Safer drug laws for Aotearoa New Zealand

Evidence to inform regulatory change

Te Puna Whakaiti Pāmamae Kai Whakapiri
New Zealand Drug Foundation

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Foreword

Fifty years ago, 87 Members of Parliament unanimously passed the Misuse of Drugs Act into law. It is difficult to imagine that any of them would consider what has transpired since to be anything but a failure.

In fact, the issues that lawmakers felt they were responding to in 1975 might seem quaint compared to the state of chaos we find ourselves in today.

Substance use disorder and other acute drug harms have increased, with fatal overdoses rising to a rate of almost three per week in 2024, driven largely by opioids and mixing substances.

We are starting to see the domestic impacts of an increasingly volatile and toxic global drug supply, with deaths from potent new psychoactive substances such as nitazenes appearing in Aotearoa New Zealand coronial data for the first time amid fears that we are woefully unprepared for more widespread adulteration.

Criminalisation has done nothing to deter drug use – in fact, the latest data shows drug use is diversifying and trending upwards. Instead, this approach has caused immeasurable harm, putting tens of thousands of people through the justice system and leaving them with the severe lifelong impacts of a criminal conviction.

The impacts on Māori in particular have been devastating – making up more than half of those imprisoned for drug offences in 2023 and suffering fatal overdose at twice the rate of non-Māori.

The Misuse of Drugs Act has only served to compound all of these harms; planting deep-seated stigma, preventing people from seeking help, and outlawing many of the interventions that could help.

It is clear that without change, things will get worse. Despite this, our drug laws remain a political hot potato, and moments of progress have been fleeting amongst 50 years of policy paralysis.

Aotearoa New Zealand was the first country to establish a national legal needle exchange programme in 1988, a move that is widely credited with keeping our HIV prevalence among the lowest globally. The Law Commission's landmark 2011 review of the Misuse of Drugs Act provided a measured pathway forward, but most of its recommendations remain unimplemented. The Psychoactive Substances Act 2013 was a promising, evidence-led response to concerns with 'legal highs', but quickly became hamstrung to the point of uselessness.

An attempt in 2019 to clarify when Police should use discretion, led to a reduction in convictions, but has worsened the inequity gap for Māori.

More recently, the establishment of a legal drug checking regime provided the first glimpse of world-leading harm reduction legislation since 1988, showing that innovation and change is possible.

This report, released on the 50th anniversary of the Misuse of Drugs Act, attempts to set a pragmatic path forward. It collates a wide range of evidence: from the impact of the Misuse of Drugs Act over the last 50 years, to people's first-hand experiences of drug harm, to the latest international evidence from jurisdictions who have attempted law reform.

Its recommendations do not purport to contain all the answers. Instead, they represent a suite of well-evidenced approaches that we hope can open the door to incremental change with broad, multi-partisan support.

It advocates for a more flexible and responsive legislative model that looks to the future and anticipates a more complex world; allowing for licensing of harm reduction interventions and creating a mechanism to carefully regulate substances on a case-by-case basis, where this is supported by evidence – at arm's length from political pressure. Amidst our current moment of global uncertainty, some will question whether now is the right time for drug law reform. This report argues that the turmoil we find ourselves in is precisely why we need drug laws that bring control, regulation, and are safer for all New Zealanders.

In a speech during the second reading of the Bill that would become the Misuse of Drugs Act, J. B. Munro, Member for Invercargill, remarked:

> *It is not easy to legislate for what is really a social problem; and coming through from all the submissions was the fact that the whole problem of drugs is much more a social problem than a criminal one. We have to recognise, I think, that New Zealand is not yet ready to accept the fact that perhaps there are other ways of trying to cope with some of these problems.*

Perhaps now, 50 years later, with five decades of hindsight, we are ready.

Sarah Helm
Executive Director | Tumu Whakarae
NZ Drug Foundation Te Puna Whakaiti Pāmamae Kai Whakapiri

Introduction

Fifty years before the release of this report, on Friday 10 October 1975, the Misuse of Drugs Act 1975 (MoDA) received Royal assent and officially became law. On 1 June 1977, the law came into force, solidifying the illegality of a wide range of substances and instituting a regime of control that has shaped our reality for half a century.

For many New Zealanders today, the approach enshrined in the MoDA is so entrenched that it may seem like the natural – and only – approach that we can take as a country. But this is not true. As we will outline, drug laws like the MoDA are not the natural evolution of history, but rather a result of global historical contexts in which they appeared.

That the MoDA is 50 years old is not in and of itself a reason for change. As we will demonstrate, the overwhelming evidence shows that instead of achieving its stated aims, the MoDA has set the conditions for escalating drug harms in Aotearoa New Zealand while outlawing the very measures that could prevent them. That is not to mention the severe and wide-ranging harms that criminalisation itself has created and compounded.

Recent data shows worrying trends for drug harm in our country. It is clear that if we stick with the status quo, things will very likely get worse.

International and national context of the Misuse of Drugs Act 1975

Legislation controlling narcotics and medicines in Aotearoa New Zealand dates back to 1901, with early laws targeting substances such as opium, cocaine, and cannabis. International developments in the 1950s, led largely by the United States, pushed for a unified drug control framework, culminating in the 1961 Single Convention on Narcotic Drugs (Single Convention) (Armenta & Jelsma, 2015). Aotearoa New Zealand's laws evolved during this period, reflecting both changing international obligations and growing domestic use of a wider range of substances, though not at the scale seen in countries such as the United States. The Narcotics Act 1965 aligned Aotearoa New Zealand law with the first United Nations drug convention, which distinguished between medical and non-medical use of drugs (Law Commission, 2011) . Figure 1 presents some of the major developments in global drug control in the lead-up to the MoDA.

In the 1970s, drug use in Aotearoa New Zealand started to shift, with substances such as LSD and cannabis becoming increasingly popular. Reported drug crime rose, as did heroin importation, which proved harder to detect at the border than cannabis.

Between 1968 and 1973, the government established a committee chaired by Deputy Director-General of Health Geoffrey Blake-Palmer, to review drug

dependency and ensure domestic laws met international obligations under the 1961 Single Convention and the 1971 Convention on Psychotropic Substances (CoPS) (Law Commission, 2011). The committee consulted widely, commissioned research, and concluded that drug misuse should be understood as a health condition that was diagnosable and treatable.

Crucially, the committee noted several key points that remain true today – some of which are still lacking in our modern framework. These included recognition that:

- people who use drugs should be supported in their communities before there is a need for hospital-level treatment or that treatment should be offered at the earliest stage possible;
- the health system needs to be adequately resourced and joined up with other government services, to help people who experience harm;
- treatment should be provided by people with genuine interest in the wellbeing of people who use drugs, including by people with drug-use experience.

The committee also recommended a new single Act with a drug scheduling system and emphasised combining treatment and legal responses (New Zealand Board of Health, 1970). While not all recommendations were adopted, the main principles of the Blake-Palmer Committee's report influenced the Misuse of Drugs Bill, introduced in 1974 (Law Commission, 2011). These principles underpin the MoDA, which remains the foundation of Aotearoa New Zealand's drug control framework today.

After its enactment, the MoDA has been subject to a number of amendments. While many of these have been relatively small (for example, scheduling changes), there have been some more substantial changes. We present some of these in Figure 2.

Figure 1
Legislative history leading up to the Misuse of Drugs Act 1975

1901

Opium Prohibition Act

Prohibition of smoking of opium and importation of the drug in a form suitable for smoking.
The Police were granted powers to search Chinese premises without a warrant.

1927

Dangerous Drugs Act

New penalties for possession, manufacture, and importation. Mainly concerned with opium, but also included cocaine and cannabis.
Medicinal substance use permitted.
Aimed at bringing Aotearoa New Zealand in line with League of Nations policy.

1960

Dangerous Drugs Amendment Act

Cultivation of cannabis, opium poppy, and coca plants prohibited.
Increased penalties for supply – from maximum 12 months' imprisonment, to maximum 7 years for supplying to adults (14 years if supplying to anyone under 21).

1961

UN Single Convention on Narcotic Drugs

Covers cannabis, cocaine, opioids, and similar substances.
Drugs to only be used for medical and scientific purposes.

1965

Narcotics Act

Set out offences for import, export, manufacture, sale, distribution, use, and possession of narcotics. Mostly consistent with international legislation, bringing Aotearoa New Zealand in line with other signatories to the Single Convention.

1966

Narcotics Regulations

Set out licensing decisions regarding import, export, supply, administering, cultivating, or possessing various narcotics. Mainly applied to pharmacists and medical professionals.

1970

Narcotics Amendment Act

Minor changes – i.e., the name of a narcotic implicated in a crime was not allowed to be published by a court, and stealing and receiving narcotics was made an offence.

1971

UN Convention on Psychotropic Substances

Reiterated an updated list of drugs that should only be used for medical and scientific purposes.

UK Misuse of Drugs Act

Response to UN Convention on Psychotropic Substances.

1975

Misuse of Drugs Act

Classification system for different drugs (A, B, C). Many similarities to UK Misuse of Drugs Act.

Figure 2
Changes to Aotearoa New Zealand drug laws

1978

Misuse of Drugs Amendment Act

Greater powers for Police to detect importations.

1982

Misuse of Drugs Amendment Act

Changes to the way cannabis offences would be enforced. Preparations of cannabis were now Class B, while the cannabis plant remained Class C.

1987

Misuse of Drugs Amendment Act

Alongside the Health (Needles and Syringes) Regulations 1988, exemptions from liability were granted under the MoDA for possession of needles and syringes only. MDMA added to Schedule II, Class B. Cocaine changed from Class B to Class A.

1992– 1998

Six minor Misuse of Drugs Amendment Acts

Minor amendments regarding ministerial approvals, Police warrants, importing controlled drugs, precursor substances or utensils, classification of certain substances.

2011

Misuse of Drugs Amendment Act (No 2)

Reclassified ephedrine and pseudoephedrine from Class C to Class B. The second notable feature of the Act was that it created a "temporary class drug notice" for up to one year. Added new offences related to drug utensil distribution (pipes).

2013

Psychoactive Substances Act

Substances that were not already controlled under the MoDA could be deemed a psychoactive substance under the Psychoactive Substances Act.

2014

Psychoactive Substances Amendment Act

Revocation of already granted licences to sell approved substances. Animal testing banned.

2000

Misuse of Drugs Amendment Act

Minister of Health must establish an Expert Advisory Committee on Drugs.

2003

Misuse of Drugs (Changes to Controlled Drugs) Order

Methamphetamine rescheduled as Class A. Methcathinone added to Schedule II.

Misuse of Drugs (Classification of Ephedrine and Pseudoephedrine) Order

Pseudoephedrine and ephedrine medicines only available with a prescription.

2005

Misuse of Drugs Amendment Act

Classification system for different drugs (A new offence, to import/export precursor chemicals, added to the MoDA. Restricted substances class (Class D) added, and benzylpiperazine added as restricted substance (restrictions on age of sale to over-18s only).

2008

Misuse of Drugs (Classification of BZP) Amendment Act

BZP and other piperazines added as Class C.

2018

Misuse of Drugs (Medicinal Cannabis) Amendment Act

Medicinal cannabis made easier to be prescribed, legal defence allowed for those in possession of cannabis who require palliation.

2019

Misuse of Drugs Amendment Act

Amended section 7 of the Misuse of Drugs Act. Police were directed not to prosecute for possession of small amounts of drugs, and to take a health-centred approach, unless prosecution is in the public interest.

2021

Drug and Substance Checking Legislation Act

Drug checking legally sanctioned.

The case for investigating an alternative approach

In 2011 the Law Commission recommended that "The Misuse of Drugs Act 1975 should be repealed and replaced by a new Act, administered by the Ministry of Health" (Law Commission, 2011, p. 23). However, this much-needed reform has not happened.

Since the MoDA became law, global illicit drug markets have substantially changed, characterised by greatly increased supply and high rates of adulteration with new psychoactive substances (NPS).

Recent wastewater data suggests unprecedented levels of consumption of certain illicit drugs. Figures 3, 4 and 5 present the average consumption of methamphetamine, cocaine, and MDMA, based on wastewater analysis. For example, methamphetamine use in 2024 was the highest ever recorded, and 74% higher than the previous three years' average (New Zealand Drug Foundation, 2025b). At the same time, the NZ Drug Trends Survey has found that frequency of methamphetamine use among people who use methamphetamine has also increased. In 2024, 54% reported at least weekly use of meth, compared to 44% the previous year (Wilkins et al., 2024). More frequent use of methamphetamine is considered likely to increase the risk of harm.

Figure 3

Methamphetamine consumption per capita (mg/day/1,000 people) over time as detected in wastewater testing (New Zealand Police, 2025)

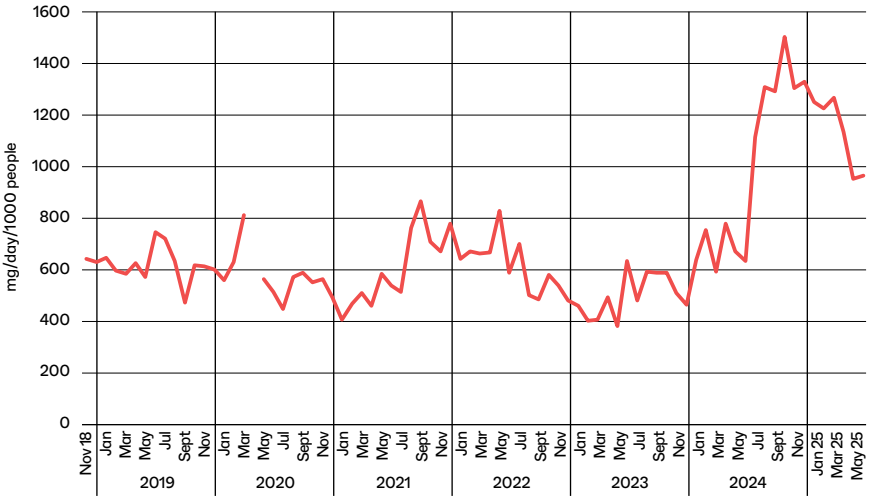


Figure 4

MDMA consumption per capita (mg/day/1,000 people) over time as detected in wastewater testing (New Zealand Police, 2025)

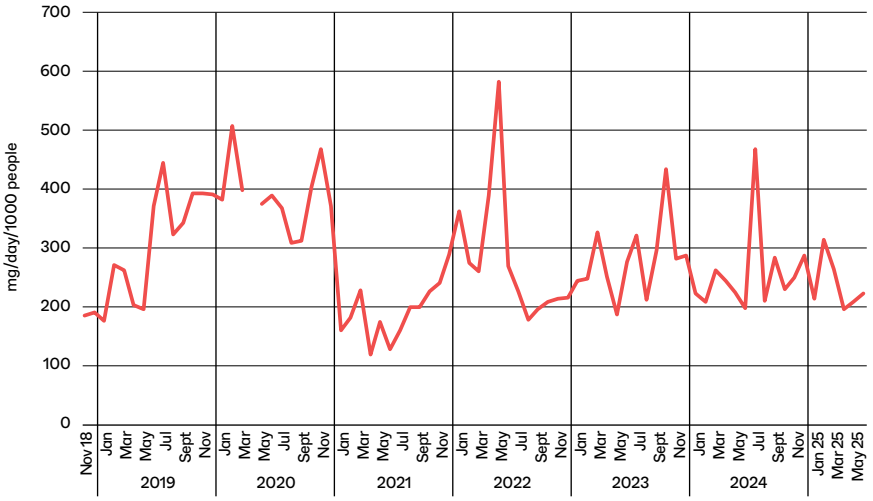
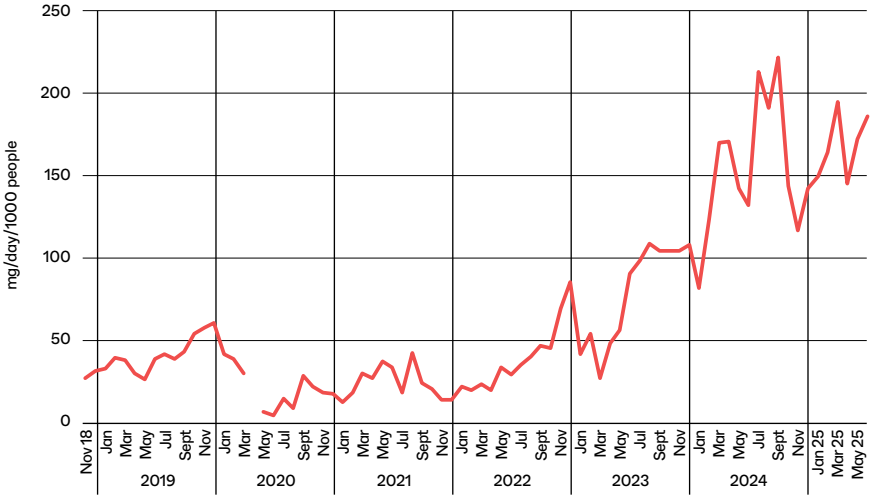


Figure 5

Cocaine consumption per capita (mg/day/1,000 people) over time as detected in wastewater testing (New Zealand Police, 2025)



Harsh legal penalties for possession, use, and supply of drugs have not only failed to reduce drug harms, but they have demonstrably worsened criminal justice, health, and social outcomes for New Zealanders. The momentum for this report came from recent statistics about drug outcomes, demonstrating the scale of harm. Our main drivers for undertaking this work included:

- **Increasing rates of fatal overdose**. Between 2016 and 2024, 1,295 people died of accidental drug overdose (New Zealand Drug Foundation, 2025a).
- **High incarceration rates and poor criminal justice outcomes, particularly among Māori.** In 2024, 5,690 people were charged, and 4,083 were convicted of drug offences. Nearly two thirds (64.4%; 2,629) of these convictions were for possession/use offences. Of people convicted of drug possession/use, nearly half (48.1%) were Māori – in raw numbers, there was a higher number of Māori than European New Zealanders who received such a conviction, despite a much smaller population size (Ministry of Justice, 2025b).
- **Continuously unmet, and growing, substance use disorder (SUD) treatment needs.** In 2021–23, 11.2% of adults (around 470,000) were at moderate or high risk of problems/harms from illicit substance use, a significant increase compared to 2016/17 when 10.1% (around 390,000) were at moderate or high risk. Correspondingly, 8.4% of adults (around 350,000 people) had an unmet need for mental health and addiction services in 2021–23, compared with 4.9% (around 190,000 people) in 2016/17 (Ministry of Health, 2024a). He ara oranga: Government inquiry into mental health and addiction describes how fear of the long-term consequences of a conviction for a drug offence "creates a significant barrier to a drug user seeking support for recovery" (New Zealand Government, 2018, p. 175).
- **Increasing harm to Māori.** In fact, before the MoDA, Māori were not considered substantially affected by drug use. The 1970 Board of Health report stated:

  > *Excluding the Chinese opium smokers, the large majority of drug abusers who now come to official notice in New Zealand are New Zealand born Europeans. While a few Maoris, other Polynesians, Chinese, and European immigrants are involved, their numbers are at present small and proportionately not significantly higher than in the population as a whole.* (New Zealand Board of Health, 1970, p. 28)

- **A growth in the volume and toxicity of the drug supply.** Unregulated illicit drug markets mean the presence of adulterants in drugs is impossible to eliminate (Csete et al., 2016). Illicit markets actively evade law enforcement and border controls by creating new and more potent psychoactive substances. These substances mimic or adulterate more

common illicit drugs, but are easier to clandestinely manufacture or transport by virtue of being active in smaller volumes.

