.”

They also considered follow-up texts and calls by the Alcohol Drug Helpline should be factored in consistently for those who need it, and that the best time to talk about drug use is probably not when face to face with Police, but when they are sober and in a less stressful situation.

The organisation suggested this model should also be used for alcohol issues which can equally harm individuals and communities.

The NZ Drug Foundation also outlined their stance on decriminalisation of drugs for personal use, though as this is outside the scope of this review.

Judicial insights

While the focus of the health-based amendment was on Police decisions when considering whether to prosecute, Police also recommend referrals to health services once in court, some of which we have covered in the Adult Diversion section. In recognition that Judges also make decisions to refer people to health services, the review team interviewed a District Court Judge and the Principal Youth Court Judge.

With respect to prosecutions, both judges noted a decrease in the number of low-end offences (small scale cannabis related for example) in Court. Cannabis charges are now more likely to be at the higher end, for example a major cannabis growing operation. Any smaller scale offences are for the higher class of drugs (e.g., class A).

Both judges were in favour of, and experienced with using, a health-based approach to the personal possession and use of drugs, including through Alcohol and Other Drug Courts.

The Principal Youth Court Judge has had a longstanding approach to health-based intervention during prosecutions brought before both District and Youth Courts. He had introduced a model in which clinicians specialising in harmful drug use participated in the court process, identifying health needs, drivers of behaviour, and provided expert recommendations for treatment.

Both judges had experience with the Alcohol and Other Drug Treatment Court (AODTC), and reflected on how the lessons from this could be used across mainstream services. The AODTC uses a non-adversarial, strengths-based approach, which looks at an individual's capabilities rather than just deficits. The Courts can refer the person to a whole suite of programmes designed to help the person see themselves as part of a community. Whānau are central to the process. In the District Court Judge's experience, creating an overall impression of fairness, being positive and taking an interest in the person is important.

The District Court Judge cautioned that there are some cases, for instance where a person is harming other people, and the community remains at risk, where a punitive approach may need to be taken. She has also found diversion screens and iwi panels to be effective.

Both observed issues with the availability of services, including significant wait times for services. However the District Court Judge thought that, while services are lacking in some situations, there is more available than is sometimes given credit, and a belief that 'there isn't enough' should not be a reason for not trying to get help, or doing nothing. Where detox and other services may not be available, judges need to be able to consider other available options and need some form of education on the wide range of treatment options available.

Both members of the judiciary noted there are opportunities to:

- **Better enable solutions-focused judging by improving the availability of clinical triage or assessment support** to District Courts. At present, health-based outcomes for the same type of offences vary. Variations by region are not solely due to the inclination of the Court but in response to inconsistent clinical resources available and at time awareness of what resources are available and their efficacy and suitability for a particular person. The value of having a person expert in identifying and triaging substance harm needs, readily available to (if not on-site at) a Court is high – it avoids health suppositions being made by lawyers and lay people and enables diversion schemes or sentencing outcomes to properly reflect a rehabilitative approach.
- **Reduce delay in access to mental health and addiction services once the need for referral to those services has been identified.** Currently, Judges may impose a diversion or sentence condition for participation in a rehabilitative or therapeutic programme but then observe people waiting for up to five months before a provider has capacity to help. The impact of these delays are not insignificant: a person may continue to struggle with AOD harm and any related offending in the interim, be brought before the Courts for additional charges, and remain caught in a cycle of unaddressed health needs and criminal justice outcomes. Delays in access to services will be discussed in the final section of this report but their criminal justice impact is worth noting here.
- **Strengthen system stewardship via more regular collaboration between participants.** The intent of the amendment's aspiration is consistent with the vision of Judicial leadership for the District Court and Judging practice. The appetite to engage in the building of relationships, strengthening of resources, and dissemination of guidance is strong. District Court Judges would be keen to connect more regularly with the Ministry of Health to discuss system trends, and to develop for the Judicial Training Programme modules outlining the different types of clinical presentations and needs associated with various forms of

substance harm, how to incorporate a health-based approach within solutions-focused Judging practice, and how to connect a Court to clinicians and providers who can best-assist.

- **Support Counsel (prosecution and defence) to better-understand and respond to health-based needs via developing guidance** outlining substance harm, its relationship to offending, and available levers which are alternative and complementary to prosecution. Such guidance and training could be developed by the Ministries of Health and Justice and delivered through the Police Prosecution Service, Public Defence Service and New Zealand Law Society Continuing Legal Education programmes.

Key finding(s):

- There appears to be a low level of awareness of providers, or buy-in, to the MoDA Referral Pathway established to support the 2019 amendment, particularly when compared with the early signs of Police utilisation of the AWHI system.
- The MoDA referral pathway and AWHI have different and complementary strengths.
- Referral systems could benefit from guidelines for best practice referrals that ensure that people seeking and agreeing to offers of help are channelled to the most appropriate provider as soon and as smoothly as possible.
- There is interest among the judiciary for guidelines to support health-based approaches for drug harm reduction through the Courts.
- There are concerns about the capacity of mental health and addiction services to accommodate any rapid growth in Police referrals.

DISCUSSION

Implementation

The implementation of the 2019 amendment involved two key aspects:

- Communications, updated guidance and instructions alerting officers to the changes and providing guidance on the health-based approach to decision-making, and how to make a referral
- A new pathway for health-based referrals to the Alcohol Drug Helpline.

It is clear from the data that there is awareness of the amendment and referral mechanisms. Further research for the final review, including interviews with frontline Police, is required to illustrate the extent to which Police are aware of and comfortable using the MoDA referral pathway, and how this varies region to region. Police do have other alternatives for referral (including AWHI) that are complementary to this approach and where direct access to a provider might be preferred by the person in contact with the Police.

Further work is needed to support the implementation of a health-based approach

We note that there are differences among stakeholders consulted in this review of the conceptualisation, understanding and interpretation of “health-based approaches”. A health-based approach is far broader than a referral to a health service and would extend to many of the other actions Police are taking to address the risk factors for and drivers of offending behaviour, as well as the social sector responses that impact drug use and offending.

A shared understanding across the government sector on what a ‘health-based’ approach can and does include would certainly reduce uncertainty and improve consistency across the country. Variations in understanding and approach can be a barrier to innovation and may inhibit referrals to and benefits from health and other supports. There is general agreement across agencies that work is needed on shared definitions, and that there would be significant value in developing a strategic framework for the Government’s health-based approach to personal drug use. This would enable a consistent view across the justice and social sectors about what a health-based approach looks like.

A cross-sector strategic framework for a health-based approach to personal drug use would also provide a basis for agencies, the sector and communities to align our approaches and resources in this space to achieve the best outcomes for our communities.

We note the Ministry of Health continues to scope opportunities within current legislative settings and work programmes to implement a holistic health approach to reducing drug harm across government. While this work is currently being conducted by the Ministry, it incorporates cross-agency work. This includes the development of harm reduction services such as a licensing regime for drug checking services and an early warning notification website, High Alert.

Several stakeholders commented on MoDA being out of date and not aligned with a health-based approach to personal drug use. The Ministry of Health took this into consideration in the development of Kia Manawanui: the long-term pathway to mental wellbeing 2021.

There would be benefit in developing a cross-agency framework to support implementation of a health-based approach. This framework could consider:

- strategic partnerships and holistic approaches that recognise the health, social, environmental and other factors connected with harmful drug use and can deliver improved equity
- how best to implement the principles of Te Tiriti o Waitangi
- innovative, safe, effective and sustainable referrals and service provision
- the implementation of Kia Manawanui and associated service improvement plans
- a monitoring and evaluation process across the whole system so that all involved can regularly assess, learn and improve on the health-based approach.

This framework would support Police to easily refer people to the mental health and addiction system which in turn needs to have capacity and processes in place to support the people who need help.

Ongoing changes in the justice system's treatment of drugs for personal use

Role and contribution of the Police

The Police role has been evolving for some time to better support a health-based approach and a reduction in harm from entry into the justice system. When an individual is identified with personal possession and use of drugs the Police decide whether it is in the public interest to prosecute or to use a non-Court resolution. The Police Prevention First operating model encourages an approach that focus on crime prevention and harm reduction. The Reframe work programme focusses on harm prevention and use of supported resolutions.

Police are well grounded in use of non-court action for personal drug offending and this is reflected in the data which shows that the majority of individuals receive non-Court action and since the 2019 amendment has continued trend upwards. This change enables the Court to focus more on cases involving community harm and is viewed positively by members of the judiciary.

The Prevention First approach could be considered a health-based approach. This approach involves dealing with the drivers, or "risk factors" for illegal behaviour including harmful drug use. Health-based approaches include more than only referrals to drug counselling and treatment programmes. The AWHI initiative, which looks at all drivers for behaviour, is most aligned with a health-based approach.

However, Police use of supported resolutions won't be as effective as it could be in addressing drug harm if there is not an adequate health response to refer people into.

We have heard from multiple sources that there is a noticeable culture shift in frontline policing, and that strong leadership is instrumental to these changes. Due to time constraints, we are unable to investigate the nature, pace or consistency. We are not able to tell how consistent this is across regions.

The data does show inconsistencies across Police Districts in the use of non-court interventions for personal possession and use of drugs. The reasons for this are unclear, the timeframe since the amendments came into effect is short and the data is not statistically significant. This is an area that could be further investigated for the final review in 2024. In addition, Police will consider how it can share with Districts ongoing data to support their decision-making.

Changes in non-court proceedings

Police prosecutions are not expected to fall to zero under the current MoDA, as the personal possession and use of drugs remain illegal and there may be some instances where Police consider it

appropriate to prosecute. Police has powers and responsibility to prosecute where they assess it would be in the public interest to do so.

The amendment is also about reducing harm from entering the Justice system. So, it is important to understand what changes there have been in the use of non-court proceedings as well as what health-based responses have been used. Post-amendment, the use of court action for Māori where possession or use of drugs is the most serious offence and the individual has no previous offences is 9 percent, for European it is 11 percent.

Prosecutions where personal possession and use of cannabis is the most serious offence has been declining for a decade. While there are fluctuations in the data, prosecutions have continued to trend downwards following the 2019 amendments. Use of supported resolutions such as warnings, continue to trend upwards.

The use of non-Court proceedings for people charged with personal possession or use of controlled drugs has been trending slowly upwards.

Prior to the 2019 amendment, use of Court action for methamphetamine was around 90 percent, in alignment with related government policy such as the Methamphetamine Action Plan.

Since Q3 2019, there has been a significant downward trend in prosecution rates for methamphetamine. This is in response to Police changing their guidelines to make methamphetamine eligible for formal warnings and Te Pae Oranga. This trend strongly aligns with the work of Reframe and the focus on use of alternative resolutions for low level offending.

Despite the significant drop, Police prosecution as a response to personal possession and use of methamphetamine remains higher than for other substances. It is too soon to tell if these rates will continue to drop. These higher prosecution rates may be due to several factors including a real or perceived difference in the level of harm associated with methamphetamine use and the recency of the change to Police guidelines taking time to firmly bed-in. We will reassess prosecution rates as part of the full review.

The use of non-Court proceedings for cannabis has been high for some time (although it has increased since the amendment). This reflects the focus of Police on crime prevention and harm reduction through its Prevention First operating model.