There is now international expert consensus (Csete et al., 2016) that health-based alternatives to criminalisation should be sought to improve health and human rights outcomes of global communities, and especially marginalised groups. From a purely human rights perspective, the same consensus is reflected in the statements made by the United Nations High Commissioner for Human Rights, who urged for a change of approach to drugs: "Criminalisation and prohibition have failed to reduce drug use and failed to deter drug-related crime. These policies are simply not working – and we are failing some of the most vulnerable groups in our societies" (United Nations, 2024). This keeps many people in a cycle of crime, where a prior conviction restricts them from full social participation, including the ability to enter sustainable employment.

Aotearoa New Zealand's legal system and criminal justice practices have also come under scrutiny at the Fourth Universal Periodic Review process at the Human Rights Council in Geneva. Member states noted the disproportionately high incarceration rates of Māori (Human Rights Council, 2024). In fact, Māori represent 52.4% of the prison population in Aotearoa New Zealand (Ara Poutama Aotearoa Department of Corrections, 2024). Over the last ten years, 19,915 Māori have been convicted of drug offences (Ministry of Justice, 2025b).

Disproportionate criminal justice impacts from Aotearoa New Zealand's drug laws are also felt by people with neurocognitive conditions and disabilities, who have much higher prevalence of illicit substance use and SUD. A 2020 discussion paper from the Chief Science Advisor for the Justice Sector (Lambie, 2020) cited data on the striking overrepresentation of people with traumatic brain injury (TBI), foetal alcohol spectrum disorder (FASD), communication disorders, dyslexia, ADHD, intellectual disability, and autism spectrum disorder (ASD) in the criminal justice system. Data shows that these conditions also increase the risk of substance use by way of self-medicating, or to cope with poor social adjustment.

Calls for legislative reform have followed a surge in overdose deaths. Between May 2017 and February 2019, synthetic cannabinoids were implicated in at least 64 Coronial cases, with a sharp spike in Tāmaki Makaurau Auckland in late 2017. In 2022, Coroner Mills held a joint inquiry into five of these deaths, convening an 'expert hui' to examine findings and recommendations. The inquiry highlighted that there were disproportionate numbers of Māori and Pasifika people who had experienced fatal overdoses. Experts at the hui also stressed the difficulty of regulating substances that constantly evolve to evade the law.

The Coroner's report observed that the Law Commission's review was:

> *over 10 years old and while some of its recommendations have been implemented, the evidence provided to my inquiry suggests that the Psychoactive Substances Act 2013 and the Misuse of Drugs Act 1975 are*

> *not effective in regulating synthetic cannabinoids. Drug law reform involves complex social and legal considerations, which are beyond the scope of this inquiry. Given the time that has elapsed since the Law Commission report, and the issues identified in this inquiry, it may be appropriate for the government to consider undertaking a further review of this legislation.* (Mills, 2023)

There is also social appetite for change. Polling commissioned by the New Zealand Drug Foundation in June 2022 (n=1,499) demonstrated that there is strong social support for drug law reform. According to the poll, 61% of New Zealanders supported "removing penalties for drug use and putting in place more support for education and treatment" (vs. 34% who were not supportive of the statement). More specifically, 68% supported "rewriting the 1975 Misuse of Drugs Act and putting in place a health-based approach" (vs. 23% who did not support the statement) (New Zealand Drug Foundation, 2022, para. 2).

Purpose and structure of this report

While there is agreement that the current approach to drugs doesn't work, there is less clarity about what an alternative should be, and what could work for communities that are at risk of drug harm. For this report, we wanted to fill this gap by gathering different types of evidence. Following this process, we set out to synthesise this knowledge to develop a pragmatic set of recommendations for future drug law reform that are informed by evidence. We have structured this paper into five main chapters:

In **Chapter I** (*Misuse of Drugs Act 1975 in action*) we use national sources of data to examine the existing indicators of drug use and harm in Aotearoa New Zealand that have occurred under the MoDA. We look at a range of measures, including prevalence of substance use, various health (overdose, poisonings, and SUD) and criminal justice measures (convictions and charges for drug offences, driving under the influence of drugs), as well as some measures of the illicit market (primarily, drug seizures, but also the diversity of substances seized, including new psychoactive substances [NPS], and some limited social indicators, e.g., welfare payment receipt).

In **Chapter II** (*Law Commission review of Misuse of Drugs Act 1975*) we re-examine the momentous work of the 2011 Law Commission review (LCR). We describe some of the small adjustments to the MoDA that have taken place since the Law Commission's review. We then identify the areas where recently emerged circumstances and new evidence might have informed a different set of recommendations had they been available to the Law Commission in 2011.

In **Chapter III** (*Achieving hauora: Aspirations of people affected by current drug laws*) we present original research that we undertook with communities at risk of drug harm in Aotearoa New Zealand. We report on the results from a large survey and a series of workshops we ran in the months preceding the release of this report. These findings are central to providing insight into the needs and aspirations of people with lived experience, who have long been advocating for themselves and their community for better access to healthcare, less stigma and discrimination, and inclusion of their voices in policy making.

In **Chapter IV** (*Alternative options for drug control – lessons from other countries*) we present an overview of evidence from jurisdictions that have attempted drug law reform. We also consider how these lessons can apply to Aotearoa New Zealand, and how to maximise the benefits of these policies, while minimising any unintended consequences.

In **Chapter V** (*Te Tiriti o Waitangi and drug law reform*) we summarise the impacts of the MoDA on Māori. We also identify lessons from other jurisdictions that could help Aotearoa New Zealand maximise the benefits of undertaking rational drug law reform and minimise any unintended consequences for Māori.

Following these five chapters, we present a set of recommendations.

Legislative reform is only one part of a pragmatic response to drugs. No legislation alone will be able to eradicate drug harm in Aotearoa New Zealand. Therefore, legislative reform must go hand in hand with the provision of services that will support New Zealanders who need help with their substance use. We have recently released a discussion paper, *A health-based approach to drug harm in Aotearoa* (New Zealand Drug Foundation, 2024), which outlines some of the principles that could inform improving our health system's response to drugs.

In this report, we have specifically not focused on the economic or fiscal aspects of drug law reform. Instead, we have prioritised health, criminal justice, and social outcomes. We are aware of research being done currently in Aotearoa New Zealand on the economic aspects of drug policy, which can supplement the approach we have taken.

Chapter I.
Misuse of Drugs Act 1975 in action

It is often argued that, after 50 years, the MoDA has failed to meet its goals. In this chapter, we will try to evaluate this statement by looking at a range of outcomes.

Drug legislation does not exist in vacuum. There are a number of external factors, such as the evolution of the global illicit market, that influence various outcomes for people at risk of drug harm. While drawing clear-cut conclusions about cause–effect connections between these outcomes and any specific policy setting is challenging, we are basing this overview on the assumption that the MoDA is a major part of this context. In a sense, drug harms occur 'under the MoDA's watch', and it is therefore justified to evaluate the MoDA by looking at the outcomes of drug harms.

In this chapter we use a range of data sources, a large number of these coming from different government agencies and departments. While it was our intention to access as much long-term data as possible, for most measures we were only partly successful, due to limited availability of older data. In presenting our findings, we have used the longest data periods we were able to access, whenever the continuity of information appeared sufficient.

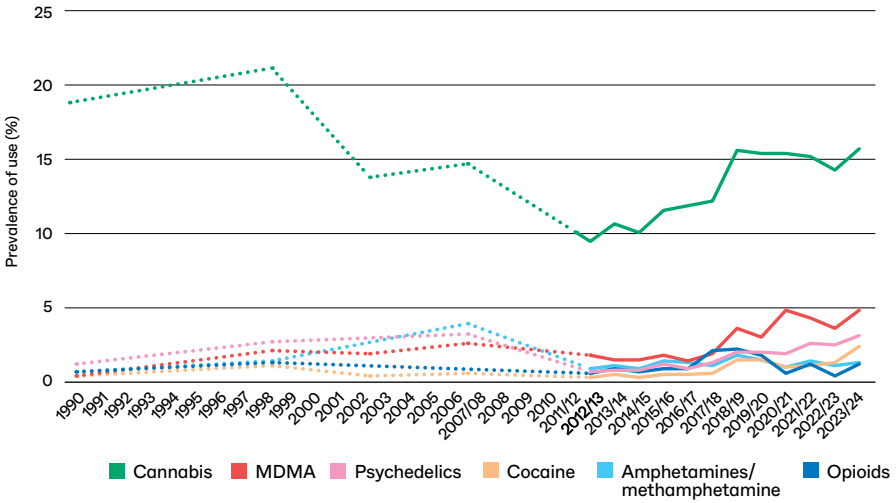
Prevalence of drug use among adults

While many people who use drugs do not experience harm, the clear aim of the MoDA is to prevent drug consumption. Even though drug use occurred in Aotearoa New Zealand for many decades before the MoDA was enacted, reliable prevalence data was not collected consistently until the NZ Health Survey began asking about past-year use in 2012/13. Earlier data mostly measured the prevalence of 'addiction' as defined by health authorities at the time.

Over time, drug use among adults has trended upward, with cannabis the most commonly used substance, followed by MDMA, psychedelics, and more recently, cocaine. The evidence shows that criminal penalties under the MoDA have not deterred drug use; from 2017/18 to 2023/24, use of cocaine, MDMA, and psychedelics has in fact increased.

Figure 6

Prevalence of past-year use of all drugs over time (adults 15+)*



**Figures are only available for the years 1990 (excluding cannabis), 1998, 2003, 2007/08, 2011/12 (cannabis only), and 2012/13–2023/24. The trend lines connecting the missing years represent estimates only. Dotted lines represent the periods with intermittent data collection.*

Sources for 1990 and 1998 figures: Ministry of Health (2001) and Field & Casswell (2021).
Source for 2003 figures (ages 13–64): Ministry of Health (2007).
Source for 2007/08 figures (ages 16–64): Ministry of Health (2010).
Source for 2012/13 figures onwards: Ministry of Health (2024b).

Prevalence of drug use among young people

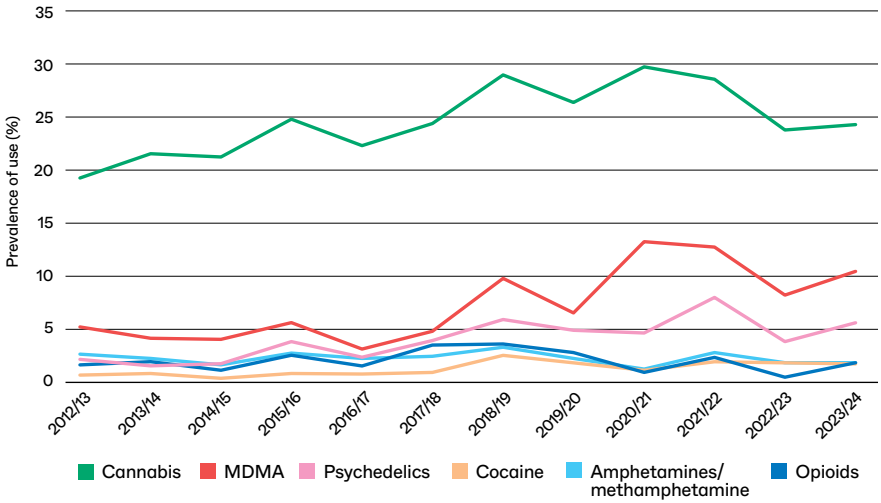
Drug use among young people (defined here as aged between 15 and 24) is also rising. Data is mainly limited to the NZ Health Survey, which has collected past-year substance use since 2012/13, broken down by age.

As with adults, cannabis is the most commonly used drug among young people, followed by MDMA and psychedelics, but prevalence is higher in the 15–24 age group.

Other research that examined drug use among secondary school students found that there had been a plateau of at-least-weekly cannabis use (from 6.5% in 2001 to about 4% in 2012, and no significant change between 2012 and 2019).

Figure 7

Prevalence of past-year use of all drugs over time (young people 15–24) (Ministry of Health, 2024b)



Availability, price, and potency of drugs

New Zealand Customs data on border seizures (from 2003) and Police data on local seizures (from 1999) confirm long-standing drug imports, with cannabis leaf, LSD, methamphetamine, MDMA, and cocaine consistently intercepted in large quantities.

Seizure data does not reveal the exact supply of drugs in Aotearoa New Zealand, but it shows clear shifts in the drug market, especially since 2010, with the arrival of NPS such as synthetic cathinones, synthetic cannabinoids, and potent opioids like nitazenes and non-prescribed fentanyl (see Figure 10).[1] Many of these substances are designed to mimic more common drugs while avoiding legal controls.

Despite strict laws, large amounts of drugs still cross Aotearoa New Zealand's borders. Wastewater testing shows widespread use of methamphetamine, MDMA, and cocaine across the country. Customs seizures have risen sharply, particularly since 2018.

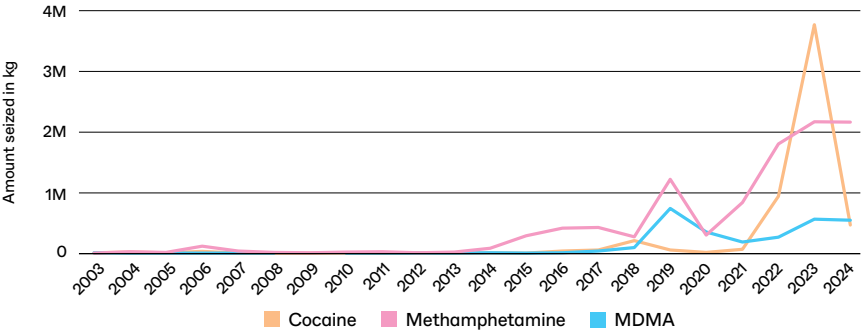
Table 1

Increase in Customs seizures of cocaine, MDMA and methamphetamine, and total amount seized between 2018 and 2024 (New Zealand Customs Service, 2025)

	Percentage increase in Customs seizures 2018–2024	**Total amount seized between 2018 and 2024 inclusive** (tonnes)
Cocaine	121%	5,563.29
MDMA	482%	2,767.01
Methamphetamine	701%	8,846.70

Figure 8

New Zealand Customs seizures of methamphetamine, cocaine and MDMA (kg) (New Zealand Customs Service, 2025)



Street prices of drugs

The table below demonstrates that the price of drugs available for sale in Aotearoa New Zealand has steadily decreased over time. Significantly, the price of heroin fell 81% between 2002 and 2024 (from approximately $1,100 per gram in 2002 to $200 per gram in 2024). The price of methamphetamine fell 55% (from approximately $800 per gram in 2002 to approximately $360 per gram in 2024).

Taking inflation into account, in real terms the price of methamphetamine fell 73.8% between 2002 and 2024.

Table 2

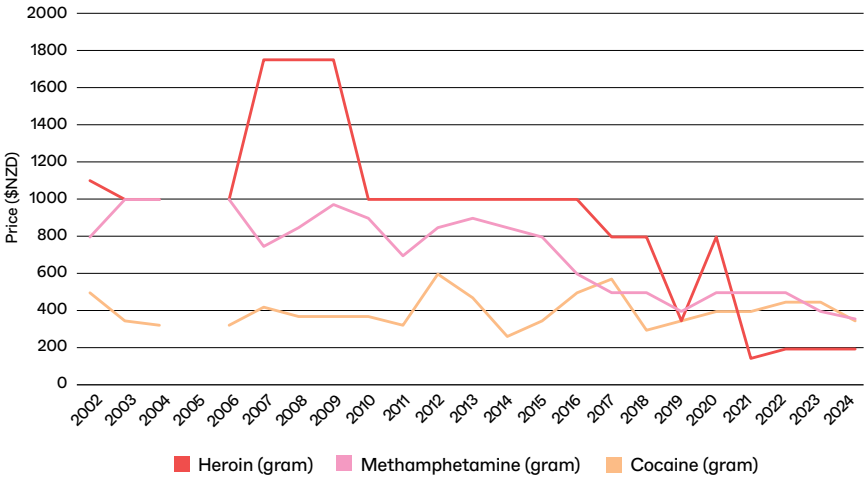
'Street price' ($) per gram of selected drugs over time (New Zealand Police, 2025)

Drug	Change in average or median $ value between 2002 and 2024		Decline in price between 2002 and 2024	Real-terms decline in price (taking inflation into account; Reserve Bank of New Zealand, 2025) between 2002 and 2024
	2002	2024		
Cannabis (gram/ tinnie/bullet)	$22.50	$20	11.1%	48.80%
Cocaine (gram)	$500	$350	30%	59.70%
Heroin (gram)	$1,100	$200	81.80%	89.50%
MDMA (tablet)	$85	$45	47.10%	69.50%
Methamphetamine (gram)	$800	$360	55%	74.10%

[1] Fentanyl is an opioid analgesic (pain reliever) that has been used in hospital settings for over 50 years to relieve pain after surgery, or alongside anaesthetics. It can also be prescribed to help patients with severe pain.

Figure 9

'Street price' ($) per gram of selected drugs over time (New Zealand Police, 2025)



New psychoactive substances

Many NPS were created in order to circumvent drug laws that control the supply and use of scheduled drugs. Many of them have been designed to mimic the effects of more common drugs such as MDMA or cannabis. Supplied from overseas, they initially avoid detection at the border (especially if they are substantially chemically different from scheduled drugs), or are unable to be seized due to being uncontrolled by legislation. By the time countries, including Aotearoa New Zealand, amend their laws to control NPS, overseas laboratories have already begun to amend the chemical structure to create a new and unregulated drug.

The two most commonly used and detected NPS groups in Aotearoa New Zealand are synthetic cathinones and synthetic cannabinoids. Others that are less commonly used, but have still been detected at our borders and by drug checking, include novel synthetic hallucinogens such as NBOMes, novel dissociatives including ketamine analogues, and novel potent opioids such as nitazenes.

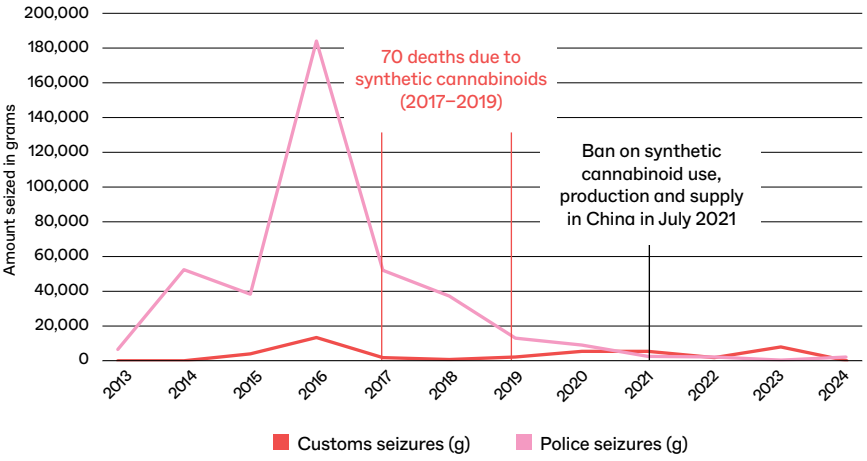
From 2010 onwards, New Zealand Customs began to systematically record and release information about seizures of NPS at our borders, such as cathinones and synthetic cannabinoids. For example, between 2015 and 2021,

Customs seized 30.3 kg of NBOMes and 4.37 kg of synthetic cannabinoids, and between 2021 and 2024, 7.18 kg of cathinones were seized.

Police recorded seizing various types of NPS from 2009 onwards, particularly synthetic cannabinoids and synthetic cathinones. The volumes seized by Police were far higher overall between 2009 and 2024 compared with Customs seizures at the border, suggesting that large quantities of NPS arrive across our borders undetected. For example, the highest volume of synthetic cannabinoids seized by Police in one year was 184.29 kg intercepted in 2016. That same year, Customs reported seizing just 13.3 kg. The highest recorded seizures occurred after synthetic cannabinoids were subject to a temporary class drug notice in 2011, after synthetic cannabinoids were restricted under the PSA in 2013, and after many synthetic cannabinoids were scheduled under the MoDA in 2019. This is not surprising given that prior to scheduling, these substances were not illicit. However, this points to a demand from domestic consumers that was met by international markets continuing to supply these substances, despite the risk of criminal penalties.

Figure 10

Synthetic cannabinoid-containing products (grams) seized by New Zealand Police and New Zealand Customs Service (2013–2024) (New Zealand Customs Service, 2025; New Zealand Police, 2025)



Health outcomes, including acute and chronic harms

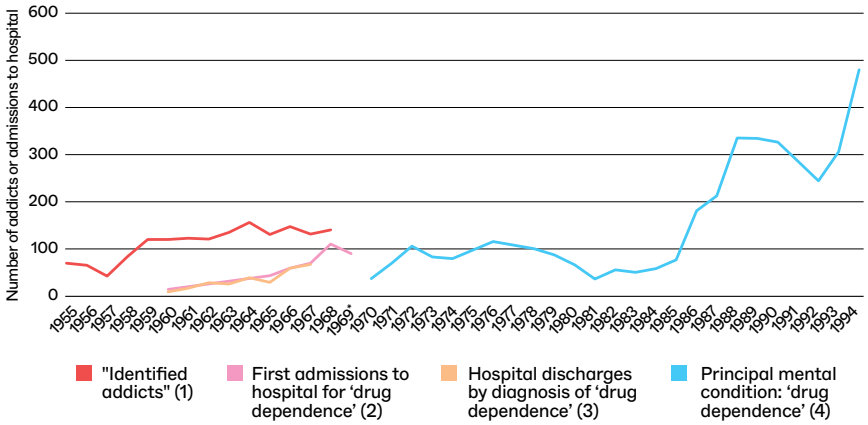
Substance use disorder or drug dependence

The most commonly reported drugs used prior to the enactment of the MoDA were opioids, specifically opium, heroin, morphine, and other opioid derivatives, as well as cannabis, and some types of prescription medications (New Zealand Board of Health, 1970; 1973). In 1967 the first 'identified addict' who reported cocaine use was noted in official statistics. That same year, there were 130 'identified addicts' who were reported to be dependent on an opioid. Figure 11 shows the changes over time.

From 1969 to 1974 the profile of people thought to be dependent on various drugs shifted: more men than women, and more people between 15 and 34 were reported as being admitted to hospital with a diagnosis of drug dependence. From 1978 to 1994, after the MoDA was enacted, the demographic profile shifted again, and the age group most admitted to hospital for drug dependence was between 25 and 34.

Figure 11

Number of people identified as having a diagnosis of drug addiction or dependence (1955–1994)

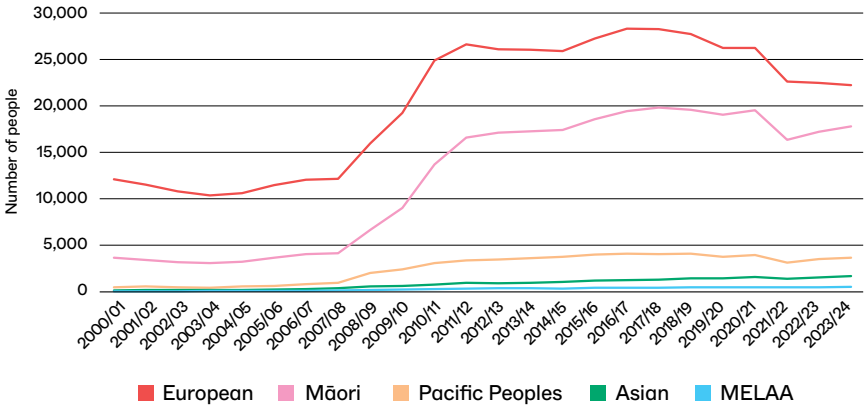


Note: The different lines on the graph are collated using different sources and methodologies, making direct comparisons challenging.

Sources:
(1): New Zealand Board of Health (1970), (2): New Zealand Board of Health (1973), (3): New Zealand Department of Health (1960), (4): Ministry of Health (1971–1994).

In later years, from 2001/02 to 2023/24, the number of people accessing specialist addiction treatment services increased from 16,070 to 45,180 – a 181% increase. There was an especially sharp increase from 2007/08 onwards, with greatest increases among MELAA (Middle Eastern/Latin American/African), Asian, and Māori New Zealanders – however, some of this reported increase may be the result of improvement in data collection (with the introduction of the PRIMHD data collection tool).

Figure 12
Number of people accessing specialist addiction treatment services by ethnicity (Ministry of Health, 2025b)



Note: Caution is required when comparing periods before and after 2008, due to implementation of PRIMHD data collection, which has improved the completeness of data.

As shown in Table 3, compared to all other ethnic groups, Māori are the one group that is overrepresented as clients of addiction services. This indicates the ineffectiveness of the current drug response to prevent harm to Māori.

Table 3

Ethnic groups as the proportions of the general population and of the population of people in addiction treatment (Ministry of Health, 2025b)

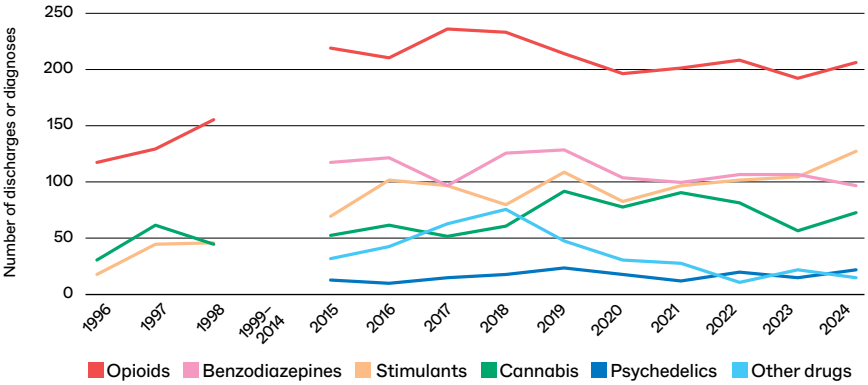
	% of population 2023	% addiction treatment population 2023/24
European	67.8%	49.0%
Māori	17.8%	39.2%
Pacific Peoples	8.9%	8.0%
Asian	17.3%	3.6%
MELAA	1.9%	1.1%

Hospitalisations due to drug poisoning

Over 540 people a year on average are treated in hospital for acute drug poisoning, suggesting a non-fatal overdose has occurred. These figures appear to have increased from the mid-1990s. Figure 13 presents changes in the number of drug poisonings over time. Opioids have accounted for the most hospitalisations (41.5%), followed by benzodiazepines (18.2%) and stimulants (17.8%). Stimulant poisonings have increased the most over the years: by 82.9% since 2015, and over six-fold since 1996.

Figure 13

Hospitalisations due to accidental drug poisoning

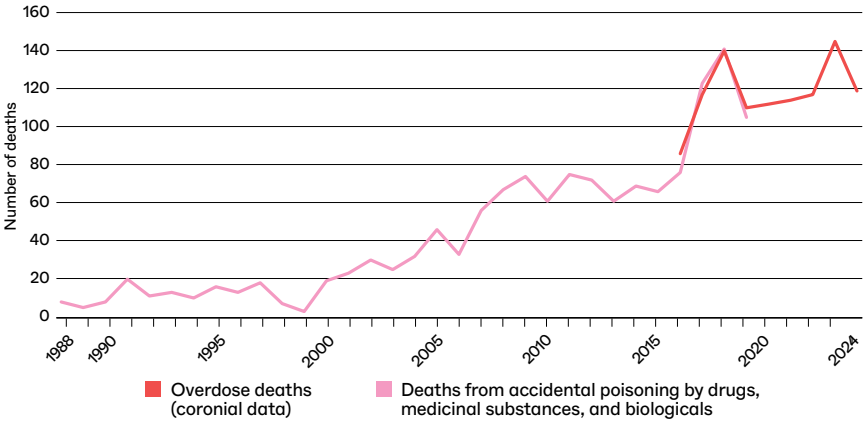


Source for data from 2015–2024: Ministry of Health (2025d).
Source for data from 1996–1998: Ministry of Health (2001).
No data available for 1999–2014.

Fatal overdose

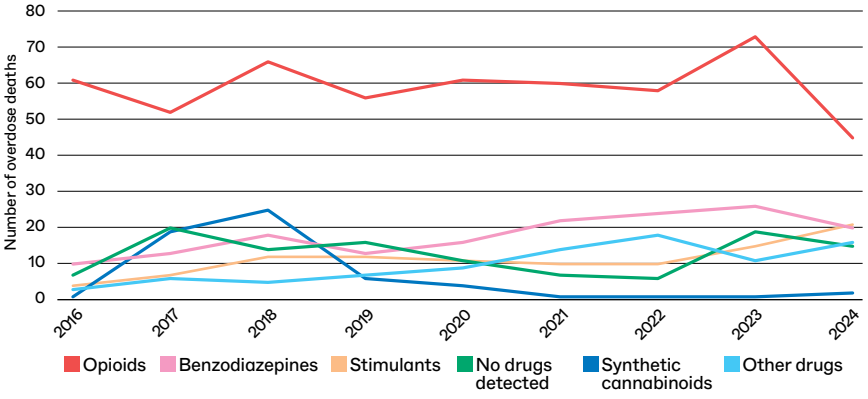
Since 1988, the earliest year this data is available, fatal overdoses have increased sharply (over 13 times). As with non-fatal overdoses, opioids are responsible for the highest number of fatal overdoses each year, with 532 total deaths from opioids occurring between 2016 and 2024. Fatal stimulant overdoses have increased in recent years, as have stimulant-related hospitalisations. Stimulants were identified as contributing to overdose fatalities in 4.7% of deaths in 2016, but in 2024 they were implicated in 17.6% of deaths. Figures 14 and 15 show these changes over time.

Figure 14
Accidental overdose deaths (1988–2024) (Office of the Chief Coroner, 2025)



Note: Mortality data on 'accidental poisoning by drugs, medicinal substances, and biologicals' provided by Health New Zealand.

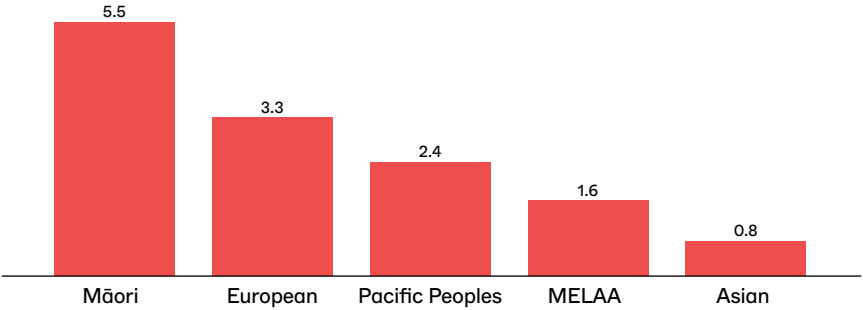
Figure 15
Overdose deaths by drug class (2016–2024) (Office of the Chief Coroner, 2025)



Māori suffer fatal overdoses at twice the rate of non-Māori. Between 2016 and 2024, the rate of fatal overdoses for Māori was 5.4 per 100,000 population. For non-Māori, the rate of fatal overdose was 2.7 per 100,000 population. Figure 16 presents the detailed ethnic population rates of fatal drug overdose in Aotearoa New Zealand.

Figure 16

Annual accidental overdose mortality rate (per 100,000 population aged 15 and over) 2016–2024 (Office of the Chief Coroner, 2025)



Blood-borne viral infections

Aotearoa New Zealand has had a very low rate of HIV incidence among people who inject drugs (five or fewer cases per year between 1996 and 2024).[2] In 1988 the New Zealand Needle Exchange Programme (NZNEP) was the first needle and syringe (NSP) programme in the world allowed to legally operate nationwide.