Improving outcomes for Māori

Police do not record instances where they decide to take no action, but they expect these numbers are likely to be low. Once individuals are identified, the probability of court action is similar, irrespective of largely similar whether the individual is Māori or non-Māori. The difference for Māori is that Māori are being identified with personal possession and use of illegal drugs at a higher rate than expected given the size of the Māori population. However, we need to acknowledge that the:

- average age of Māori is younger than non-Māori (20s rather than 40s); we know that identified drug use and self-reported drug use is highest in the 18-29 year age group and after that starts to drop off; and
- that there are higher self-reported rates of drug use among Māori.

These variables have not been controlled for in the data.

There is also a question about how policing of personal possession and use of illegal drugs is being done and the impact of this on the number of Māori identified. Police is working with the University of Waikato on a major piece of research looking at how Police can ensure it delivers policing that is

fair and equitable for all our communities. “Understanding Policing Delivery” will be a long-term research programme focussed on examining where bias may exist within Police policies, processes, and practices. The findings will inform Police work programmes and help it deliver on our commitment to Māori, and the Treaty, by ensuring their actions are fair, reasonable and proportionate for all New Zealanders. Findings from this study will be available for next review in 2024.

A health-based approach to drug use, Prevention First approach and Reframe work programme are expected to improve outcomes for Māori and Pacific communities through the focus on harm prevention and the use of supported resolutions. A health-based approach cannot be delivered by the Police alone. Through this review, we have identified areas where a health-based approach may be better supported.

Referral services

The review team considered uptake of the MoDA Referral Pathway to be low, particularly when compared with AWHI referral numbers from the Bay of Plenty District to addiction services and Police referrals to AOD and CEP teams. The low uptake requires further investigation and interviews with frontline Police to understand why. Potentially this is a combination of decisions to address other needs (eg. homelessness, family violence), a low level of awareness that the referral process exists and of what follows, and potentially a lack of trust in the process and a belief that mental health and addiction service providers do not have capacity to respond in a timely fashion.

In contrast, we note the high degree of buy-in to AWHI, and consider that the grassroots, relationship-based nature of the AWHI initiative has contributed to its success. We also note that services like this have previously been attempted by publicly funded agencies. We find that it is likely that the local nature of the initiative has aided in buy-in by users of the service. We also note that there was rapid growth in uptake of the service in response to the COVID-19 restrictions, and that the remaining four districts are keen to use this service, as reportedly are the judiciary in its use in court. The review team was also very encouraged by the investment of Police National Headquarters in the development of AWHI, part of which is to create a national online platform.

Thought needs to be given to how different Referral Pathways work together in future. . The MoDA Referral Pathway and AWHI have different and quite complementary strengths.

TABLE 5. STRENGTHS OBSERVED IN THE MODA REFERRAL PATHWAY AND AWHI

MoDA Referral Pathway	AWHI
<ul style="list-style-type: none"> • someone is available on the line around the clock when a person is ready to talk • a qualified phone counsellor can make sure the person gets to the right service • referrals to face to face services – referred to publicly-funded services, on the expectation these will be maintained 	<ul style="list-style-type: none"> • can offer a broad range of health and social supports • Monitors providers and individual referrals – a requirement that the provider can take the call within 48 hours, and if this does not happen, a person will be referred on • based on strong relationships between Police and providers • strong buy-in by Police

Conversations are needed on how both systems complement one another and can better align in the future, to support easy access to services of an appropriate type and quality. There is potential for funding agencies (eg, DHBs, the Ministry of Social Development) to provide specialist assistance for the selection of providers, to expand on the options available and support quality referrals (eg. mechanisms to address any quality concerns).

We also consider there is potential for both referral pathways to be improved, and ensure they are evidence-based, safe, and facilitate easy access to the most appropriate service or other support. For example, at different stages both referral pathways are using cold calling, which is not supported by the evidence base. We also consider further research could be warranted into the engagement following these referrals, to understand the proportion of referrals that end up in engagement and how that relates to need, whether people are being referred through to appropriate services, and what kinds of options and choice they are able to exercise.

CAPACITY OF MENTAL HEALTH AND ADDICTION SERVICES

The mental health and addiction system needs the capacity to respond to demands for services to support a health-based approach. The scope of the review has not allowed for a deep examination of the health response, but it is important to understand the complete picture to be able to measure success of the shift to a health-based approach. This will be an important part of the 2024 review.

We do know that currently there is not a consistent range of alcohol and other drug supports in place across the country with capacity to meet all of the demand that referrals from Police and other sources (primary health care, Oranga Tamariki, Courts, social services) generate. The investment in Budget 2019 in mental health and addiction services is intended to bolster existing services and establish new initiatives.

There are not the supports in place across the country with capacity to respond to an influx of referrals from Police, and that more referrals would require increased and sustainable funding, as well as upscaling of the workforce and infrastructure surrounding alcohol and other drug support. Both members of the judiciary interviewed noted prolonged delays for residential and drug counselling services, and that this is impacting on the system's ability to reduce reoffending and improve individual and community outcomes. Subject to adequate resourcing being in place, there may be more scope for the health and addiction sector to upscale harm reduction services in the short-term.

PART TWO - REVIEW OF IMPACT OF CLASSIFICATION OF AMB-FUBINACA AND 5F-ADB

Review objectives

This part of the review is specific to the amendment which classified two synthetic drugs, AMB-FUBINACA and 5F-ADB in Schedule 1 (Class A controlled drugs) of MoDA.

Classifying the drugs under MoDA increases the offences and penalties that can be imposed for activities such as importing, manufacturing and supply of the drugs, and accordingly Police and Customs have greater search and seizure powers. These powers increase the ability of Police and Customs to disrupt supply and reduce the availability of the drugs to those who may use them harmfully.

This part of the review considers the impact classification has had on:

- preventing or reducing drug-related harm from AMB-FUBINACA and 5F-ADB, and
- interrupting manufacture, and supply of AMB-FUBINACA and 5F-ADB.

The review does not investigate broader policy issues, such as the rationale for classifying AMB-FUBINACA and 5F-ADB as Class A controlled drugs under MoDA.

What are AMB-FUBINACA and 5F-ADB?

AMB-FUBINACA and 5F-ADB are synthetic cannabinoids. Synthetic cannabinoids are a broad collection of manufactured substances that act on the cannabinoid receptors in the body. The compounds are ordinarily imported as a powder which are then dissolved and sprayed on plant material such as damiana or other plant material. This is then sold as synthetic cannabis. Some synthetic cannabinoids have a high risk of harm even when used at low doses. Health-related harms from AMB-FUBINACA and 5F-ADB include severe nausea, loss of consciousness, cardiac and neurological irregularities, seizures, loss of consciousness and death.

Despite the similarity of name, synthetic cannabinoids bear very little relation to cannabis, meaning cannabis is not a true alternative drug.

Prior to being classified under MoDA, AMB-FUBINACA and 5F-ADB were unapproved products under the Psychoactive Substances Act. The Expert Advisory Committee on Drugs (the Advisory Committee) recommended to the Minister of Health that AMB-FUBINACA and 5F-ADB be classified as Class A drugs because of the risk of harm they pose. This recommendation was agreed to and included in the 2019 MoDA amendments. At that time AMB-FUBINACA and 5F-ADB were regarded as posing the greatest risk so quick action was taken. Currently another 8 synthetic cannabinoids are being considered for classification as Class B1 controlled drugs.

Synthetic cannabinoid analogues

Once AMB-FUBINACA and 5F-ADB were classified as Class A controlled drugs, analogues (substances with similar structures) of AMB-FUBINACA and 5F-ADB became controlled drug analogues for the purposes of MoDA³. This means that analogues of AMB-FUBINACA and 5F-ADB are subject to penalties under MoDA, providing a deterrent for importers, suppliers and manufacturers to move to similar substances.

³ Section 2 MoDA.

A broad range of activities were already underway to address synthetic drug harm

Alongside the policy decisions for legislative change, Cabinet approved in December 2018, a time-limited discretionary fund of \$1.89 million per annum from 1 July 2018 to 30 June 2022 to support local surge responses to acute harm situations caused by synthetic drugs. More details are included in Appendix 6.

The fund aims to provide urgent funding to support short-term flexible and rapid responses, where need is identified (for example via increases in emergency department presentations). The fund was intended to support communities to address sudden or serious increases in synthetic-related acute drug harm, such as overdose, other medical incidents, or deaths.

The definition of acute drug harm for the purpose of the discretionary fund was defined as a subset of drug harm that is categorised by short-term harms, often geographically isolated, in response to emerging substances and/or adverse reactions to a particular drug. This can also include serious rapid-onset medical events. This was based on the synthetic cannabinoid crisis observed in 2017 and 2018.

Since the fund was created, the Ministry has developed a more detailed understanding of acute drug harm, based on intelligence reports from the National Drug Intelligence Bureau, processing funding applications and stakeholder feedback. In particular we now have a better understanding of how the system and services could be adapted to reduce harm in New Zealand. Opportunities exist to improve the scope and operation of current funding and ensuring the system is prepared to respond.

Responding to acute drug harm requires a flexible, responsive and tailored approach, that is different from traditional service delivery models. The synthetic cannabinoid crisis (from 2017 to 2019) showed that many AOD and social services were not well prepared to respond to acute drug harms for a variety of reasons, including:

- systems and services were not flexible or adaptable enough to respond quickly
- little information was available about what best-practice responses look like, including interventions, systems and policies
- there was limited AOD or specialist training for frontline staff
- there was mixed or no public health messaging and resources that were appropriate for the substances and affected populations.

As a result, many of the most vulnerable experienced avoidable acute drug harms and/or did not receive the right support at the right time. Some support is reaching people at the right time because of improvements to various work programmes (e.g. DIANZ and the community of practice). However, these mechanisms alone are not providing the rapid widespread change across systems and services that is required to proactively respond to and reduce acute drug harm. These systems and services can be improved by providing dedicated resource to develop a package of solutions that supports these changes.

The funding criteria could be updated to focus on the presence of severe synthetic-related acute drug harm (short-term harms that can have significant impact on that person's health or life), instead of only 'surges' (sudden or serious increases). This would allow the fund to still be available for 'surges' of acute harm, but other communities will also be able to apply to the fund when a 'surge' is difficult to show or when severe acute drug harm is already present.

Drug Information Alert NZ

Also prior to the amendments, the National Drug Investigation Bureau was establishing a drug early warning system to gather information, analyse and provide alerts around high risk substances. The system has been formalised as the Drug Information and Alerts NZ network (DIANZ) and is a joint operation between the Ministry of Health, Customs Service and Police. It is supported by a network of health professionals and social services who both provide and receive information.

DIANZ launched its public facing website, High Alert (www.highalert.org.nz) in June 2020. Alerts and notifications are published on the website to inform the public and health professionals of increased health risks from new drug trends or threats, such as adulterated drugs. Harm reduction information and advice is available. The website also allows people who use drugs to report unexpected or concerning effects from drug use to the DIANZ team. If a high-risk situation exists, an alert will be published on the website, and lower risk situations may result in a notification being published.

Since the launch and as at 13 July 2021, 11 notifications have been published on the website alerting the public to dangerous substances in the community. This includes a notification on 22 September 2020 that AMB-FUBINACA was being detected in New Zealand and a notification on 8 July 2020 that an analogue of 5F-ADB had been detected. Over 160,000 people have visited the website over the last nine months, accounting for 245,970 views of DIANZ's harm reduction content. DIANZ was funded as part of Budget 2019.