> *As in other countries, the ground for legislative reform was laid by activist action among the affected communities and their allies. In context of growing HIV/AIDS notifications, the provision of injecting equipment was positioned as a necessary, albeit politically contentious, public health priority.*
>
> (Harris, 2021)

This pioneering intervention has been widely credited as not only benefiting people who inject drugs. The early introduction of NSPs here is also considered a major contributor to the very low prevalence of HIV among the heterosexual

[2] The one exception is in 2002, when there were eight new diagnoses of HIV via injecting drug use.

population in Aotearoa New Zealand, which continues to this day (Saxton et al., 2020).

However, stigma associated with drug use, including injecting drug use, persists, and continues to be a barrier to people seeking help, indicating that continuous efforts are needed to sustain these beneficial effects of NSPs (Vidourek et al., 2019).

There is a scarcity of data for the numbers of people who have acquired other, more common, blood-borne viruses via drug injecting, such as hepatitis C and hepatitis B. A 2018 prevalence study estimated that among New Zealanders with recent injecting drug use, 53.9% (12,000) were living with a hepatitis C infection. This was higher than the estimated prevalence of 39.2% among people who had injected drugs worldwide. It was also higher than the estimated prevalence of hepatitis C among Australian people with recent injecting drug use (40.1%) (Grebely et al., 2019). These results are concerning, and suggest that more needs to be done to improve access to safer injecting equipment and information to communities at risk of infection.

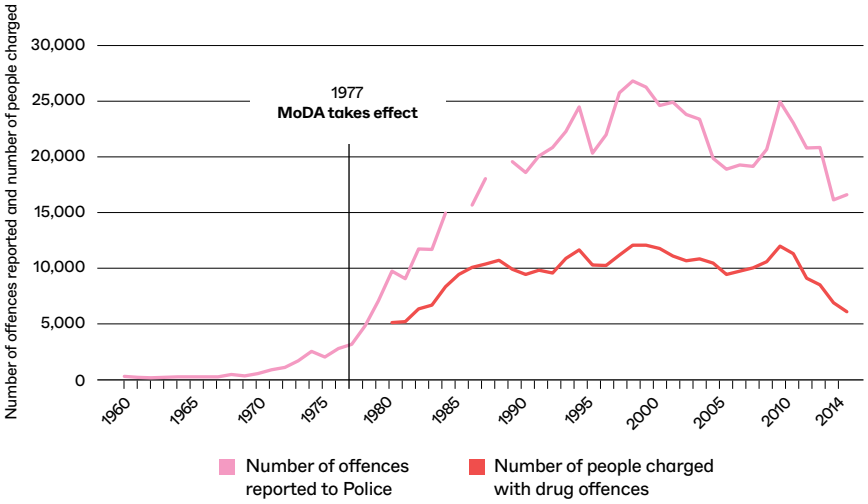
Criminal justice system outcomes

Charges for drug offences

The number of drug offences has increased significantly since 1960, and most significantly since 1977, when the MoDA was enacted. Figure 17 shows these changes over time. It is important to bear in mind that these figures are different to the data that the Ministry of Justice now reports on charges and convictions for drug offences (which is available from 1980), making direct comparisons challenging. However, both data sources show similar upward trends in the numbers of drug offences since 1977.

Figure 17

Number of drug offences reported to Police (1960–2014) and number of people charged with drug offences (1980–2014) (Ministry of Justice, 2025c; Newbold, 2016)



Convictions for drug offences

Between 1980 and 2024, more than 3,000 people were convicted of drug offences every year. Despite representing a much smaller proportion of the Aotearoa New Zealand population, in 2022 the number of Māori convicted overtook the number of NZ Europeans convicted each year.

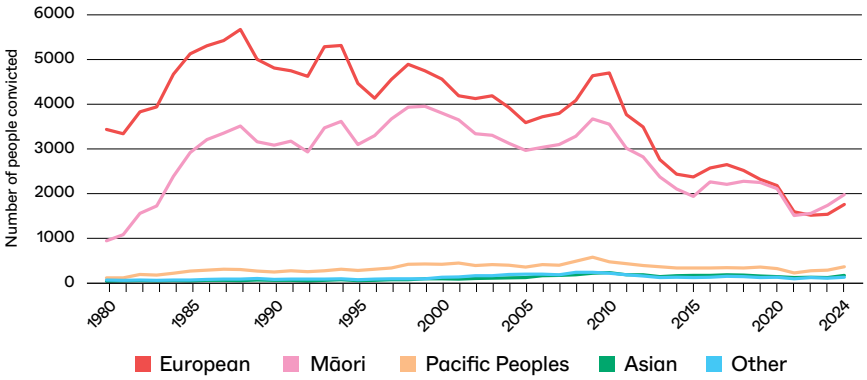
These figures are even more striking when we consider incarcerations. Since 2009, and for some years before that, Māori were incarcerated in greater numbers for drug offences than NZ Europeans. In 2023 Māori comprised more than half of imprisonments for drug offences (53.2%), despite accounting for just 17.8% of the population. Table 4 and Figure 18 present these differential impacts.

Table 4
Imprisonments and convictions for drug offences, population proportions

	% of population 2023	% of convictions for drug offences (2023)	% of imprisonments for drug offences (2023)
NZ European	67.8	43.9	38.2
Māori	17.8	49.6	53.2
Pacific Peoples	8.9	7.6	8
Asian	17.3	2.8	4.2
Other (including Middle Eastern, Latin American, African, Unknown)	3	4.4	5.8

Source for population data: Stats NZ (2024).
Source for conviction and imprisonment data: Ministry of Justice (2025c).

Figure 18
Number of people convicted of drug offences by ethnicity (Ministry of Justice, 2025c)

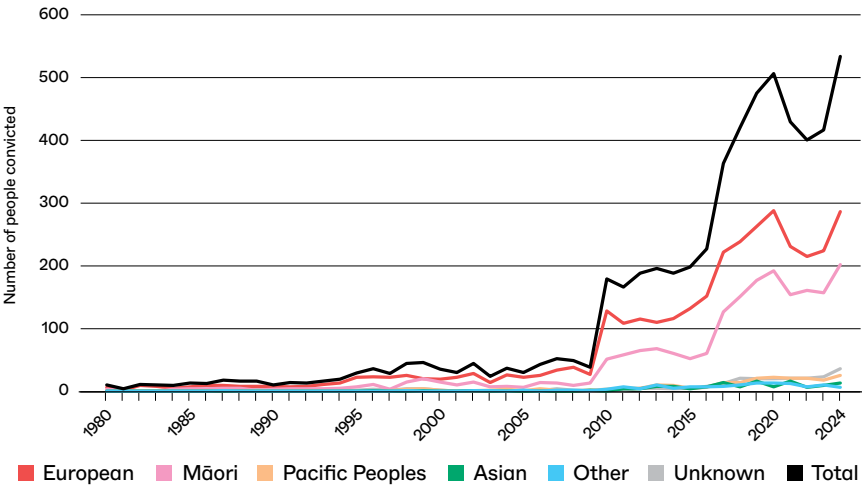


Convictions for driving under the influence of drugs

The numbers of people convicted of driving under the influence of alcohol far exceed those convicted of driving under the influence of drugs. However, the number of convictions for driving under the influence of drugs have been increasing over the last two decades. Figure 19 shows the changes in the number of convictions for 'drug driving' over time.

Similar to other harm measures we describe in this report, Māori have been disproportionately convicted of driving under the influence of drugs compared with other ethnicities. In 2023, for example, 37.6% of people convicted were of Māori ethnicity, despite comprising just 17.8% of the total population.

Figure 19
Number of people convicted of drug driving by ethnicity* (1980–2024) (Ministry of Justice, 2025c)



** 'Multiple ethnicity' information has been used in this chart. This means for each ethnicity a person is counted once per year (e.g., they may be counted in both NZ European and Māori). As some people have multiple recorded ethnicities, this will result in the sum of ethnicities being greater than the total number of people each year.*

Social outcomes

Assessments of the social, community, and familial harm that drugs cause in Aotearoa New Zealand have been carried out in recent years. The New Zealand drug harms ranking study (Crossin et al., 2023) evaluated a wide range of harms to individuals who use drugs, others around them, and society at large.

These included harm to communities (for example, a decline in social cohesion, or distortion of tikanga), environmental damage, and economic costs.

Crossin et al. (2023) ranked the most commonly used drugs in Aotearoa New Zealand in terms of their harms to an individual and to others, for the general population and youth. For both groups, alcohol was ranked the most harmful, followed by methamphetamine and synthetic cannabinoids. Some drugs that are currently scheduled as Class A under the MoDA ranked towards the lower end of the harm rankings, such as MDMA (ranked 17th on the list) and hallucinogens (psychedelics), ranked even lower at 21st.

The drugs considered to have the most impact on others reflect a range of societal and economic harms. For methamphetamine, synthetic cannabinoids, various opioid drugs, and alcohol, the impact can be expressed thorough a variety of outcomes. These include familial harm, for example child abuse or neglect, or intimate partner violence. Housing instability, drug-related debt, and imprisonment have all been suggested as contributors to intergenerational harm through economic hardship, psychosocial impacts, and family and community disconnection (Crossin et al., 2023). Figures 20 and 21 present the rankings for the general population and youth.

Figure 20

Drugs ranked in order of 'harm to self and others' score – overall population (Crossin et al., 2023)

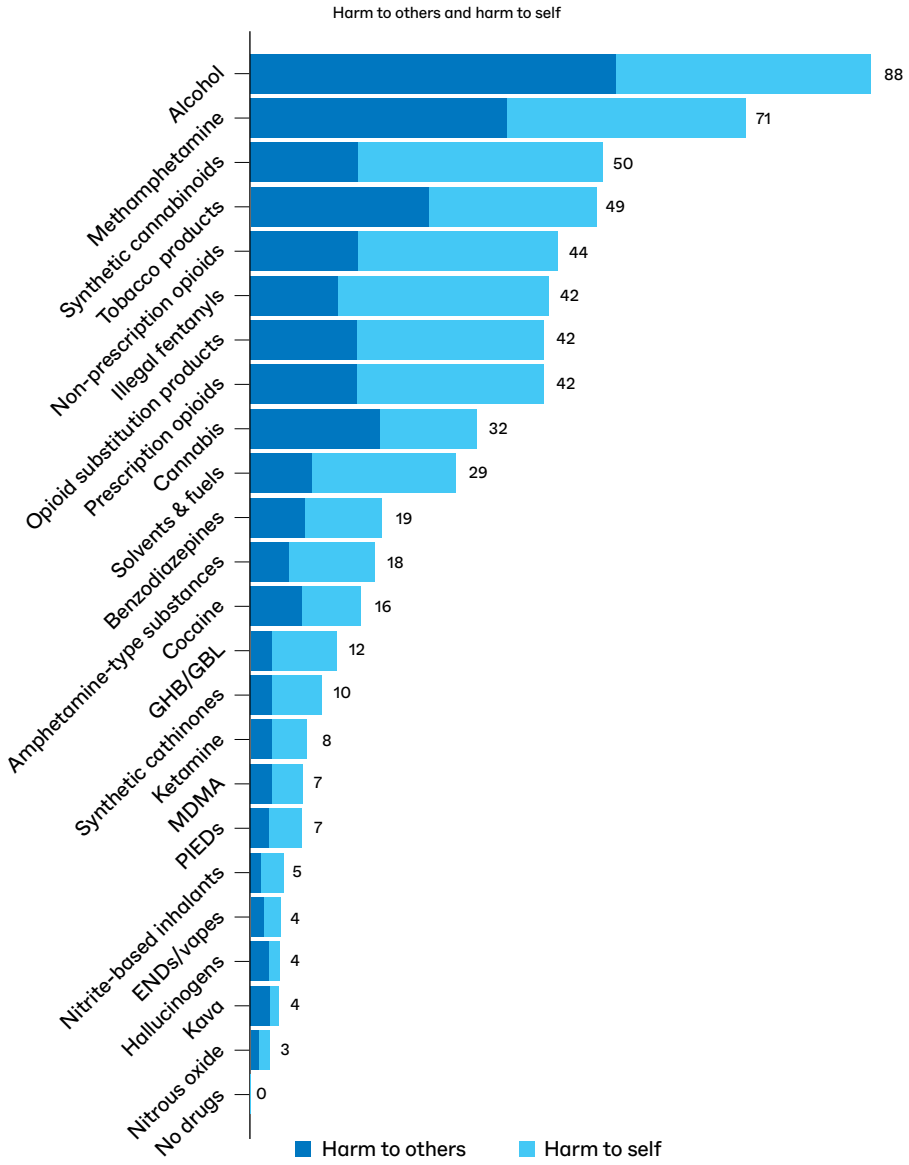
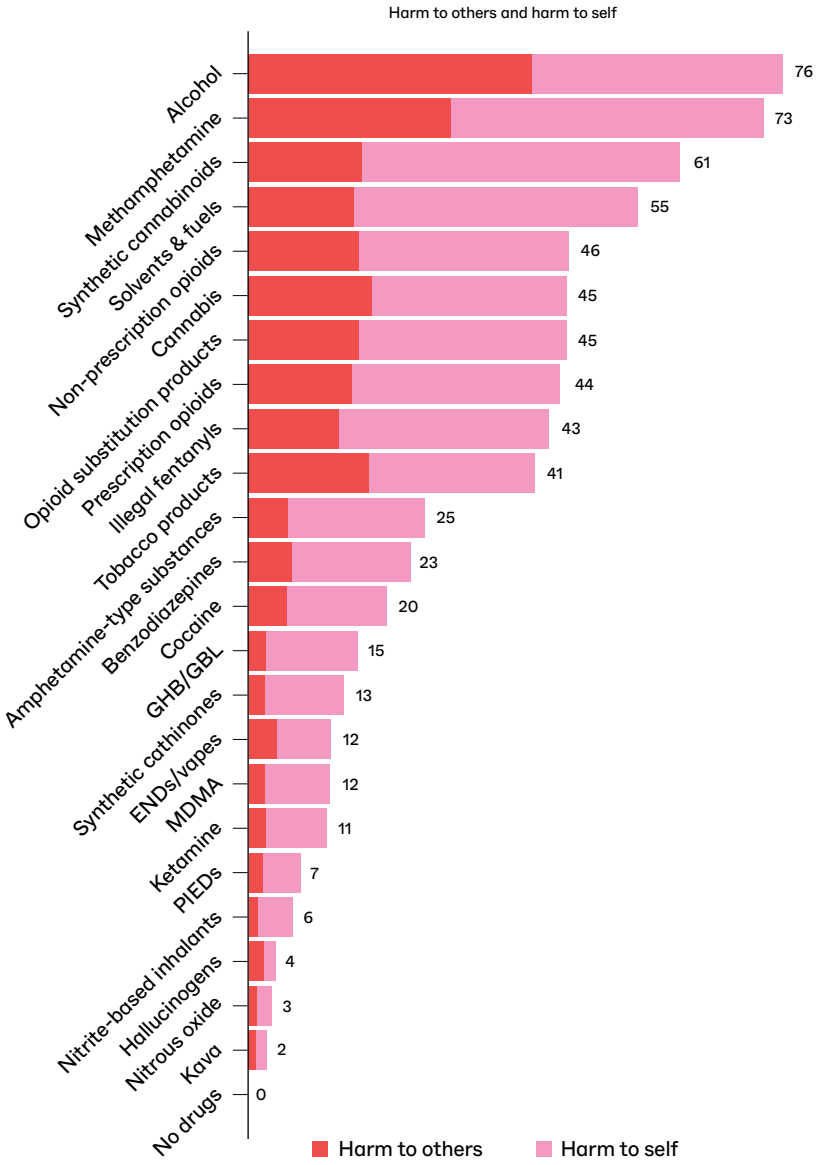


Figure 21

Drugs ranked in order of 'harm to self and others' score – youth (Crossin et al., 2023)



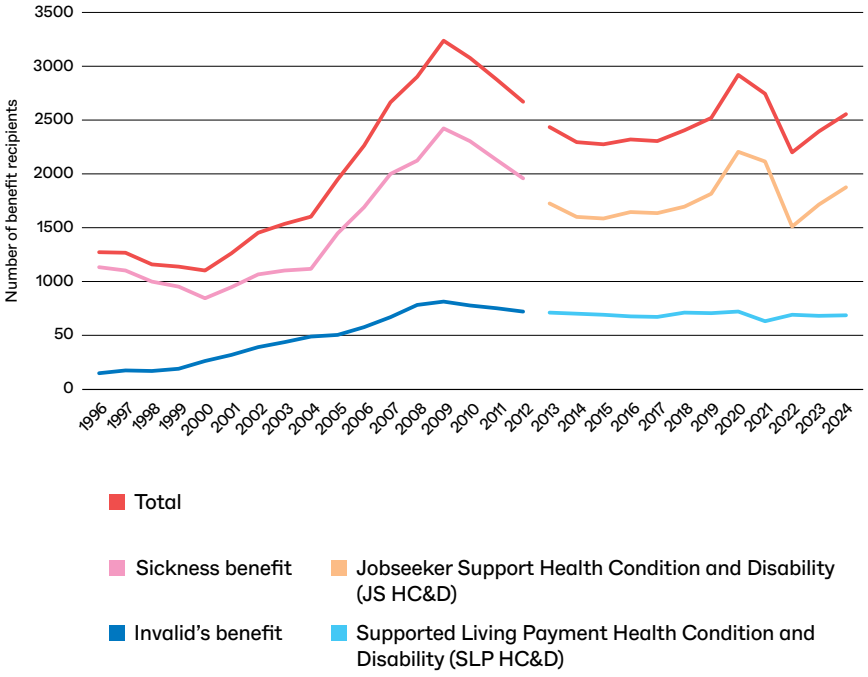
Social welfare outcomes

Substance use disorders in Aotearoa New Zealand are linked to longer-term benefit receipt. By age 32, 13% of Dunedin Study participants had a diagnosis of substance dependence in the 12 months prior, which is associated with extended periods on benefits. An unpublished analysis found that 36% of benefit recipients at this age had a substance dependence diagnosis (Ministry of Social Development, 2012).

Ministry of Social Development data shows that between 1996 and 2024 the number of people requiring benefits for drug abuse or dependency has increased. For instance, recipients of the Invalid's or Sickness Benefit rose 110% from 1,269 in 1996 to 2,664 in 2012, averaging 1,960 claimants per year. After these benefits were replaced (with different application criteria) by Jobseeker Support and Supported Living Payment in 2013, the annual average number of claimants from 2013 to 2024 was 2,449, reflecting a sustained rise in overall recipients (Ministry of Social Development, 2025).

Figure 22

Number of working-age benefit recipients with drug dependence or abuse (Ministry of Social Development, 2025)



Summary

In this chapter, we have assessed a range of drug-related outcomes after 50 years of the MoDA control. Despite the prohibitive approach of the law, drug use has been persistent and rising in the long term in Aotearoa New Zealand.

We have also observed falling drug prices, the emergence of NPS, as well as escalating health harms, such as SUD and overdose. At the same time, the criminal justice burden continued to be high, which further exacerbated health and social harms. Across the outcomes, Māori were especially severely impacted, demonstrating the Act's failure to protect Māori from drug harm.

It appears that reform is needed, and that alternative options for drug control should be explored to ensure safety for New Zealanders, and to reduce the risk of harm. In the next chapter we will explore the possibility of a reform by looking at the formal assessment of the MoDA by the Law Commission, and by presenting the findings from our engagement with communities directly impacted by the drug laws. Finally, we will also present an overview of the international evidence from countries exploring law reform.

Chapter II.

Law Commission review of the Misuse of Drugs Act 1975

The 2011 Law Commission review of the MoDA – *Controlling and regulating drugs* – represented a landmark assessment of Aotearoa New Zealand's drug law and policy. Through a comprehensive appraisal, the Commission identified significant shortcomings in the existing framework and recommended repealing and replacing the MoDA with a new, health-centred Act "administered by the Ministry of Health" (Law Commission, 2011, R1).

Since the review's inception in 2007, both global and domestic drug markets have evolved markedly, with increased illicit supply, adulteration, and methamphetamine-related harm, while international evidence on drug law reform has expanded. This chapter outlines the LCR's context, key findings, and implementation, and situates its recommendations within Aotearoa New Zealand's contemporary drug policy context.

The Law Commission and its role in the legal system

Te Aka Matua o te Ture | Law Commission is an apolitical, independent Crown entity established by the Law Commission Act 1985 to advise Ministers on the review, reform, and development of Aotearoa New Zealand law. It operates objectively, preparing reports at the direction of its relevant Minister. In carrying out this work, the Commission is statutorily required to consider te ao Māori, reflect Aotearoa's multicultural society, and ensure laws are as simple and accessible as possible.

While its recommendations are not binding, they frequently shape legislative agendas by identifying outdated or inconsistent areas of law and proposing practical reforms. The Commission's reports can influence Cabinet decisions, guide departmental policy, and provide the basis for new legislation, serving as a bridge between legal scholarship and the political process.

Background to the review of the Misuse of Drugs Act 1975

In 2007, under Hon Simon Power as both Minister of Justice and Minister responsible for the Commission, the Government invited the Law Commission to undertake a broad review of the Act. The Ministry of Health led the work alongside the Ministry of Justice and Police (Anderton, 2007). The review was prompted by the emergence and marketing of NPS (at the time, commonly referred to as 'legal highs'), and inconsistencies between the MoDA, which focused on controlling supply, and the national drug policy, which emphasised demand reduction and harm minimisation more strongly.

The rise of 'legal highs' in Aotearoa New Zealand reflected a global trend. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2018) reported rapid increases in the availability and variety of NPS, including

smokable herbal products containing synthetic cannabinoids. In many jurisdictions, including Aotearoa New Zealand, the sale of analogues of illegal substances as legal alternatives was permitted, enabling producers to circumvent established drug controls. This was due to the inability of legal frameworks that relied on listing prohibited substances to keep up with the rapid development of new compounds.

Shortly ahead of the LCR, the Commission also released two related reports: one in 2010 on the regulatory framework for liquor (Law Commission, 2010a), and another on compulsory treatment for substance dependence, reviewing the Alcoholism and Drug Addiction Act 1966. The latter was published nine months before the LCR to align with the Government's Methamphetamine Action Plan (Law Commission, 2010b).

The Law Commission review: *Controlling and Regulating Drugs*

The LCR terms of reference included examining whether Aotearoa New Zealand's legislation should reflect the goals of harm reduction, reassessing the classification and penalty system, addressing NPS, and determining appropriate enforcement powers and agencies for administering our legislation. Alcohol and tobacco were excluded, and were addressed separately.

The review emphasised that Aotearoa New Zealand should maintain consistency with international drug conventions. The main principle the Commission adopted was that the degree of control involved in the regulatory strategy should also be the minimum required to achieve its objective. Absolute prohibition should be considered a last resort, and in place only when other responses such as treatment were provided. It framed drug control as both a health and criminal justice issue, calling for multi-sector responses to reduce demand and harm while noting that criminalisation itself can cause harm, particularly for young people and Māori.

The review highlighted that Māori and Pacific peoples faced the highest drug-related harms, with Māori three times more likely to be arrested and convicted for cannabis offences. The Commission acknowledged the likely contribution of "some sort of bias or stereotyping" (Law Commission, 2011, p. 106) and argued that punitive approaches exacerbate harms for Māori. It recommended more therapeutic responses, especially for young people and those most at risk. This aligned with claims brought to the Waitangi Tribunal, where multiple applicants identified Crown failures in addressing the disproportionate level of methamphetamine-related harm (and the underlying causes of SUD) in Māori communities (Walker, 2019).

Key recommendations from the LCR included modernising the legislative framework, reforming the drug classification system, introducing new responses to drug use, and addressing disproportionate impacts on the populations most

at risk of harm. For NPS, the Commission proposed a pre-market approval system to assess safety. It stressed that reform would require resources, training, public education, and ongoing evaluation to ensure policies remain effective and equitable.

Response to the Law Commission's recommendations

Ministerial response

In 2011 Associate Minister of Health Hon Peter Dunne welcomed the LCR, and announced that the MoDA would be overhauled (Dunne, 2011). The Government identified the regulation of psychoactive substances, particularly synthetic cannabinoids, as an urgent priority. Its Regulatory Impact Statement signalled the intention to establish a regime consistent with the Commission's recommendations (Wood, 2011), while Associate Justice Minister Hon Simon Power's office confirmed that policy development was underway for drug courts (Power, 2011).

Although the central recommendation to repeal and replace the MoDA was not adopted, two significant reforms followed: the enactment of the PSA and the introduction of Alcohol and Other Drug Treatment Courts (AODTC).

Implementation of the Law Commission's recommendations

The Psychoactive Substances Act 2013

The PSA attempted to implement around 30 of the Law Commission's recommendations. It introduced a regulatory regime that would require psychoactive products to be proven low risk before approval was given for marketing. It established a licensing system allowing for the supply of psychoactive substances, a regulatory authority, and alternative enforcement tools for manufacture, import, and sale of psychoactive substances – marking a shift from the MoDA's reliance on criminal sanctions. Notably, penalties for personal possession were reduced to an infringement-level fine.[3] However, a 2014 amendment prohibiting animal testing data effectively stalled the approval system, leaving no products legally available under the PSA to date.[4]

In practice, the PSA has therefore failed to achieve its purpose. A 2018 review found that the prohibition on animal testing left regulators without an ethical testing framework, which meant that no substances could be approved (Ministry of Health, 2019). The psychoactive substances market was consequently driven

[3] The maximum penalty for personal possession of a substance under the PSA is a fine of $500 (no criminal conviction if the person accepts the fine given by Police), while under the MoDA personal possession or use of a substance can result in an imprisonment of up to three or six months and/or a $500/$1,000 fine, depending on the class of the substance.

[4] The only exception is when overseas animal studies show that a substance causes harm – in that case, regulators may use the evidence to reject an application, but not to support one.

underground, with seizures and convictions rising. Between 2013 and 2017, convictions under the PSA had grown from seven to 172, 68.6% of which were of Māori or Pasifika people (Ministry of Health, 2019). Synthetic cannabinoids continued to cause significant harm, including dozens of deaths investigated by the Coroner. Despite its intent to reduce harm, the PSA has entrenched unregulated markets and reinforced inequities, falling short of its statutory aim to protect public health.

Alcohol and Other Drug Treatment Courts

The LCR recommended trialling drug courts in Aotearoa New Zealand using a post-plea, pre-sentence model, subject to monitoring and evaluation (Law Commission, 2011, R142, R143). While noting mixed international evidence, the Commission argued that drug courts could be effective if supported by clear objectives, interdisciplinary collaboration, well-trained staff, and robust eligibility criteria. It cautioned against enrolling low-level offenders in resource-intensive programmes that might result in disproportionate interventions.

The pre-sentence model (as opposed to a post-sentence model) was seen as particularly valuable, offering incentives for compliance and flexibility in addressing breaches. It was also intended to address concerns about leniency towards the offender that might exist from victims of their crimes, by delaying sentencing until treatment programme completion. Importantly, the Commission noted that this model would fit within the existing legislative framework, avoiding the need for creating new legislation. On the basis of these recommendations, two pilot Alcohol and Other Drug Treatment Courts (AODTCs) were established in 2012, with $2 million in funding and the intent to have 100 offenders a year take part (NZPA, 2011). In 2019 the pilots were rolled out as two permanent courts in Tāmaki Makaurau Auckland, and one in Kirikiriroa Hamilton. Their aim is to address the underlying causes of offending by providing a therapeutic alternative to imprisonment (Ministry of Justice, 2025a).

AODTCs accept offenders facing up to three years' imprisonment where substance dependency is a key factor in their offending. Exclusions apply to serious offences such as sexual violence or arson. Eligible participants have sentencing adjourned while undertaking intensive treatment, monitoring, drug testing, and court appearances. Successful programme completion often results in reduced sentencing, while lack of completion leads to normal sentencing processes. Victims may choose to be updated on progress. Operating within the existing justice system, AODTCs rely on judicial discretion and legislation such as the Sentencing Act, Bail Act, and Criminal Procedure Act, functioning as specialised divisions of the District Court.

Evaluation of the Alcohol and Other Drug Treatment Courts

Evaluations of the AODTCs have shown both promise and challenges. The first evaluation in 2014 assessed implementation and found 99 participants enrolled in the first year, with 26 discontinuing – figures consistent with international experience. Areas for improvement included clarifying the role of tikanga Māori, criteria for offenders with violent histories, and processes for victim involvement (Gregg & Chetwin, 2014). A 2016 evaluation concluded that implementation was largely consistent with design, highlighted the integration of tikanga Māori through Te Pou Oranga role, and reported positive outcomes for participants and their whānau, describing the courts as enabling "transformational change" (Gregg & Chetwin, 2016).

The 2019 evaluation found graduates experienced improved health, whānau relationships, employment, and cultural engagement, with some maintaining sobriety for up to four years afterwards. Participants were less likely to reoffend or be imprisoned within two years compared to those in the mainstream system. However, benefits experienced by participants diminished over longer follow-up periods, including a lack of reoffending, reflecting the chronic and relapsing nature of substance use disorder. The evaluation recommended refining processes and considering expansion of AODTCs to other locations (Ministry of Justice, 2019).

Overall, AODTCs have improved outcomes for graduates who completed the programme. However, large-scale impact is limited by the small numbers of participants and the high costs involved (especially for urine drug testing, comprising a third of annual costs) (Ministry of Justice, 2019).[5] On balance, they are considered a positive aspect of a health-based approach to drug use, demonstrating that diversion from the criminal justice system can make a positive impact.

[5] At the time of the 2019 evaluation, the Ministry of Health provided around 74% of operational funding for AODTCs, the Ministry of Justice provided around 21%, Police provided 5%, and the Department of Corrections provided 1%.

Misuse of Drugs Act Amendments since the Law Commission review

The LCR informed three other major changes implemented since the report was published:

Medicinal cannabis for palliation

The LCR did not make a specific recommendation on medicinal cannabis, but stated it "should be treated in the same way as all other prohibited drugs that can be used medicinally" (Law Commission, 2011, p. 298). The Commission noted that, if clinical trials confirmed its safety and effectiveness, cannabis could be made available on prescription, and in the interim, Police should avoid prosecuting patients using it to relieve symptoms of illness. Subsequent legislative change came through the Misuse of Drugs (Medicinal Cannabis) Amendment Act 2018. Section 8 (6A) of the MoDA provided an exception and statutory defence for people using cannabis or cannabis utensils who required palliative care, narrowly defined as those with advanced, life-limiting conditions nearing the end of life.

Broader access to medicinal cannabis in Aotearoa New Zealand was enabled through the creation of the Medicinal Cannabis Scheme under the Misuse of Drugs (Medicinal Cannabis) Regulations 2019.

In general, controlled drugs that are not approved medicines are subject to discretionary ministerial approval before they can be prescribed to patients, which creates a major access barrier. In the case of cannabis, patient advocacy helped push for streamlined access and the establishment of the scheme.

Currently, the scheme provides a legal framework for licensing the cultivation, manufacture, and supply of medicinal cannabis products. Administered by the Ministry of Health, it allows licensed companies to grow cannabis and manufacture products that meet minimum quality standards. These are prescription medications that physicians can prescribe as unapproved – and unfunded – medicines under s29 of the Medicines Act.

Drug checking legislation

Drug checking, which gained prominence as a harm reduction measure after the LCR was released, was not included in its recommendations but later addressed through the Drug and Substance Checking Legislation Act 2021.

This Act amended several statutes, including the MoDA and PSA, to establish a legal framework for free drug checking by licensed providers. It created licensing requirements, offences for breaches, and empowered the Director-General of Health to approve and monitor testing methods (Ministry of Health, 2025b). The framework also provided legal protections for service providers handling controlled substances and ensured that Police could not use evidence from service use in prosecutions, thereby encouraging uptake without legal risk.

Evidence around the effectiveness of drug checking as a harm reduction intervention is discussed later, in Chapter IV.

Discretion for prosecutions for possession and use

The LCR stated that possession and use charges consumed substantial Police and court resources, and questioned the effectiveness of charging people who use drugs who could instead benefit from health support. They noted that discretionary approaches could lead to inconsistent or discriminatory outcomes.

While decriminalisation of personal drug possession was not considered due to perceived international treaty constraints (although this position has since been considered inaccurate),[6] the Commission recommended a mandatory cautioning scheme with brief interventions for personal possession offences. Prosecution would be reserved for repeat offending instead. In 2019 the Misuse of Drugs Amendment Act reinforced Police discretion under s7(1)(a), directing Police to prioritise health-based or therapeutic responses if they considered these to be in the public interest. Although aligned with the Commission's intent to focus on treatment, this discretionary approach has had limited impact on reducing the disproportionate conviction rates among Māori, highlighting the case for broader decriminalisation of personal possession and use. In Chapter IV of this report we discuss the international evidence associated with decriminalisation models.

[6] The LCR caveated nonetheless that if decriminalisation was a policy option they could recommend, "it is by no means clear that the benefits of such a policy would outweigh the harms" (Law Commission, 2011, p. 49).

The way forward

For the last 14 years, the LCR has offered subsequent governments detailed recommendations to replace our deficient drug laws. During this period very little change has occurred – with a few positive exceptions, such as the Drug and Substance Checking Legislation Act 2021. In the meantime, many of the LCR's recommendations appear to have become obsolete, because the drug landscape has changed so drastically.

The LCR originated in the policy and social context of the time, in response to the emerging challenges at hand. One of the characteristics of volatile illicit drug markets, however, is their constant and rapid evolution. Because of this, many emerging risks were not known at the time the LCR was drafted. In her inquiry into a series of synthetic cannabinoids deaths, Coroner Mills (2023) noted the continuous ineffectiveness of the MoDA. Mills also noted that the LCR had been developed in a different environment and may no longer be fit for purpose. She recommended that another review be undertaken and that the MoDA be amended to prevent future harm.