Harm profile of synthetic cannabinoids AMB-FUBINACA and 5F-ADB

Deaths involving illegal drugs

The review team looked at deaths involving illegal drugs to understand overall trends. The findings in closed coronial cases involving synthetic cannabinoids from 2016 – 2020 showed that in the majority of cases AMB-FUBINACA was detected.

Table 6 below shows the number of deaths in closed cases where a cause of death has been determined by a coroner, a finding or certificate has been issued and the drug involved was synthetic cannabinoids. There was a surge in deaths in 2017 – 2018 and a significant drop in deaths in 2019. This correlates with samples tested by the Institute of Environmental Science and Research (ESR) also shows that that AMB-FUBINACA and 5F-ADB made up 89% of the samples tested from the community in May to October 2017 and 77% of the samples tested between July 2018 and March 2019.

TABLE 6. NUMBERS OF DEATHS IN CLOSED CORONIAL CASES BETWEEN JANUARY 2016 AND 30 APRIL 2021 INVOLVING SYNTHETIC CANNABINOIDS ⁴

Closed Coronial cases involving synthetic cannabinoids					
2016	2017	2018	2019	2020	2021
0	13	29	4	Not available	Not available

⁴ Closed cases have a cause of death that has been determined by a coroner, and a finding or certificate issued. The data is indicative as not all deaths are investigated by the coroner. There is also a time lag between when a death happens and when the Coroner's Inquiry is completed. The data was extracted from the Ministry of Justice's case management system on 24 May 2021. Cases are included based on the date the case was notified to the coroner, which can differ from the date of death.

Currently Coroner A J Mills is conducting an inquiry to understand the circumstances of the surge of deaths in the broader sense, and to consider recommendations or comments. The focus will be on what can be done to prevent further deaths in similar circumstances. The inquiry will be forward looking with an emphasis on what can be learnt from the 2017- 2018 surge that could prevent similar clusters of deaths in the future.

Hospitalisation discharge data

The review team received information from the National Minimum Data Set which is collated quarterly.⁵

Admissions that involve harmful substances are flagged at discharge. Substances flagged are opiates, cannabis, hallucinogens, stimulants, alcohol, cocaine, methamphetamine, GHB, MDMA, ketamine, sedative/hypnotic drugs, synthetic cannabinoids, tobacco, solvents, and polydrug use. Data collected does not distinguish between different synthetic cannabinoids so there is no specific information on hospital discharges involving AMB-FUBINACA and 5F-ADB.

Table 7 shows that since the surge in 2017 - 2018 numbers of hospital discharges with a synthetic cannabinoid diagnosis returned in 2019 and 2020 to pre-surge levels. This suggests that synthetic cannabinoids in general are still available and causing harm but at greatly reduced levels. This data does not tell us if these hospitalisations were due to AMB-FUBINACA and 5F-ADB.

TABLE 7 HOSPITAL DISCHARGES WITH A SYNTHETIC CANNABINOID GENERAL DIAGNOSIS AND PRINCIPAL DIAGNOSIS⁶

Year	Number of hospital discharges with a synthetic cannabinoid diagnosis	Number of hospital discharges with a synthetic cannabinoid related principal diagnosis
2015	27	18
2016	37	31
2017	89	67
2018	102	81
2019	37	26
2020	22	16

⁵ The National Minimum Data Set is a national collection of public and private hospital discharge information, including clinical information, for inpatients and day patients. The National Drug Investigation Bureau is provided with alcohol and other drug National Minimum Data Sets each quarter. This data includes encrypted NHI numbers, age, gender, ethnicity, DHB of domicile, domicile code, length of stay, facility code, agency code, and diagnosis. Every record must have a valid NHI number. Only instances where the patient was treated for three hours or more are recorded. **It therefore does not necessarily include emergency department admissions.**

⁶ The principal diagnosis (refer to ACS 0001 p10) is defined as the diagnosis established after study, to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or attendance at the healthcare establishment, as represented by a code. The phrase 'after study' in the definition means evaluation of findings to establish the condition that was chiefly responsible for the episode of care. Findings evaluated may include information gained from the history of illness, any mental status evaluation, specialist consultations, physical examination, diagnostic tests or procedures, any surgical procedures, and any pathological or radiological examination.

Table 8 below shows the percentage of hospital discharges with a synthetic cannabinoid related principal diagnosis, by ethnicity.

The table shows that the percentage of Māori represented in synthetic cannabinoid hospitalisations is higher than the proportion of Māori in the general population. In every year, except in 2016 and 2018, the percentage of Māori being discharged following a synthetic cannabinoid related principal diagnosis was equal to or more than the percentage of non-Māori. The review team acknowledges the numbers are small with 13 Māori being discharged with a synthetic cannabinoid related principal diagnosis in 2019 and 9 2 Māori in 2020.

TABLE 8 THE PERCENTAGE OF HOSPITAL DISCHARGES WITH A SYNTHETIC CANNABINOID RELATED PRINCIPAL DIAGNOSIS BY ETHNICITY

Ethnicity	2015 (% of total)	2016 (% of total)	2017 (% of total)	2018 (% of total)	2019 (% of total)	2020 (% of total)
Māori	67%	45%	54%	36%	50%	56%
Non-Māori	33%	55%	46%	64%	50%	44%
Grand Total	100%	100%	100%	100%	100%	100%

The New Zealand Drug Foundation’s report on insights into synthetic cannabinoids use in New Zealand completed in December 2018⁷, showed that half of the respondents to its survey on people using synthetic cannabinoids were Māori, and most were male. Respondents ranged in age, with two thirds unemployed or on a benefit, and half of the sample were homeless. The Foundation also reported that there was consistent anecdotal information to suggest that other groups of people using synthetic cannabinoids were:

- young people who are not in work or training and are using out of boredom
- people avoiding workplace drug testing
- people who used legally available products and maintained use after they were removed from the legal market in 2014.

The mortality, hospitalisation and ethnicity data that we have reviewed does not include information on whether these factors were also present for the people represented in the data.

These are highly marginalised segments of society whose access to health services is minimal and/or sporadic. Given the complex social issues present in these areas of society, responding requires a flexible, and tailored approach, that may be different from traditional service delivery models. This review highlights the opportunity to continue to target support services to Māori and vulnerable populations to address the issues associated with deaths and hospitalisations due to synthetic cannabinoids.

Interrupting manufacture and supply of AMB-FUBINACA and 5F-ADB

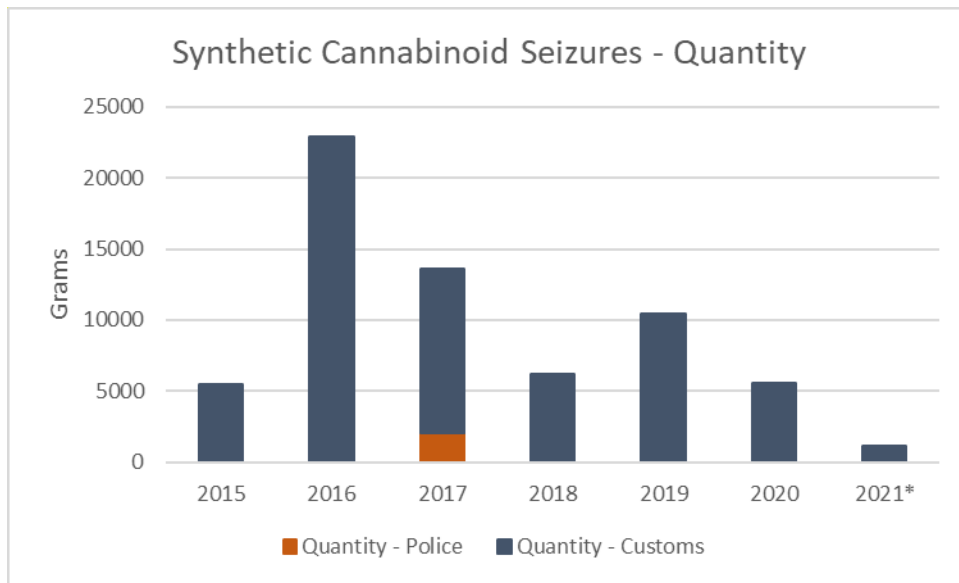
Customs and Police seize suspicious products (often identified as an unknown white powder if in raw form), some of which may be AMB-FUBINACA and 5F-ADB or their analogues. Not all seized material is tested. The data therefore does not separate out AMB-FUBINACA and 5F-ADB from other substances.

⁷ <https://www.drugfoundation.org.nz/assets/uploads/Synthetic-cannabinoid-crisis-insights-and-recommendations-Dec-2018-2.pdf>

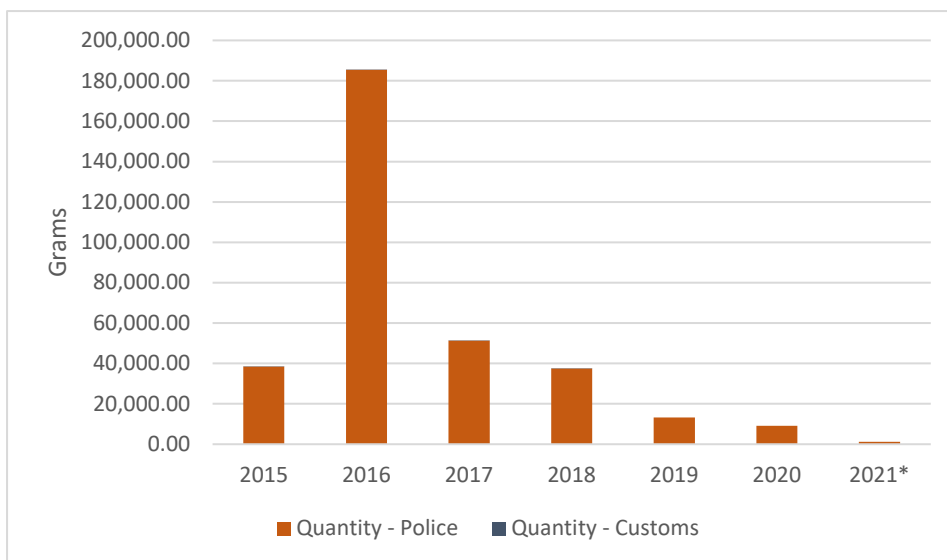
Graph 20 shows a reduction in the quantities of synthetic cannabinoid powder seized since 2019. This would suggest that the amount of synthetic cannabinoids being imported has reduced and consequently less synthetic cannabis is being manufactured in New Zealand.

Graph 21 shows the quantities of plant matter containing synthetic cannabinoids seized has substantially reduced since 2018. However, it is not clear whether supply or demand reduced first, or the extent to which international markets and regulatory changes impacted on the trends seen in New Zealand.

GRAPH 20. SYNTHETIC CANNABINOID SEIZURES - QUANTITY⁸



GRAPH 21 SYNTHETIC CANNABIS SEIZURES - QUANTITY⁹



⁸ This graph depicts the raw ingredient (the cannabinoid powder) which is the way it is imported into New Zealand. It is very rare for police to detect this format of the drug so most seizure data is from Customs.

⁹ Customs are unlikely to find the finished product (cannabinoid applied to a leaf material) because it is usually manufactured in New Zealand from imported powder and leaf material so most seizure data is from Police.

ESR testing

ESR has analysed numerous samples of plant material, suspected to contain one or more synthetic cannabinoids, from 2017 to 2021. Four nationwide surveys were undertaken to gain an understanding of the synthetic cannabinoids being distributed and consumed in New Zealand over different time periods. This allows the monitoring of trends over time.