We agree with the view that the MoDA needs to be urgently amended, and that many of the detailed recommendations from the LCR may no longer be relevant today. However, many of the LCR's general propositions are still valid. In the spirit of the LCR, we suggest the following key principles to pave the way forward in the modern context:

- repeal and replace the MoDA with health-based legislation;
- move away from criminalisation as a primary response to drug harms;
- establish a more flexible system of drug classification, governed by a health agency that is able to act rapidly to prevent drug harm: in an apolitical way, with regard to evidence;
- ensure that a system of licensing is primarily governed by that same apolitical function to drive harm reduction policy.

We will return to further reflect on the recommendations from the LCR when examining the international evidence in Chapter IV.

Chapter III.
Achieving hauora: Aspirations of people affected by current drug laws

The previous sections have covered national data relating to the harms caused by illicit drugs and ineffective drug policy on the lives of New Zealanders. However, this paints only a partial picture, and data cannot speak to the lived experiences of people who use drugs, their whānau and communities.

In this chapter we will describe the initial findings of our research to better understand the aspirations of people who have experienced or are at risk of drug-related harms. Our aim was to engage directly with those who are harmed under current legal settings, and identify ways in which drug policy could help reduce harms and better protect those vulnerable to drug harms. These findings helped us contextualise the international evidence, sense-check it with those affected, and build recommendations to improve Aotearoa New Zealand drug policy.[7]

A Pathway for Better Drug Laws community research

The purpose of this engagement was to describe the harms experienced by communities of people who use drugs and their whānau from their own perspectives, and better understand how the legal framework of the MoDA affects these harms. We also wanted to hear how legal frameworks could be improved to reduce these harms, and, critically, what desired outcomes or goals should be prioritised and why.

To answer these questions, we conducted a survey and organised a series of workshops with people with lived and living experience of drug harm. We will describe the methods and results of these two research components separately, and we will follow these subsections with a discussion summarising our learnings from both components.

Study ethics

The study was reviewed and approved by the Aotearoa Research Ethics Committee (AREC25_33).

[7] In this report, we present only high-level findings from this engagement, as a more complete presentation of this mixed-methods research requires a standalone publication. We are planning a release of a larger paper or a series of papers covering this research at a later date.

Part 1. Survey with people who have experienced or are at risk of drug harm

Survey methods

An anonymous, cross-sectional online survey was conducted to gather perspectives on drug laws from people who have experienced, or are at risk of experiencing, drug-related harms, as well as from those who have supported others in these situations. Eligible participants were those aged 18 or older, able to speak English, and who either disclosed having at least one of the relevant harm or risk of harm experiences, or who supported someone with these experiences. Relevant experiences included:

- using illicit drugs (lifetime),
- drug addiction,
- drug overdose,
- injecting drugs,
- accessing opioid substitution therapy,
- selling drugs to other people,
- being charged or convicted for drug-related offence(s), including being imprisoned for drug offences,
- homelessness, if, in a participant's view, drugs were a contributing factor.

The survey ran between 21 July and 20 August 2025 and was hosted on the Typeform platform. It included both closed and open-ended questions covering experiences of harm related to drug laws, attitudes towards current legislation, and views on the goals of an ideal drug policy. Basic sociodemographic information was also collected. The survey was promoted via the New Zealand Drug Foundation and The Level websites, social media channels, and through the networks of allied organisations. Posters containing QR codes were also used, and displayed in places such as Auckland City Mission or at New Zealand Needle Exchange Programme providers' sites.

Participants who completed the survey were able to enter a draw for one of ten $50 vouchers, with contact details collected separately from survey responses to maintain anonymity.

[8] While most drug use is associated with little harm, we considered any use of illicit drugs a risk for harm to occur due to the risks of engaging with the illicit market and criminalisation of drug use.

Data analysis

Survey data from closed-ended questions was analysed using descriptive and inferential statistics, as appropriate, using Jamovi software. Open-ended survey responses were coded thematically by the research team.

Survey results

Survey participants and their lived experiences

Over the survey period, 518 people completed the eligibility questions of the survey. Of these, 442 (85.3%) completed the survey and were deemed valid and eligible. Some of the excluded responses included those we classified as bot-generated: through undertaking a manual scan, we detected 20 anomalous responses (3.8%) that were suspicious due to certain characteristics.[9]

Table 5 presents participant characteristics after data cleaning. Participants ranged in age from 18 to 81 years (M=46.6, SD=16.4). Over one fifth identified as Māori. A substantial proportion of participants belonged to the rainbow community, with a large proportion identifying as bisexual (16.5%), and some identifying as gay or lesbian; a small group of participants identified as transgender. Over one third reported having a disability, and, notably, 41% identified as neurodiverse. ADHD was self-reported by one third of participants, including 11.1% of all participants reporting a formal diagnosis.

Table 5
Survey participant characteristics (n=442)

Characteristic	n	%
Age		
18–24	59	13.3
25–34	58	13.1
35–44	60	13.6
45–54	113	25.6
55–64	88	19.9
65 and over	64	14.5

[9] A specific combination of features that occurred in all of the disqualified responses was: being part of a cluster of responses that started and ended within a very short period of time; having patterns of ethnicity responses that were unusual for the Aotearoa New Zealand population or inconsistent in context of other provided responses; generic-appearing responses written using unusually formal syntax, grammar, and punctuation that additionally, notably, consistently included US spelling of words (e.g., "criminalization") and references to US-specific issues (e.g., "calling 911"). We have excluded these from the analysis. A researcher-performed exploration of the remaining responses for these or other anomalous features did not result in further disqualifications.

Ethnicity		
NZ European/Pākehā	373	84.4
Māori	94	21.3
Pacific	12	2.7
MELAA	9	2.0
Asian	8	1.8
Region		
Auckland	87	19.7
Bay of Plenty	44	10.0
Canterbury	57	12.9
Gisborne	7	1.6
Hawke's Bay	17	3.8
Manawatū	29	6.6
Marlborough	4	0.9
Nelson	9	2.0
Northland	29	6.6
Otago	32	7.2
Southland	1	0.2
Taranaki	15	3.4
Tasman	2	0.5
Waikato	40	9.0
Wellington	65	14.7
West Coast	4	0.9
Gender		
Female	224	50.7
Male	209	47.3
Non-binary	9	2.0
Sexuality and gender identity		
Bisexual	73	16.5
Heterosexual	311	70.4
Gay or lesbian	25	5.5
Transgender identity	10	2.3
Disability status		
Non-disabled	260	63.3
Disabled	151	36.7

Neurodiversity status		
Non-neurodiverse	261	59.0
Neurodiverse (any form)	181	41.0
ADHD status		
Non-ADHD	296	67.0
ADHD (diagnosed or suspected)	146	33.0
ADHD (diagnosed)	49	11.1

Note: Values are presented as frequencies (n) and percentages (%). Percentages may not total 100 due to multiple response options. Transgender identity status was established by an additional question, separate from gender or sexual identity.

The vast majority of participants reported personal experience of using illicit drugs, and most of these participants reported experiencing harm or higher-risk drug practices – consistent with the recruitment prioritising such population.

Table 6 shows the details of participants' reported personal experiences. Over one third of participants reported drug addiction, and a similar proportion reported dealing drugs. Personal experience of criminalisation was reported by 67 participants (15.2%).

Table 6
Participant personal experiences of drug use and drug harm (n=442)

Personal experience	n	%
I have used illegal drug(s)	405	91.6
Experienced ANY harms or higher-risk drug practices	271	61.3
I have experienced drug addiction	151	34.2
I have been treated for drug addiction	53	12.0
I have experienced an overdose	54	12.2
I have injected drugs	65	14.7
I have accessed opioid substitution therapy	25	5.7
I have sold drugs to other people	144	32.6
I have been charged or convicted for drug-related offence(s)	67	15.2
I have been in jail for drug-related offence(s)	16	3.6
I have been homeless in my life	37	8.4
I have experienced other harms related to drugs	124	28.1
None of the above	19	4.3

Note: Values are presented as frequencies (n) and percentages (%).

A part of the study sample (108 participants) included people who have provided support to people experiencing drug harms with no reported experience of personal harms. Three quarters of these, the largest group, reported supporting a person with addiction, followed by supporting someone who was dealing drugs, or someone with drug convictions. Table 7 presents these experiences of support.

Table 7
Experience of supporting someone with a history of drug harm (n=108)*

Experience of support	n	%
They have experienced drug addiction	81	75.0
They have been treated for drug addiction	25	23.1
They have experienced an overdose	17	15.7
They have injected drugs	23	21.3
They have accessed opioid substitution therapy	7	6.5
They have sold drugs to other people	50	46.3
They have been charged or convicted for drug offence(s)	32	29.6
They have been in jail for drug offence(s)	24	22.2
They have been homeless	17	15.7

Note: Values are presented as frequencies (n) and percentages (%).

There was a large range of substances that were part of the participants' or supported persons' experiences, as shown in Table 8. Most study participants reported drug use experiences with cannabis, followed by alcohol. Among respondents reporting personal drug use or experiences of harm, psychedelics were reported as the third most common substance involved. Among those without personal drug harm but who supported others, methamphetamine was reported as the third most common substance.

Table 8
Substances contributing to relevant experiences

Drug use or harm experience	Personal experience of drug use n=405		Participants with personal experience of harm n=271		Participants with no personal drug harm who supported others experiencing harm n=104	
Substance	**n**	**%**	**n**	**%**	**n**	**%**
Cannabis	355	87.7	242	89.3	77	74.0
MDMA	182	44.9	126	46.5	32	30.8
Meth	139	34.3	104	38.4	46	44.2
Cocaine	109	26.9	80	29.5	18	17.3
Opioids	139	34.3	108	39.9	32	30.8
Benzos	91	22.5	77	28.4	18	17.3
Psychedelics	195	48.1	142	52.4	23	22.1
Ketamine	82	20.2	67	24.7	8	7.7
Alcohol	269	66.4	188	69.4	59	56.7
Other	34	8.4	28	10.3	7	6.7

Note: Values are presented as frequencies (n) and percentages (%). Participants were able to select as many substances as they wished.

Participant beliefs and drug law aspirations

Figure 23 shows the degree to which participants agreed with a variety of statements about the current drug laws. Most strikingly, the vast majority of the participants (90.8%) disagreed or strongly disagreed that drug laws in Aotearoa New Zealand are fit for purpose. A similarly high proportion (78.7%) believed the illegal status of drugs created a barrier for people who used substances to engage with health services.

Concerningly, due to drug illegality, less than half of the participants felt comfortable about calling for help in the event of an overdose.

Over half of participants experienced stigma in healthcare in relation to substance use, and a similar proportion expressed belief that disclosing substance use would lead to poorer access to healthcare. Having personal experience of substance harm increased the odds of reporting personal

experience of stigma as well as worry about losing access to healthcare following drug use disclosure. Table 9 presents the results of a series of adjusted logistic regressions to determine whether experience of personal harm was associated with having differential responses to these, and other, statements.

Figure 23
Agreement with statements about current drug laws (n=442)

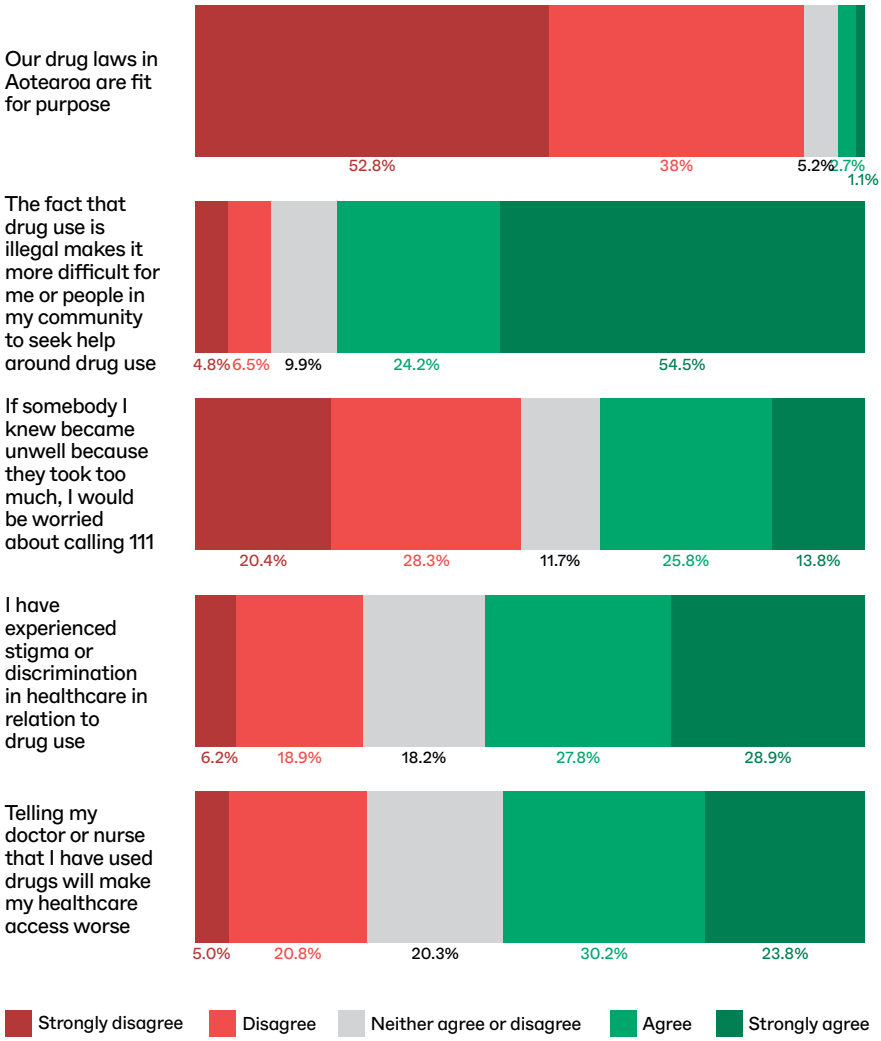


Table 9

A series of adjusted* logistic regressions (n=442)
Factor considered: Having personally experienced drug harm

Statement	OR	Confidence interval (95%)		p
Our drug laws in Aotearoa are fit for purpose.	0.98	0.39	2.48	0.97
The fact that drug use is illegal makes it more difficult for me or people in my community to seek help around drug use.	1.03	0.62	1.71	0.90
If somebody I knew became unwell because they took too much of a drug (or drugs), I would be worried about calling 111 or taking them to hospital because I know using drugs is illegal in New Zealand.	1.57	0.78	1.72	0.47
I have experienced stigma or discrimination in healthcare in relation to drug use.	**1.62**	**1.09**	**2.40**	**<0.05**
Telling my doctor or my nurse that I have used drugs will make my healthcare access worse.	**1.64**	**1.10**	**2.46**	**<0.05**

Note. This simplified table presents the results of five logistic regression models with the outcome variable of agree ("strongly agree" and "agree") with a given statement. The odds ratios represent the odds of agreement with the given statement, depending on whether the person has personally experienced harm.

** The model has been adjusted for age, gender and Māori ethnicity status.*

Table 10 presents the results of a question asking participants to rate the potential drug goals as "bad", "good", or "great". The goals most considered "great" were centred around giving people reliable information about substances, preventing overdose deaths, and ensuring access to healthcare and therapeutic controlled drugs. Conversely, the goals most considered "bad" were preventing drug use in general, and punishing drug suppliers. While most participants considered allowing companies to profit from legal drug supply a "good" or "great" goal, one quarter considered it a "bad" goal.

Table 10
Proportions of participants rating each goal as "bad", "good", or "great" (n=442)

Goal	Bad (%)	Good (%)	Great (%)
Giving people the information they need to make healthy decisions around substance use.	1.8	16.5	78.7
Preventing drug overdose deaths.	2.9	15.2	78.1
Making sure patients can access therapeutic (medical) drugs (for example, medicinal cannabis, psychedelic-assisted therapies, opioids for pain).	3.2	14.0	77.8
Improving access to health services for people who use drugs.	2.3	20.4	71.3
Reducing harm from drug use among people who use drugs.	4.1	24.2	67.6
Reducing crime related to drug use or the black market.	6.6	27.1	60.4
Reducing the number of people in prisons.	8.1	26.0	60.4
Protecting the rights of Māori under te Tiriti o Waitangi (Treaty of Waitangi).	14.9	22.9	53.2
Creating tax income or economic growth from substances that are made legal (such as alcohol, or cannabis where it is legalised).	19.2	33.5	38.9
Stopping young people from using drugs.	17.2	43.2	36.2

Allowing local companies to legally profit from the sale or production of legal drugs to the public.	24.2	36.0	31.7
Punishing people who are dealing drugs.	47.7	31.0	15.2
Stopping people from using drugs.	60.2	25.6	10.2

In another question, participants were asked to pick a maximum of three "top" goals for drug laws. Among participants who reported personal drug use experiences, the most commonly selected top three goals were:

- *Giving people the information they need to make healthy decisions around substance use* (240/405; 59.3%).
- *Reducing harm from drug use among people who use drugs* (184/405; 45.4%).
- *Making sure patients can access therapeutic (medical) drugs (for example, medicinal cannabis, psychedelic-assisted therapies, opioids for pain)* (178/405; 43.9%).

Table 11 presents the occurrence of "top" goals among these participants, split by whether participants reported personal harm associated with drug use or not. Notably, those with personal harm were more likely than other participants who used drugs to select reducing harm from drug use and reducing the number of people in prisons among their top three goals. Those with no personal experience of harm were also significantly more likely to prioritise creating tax revenue or economic growth than those who experienced drug harm.

Table 11
Count and percentage of selection among top three goals among participants disclosing illegal drug use (n=405) depending on the experience of personal harm

Top goal	No personal harm (n=153)	Personal drug harm (n=252)	χ^2	df	p
Giving people the information they need to make healthy decisions around substance use.	98 (64.1%)	142 (56.3%)	2.34	1	0.126

Preventing drug overdose deaths.	28 (18.3%)	55 (21.8%)	0.726	1	0.394
Making sure patients can access therapeutic (medical) drugs (for example, medicinal cannabis, psychedelic-assisted therapies, opioids for pain).	74 (48.4%)	104 (41.3%)	1.95	1	0.163
Improving access to health services for people who use drugs.	27 (17.6%)	50 (19.8%)	0.298	1	0.585
Reducing harm from drug use among people who use drugs.	**51 (33.3%)**	**133 (52.8%)**	**14.5**	**1**	**<.001**
Reducing crime related to drug use or the black market.	32 (20.9%)	46 (18.3%)	0.434	1	0.51
Reducing the number of people in prisons.	**10 (6.5%)**	**47 (18.7%)**	**11.6**	**1**	**<.001**
Protecting the rights of Māori under te Tiriti o Waitangi (Treaty of Waitangi).	10 (6.5%)	28 (11.1%)	2.34	1	0.126
Creating tax income or economic growth from substances that are made legal (such as alcohol, or cannabis where it is legalised).	**33 (21.6%)**	**25 (9.9%)**	**10.5**	**1**	**0.001**
Stopping young people from using drugs.	37 (24.2%)	70 (27.8%)	0.633	1	0.426
Allowing local companies to legally profit from the sale or production of legal drugs to the public.	13 (8.5%)	18 (7.1%)	0.247	1	0.619
Punishing people who are dealing drugs.	13 (8.5%)	12 (4.8%)	2.29	1	0.13
Stopping people from using drugs.	13 (8.5%)	14 (5.6%)	1.32	1	0.25

We will further discuss and contextualise the survey results in conjunction with the qualitative data from the survey and the workshops.

Qualitative insights from the survey

A very large proportion of the eligible participants (403/442; 91.2%) provided an answer to the free-text question about the impacts of drug laws on drug harms ("Thinking about your experiences of harm related to drugs, how do you think our drug laws affected how these harms played out? If you haven't experienced drug harm yourself, think about the people in your community who have experiences of drug harm."). After initial analysis, 47 responses (11.7%) were considered insufficient for analysis or ambiguous to analyse in the context of the question, leaving 356 valid responses.

We have identified five major themes that consist of 20 sub-themes, presented in Table 12.

Table 12
Frequencies of meta themes and sub-themes (n=356)

Meta theme and sub-theme	n	%
MoDA compounding drug harm	278	78.1
Reinforcing harms	252	70.8
Health and harm reduction barriers	118	33.1
Criminalisation impacts	73	20.5
Drug and addiction stigma	66	18.5
Draconian laws	44	12.4
Specific harms of MoDA	106	29.8
Volatile and toxic supply	47	13.2
Criminal market harms	45	12.6
Use of more harmful substances	30	8.4
Overdose and acute drug harm	20	5.6
Health-based approach	120	33.7
Focusing on health	54	15.2
Moving away from prohibition	36	10.1
Social harms of a criminalisation approach	22	6.2
Ineffectiveness of reducing demand or supply	20	5.6
Decriminalisation	20	5.6

Cannabis and classification of substances	61	17.1
Cannabis liberalisation	43	12.1
Alcohol harms	16	4.5
Access to beneficial effects of drugs	14	3.9
Differential drug policies	10	2.8
Appropriateness of MoDA	46	12.9
Neutral or positive impacts of MoDA	29	8.1
Hard-line approach needed	17	4.8

Note. Each response could have been coded into several themes.

The MoDA compounding drug harm

Most participants (78.1%) used the open response box to share their views that drug laws in Aotearoa New Zealand compound drug harms, instead of preventing or reducing them. They outlined the various mechanisms through which they have observed it in their own lives or in the lives of people in their community. This meta theme includes five sub-themes, described below.

Reinforcing harms

Participants spoke directly about the fact that drug harms are exacerbated by drug laws, more so than by the drugs themselves.

> *The harms in my … case are entirely due to drug laws. They constrict my rights, choices and endanger me by generating crime. I realise that some people are harmed by using some drugs, but harms are exacerbated by drug laws.*
>
> – Male, NZ European, 65+

Many contextualised it with the fact that drug addiction has complex roots, and a criminal justice approach makes things worse for people.

> *Drug laws perpetuate the problem with punitive punishments and not enough focus on rehabilitation support. Most people with drug addiction issues have terrible trauma histories from childhood."*
>
> – Female, Māori, 45–54

Health and harm reduction barriers

Some of the most negative impacts were described as arising from the fact that existing drug laws make it harder for people to access help, health information, or harm reduction support.

One participant summarised his own experience with this:

Our laws made help feel inaccessible, made seeking help feel dangerous.

– Male, Pacific, 18–24

Critically, some participants felt that current drug laws made people reluctant to engage with support services at an early stage of their substance use.

Illegality makes help inaccessible by proxy. It unnecessarily makes people second guess seeking help.

– Female, Asian, 18–24

Criminalisation impacts

The impacts of criminalisation were experienced by participants first-hand, particularly affecting those who experienced addiction. One participant shared her disappointment with this:

I was not offered alternatives to criminalisation. Treatment was offered in [p]rison or a condition of parole.

– Female, Māori, 55–64

The impacts of drug criminalisation are persistent and continue to take a toll on people's lives – even when they no longer engage in harmful drug use.

I no longer experience the level of drug harm I did in my youth … [but] because I have been sentenced to prison … I will forever have to disclose this history.

– Male, Māori/NZ European, 33

Some participants also shared that criminalisation puts people who use drugs directly in harm's way, by increasing their risk of becoming a victim of crime, or making it difficult to engage with law enforcement for support.

People, including myself, are less likely to report crimes committed against us if we have been under the influence of drugs …

– Female, Māori/NZ European, 35–44

Drug and addiction stigma

A large proportion of participants shared that stigma associated with drug use and addiction is among the most detrimental effects of Aotearoa New Zealand's drug laws. For many participants, the criminalisation of drug use meant that they felt 'othered' by society, or lost a sense of belonging.

The simple fact of being forced into an underground society because of the laws that make us feel as if we are "other" and somehow not being part of society.

– Female, NZ European, 55–64

This stigma extended to healthcare settings, and participants expressed fear that disclosing drug use would impact their experience with health services.

And because they are illegal, I feel as though I cannot tell health professionals and counse[l]lors, the true extent of my usage; And even though I have wanted to get some help at times, I can't admit it or else they will cut off some assistance to me and limit their services to me in some way, discriminating against me if … tell them what I am going through.

– Female, Māori/NZ European, 35–44

The focus on illicit drug use in healthcare settings, and prioritising it by healthcare providers as the main issue (diagnostic overshadowing) regardless of a patient's perspective, created disconnection between some participants and these services. This concern extended to other public services such as the Police. One participant reflected that Police could also not be trusted by people who used drugs:

Doctors are judgmental and only care about getting you off the "illegal" drugs a lot of the time. Police were a source of fear.

– Female, unknown ethnicity, 18–24

Several participants described how the stigma of illegal drug use had directly resulted in them not receiving help. It is evident that this stigma can cause serious or lethal harm, as shared by one participant:

Because of the "silence" around illegal drug use, my friend that used and abused opiates overdosed and died. He was a successful person with [academic credentials]. But there was no help for him because it's illegal and so much stigma was attached to admitting what he was doing.

– Female, NZ European, 45–54

Draconian laws

Drug legislation was often seen as harsh, and disproportionate to the severity of offending, especially when compared to violent crimes.

[It is] disproportionate compared to serious crimes.

– Female, Māori/NZ European, 45–54

Several participants shared stories of whānau members who were affected. One study participant in the 65+ age group shared the long-term impacts of the laws that she has observed in the life of a family member.

Being convicted as a criminal for marijuana use very unfair and affected my sister-in-law all the rest of her life.

– Female, NZ European, 65+

Specific harms of the MoDA

Many participants shared in detail how Aotearoa New Zealand's drug laws created harms that would otherwise not have occurred or have been as severe with a different legal framework. These policy-related risks were wide ranging, and related to the volatility of illicit markets, and its impacts on people who used substances, especially those with addiction.

Volatile and toxic supply

A number of participants contrasted the relative safety of the drugs they thought they were accessing with the misrepresented substances they were actually supplied in the illicit market. One participant had primarily positive experiences with substances and experienced no harms outside of those from exposure to toxic supply.

> *All the harm came from prohibition and not being sure of safe supply (what the drugs were cut with). The drugs themselves were a good time.*
>
> – Female, Māori/NZ European, 55–64

Some participants recounted the details of their challenging or dangerous experiences with adulterated or toxic illicit supply, many concluding that these harms could have been avoided in a regulated or controlled setting.

> *The worst harm I've seen and experienced first-hand was where myself and a group of friends bought what we thought was MDMA. We took the MDMA and some LSD together, a couple of people were severely negatively affected, unable to communicate for 8hrs or more and trying to harm themselves unintentionally. The next day we were able to get the drugs tested and our MDMA turned out to be bath salts. If drugs were legal or easier to test prior to use, our experience could have been avoided.*
>
> – Female, Māori/NZ European, 35–44

The illicit drug market is evolving, and the risks experienced by people using substances today are different from the risks present in previous decades. This growth in volatility has been noted by participants who shared that young people who experiment with substances today are in a higher-risk environment than they were when they were younger.

> *Without access to information at the start we engaged [in] significantly risky polydrug experiences. We were lucky the harm was minimal and we have grown out of risk taking. Allowing drug testing has been one step in the right direction ...*
>
> – Male, Māori, 35–44

Criminal market harms

For many participants, the exposure to criminal activity associated with the illicit drug market meant they experienced severe harms. This included people who shared that the strict laws restricting access to drugs to the black market contributed directly to their experience of violence, including sexual violence.

> *By making it not able grow own cannabis I risked buying [from the black] market. Not all was happy ending. Sexual assaults, ripped off.*
>
> – Female, NZ European, 55–64

Illicit markets contribute to the cycle of violence that creates crime, locking people in situations where they may be both perpetrators and victims of crime. For example, one participant shared that these harms would likely not occur if drugs were accessible without being forced to engage with the criminally controlled drug markets.

> *I've been a criminal my entire life. I've never once been able to trust a police officer … I've gotten into violent situations that never would've occurred if I could've gone to a pharmacy and bought my drugs legally. If drugs were legal I never would've experienced drug-related violence.*
>
> – Female, NZ European, 25–34

Some participants shared that while drug laws contribute to harm, they may help generate wealth through increasing profits from criminal activity. One participant who has been involved in supplying drugs, and has experienced addiction, shared his view about this clearly:

> *Certainly [drug laws] did not help. Except making pot dealing profitable.*
>
> – Male, NZ European, 45–54

Use of more harmful substances

Participants noted the consequences of substituting one substance for another, depending on their availability or legal status. For some, the lack of availability of lower-risk substances in the legal supply and their unreliable supply in the illicit market meant that they were exposed to higher-risk substances.

> *The drug laws steered me towards more harmful drugs like methamphetamine when I would have preferred to take milder things if available.*
>
> – Male, NZ European, 35–44

A substantial number of participants pointed to the antisocial effects of Aotearoa New Zealand's most harmful, yet legal, substance – alcohol. They would often contrast alcohol harms with the lower harm profile of cannabis.

> *[My] partner is an alcoholic … A lot of people my age self-medicating with alcohol and drinking alcohol every night at home. Since I was a teenager myself cannabis smoking everywhere by all ages but people not aggressive or*

smashing anything up.

– Female, Māori/NZ European, 65+

Overdose and acute drug harm

Participants noted that the illegality of drugs increases the risk of serious harm occurring when people use them. It also prevents people from seeking help if an emergency occurs.

The fear of seeking help for myself and others. I still remember dropping a friend off in a phone box after [dialling] 111.

–Female, NZ European, 55–64

Another participant shared that she had lost her daughter to an overdose with prescribed substances. This reinforced the participant's belief in harm reduction and the need to make sure people are safe from criminalisation and have support around them.

… so yes people should be able to do what they want [to] in their homes of course underage kiddies no and to make sure they are … looked after … prescription meds are the killers … daughter of last year took her life 33 opioids … etc …

– Female, NZ European, 55–64

Health-based approach

A health-based approach to drugs is centred on the need to treat drug issues as health issues, not criminal ones. Many of the survey participants shared that this must be the priority for national policy, and explained the mechanisms through which this should be achieved. Many also outlined the barriers under the current legislation.

Focusing on health

One participant summarised how current drug laws prevent the focus on health from happening:

Current drug laws criminali[s]e people who are sick, vulnerable and need support.

– Non-binary, Māori/NZ European, 35–44

Many participants offered policy solutions that would bring our national responses closer to a health-based approach. For example, one participant recommended that the Police should not be the default responders to drug-related incidents. Instead these events could be attended by a health worker.

... police needs to be replaced with first responders that are more like social work[ers] that have skills in de-escalation and empathy for drug related callouts.

– Male, Māori/NZ European, 25–34

Moving away from prohibition

Shifting from prohibition to evidence-based regulation was seen as a pragmatic step. Participants recognised that drug use will inevitably occur, and that regulation was a necessary tool in reducing resultant drug harms as much as possible.

For me it all comes down to regulation. The black market is unregulated, which inherently makes it unsafe. People will take drugs if they want to, you will NEVER stop that. Having the government be able to regulate quality, harm reduction methods and quality of goods, I think it would make the NZ drug scene a lot safer.

– Male, NZ European, 25–34)

Many participants drew on their lived experience to provide examples of harm reduction approaches that had worked in their lives. For instance, one of the participants shared how they were able to avoid serious harms thanks to drug checking:

Prohibition has turned a public health issue into a criminal one ... When the law acknowledges harm reduction practices it has helped to ensure my safety and the safety of other users I know. For example, legal and free drug testing clinics have provided services and education that have allowed me to take drugs for years without ever needing to access medical assistance for my use.

– Female, NZ European, 25–34

Social harms of a criminalisation approach

Taking a criminal justice approach in drug policy meant continuous, flow-on effects on people's lives that created harms over time. A participant shared his concerns about the effects on the whānau of people who received criminal convictions:

Imprisoning people selling them further contributes to families going hungry and kids ... being improperly treated.

– Male, European, 18–24

Broader social harms may include family harms and the threat of serious consequences that parents of children using drugs had to consider when seeking support. One participant shared their experience:

There was the hurdle of stigma and being unsure where children sit, within the law of remaining a family, loss of potential employment and not knowing if they could contact police, these were needed to be [overcome] before seeking help.

– Female, Māori/NZ European, 55–64

Decriminalisation

Many participants felt that drug decriminalisation was a necessary element of a health-based approach. Often, participants described how criminalisation compounded harms to the individuals who used drugs, and focused on how closely the need to decriminalise drug use was tied to improving health-seeking behaviours.

People in the community should not be jailed immediately for drug use or possession. Help should be provided for those with issues and guidance provided for those wanting to try.

– Female, NZ European, 25–34

Ineffectiveness of reducing demand or supply and paradoxical effects on use

Despite being illegal, drugs continue to be used by a large number of New Zealanders. Many participants shared that accessing drugs was not an issue for them. For example, one participant who had experienced severe harms, such as SUD, overdose, and criminal drug charges said accessing a range of drugs was very easy.

It was too easy to score other drugs [than] marijuana.

– Male, NZ European, 55–64

For a few participants, all of whom personally experienced drug harms, the illegality of drugs contributed to their attractiveness. One young participant shared this sentiment and described it as an intrinsic part of being young.

I feel like them being illegal just pushes our rangatahi to want to do it more, they want to feel rebellious & that makes it so much more eye catching to them.

– Female, Māori/Pacific, 18–24

Cannabis and the classification of substances

Some survey participants focused on how the harms caused by certain substances differed from others. They believed that overall drug harms were exacerbated by inappropriate and biased policies that did not appropriately account for the characteristics of different substances.