The ESR data tested for 19 synthetic cannabinoids including AMB-FUBINACA and 5F-ADB. Approximately half of the substances identified by ESR are likely to be captured as analogues of either AMB-FUBINACA or 5F-ADB. The others are either psychoactive substances or have not been assessed. Not all of the substances have been assessed to determine their risk of harm.

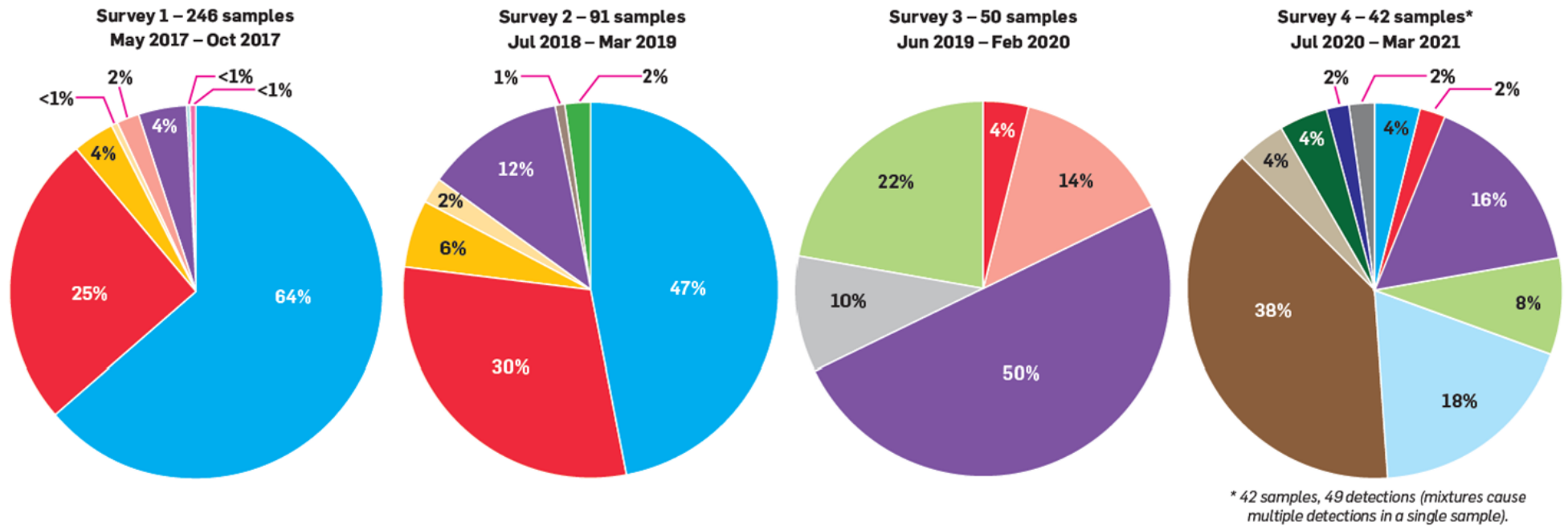
The data shows a decline in the percentage of samples containing AMB-FUBINACA from 64 percent (May 2017 to October 2017) to 47 percent (July 2018 - March 2019) and none from June 2019 to February 2020. However, 4 percent of samples tested contained AMB-FUBINACA from July 2019 to March 2021 showing it is still present in the community. The decline is particularly evident from July 2019, but it is difficult to attribute this to an impact of the 2019 amendments as it was part of a continuing trend.

There has been an overall decline in the percentage of samples containing 5F-ADB from 25 percent (May 2017 to October 2017), rising to 30 percent (June 2018 to March 2017) and then declining to 4 percent (June 2019 to February 2020) and 2 percent (July 2020 to March 2021). Again, it is difficult to attribute the decline to the 2019 amendments.

The data shows that other substances are increasingly being found. Significant in the ESR data is that MDMB-4en-PINACA was the most found synthetic cannabinoid from the end of 2020 and beginning of 2021, and that it was not detected in previous surveys. MDMB-4en-PINACA is an analogue of 5F-ADB. Approximately half of these other substances are analogues of AMB-FUBINACA and 5F-ADB and will therefore be captured by the amendments, making them class C controlled drugs. The remainder are in the process of being scheduled as controlled drugs or are controlled by the Psychoactive Substances Act.

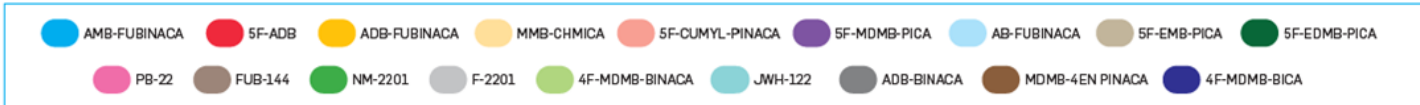
This is further evidence of the fast-moving synthetic drug market and highlights the importance of close collaboration across the drug detection network to be able to quickly identify and respond to new substances coming onto the market.

GRAPH 22 ESR TESTING FOR SYNTHETIC CANNABINOIDS



RESULTS DISCUSSION

A total of 18 synthetic cannabinoids were detected in the four surveys, with six synthetic cannabinoids detected for the first time in the most recent survey. The most prevalent synthetic cannabinoids at the end of 2020/beginning of 2021 was MDMB-4en-PINACA, which wasn't detected in previous surveys.



New context from changing international regulations

On 11 May 2021 China issued a statement announcing a ban effective 1 July 2021 on 'all synthetic cannabinoids', and 18 other individual substances mostly of the cathinone, dissociative, and benzodiazepine groups. The key points for New Zealand (as reported by High Alert):

- Synthetic cannabinoids will *possibly* be produced (lawfully or illicitly) in another country, or it is possible large-scale international production ceases.
- It is *unlikely* illicit production of synthetic cannabinoids will occur in China on a large scale.
- If the manufacturing of synthetic cannabinoids is unable to meet international demand, it is *likely* New Zealand will experience a synthetic cannabinoid shortage. Any shortage of synthetic cannabinoids will likely lead to substitution with alcohol and other drugs.
- It is *likely* Chinese synthetic cannabinoid manufacturers will design and produce new, legal compounds not covered by MoDA.
- For the other individual analogues banned by China, it is *almost* certain Chinese manufacturers will develop new substances not included in the ban and export to New Zealand using the same modus operandi as before.

This means that intelligence gathering, and the temporary drug classification orders will be important in managing harmful substances in the future.

Key findings:

- Seized synthetic cannabinoids are not routinely tested to determine whether it is AMB-FUBINACA or 5F-ADB.
- Closed coronial cases involving synthetic cannabinoids showed a surge in deaths in 2017 – 2018 and in the majority of cases AMB-FUBINACA was detected.
- Hospitalisation, Police and Customs data does not distinguish between AMB-FUBINACA and 5F-ADB, and other synthetic cannabinoids. However, Police and Customs data shows the quantities of seizures of synthetic cannabinoid powder and synthetic cannabis has reduced considerably since 2019 indicating there has been a reduction in the amount of synthetic cannabinoids in the community. This was a continuation of an existing trend so the reduction is unlikely to be due to the amendment.
- Coronial and hospitalisation data shows that since the surge in 2017 - 2018 numbers of deaths and hospital discharges have returned to pre-surge levels.
- The number of Māori represented in synthetic cannabinoid hospitalisations is higher than the proportion of Māori in the general population although the dataset is small.
- ESR testing shows a significant decline since 2019 in the percentage of samples containing AMB-FUBINACA and 5F-ADB. This indicates that there has been a shift towards other synthetic cannabinoids since the scheduling of these substances although a link cannot be inferred. We are unable to comment at this time on the relative harms of these substances but understand that approximately half are likely to be captured under MoDA as analogues of AMB-FUBINACA and 5F-ADB.

PART THREE - TEMPORARY CLASS DRUG ORDERS

This part of the report considers the impact of the amendment which enables temporary class drug orders (TCDOs) to be issued for emerging and potentially harmful substances. To date no TCDOs have been issued, and one application was received on 29 June 2021 and is currently being considered.

Legislative history leading up to the amendments

In 2011 an amendment to MoDA allowed for temporary class drug notices to provide a mechanism for prohibiting the import, manufacture, sale and supply of potentially harmful substances. The effect of the temporary class drug notices was to classify the substance under MODA as a Class C controlled drug, with a requirement that the Minister seek advice regarding the appropriate classification of the drug. The temporary class drug notices could be quickly ordered through a notice issued by the Minister and would last for 12 months with the option to renew for a further 12 months if required.

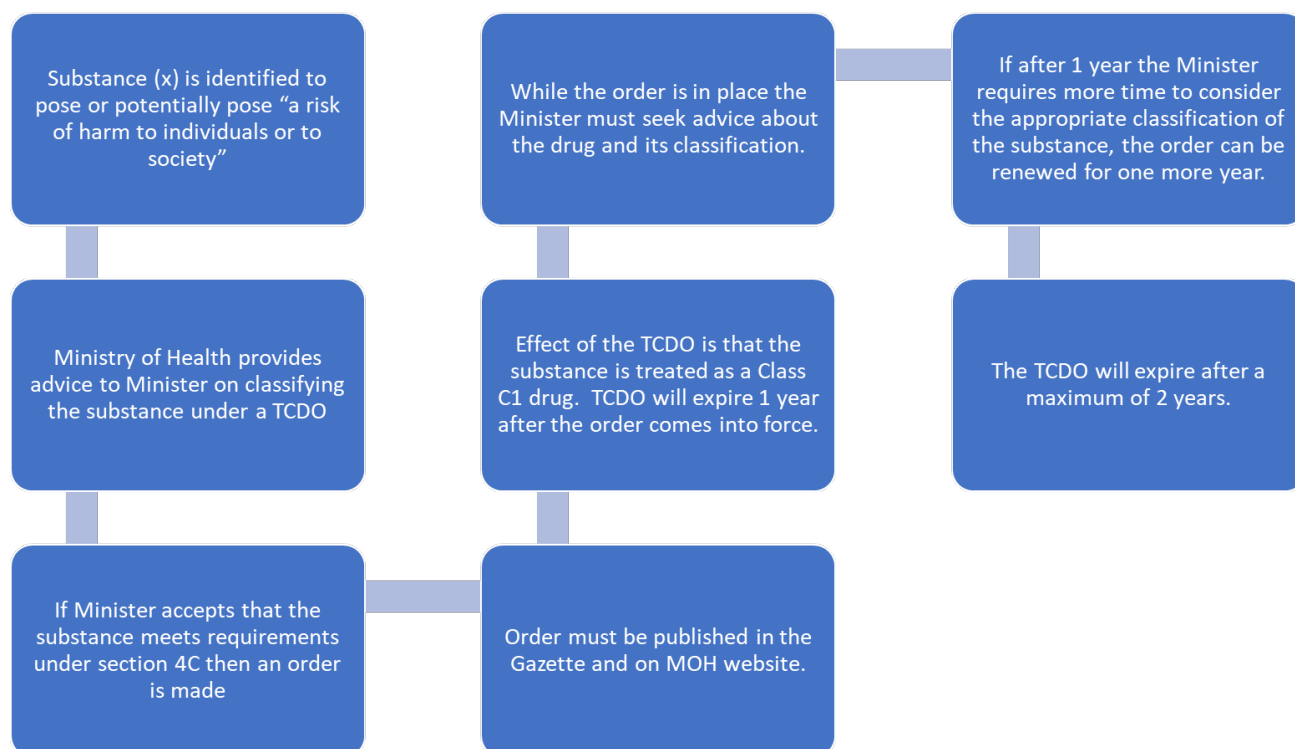
A total of 22 compounds were the subject of temporary class drug notices from August 2011 to July 2013. These notices provided an emergency solution where there were suspected safety issues. Ultimately none of the substances classified under temporary class drug notices went on to be permanently classified under MODA. This demonstrates the rapid volatility in the synthetic drug market where harmful drugs can be quickly replaced by new ones.

The provisions for temporary class drug notices were repealed in 2013 through Section 110 of the Psychoactive Substances Act 2013. The substances that could have been controlled through the temporary class drug notices were unapproved products under the Psychoactive Substances Act 2013. This meant that importation, manufacture and sale of these products were offences subject to penalties. Further information on the Psychoactive Substances Act 2013 can be found in Appendix 1.

The temporary class drug orders (TCDOs).

The amendments reinstated the ability for the Minister of Health to temporarily classify a substance under MoDA through a Temporary Class Drug Order (TCDO). This order operates in a very similar way as the previous temporary class drug notices. The Minister can issue a notice in the Gazette that temporarily classifies a substance as a Class C1 drug under MODA. That order is set to expire after one year, during which time the Minister must seek advice (from the Advisory Committee) about the drug and whether it should be classified permanently. If more time is required to adequately review the drug the Minister can renew the order for one more year.

Flow chart of Temporary Class Drug Orders - sections 4C-G of MoDA



Objective of the amendment

To issue a TCDO the Minister must be satisfied that the substance poses, or may pose, a risk of harm to individuals or society. The intent of this provision is to enable immediate action to reduce harm of a substance. The effect of temporarily classifying the substance is to provide a mechanism for the immediate search and seizure of the substance and to increase penalties associated with its sale and importation.

New and potentially harmful products are rapidly produced, and the existing permanent classification process under MoDA is complex, takes time and for some substances may be inadequate for a swift response. Being able to quickly classify emerging products under MoDA allows for a fast response to a rapidly adapting synthetic drug market and ensure the continued disruption of the supply of new synthetic drugs.

The objective of the amendment is to:

- provide a mechanism for immediate use of MoDA powers and penalties, for substances that pose or may pose a risk of harm
- prevent the supply of such substances.

Mechanism for immediate use of MoDA powers and penalties

MoDA is generally silent on any requirements for TCDOs with the only guidance provided being that:

“The Minister must not make an order unless satisfied that the substance, preparation, mixture, or article that is to be specified in the order –

- (a) poses, or may pose, a risk of harm to individuals or to society*

*(b) has not been classified under this Act, except as a controlled drug analogue*¹⁰

There is a process in place for receiving applications for and making TCDOs, but it is untested. The review team received feedback from stakeholders that the process was unclear, they had difficulty knowing who to apply to, how to go about it and what information to include. The review team recommends that the existing application process be refined, and clearly communicated to relevant stakeholders. We did not find, however, that clarity of the process prevented any applications being made to date.

On 29 June 2021 the Ministry received its first request for a TCDO from the National Drug Intelligence Bureau. This provides an opportunity to test the process.

The process will continue to evolve and be defined as more substances go through it. The agreed evaluation framework for the final review should include information from the TCDO process including the number of TCDOs, the kinds of substances being classified under a TCDO and the proportion of TCDOs ultimately classified permanently in MoDA. This will tell us how often the process is being used and how many applications reach the threshold of harm.

Demand for TCDOs to be made has been low. This is in part due to the analogues of AMB-FUBINACA and 5F-ADB being captured as class C controlled drugs as result of the amendment. It also reflects the drug market in New Zealand which has not recently seen a proliferation of new, harmful substances aside from these analogues.

DIANZ (set up in June 2020 as part of the Amendment funding package) and High Alert notifications (refer glossary) will greatly assist in identifying substances that would be appropriate for a TCDO. This process scans across the country and provides early and quick information on harmful substances in regions.

Key findings:

- The Ministry received the first application for a temporary class drug order on 29 June 2021 which is currently being processed.
- There is an opportunity to refine the existing TCDO application process and more clearly communicate the process to relevant stakeholders.

¹⁰ S. 4C(3) MoDA

PREPARATIONS FOR THE 2024 REVIEW OF THE IMPACT OF THE 2019 AMENDMENTS TO MODA

The full review is an opportunity to address any data and information gaps and provide a fuller picture of the impact of the 2019 amendments.

An evaluation framework will be developed by the end of 2021 to guide the final review in 2024. In order to fully understand the implementation and impact of the 2019 amendments agencies will work together to determine the key datasets for the 2024 final review and investigate the following factors:

- engage with front-line Police to explore their understanding, beliefs, confidence and decision-making processes in using health-based approaches to reduce drug-related harm
- interview people who use drugs on their experiences of the justice system's use of health-based approaches, and what's helped them to reduce drug harm
- assess performance against the principles of Te Tiriti o Waitangi including the perspectives of iwi and the community
- data on the AOD sector, the level of referrals pre and post-amendment
- unmet need for Māori including how the sector is taking a kaupapa Māori approach.

Sufficient time will be required for survey and interview design, ethics approval, and measures to both learn from people using drugs and avoid causing any harm.

SUMMARY OF FINDINGS

Implementation of the amendments
A new nationally consistent system for health-based referrals was established, and Police advised its staff of the amendments and implications for operations. Changes were made to Policing instructions to allow a health-based approach for methamphetamine offences.
Drug prevalence
Police and Customs drug seizure data and wastewater testing indicate that: <ul style="list-style-type: none"> • overall illegal drug supply in New Zealand has remained steady over the last five years • cannabis, methamphetamine and MDMA are the most prevalent commodities in the New Zealand illegal drug landscape.
Police prosecutions
There has been a general downward trend in Police proceedings for personal possession and use of illegal drugs, particularly in relation to cannabis.
Since 2019 Police has increased the use of non-Court proceedings compared to court proceedings when dealing with all personal possession and use of drugs offences.
Since 2019 there has been a sharp increase in the use of non-Court proceedings for personal possession and use of methamphetamine that can be attributed with some confidence to the 2019 amendments.
The data shows that all Police districts have increased their use of non-Court proceedings compared to Court proceedings in situations where personal possession and use is the most serious offence, and the rate of increase varies across the districts.
Court proceedings
Adult diversion prosecutions show a continued a gradual downward trend that began prior to the 2019 amendment.
The majority of drug-related adult diversions are cannabis-related personal possession and consumption charges. An investigation into individual cases might identify there is still some progress to be made in helping people using other substances to access the scheme.
There has been a clear downward trend in Police prosecutions for personal possession and use over the past decade. The trend had flattened in the three years prior to the 2019, but noticeably decreased following the 2019 amendment illustrating a strong operational shift in that time.
The downward trend in Police prosecutions is much weaker for repeat offenders than first-time offenders, including after the 2019 amendment
Equity
The proportion of Māori being identified by Police for personal possession and use of illicit drugs is larger than the proportion of Māori in the general population
Māori and non-Māori cases are similarly distributed across non-Court and Court actions (suggesting that once people are in the justice system, they are treated similarly)
Conviction rates are declining for both Māori and non-Māori, but the decline for non-Māori is steeper than for Māori
The number of Māori represented in synthetic cannabinoid hospitalisations is higher than the proportion of Māori in the general population.
Referrals to health services
There appears to be a low level of consented referrals to the MoDA Referral Pathway established to support the 2019 amendment, particularly compared with the early signs of Police buy-in to the AWHI system

The MoDA Referral Pathway and AWHI have different and complementary strengths. Consideration should be given as to how both systems can work alongside each other as AWHI expands to facilitate easy access for people to the most appropriate service.
Referral systems could benefit from guidelines for best practice referrals that ensure that people seeking and agreeing to offers of help are channelled to the most appropriate provider as soon and as smoothly as possible.
There is interest among the judiciary for guidelines to support health-based approaches for drug harm reduction through the Courts.
There are concerns about the capacity of mental health and addiction services to accommodate any rapid growth in Police referrals
Supply of AMB-FUBINACA and 5F-ADB
Closed coronial cases involving synthetic cannabinoids showed a surge in deaths in 2017 – 2018 and in the majority of cases AMB-FUBINACA was detected.
ESR testing shows a significant decline since 2019 in the percentage of samples containing AMB-FUBINACA and 5F-AKB.
Coronial and hospitalisation data shows that since the surge in 2017 - 2018 numbers of deaths and hospital discharges relating to synthetic cannabinoids have returned to pre-surge levels.
Police and Customs data shows the quantities of seizures of synthetic cannabinoid powder and synthetic cannabis has reduced considerably since 2019.
Hospitalisation, Police and Customs data does not distinguish between AMB-FUBINACA and 5F-ADB, and other synthetic cannabinoids.
Temporary Class Drug Notices
The Ministry received the first application for a temporary class drug order on 29 June 2021 which is currently being processed.
There is an opportunity to refine the existing TCDO application process and clarity about the process be communicated to relevant stakeholders.

Appendix 1: Glossary

Psychoactive Substances Act: The Psychoactive Substances Act 2013 came into force to regulate the availability of psychoactive substances in New Zealand to protect the health of, and minimise harm to, individuals who use psychoactive substances. The Act put the onus of proof that products are of a low risk of harm onto the manufacturer, importer or distributor rather than requiring regulators to prove they were safe. This means that a product must be proven safe before it could be legally sold. Subsequent amendments have included removing all interim approvals and licences from the New Zealand market (resulting in all products being recalled), prohibiting animal testing when assessing if products are of low risk and therefore able to be approved, and regulations allowing applications for product approval and retailers' and wholesalers' licences to sell approved products. To date no products have been approved under the Act.

Alcohol and Other Drug Treatment (AODT) Court Te Whare Whakapiki Wairua: The first AODT Court, was established in November 2012 as a pilot across two District Court sites: Auckland and Waitākere. In June 2021, a further court was launched in Waikato. The Auckland-Waitākere AODT Court has a combined maximum capacity of 100 participants at any one time, with 50 participants at each site. The Court aims to break the cycle of offending by treating the causes of that offending. It provides an alternative to imprisonment for people whose offending is being driven by alcohol or drug substance use disorders, and provides an evidence-based, best practice treatment pathway that includes intensive monitoring, case management, drug testing, and mentoring. Sentencing is deferred while participants work through the programme, which includes regular court appearances to check on progress. The programme may take between one to two years to complete.

Police Prosecution Service: There are over 300 staff (including 212 prosecutors) within the Police Prosecution Service. They are spread between a national office in Wellington and 41 offices throughout the country, servicing over 60 district courts. The service conducts proceedings for prosecutions commenced by Police from first appearance to disposal, including Case Review and Trial as required except where the proceeding becomes a Crown Prosecution (eg, jury trials). The service also conducts proceedings for Youth Court prosecutions, advocates for Police at Coroners' inquests as required, and administers the Adult Diversion Scheme.

Solicitor-General's Prosecution Guidelines: The purpose of these Guidelines is to ensure that the principles and practices as to prosecutions in New Zealand are underpinned by core prosecution values. These values aim to achieve consistency and common standards in key decisions and trial practices. If these values are adhered to, New Zealand will continue to have prosecution processes that are open and fair to the defendant, witnesses and the victims of crime, and reflect the proper interests of society.

Evidence Based Policing Centre: The New Zealand Evidence-Based Policing Centre (EBPC) was established in December 2017 as a joint partnership between New Zealand Police, the University of Waikato, the Institute of Environmental Science and Research and Vodafone New Zealand. EBPC combines the existing skills, knowledge and experience of Police with research, crime science, problem-solving and testing. This is then used to guide and inform the choices of Police decision-makers with approaches and tactics proven to reduce harm. EBPC shows the evidence behind why, how, where and when Police take specific actions.

Mental health and addiction sector: New Zealand’s mental health and addiction sector comprises a number of health and social agencies, clinical health settings (from DHB to GP practices), mental health and addiction service providers, advocacy and community groups, and individuals and their whānau. For the purposes of this review, the mental health and addictions sector refers to clinical health settings, providers of treatment services and advocacy groups.

Alcohol Drug Helpline administered by Whakarongorau (Formerly Homecare Medical):

Whakarongorau has a ten-year contract with the Ministry of Health (and other agencies) to deliver free around the clock digital telehealth services spanning mental health and addictions support. Whakarongorau is owned by primary health organisations ProCare and Pegasus health and its team includes nurses, mental health professionals, doctors, health advisors, and sexual harm professionals who are based throughout New Zealand from Kaitaia to Bluff.

Substances relevant to this report:

- **Cannabis** is a natural plant that has psychoactive properties primarily from the cannabinoid THC (tetrahydrocannabinol). Cannabis commonly results in relaxation and euphoria and is also used for therapeutic purposes including pain relief, appetite stimulation, reducing nausea and reducing muscle spasms. Adverse health effects are primarily from early initiation and heavy regular use and can include low motivation, worsening mental health and paranoia.
- **Cocaine** is a stimulant¹¹ that primarily releases dopamine and provides feelings of happiness, euphoria and arousal. Cocaine is a highly concentrated form of the coca leaf. Adverse effects from high doses include tremors, convulsions, heart pain and potentially result in seizures or heart attack.
- **GHB/GBL** (Gamma hydroxybutyrate/Gamma-Butyrolactone) is a depressant¹² which provides a similar effect to alcohol including increased mood, relaxation, confidence, strong sex drive, disinhibition, and euphoria. GBL is a precursor of GHB and rapidly metabolises when taken but is slightly more potent GBL is the form predominantly available form in New Zealand. Adverse effects are primarily from the risk of overdose with the difference between an active dose and potentially fatal overdose very small. This risk is heightened with GHB/GBL primarily sold in liquid form.
- **MDMA** (3,4-Methylenedioxymethamphetamine/ecstasy) is a stimulant¹³ that releases serotonin and provides euphoria, increased mood, confidence and feelings of connection. Adverse effects can be acute and include hypertension, seizures, faintness, disabling anxiety attacks, sensory and movement issues, overheating, cardiac stress and death. There is also a risk of serotonin syndrome with regular use of MDMA or used while on anti-depressants or anti-anxiety medication, this syndrome can be fatal.

¹¹ Stimulants are substances that speed up body functions increasing alertness, euphoria and confidence while reducing inhibitions. High doses of stimulants can result in elevated body temperature and blood pressure, confusion, seizures and in some cases death (from toxicity or stress on the body).

¹² Depressants are substances that depress the central nervous system and slow down body functions. High doses of depressants or using multiple depressants within a period of time (including alcohol and medications) can result in respiratory depression, unconsciousness and death.

¹³ Stimulants are substances that speed up body functions increasing alertness, euphoria and confidence while reducing inhibitions. High doses of stimulants can result in elevated body temperature and blood pressure, confusion, seizures and in some cases death (from toxicity or stress on the body).

- **Methamphetamine** is a stimulant¹⁴ that releases dopamine, serotonin, and noradrenaline resulting in intense alertness, increased sociability, and euphoria. Methamphetamine is the most potent form of amphetamine. Adverse effects include grinding teeth, irregular heartbeat, change in blood pressure, blurred vision with risk of seizures or heart attack from high doses. The risk of psychosis is exacerbated by lack of food and sleep associated with regular or heavy use.
- **Opioids (including heroin)** are depressants¹⁵ that provides relaxation, pain relief and euphoria. Heroin is a highly concentrated opioid made from the opium poppy but is rare in New Zealand, illegal supply is largely diverted pharmaceuticals such as morphine, tramadol and codeine. Adverse health effects are due to risk of overdose which is increased from variable purity of supply. There are risks around blood borne viruses and soft tissue damage with injecting the common method of use.
- **Synthetic cannabinoids** are artificially manufactured substances that act on the cannabinoid receptors in the body, mimicking the effect of THC. The compound is ordinarily diluted and sprayed on plant material with making dosage difficult to predict. The effect of chemicals used in synthetic cannabinoids can be up to 75 times stronger than cannabis. Health-related harms can be acute and include severe nausea, loss of consciousness, cardiac and neurological irregularities, seizures, loss of consciousness and death.
- **Synthetic cathinones** are a broad category of laboratory produced stimulants¹⁶ and research chemicals designed to mimic stimulants such amphetamine and MDMA and avoid legal classification. Broadly, synthetic cathinones increase alertness and mood and are more likely to result in adverse effects compared to other stimulants particularly around anxiety, paranoia and difficulty sleeping. The dose effects and toxicity of synthetic cathinones can vary both across and within batches, as well as between individuals. Hospitalisations with the emergence of new synthetic cathinones such as n-ethylpentylone and eutylone are common with deaths reported internationally.

¹⁴ Stimulants are substances that speed up body functions increasing alertness, euphoria and confidence while reducing inhibitions. High doses of stimulants can result in elevated body temperature and blood pressure, confusion, seizures and in some cases death (from toxicity or stress on the body).

¹⁵ Depressants are substances that depress the central nervous system and slow down body functions. High doses of depressants or using multiple depressants within a period of time (including alcohol and medications) can result in respiratory depression, unconsciousness and death.

¹⁶ Stimulants are substances that speed up body functions increasing alertness, euphoria and confidence while reducing inhibitions. High doses of stimulants can result in elevated body temperature and blood pressure, confusion, seizures and in some cases death (from toxicity or stress on the body).

Appendix 2: Review scope, objectives, approach, data, constraints and limitations

Review Scope

This report is specific to the section 7 amendments to MoDA (the “Health-based approach amendment”) and considers the implementation and impact of the exercise of Police discretion.

As amended, the relevant subsections of section 7 are:

(5) To avoid doubt, it is affirmed that there is a discretion to prosecute for an offence against subsection (1)(a), and a prosecution should not be brought unless it is required in the public interest.

(6) When considering whether a prosecution is required in the public interest, in addition to any other relevant matters, consideration should be given to whether a health-centred or therapeutic approach would be more beneficial to the public interest

The review has not been commissioned to investigate:

- changes to wider policy or operational expectations, including any changes to the Solicitor-General’s Prosecution Guidelines
- adjustments to broader categories of Police discretion or New Zealand Police operating practices
- changes to criminal justice policy or procedure
- shifts towards decriminalisation of cannabis or other substances.

The review has not sought to undertake a performance audit of individual agencies or service providers, nor to explore structural changes to the health sector and delivery of its regulated services. The review will highlight opportunities to uplift operational performance across the full system.

Review objectives

The overarching objective of the review is to understand the Police discretion amendment’s impact on supporting a health-based approach to drug-harm reduction and whether the intent of minimising harm associated with entry into or progression through the criminal justice system is being realised.

In order to achieve this objective, the review team has sought to:

- understand how the amendments have been implemented, including systems and processes to support the intent of the amendment
- understand the impact of the health-based approach amendment on relevant groups: New Zealand Police; mental health and addiction service providers; the court system and Judiciary; and people and communities who are affected by drug use.
- identify the relationships between the implementation of the amendment and referrals to health services from Police
- capture any geographic or demographic differences in how the amendment is being implemented; and
- identify any implementation barriers, their causes and opportunities for improvement.

Review approach

A number of government, judicial, health service-provider, and community actors have been impacted by – and are responsible for giving effect to – this amendment. Accordingly, this review has been supported by engagement with:

- New Zealand Police (Policy and Data Divisions, and Police Prosecutions Unit)
- The National Drug Intelligence Bureau (joint Ministry of Health, Police and Customs initiative)
- the Ministry of Justice (including the Courts and Tribunals Unit), and members of the Judiciary
- the New Zealand Customs Service
- Mental Health and Addiction Service Providers (Including Whakarongorau, formerly Homecare Medical and individual providers)
- The New Zealand Drug Foundation
- the Ministry of Health.

The review has been supported by a cross-agency working group and oversight group.

Data sought for the review

The review team has sought data from a number of agencies to provide an indication of:

- the prevalence of drugs in communities: drawing on NZ Customs and NZ Police seizure data, as well as wastewater sampling undertaken by the Environmental Science Research Institute (ESR)
- the number of identified instances of possession for personal use, by drug type whether possession is a first or repeat offence
- the complex roles Police officers perform in often fluid and sensitive frontline situations
- the number of interactions NZ Police has with people who use drugs by type of interaction (eg, no action, referral, informal warning, formal warning, charging, prosecution)
- the number of health referrals made by NZ Police: through the app, and to alternative pathways such as Te Pae Ora and Te Ara Oranga
- the number of Police referrals received by Mental Health and Addiction service providers (through the app and – where possible – locally- made referrals independent from the app process)
- strengths and opportunities for improvement in existing referral processes and in the quality of services delivered following referral
- volumes of court hearing addressing possession for personal use (further broken down as to where possession is the most serious offence or one of a number of offences)
- how diversion and other pathways may be used, during the prosecution process, to achieve health-based outcomes within the criminal justice setting
- how the system is currently performing from an equity perspective – working with Iwi and other partners to improve outcomes for those most vulnerable to drug-related harms.

Where possible, data has been broken down to capture demographic variations including insights and innovations specific to regions, as well as any trends relevant to wider equitable outcomes (eg, impacts by age of people who use drugs).

Quantitative data has been supplied throughout the review by NZ Police, NZ Customs Service, Ministry of Health Divisions and the Ministry of Justice.

A survey of mental health and addiction service providers has been carried out. This survey was issued to 48 providers identified by the Ministry of Health and associated with the NZ Police's AWHI network.

The Review team has also undertaken structured interviews with mental health and addiction services providers, the New Zealand Drug Foundation and members of the judiciary.

Approach constraints

Due to time and operational constraints, the Review team has not been able to interview frontline Police officers to capture their experiences in applying a health-based approach to the public interest test. It has, however, been informed by a parallel piece of work exploring frontline police perspectives of referring people through to Te Pae Ora iwi panels.

The review team has not directly interviewed individuals or whānau about their experiences pre- and post-amendment. This was not done as there was insufficient time to work through the ethical considerations (e.g. potentially retraumatising people) in an appropriate manner.

A balanced approach has been taken to ensure the data used is as robust as possible, in the timeframe available, and this report recommends ongoing efforts to better synthesis data-gathering and knowledge-sharing system wide.

Data limitations

For a number of reasons, there will be margins of error in this report's analysis. Datasets have been collected separately by agencies and for differing purposes, so it not always possible to align the information. There are some key gaps in datasets, and some areas where datasets have complexities, we have not been able to resolve during this review. This means that, in several instances, we can make observations, but not be conclusive about the actual trends the data illustrates. Limitations include the following:

- the time period from the amendments taking effect to this review is short, and many of the effects may not yet be evident, or conclusive. During this time there has been a global pandemic, and we do not have information of the full impacts of COVID-19 on drug supply, drug use, policing, health and social services and individuals, whānau and communities
- Police data does not include interactions where officers determine it is not in the public interest to prosecute individuals for personal possession and use of illegal drugs
- Police has only recently started to record local referrals to mental health and addiction services (referrals to the addiction helpline are recorded by the helpline provider)
- synthetic and botanical cannabinoids are not detectable in wastewater sampling, making it difficult to confirm proportion between overarching prevalence and the number of health and criminal justice interactions identified
- Police and service provider data does not always capture individuals' ethnicity and other demographic information (due to lack of opportunity to record and inappropriateness of

assuming demographics). The review includes some ethnicity analysis, but does not study gender differences or socio-economic factors

- Ministry of Health datasets do not capture addiction services falling under disability services funded by the Ministry of Social Development
- some datasets do not distinguish referrals for personal drug use from mental health, gambling or other issues.

Appendix 3: Inquiry into Mental Health and Addiction System and recent Government investment in the mental health and addiction system

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction

In 2017, the incoming Government commissioned an inquiry into mental health and addiction in New Zealand. The inquiry was mandated to look at mental wellbeing from mental distress to enduring psychiatric illness, and to take account of the determinants of mental health, many of which lie outside the health system.

He Ara Oranga: Report of the Government Inquiry in Mental Health and Addiction (He Ara Oranga) was released in 2018. The report highlighted the need for an approach to mental health and wellbeing that addresses the determinants of wellbeing (such as poverty and exclusion). The report includes wellbeing promotion and the prevention of mental distress, puts people at the centre, and supports people to stay well and to recover in their communities. It also noted that the new approach needed to be based on:

- honouring Te Tiriti o Waitangi and promoting equity
- listening to the voices of people with experience of mental distress and the mental health system
- recognising mental wellbeing is a shared responsibility
- building on existing foundations for success.

He Ara Oranga noted that New Zealand did not have a complete continuum of care. It stated that components of the system are missing for New Zealanders with mild to moderate mental health and addiction needs, who do not meet the threshold for specialist services. Key recommendations were to support access and choice and build this 'missing middle', and to transform primary care so that people can get mental health support in their communities. *He Ara Oranga* describes a future system with people at the centre that:

- is responsive to different ages, backgrounds and perspectives
- has greater community-based support and local hubs, using a mix of peer, cultural, support and clinical workforces.

Key recommendations, specific to drug harm, made within the report included:

- Recommendation 27: 'Replace criminal sanctions for the possession for personal use of controlled drugs with civil responses (for example, a fine, a referral to a drug awareness session run by a public health body or a referral to a drug treatment programme' and
- Recommendation 28: 'Support the replacement of criminal sanctions for the possession for personal use of controlled drugs with a full range of treatment and detox services'. The 2019 MoDA amendments were sympathetic to these recommendations and, through their focus on harm-minimisation and health-promotion contributed to ongoing progress.

The intent of these recommendations is partly being implemented by the Police using their discretion not to prosecute for possession and personal use of controlled drug offences. Criminal sanctions are avoided and instead people are directed to health-based services. In addition,

substantial progress has been made to provide a broad, accessible and sustainable range of services for people who use illegal drugs harmfully.

Budget 2019 – shoring up existing services and establishing some new initiatives

Budget 2019 invested \$69 million over four years in alcohol and other drug services as follows:

- specialist AOD services (\$42m over four years for Vote Health, \$2m for Vote Corrections)
- primary and community AOD services (\$14m over four years)
- the expansion of Pregnancy and Parenting Services to two new sites (\$7m over four years) and
- sustainable funding for Te Ara Oranga, the Northland methamphetamine harm reduction pilot (\$4m over four years).

A large part of the \$42 million over four years investment in specialist alcohol and other drug services made in the Vote Health Budget 2019 is being used to 'shore up' existing specialist services delivered by regional NGO providers. This included stabilising the residential treatment sector as most services had not received any funding increases since 2009. In effect there had been considerable erosion on what they could afford over the ten-year period, and in particular there were significant increased costs for capital expenditure.

A small number of new service initiatives were also established using the specialist Budget 19 funding. Some examples include:

- managed withdrawal services across the South Island
- new residential care beds in Hawke's Bay
- services across the Midland region, including support for people before and after they access residential care in Tairāwhiti and Lakes DHBs.

The Primary and Community alcohol and other drug funding in Budget 2019, once fully rolled out over its four-year period, will support the establishment of services in 10 locations. Investment has been focused on taking an outreach approach, based around peer support and brief intervention, but with flexibility to respond to local needs. The Ministry has invested in services in central Auckland (Haven Recovery Café), Taranaki, Capital & Coast and Hutt Valley DHBs. The Ministry is currently negotiating with two further DHBs, and a further \$1m is available in the 21/22 and 22/23 financial years.

Te Ara Ora, a community-based methamphetamine harm reduction initiative, has been established in the Northland region. It enables an integrated approach across health, Police and the community, with a kaupapa Māori focus, to reduce drug-related harm and support priority populations to have better health, social and justice outcomes. Since its launch in October 2017, the programme has supported more than 2300 people. Budget 2019 investment supported the continuation of this initiative.

He Ara Oranga recognised that the current alcohol and other drug service landscape was not meeting the needs of New Zealanders, with limited variety in service delivery and a significant reliance on abstinence-based, episodic support such as residential care. Budget 2019 was therefore intended as a stepping-stone. This included 'shoring up' the system we have and building momentum for widespread, transformative change by addressing acknowledged gaps (such as for community alcohol and other drug services). Further work was done to design an improved system that can fully respond to the challenges of alcohol and other drug harm and addiction. Significant

design work has been undertaken by the Ministry since that time. The implementation of a new system of care that provides better access to and choice of services requires both a reconfiguration of existing services, as well as additional funding.

Funding to address local surges of synthetic drugs

Shortly after making the legislative changes, the Government approved a time-limited funding to support local surge responses to acute harm situations caused by synthetic drugs. This was for \$2.15 million per annum from 1 July 2018 to 30 June 2022. Funding was allocated from the Acute Drug Harm Discretionary Fund (the Fund).

To date, \$2.4 million in funding has been committed for a variety of responses including:

- a recovery café in central Auckland providing support to people using synthetic drugs and experiencing homelessness and mental health issues;
- a Wellington-based multidisciplinary mobile crisis response team; and
- a local outreach and drop-in service, offering AOD and peer support in Taranaki.

The Fund has also supported an acute drug harm community of practice. This is a national network of alcohol and other drug and social organisations. This community of practice (coordinated by the New Zealand Drug Foundation) shares insights, trends, and innovative responses to reduce acute drug harm in their communities.

Funding has also been used to establish the Drug Information and Alert NZ (DIANZ) within the National Drug Intelligence Bureau. Launched by the Ministry of Health, Police and Customs in 2020, it is an early warning system for dangerous drugs and supported by a network of health professionals and social services. When something is identified that poses significant harm, DIANZ issues alerts and notifications at High Alert (www.highalert.org.nz) and via email.

Appendix 4: Police Initiatives underway before the Amendment

Prevention First operating model

In 2011, NZ Police introduced the Prevention First operating model that maintains a focus on resolving crime while emphasising the immediate and longer-term benefits of integrating prevention into all aspects of policing. It encourages police to look for every opportunity to prevent harm and reduce the risk of reoffending.

Prevention First enables police to respond effectively to offending and harm causing behaviours and recognising the need to change long-term crime and harm patterns. Prevention First focuses on the smart use of technology and targeting resources to the most significant crime problems.

Deployment efforts are directed towards the areas to have the greatest possible impact on demand and to address the underlying causes of crime and address the harm in communities.

Police report the six drivers of demand as:

- Alcohol
- Youth – Rangatahi
- Families – Whānau
- Roads
- Organised crime and drugs
- Mental health.

Prevention First also brings the victim to the centre of policing. All staff have been asked to provide a greater level of service and support to victims, which includes preventing re-offending and therefore re-victimisation. Empathetic interactions are employed to identify ways Police can make a longer term or more sustainable difference, either for that individual or for others who may end up in a similar position.

Rather than applying a 'one size fits all' approach, Prevention First is about understanding the issues that drive the behaviours that lead to offending. These issues can take more time to resolve, but the long-term benefits for the individual and communities greatly outweigh the cost. With support and restorative resolutions, people who want to can make better decisions and change their future.

Te Huringa o Te Tai- A whanau ora crime and crash prevention strategy

Te Huringa o Te Tai builds on the Prevention First approach with a focus on keeping Māori from entering the criminal justice system and addressing the underlying causes of offending. Set within the framework of Police's Prevention First Operating model, Te Huringa o Te Tai focuses Police's effort around three pou:

- people and mindset
- effective initiatives and improved practice
- effective partnerships.

Reframe – Improving frontline practice for better resolution outcomes

NZ Police is redefining its end-to-end Resolutions Framework to make the framework more consistent, transparent and accountable. The reframe strategy is underpinned by four principles:

- humanity and fairness

- informed decision-making
- supported resolutions as the first choice, and
- strengthened partnerships.

Reframe is a multi-year initiative that is focused on achieving:

- Appropriate outcomes for those who have been harmed and those who cause the harm including:
 - More equitable outcomes for Māori, women and minority groups regionally across NZ
 - People who have been harmed feel safe and heard
 - Reduced risk of future harm
 - Improved public trust and confidence in the justice system.
- Improved Police contribution towards effective and timely case resolutions including:
 - Improved evidential quality
 - Improved contribution to judicial confidence
 - Improved public trust and confidence in the justice system
 - Less rework.

Te Pae Oranga Iwi Community Panels

Te Pae Oranga Community Panels began in 2013 and are a way that Police and iwi and other Māori partners deal with crime and prevent reoffending. It's an approach that holds offenders accountable while also helping them to address problems they are facing. It is available to people of all ethnicities if they are 18 years and over.

The following criteria must be satisfied:

- The offence is supported by evidential sufficiency (refer Solicitor General's Prosecution Guidelines)
- The participant must:
 - be 18 years or over
 - admit responsibility for the offence and agree to participate
- The offence must:
 - carry a penalty of 6 months imprisonment or less, or
 - be Possess/Uses Utensils (codes 3185, 3284 or 5985), or
 - be a non-qualifying offence approved for an exemption (see below)
- The offence must not have arisen out of:
 - family violence-related offending
 - driving charge with mandatory disqualification
 - firearm charge
 - second-hand dealer offences.

- The participant must not:
 - have active charges being pursued through the Court

Te Pae Oranga is mainly for people whose offending is related to underlying issues and who need support to get their lives back on track. The model is designed to help them overcome problems like addiction, abuse, financial stress and difficulties getting employment or education. Te Pae Oranga is available to people of all ethnicities and from all walks of life. It has a strong restorative justice element and victims are encouraged to take part in the process and its outcomes.

The panel helps the person who has been referred to make a plan to put things right and help everyone who takes part. The participant's plan can include actions such as:

- getting support to quit drugs and alcohol
- getting a driver licence, a job or training
- doing an anger management course
- paying for damage (reparation)
- hearing how victims were affected and apologising to them.

The provider stays in touch as the participant works through their plan. They tell Police if the person completes it. If they do, Police take no further action. Details about why the person was referred stays on Police records, but notes the participant successfully completed Te Pae Oranga.

If a person referred to Te Pae Oranga does not meet the panel or fails to complete their plan, Police will consider whether to proceed with prosecution.

Adult Diversion

Adult Diversion is a Police-managed, post-charge resolution pathway, enabling some offences to be dealt with in an alternative manner to prosecution.

The primary purposes of diversion are restoration and rehabilitation. Therefore, diversion is typically accompanied by agreed conditions that enable an offender to make amends for harm caused, and/or to receive the help and support they require to address the underlying conditions of their offending. In its utilisation of specialist service provision, diversion is therefore (in part) a process for the administration of supported resolution within the post charge environment.

All cases can be considered for diversion, although there are specific offender and offence-specific considerations to be taken into account in determining whether its use is appropriate in a specific instance. Considerations include:

- offender factors (such as the nature and extent of an individual's criminal history, whether diversion has been utilised previously, acceptance of full responsibility, and voluntary agreement to participate in the diversion process)
- offence factors (such as severity, nature, and characteristics)
- the views of the victim as to the use of diversion (when a victim is involved).

These collective considerations enable Police to administer diversion through the lens of the Solicitor General's Prosecution Guidelines, the 'public interest test' element. We note that all police resolutions already rely on the 'evidential test' being met, and so any deficiency here would result in the withdrawal of a case, not an alternative resolution response. On the basis of public interest

considerations, diversion has therefore typically been, or is, utilised as a response to lower levels of offending.

The Diversion Scheme is managed by the Police Prosecution Service, on behalf of Police, and is integrated within the prosecutorial area of the resolution process. In instances where a case may be suitable for diversion, a Prosecutor will advise the court of the need to adjourn so as to enable an assessment to be made. Then subsequently, if diversion is a viable option, further adjournment will be sought to enable the individual to undertake the activities outlined in their diversion agreement.

Diversion conditions will be relevant to the nature of the specific offending, and will vary from case to case, but may include one or more of the following:

- making an apology to the victim or victims
- reparation of expenses incurred by the victim as a result of the offending
- restoration of harm caused through work in the community
- a Restorative Justice conference (often) involving the victim
- referral to support services (eg, educational programmes, counselling, addiction treatment).

In situations where diversion conditions are successfully completed, a prosecutor will make a request to the court to dismiss the charges. Where diversion is not successfully completed, however, the case will progress through its normal resolution pathway.

[AWHI](#)

Alternative Pathways for Help Intervention. AWHI is an interactive pdf which allows Police officers to refer people in need of support directly to local agencies who can help them. AWHI referrals are made with the consent of the person and can cover a variety of social issues. AWHI was first developed in the Bay of Plenty district as a way for Police to help people address issues which, if left unattended, could lead them into offending, reoffending or victimisation. It is currently in eight out of the 12 Districts and is in the process of being rolled out nationally.

[Changes to Police Operational Instructions concerning personal possession/use of methamphetamine](#)

In July 2019, Police Instructions were changed to expand the types of offending that are eligible for a Pre-charge Warning (now Formal Warning) or a Te Pae Oranga referral. This change meant that personal possession and use of methamphetamine or a drug utensil were eligible for the formal warning pathway.

Appendix 5: Drug seizures 2016 to May 2021

Seizure volumes

Total

*2021 only includes data from January to May

TABLE 9. METHAMPHETAMINE ANNUAL SEIZURE QUANTITY (KILOGRAMS)

Year	Customs	Police	Total
2016	390	551	941
2017	427	50	477
2018	273	27	300
2019	1,231	616	1,846
2020	273	31	304
2021*	333	7	340

TABLE 10. CANNABIS HEAD/LEAF ANNUAL SEIZURE QUANTITY (KILOGRAMS)

Year	Customs	Police	Total
2016	1	557	559
2017	4	535	539
2018	111	781	892
2019	4	511	515
2020	2	762	764
2021*	3	341	343

TABLE 11. SYNTHETIC CANNABINOID PLANT MATERIAL ANNUAL SEIZURE QUANTITY (GRAMS)

Year	Customs	Police	Total
2016	71	185,382	185,453
2017	1	51,233	51,234
2018	7	37,551	37,558
2019	0	13,229	13,229
2020	0	9,062	9,062

TABLE 12. SYNTHETIC CANNABINOID POWDER ANNUAL SEIZURE QUANTITY (GRAMS)

Year	Customs	Police	Total
2016	22,748	1	22,749
2017	11,449	2,028	13,477
2018	6,239	0	6,239
2019	10,192	48	10,240
2020	6,968	0	6,968

TABLE 13. MDMA ANNUAL SEIZURE QUANTITY

Year	Customs		Police		Total	
	Powders (Kg)	Tablets/Capsules	Powders (Kg)	Tablets/Capsules	Powders (Kg)	Tablets/Capsules
2016	9	7,947	2	324	12	8,271
2017	39	4,407	1	1,631	40	6,037
2018	88	23,115	11	1,222	99	24,337
2019	684	6,764	8	3,332	692	10,096
2020	298	3,374	10	6,160	308	9,534
2021*	24	2,421	2	6,212	26	8,633

Wastewater testing

TABLE 14. WASTEWATER TOTAL LOAD (GRAMS)

Date	Methamphetamine	MDMA	Cocaine
December 2018	12,214	3,739	642
January 2019	14,546	4,168	730
February 2019	14,021	6,018	953
March 2019	13,336	6,018	894
April 2019	14,167	4,735	677
May 2019	13,048	4,563	616
June 2019	16,906	8,852	1,081
July 2019	16,862	10,380	1,025
August 2019	14,787	7,604	903
September 2019	11,339	8,114	1,000
October 2019	14,927	8,899	1,214
November 2019	13,698	8,771	1,290
December 2019	13,354	8,824	1,393
January 2020	12,380	8,440	919
February 2020	14,836	11,834	912
March 2020	18,909	9,473	693
May 2020	10,262	6,948	128
June 2020	9,440	7,217	88
July 2020	10,612	8,720	367
August 2020	13,402	7,304	203
September 2020	13,682	7,273	669
October 2020	12,902	9,538	519
November 2020	13,156	10,959	428
December 2020	11,552	8,731	416
January 2021	9,513	3,856	337
February 2021	11,011	4,311	427
March 2021	11,838	5,211	729
April 2021	10,221	2,740	606

TABLE 15. SEIZURE FREQUENCY

*Number of Synthetic Cannabis Seizures for Supply
(56 grams or more)*

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	4	3	5	7	2	4	3	7	4	4	5	1	49
2019	1		3	2	1	2	4	1	1	1	1	2	19
2020	1		2		3	5			1	2	1	1	16
2021			2	3									5

*Number of Synthetic Cannabis Seizures for Personal Use
(Less than 56 grams)*

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	20	28	21	26	45	30	31	28	27	23	20	18	317
2019	33	14	14	22	11	13	11	17	8	5	11	11	170
2020	8	9	11	10	16	9	3	3	7	6	7	6	95
2021	4	2	7	12									25

*Number of Cannabis Seizures for Personal Use (Less
than 28 grams)*

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	286	304	461	639	630	458	468	483	414	386	421	458	5,408
2019	346	357	428	611	675	544	546	513	464	477	390	456	5,807
2020	473	406	464	770	833	660	460	436	455	349	292	403	6,001
2021	248	246	365	471									1,330

Number of Cocaine Seizures for Personal Use (Less than 5 grams)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	5	4	2	1	2	2	3	3	2	1	4	4	33
2019	6	5	7	7	3	2	5	9	5	6	7	8	70
2020	9	10	2	5	4	7	2	7	7	8	5	2	68
2021	8	3	1	8									20

Number of GHB/GBL Seizures for Personal Use (Less than 56 grams)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	12	5	8	4	5	9	12	7	2	4	8	6	82
2019	6	6	4	4	12	6	7	6	4	2	12	5	74
2020	3	4	7	7	12	12	15	12	11	10	19	15	127
2021	7	9	10	11									37

Number of MDMA Seizures for Personal Use (Less than 5 grams or 100 tablets)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	21	14	19	18	11	15	9	21	14	15	15	35	207
2019	31	19	13	22	32	22	23	29	20	24	28	62	325
2020	46	35	30	24	28	24	29	31	41	39	21	43	391
2021	23	17	19	13									72

*Number of Methamphetamine Seizures for Personal Use
(Less than 5 grams)*

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2018	169	146	172	149	182	181	166	198	139	155	187	179	2,023
2019	158	140	170	197	238	187	203	222	214	250	214	180	2,373
2020	222	183	208	274	182	215	175	148	153	135	106	131	2,132
2021	102	97	113	138									450

2020 data is provisional and subject to change.

2021 data is year to date 1 January 2020 – 30 April 2021 and provisional and subject to change.

Methamphetamine and cocaine data does not include liquid or pill form.

Cannabis is head/leaf only.

Police Seizures only.

Appendix 6: Acute Drug Harm Discretionary Fund agreed by Cabinet in 2018

In December 2018, Cabinet [CAB-18-MIN-0620 refers] approved a time-limited discretionary fund of \$2.15 million per annum from 1 July 2018 to 30 June 2022 to support local surge responses to acute harm situations caused by synthetic drugs.

This funding was part of a package of solutions implemented in response to the synthetic cannabinoid crisis which caused significant harm in New Zealand. Acute drug harm is defined as a subset of drug harm that is categorised by short-term harms, often geographically isolated, in response to emerging substances and/or adverse reactions to a particular drug. This can also include serious rapid-onset medical events.

Based off the rapid escalation of the synthetic cannabinoid crisis, the Fund aims to provide urgent funding to support flexible and rapid responses, where need is identified (for example via increases in emergency department presentations). The Fund was intended to support communities to address sudden or serious increases in synthetic-related acute drug harm, such as overdose, other medical incidents, or deaths. It is not intended in cases where chronic drug harm is occurring (ie, when dependency in the community is evident).

Cabinet agreed the Fund was to:

- enhance the New Zealand Drug Foundation's work with drug-taking communities to develop and disseminate messaging
- provide primary prevention and local messaging, led by public health units or other community services/non-governmental organisations (NGOs), and informed by messages developed by the New Zealand Drug Foundation
- provide brief interventions, locally and/or within emergency departments for people presenting with synthetic drug-related harm, provided by district health boards (DHBs) or NGOs
- support local, more mobile addiction treatment services, provided by DHBs and/or NGOs
- provide social, employment and/or housing support, to enable people who have experienced harm to make a lasting change in their lives, following clinical intervention
- provide social managed withdrawal (including detoxification). Clinical experience shows that the detoxification period for synthetic drugs can be longer, and therefore places additional pressure on detoxification services.

At present, the Fund is administered by the Ministry of Health and is intended to be readily accessible when needed.

Current State – as at 8 July 2021

To date, \$2.4 million in funding has been committed for a variety of responses. Examples include:

- a crisis recovery café in central Auckland providing support to people using synthetic drugs and experiencing homelessness and mental health issues
- a Wellington-based multidisciplinary mobile crisis response team
- a local outreach and drop-in service, offering AOD and peer support in Taranaki.

The Fund has also supported an acute drug harm community of practice. This is a national network of over 200 people from a range of AOD and social organisations. This community of practice (coordinated by the New Zealand Drug Foundation) shares insights, trends, and innovative responses to reduce acute drug harm in their communities.

More info here: <https://www.drugfoundation.org.nz/info/acute-drug-harm/community-of-practice/>