Cannabis liberalisation

A major focus for a subset of participants was cannabis laws. A recurring belief was that cannabis had a low risk profile, especially when compared with other substances. For example, one participant shared his observation about the impacts of cannabis in the community:

> *Well weed is different I [don't] see it doing much harm as say P does to the community …*
>
> – Male, Māori/NZ European, 45–54

For some participants who had experienced drug harms, the illegality of cannabis was a contributing factor to more severe harms experienced from other substances. One participant with a history of addiction and involvement in supplying drugs wrote that their initiation into other drugs was caused by being exposed to the illicit market.

> *Cannabis laws. If I had just stuck to cannabis I would have been ok. But because [it's] illegal I came into contact with other drugs.*
>
> – Female, NZ European, 65+

Alcohol harms

Many participants believed that criminalisation or lack of regulation of illicit drugs resulted in more alcohol harms. Some highlighted the serious harms caused by alcohol, pointing to its widespread availability and the damage it causes in communities. One participant contrasted the strict cannabis policies with the much less strict regulations on alcohol, focusing on young people.

> *I think that weed for adults or medical use should be decriminalised. We need stricter laws around the use of alcohol – your brain isn't mature until 25, why allow 18-year-olds to consume it freely? I have seen more harm from alcohol and meth use than anything else.*
>
> – Female, NZ European, 35–44

Access to beneficial effects of drugs

Participants commonly wrote about the harmful restrictions that drug laws placed on substances with therapeutic value. While some mentioned the value of enjoyment and pleasure afforded by drugs, many focused on the healing properties of certain substances. One participant spoke about cannabis and psilocybin as examples, and described how drug laws contributed to 'demonising' them.

> *I think cannabis and psilocybin will do more good than harm when they are used mindfully, not recreationally, but as a medicine. especially for our neurodivergent communities. it can prevent meltdowns, treat depression,*

encourage constructive introspection and reflection. These two substances are demonised more than they should be …

– Male, NZ European, 18–24

Differential drug policies

Similarly, a number of participants shared that certain criteria should influence how substances are regulated. A commonly occurring point of distinction was around natural as opposed to 'lab-produced' substances.

I think weed should not be illegal as it does not cause as much harm and damage [as] alcohol. As well as shrooms and other safe or natural [psychedelics]. These drugs do not cause harm to people and can actually be beneficial for some …

– Male, NZ European, 18–24

Appropriateness of the MoDA

A relatively smaller proportion of participants did not believe that the MoDA was compounding harms, with a few mentioning positive effects.

Neutral or positive impacts of the MoDA

Some participants shared the belief that our drug laws had no real impact on drug harms in Aotearoa New Zealand. A very small number shared the sentiment that the MoDA was having positive impacts. One participant's response illustrated a more common sentiment, that drug use and harm takes place regardless of drug laws.

The laws have had essentially no [e]ffect on the access or use of drugs."

– Male, NZ European, 18–24

Some of the more uncommon responses mentioned positive impacts of criminalisation on improving a person's health outcomes. As in the response below, they sometimes followed a narrative of redemption or just retribution for harms caused.

Actually, our drug laws eventually meant I entered treatment or was sent to prison for the crimes I committed. On reflection I deserved what I got.

– Male, Māori/NZ European, 65+

Hard-line approach needed

Rarely, participants expressed a wish for a stronger enforcement focus. This was typically focused on the supply of substances.

They are too soft on dangerous drugs like meth and seem to not be interested in stopping supply. I have informed police multiple times of dealers and they do nothing.

– Male, NZ European, 45–54

Part 2. Drug law workshops with people who have experienced or are at risk of drug harm

Workshop methods

Small-group workshops were conducted to explore participants' experiences and aspirations for drug law reform in more depth. The recruitment channels were the same as for the survey, with the additional option for survey respondents to register interest via a separate link. Participants were able to take part in either the workshop or the survey, or both. To ensure survey anonymity, we were not able to link survey results with workshop registrations. The target size for each workshop was between three and 10 participants.

Workshops were held either in person or online, depending on participant preference and feasibility. Māori participants could choose to attend a general workshop or a Māori-only workshop, facilitated by Māori staff. Each workshop was co-facilitated by a member of the research team and another facilitator – one of the facilitators was required to either have relevant lived experience or registration as an addiction practitioner. Facilitators received training in confidentiality, participant safety, and managing distress.

The workshop format included an introductory discussion, prompts about the effects of current drug laws, and a ranking activity in which participants discussed possible goals of drug policy. Discussions were audio-recorded, transcribed, and anonymised, with facilitators also taking notes during the sessions. Each workshop lasted up to two hours, and each participant received a $70 eGift voucher in recognition of their time.

Data analysis

Workshop transcripts and facilitator notes were analysed using thematic analysis to identify common themes, perspectives, and priorities expressed by participants. To solidify our understanding of what the participants shared, we held a sensemaking session with the workshop facilitators. We present the high-level findings from this component of the study.

Workshop results

Workshops

From 8 to 25 August we ran six workshops with people with lived and living experience of drug harm or those who supported others experiencing drug harm. The number of participants in each workshop ranged from three to eight. Three of the workshops were held in person: one in Te Whanganui-a-Tara Wellington, and two in Tāmaki Makaurau Auckland, including one with clients of a social detox service. The remaining three were held online. One of the workshops was a dedicated Māori workshop, and was held online. The workshops were attended by 31 participants in total.

Workshop participant characteristics

Table 13 presents the characteristics of the workshop participants. Participants' ages ranged from 20 to 72 years (M=44.45, SD=14.27). There were slightly more women than men who participated in the workshops. Well over half of the workshop participants were Māori, but only a small proportion (9.7%) identified with other non-European ethnic groups. A substantial proportion belonged to the key populations at increased risk of drug harm, including over a quarter of participants identifying as disabled. Most had experienced addiction, and over half reported selling drugs.

Table 13
Workshop participant characteristics (n=31)

Characteristic	n	%
Age		
18–24	3	9.7
25–34	5	16.1
35–44	9	29.0
45–54	7	22.6
55–64	4	12.9
65 and over	3	9.7
Gender		
Female	17	54.8
Male	14	45.2
Ethnicity		
NZ European/Pākehā	22	71.0
Māori	19	61.3
Pacific	2	6.5
Asian	1	3.2

Disability status*		
Yes	9	29.0
No	14	45.2
Rainbow identity*		
Yes	5	16.1
No	18	58.1
Neurodiversity status*		
Yes	7	22.6
No	16	51.6
Addiction experience (participant)		
Yes	23	74.2
No	8	25.8
Criminalised for drug offences*		
Yes	10	32.3
No	16	51.6
Supported others with drug harms*		
Yes	8	25.8
No	14	45.2
Supplied drugs to others*		
Yes	18	58.1
No	6	19.4
Experienced overdose*		
Yes	11	35.5
No	11	35.5

Note. Values are frequencies (n) and percentages (%). Ethnicity is total response (percentages may sum to >100).

** Indicates variables with missing data.*

Workshops insights

In this section we present key high-level findings from the workshops, as identified by the workshop facilitators through notes and the sensemaking session. Table 14 presents key insights that were raised in the workshops.

Table 14
Key insights from the workshops (n=31)

Insight	Common discourse
Stigma and barriers to healthcare	Fear of disclosing drug use to medical professionals; experience of refusal of treatment, labelling as 'drug-seeking', diagnostic overshadowing. Social exclusion due to drug use or addiction.
Inequities in the application of drug laws and overcoming them	Disproportionate impacts on communities, especially Māori. Excessive policing of Māori communities – or leniency towards Pākehā New Zealanders. Support for kaupapa Māori approaches, intergenerational perspectives, and ensuring kuia/kaumātua voices are heard.
MoDA and lack of health-based approach	Legislation seen as arbitrary and not effective at reducing harm. Drug laws not deterring use. Prosecution for small-scale dealing more harmful; small-scale dealing intertwined with supporting personal use; must be distinguished from organised crime. Punishment-focused approach harmful; overarching "keeping people safe" goal not being met.
Alcohol harms	Alcohol more harmful than illicit drugs, yet under-regulated. Calls to restrict alcohol oversupply and reduce to exposure to alcohol. Frustration with alcohol harms downplayed, compared to illicit drugs.
Regulation of drugs, profits, and access	If legalised: strict regulation of pricing, access, and regulation of medicinal/pharmaceutical markets. Reservations around corporate profits from legal drug markets; preference for revenue to fund health and support; concern about overexposure. Support for therapeutic availability of controlled drugs, but barriers exist in accessing treatment (e.g., ADHD medication restrictions, methadone over- and under-prescription).

Insight	Common discourse
Protecting and supporting young people	Protecting young people as a major motivation to participate in workshops. Aspiration for drug laws: protecting rangatahi/mokopuna from harm. Support for youth-led initiatives and early interventions. Recognition that intergenerational trauma contributes to harm and must be addressed.
Harm reduction and addressing toxic supply	All substances carry a level of risk. Concerns about toxic supply and overdose; emphasis on harm reduction tools. Drug checking praised and seen as highly beneficial. Support for any interventions that reduce death and acute harm
Broader determinants of drug harm	Mental health issues and lack of early intervention linked to drug harms. Social determinants such as food security, housing, and wraparound services foundational. Need to learn from good practice overseas.
Harm-reduction-centred goals	Support for harm-reduction-centred goals – including all goals about information provision, overdose prevention, and similar. Goals around "preventing drug use" not supported – unrealistic, and compounding harm. Complexities about preventing drug use among young people specifically – mixed support; focus on need for harm reduction to respond to needs of young people. People with experience of severe harm with concerns about permissive legalisation: need to reduce exposure to substances, stop oversupply, regulate in a strict and effective way.

Stigma and barriers to healthcare

Many participants shared hesitancy to disclose drug use to healthcare professionals for fear of refusal of treatment or diagnostic overshadowing. Participants also expressed concern about social and legal ramifications of disclosure and the impact this could have on their lives. For some participants, this was a major deterrent for seeking help.

One workshop participant shared a friend's experience of being refused treatment:

Somebody [I know] went to a doctor once [to] get help, and he asked her, "are you on any drugs, methamphetamine?" She admitted to [using] methamphetamine. And he just said, "sorry, I can't help you, go away", not giving her any health assistance.

– Female, Māori/NZ European, 35–44

Participants expressed fears of stigma in healthcare settings, not only around addiction, but particularly in relation to illicit drugs. For example, a participant obfuscated their drug use as alcohol use when seeking help, because she did not want drug use to appear in her medical history:

So, when I first went to the doctor's and I was trying to get help to get into rehab, I told them I was an alcoholic because, you know, it's not a drug. So, my fear of telling them [was] that it'd go into my medical history ...

– Female, Māori, 35–44

For some, the stigma associated with engaging in the illegal act of using drugs meant exclusion from the mainstream society and social isolation. One participant shared how being labelled a 'criminal' had the potential to invalidate people's positive social roles:

It's like, you know, you're a criminal or you're a contributing member of society, you know, like, it's one or the other, and you can't be both.

– Female, Asian, 35–44

Inequities in the application of drug laws and overcoming them

Participants acknowledged the harsher application of drug laws by law enforcement against Māori. In particular, people felt that this pattern of disproportionate legal penalties given to Māori contributed to the cycle of reoffending and, more generally, diminished opportunities for Māori people who use drugs to improve their health. One participant illustrated this inequity:

The fines that [Māori] people get, the incarcerations that everybody gets. You know, we look at our counterparts – I'm not going to be biased or racist or anything, but I want to say, 'white privilege' and call it out for what it is.

– Male, Māori, 45–54

This perspective was shared by Māori and non-Māori participants. For example, one participant acknowledged that their experience of the roadside drug testing programme planned to be rolled out in Aotearoa New Zealand may be very different than for someone with a different positionality:

I'm in a very lucky seat, because even if I did have cannabis now, chances are the police would look at me like an old lady, and I'd get by, and you might not.

– Female, Māori/NZ European, 65+

For some participants, these compounded harms for Māori meant that specific health interventions were required to counteract them. One of the participants shared their hopes for a future that integrates kaupapa Māori approaches and te ao Māori into how drug use and harm is addressed:

I think that tangata whenua approach to holistic and health and community wellbeing allows space for treatment of the individual, spiritually, mentally, physically …

– Female, Asian, 35–44

The MoDA and lack of health-based approach

Overwhelmingly, participants felt that the current drug laws in Aotearoa New Zealand were not fit for purpose, evidence based, or effective in reducing drug harm. Drug use being treated as a criminal issue – instead of a health focus – was perceived as ineffective and, in some cases, participants felt it actually contributed to the cycle of drug use and harm. A participant shared their lived experience of being criminalised for drug use:

Personally, like, I went to jail for drug offenses when I was 19, and I went into jail, you know, an addict, bit of a peddler, I came out a fucking gangster. You know, I just met so many people, and it upset my life for the next 10 years …

– Male, NZ European, 35–44

A sentiment that a health-focused approach should replace the current criminal justice approach emerged clearly in the workshops. For example, a participant shared:

I would want to see, I think, pretty much everything decriminalised and have the legislation, a massive intent to change into making it a health issue, harm reduction, massive public health investment into that side of things, rather than criminalising people for it.

– Male, NZ European, 35–44

Many participants in the workshops felt that drug laws in Aotearoa New Zealand should enable harm reduction practices that help keep people who use drugs – and the general public – safer and healthier. One participant shared their perspective:

Good drug policy should be around making sure the person who's taking the drugs has got good choices, the right help when they need it, and the right information when they need it, and that they're not stigmatised for their choices and feel they can engage.

– Male, Māori/NZ European, 55–64

Alcohol harms

Despite alcohol being legal in Aotearoa New Zealand, participants reflected that it often caused greater harms than illicit substances. Many participants shared the sentiment that despite the risks and harms from alcohol, it was treated differently to illicit drugs from both legal and social perspectives:

Lots of people are under the impression that, because alcohol is legal, it's fine and not harmful, but it's one of the most harmful things in the society.

– Female, Māori/NZ European, 45–54

Regulation of drugs, profits, and access

Some participants reacted positively to the concept of regulating illicit drugs. However, there were many 'sticking points' around how this could be achieved in Aotearoa New Zealand to avoid corporate capture, ensure accessibility and equity, and avoid excessive product availability. A participant shared their ideas on reinvestment:

If things were regulated … if they had some kind of tax or levy attached to it that could be pumped back into the harm reduction side of things, just like, you know, they do with an ACC levy, you know, it's pumped back into health and things like that.

– Male, NZ European, 35–44

Other participants felt that drug regulation, particularly without strict controls, could result in more harm in the community, especially among people experiencing addiction. One participant commented on the challenges that may arise from the existence of a commercially regulated market:

[The goal of] allowing local communities to legally profit from the sale and production of legal drugs to the public. Definitely not, why should we make this a business out of it, just so people can earn money or gain from addictions. The benefits don't outweigh the risk.

– Female, Māori/NZ European, 35–44

Protecting and supporting young people

Across the workshops, there was considerable agreement about the importance of prioritising the protection, support, and education of young people in our approach to drug laws. In fact, wanting to make it better and safer for younger generations was a major reason participants were motivated to take part in this research.

Ensuring rangatahi and mokopuna were protected from drug harm was paramount for many participants, particularly in the context of breaking cycles of harm and intergenerational trauma. For example, one participant shared:

Do you know how hard it is as an adult, trying to re-regulate what you've already known as normal? Trying to break generational cycles so your kids don't grow up in the same trauma that you did?

– Female, Māori, 25–34

Harm reduction and addressing toxic supply

For the most part, participants shared the perspective that the volatile, unpredictable, and increasingly toxic nature of the drug supply is a significant contributor to the harm people experience. As drugs are illegal, there is no quality control for consumers. One participant illustrated this:

You can't control the quality, and you'll always get people with terrible intentions that don't want to look after their customers, they just want to make money.

– Female, NZ European, 54–65

Another participant commented on the growing range of highly potent products appearing in the illicit market, which poses a heightened risk both now and in the future for those who use drugs:

I've seen some of the, you know, like benzo substitutes, black market benzos, or fentanyl and all sorts of dangerous shit in it.

– Male, NZ European, 35–44

To counteract these risks, participants often shared that harm reduction initiatives were essential as they address the unregulated and volatile drug supply. Many raised the example of drug checking as an excellent case for a positive intervention. One participant shared:

But with drug [checking] and the fact that you can go in and have no repercussions, and talk to someone who has a wealth of knowledge, in my experience, around all kinds of drugs, and obviously the spectrometers … tell you exactly what compounds you're consuming, and the ability to take it or

dispose it if you need to, is amazing, and we need to do more legislation like that, more reform like that.

– Male, Māori/NZ European, 25–34

Broader determinants of drug harm

Participants cited a wide variety of factors that contributed to some people who use drugs experiencing harms or to exacerbation of these harms. Some shared that drugs were used to help people deal with mental health and trauma – particularly when they had limited alternative ways of coping. Some shared that this complicated access to help as well:

Also, if you've got a mental health problem, usually one feeds the other with the drugs and the mental health. Mental health [services] won't help you if you've got a drug problem. The drug people [services] won't help you if you've got a mental health problem.

– Male, NZ European, 20–24

Participants also cited a variety of social determinants of overall health and wellbeing that impacted drug use and harm. This included things such as lack of food security, unstable housing, financial instability, and disconnection from culture and community. As one participant put it:

We need a holistic approach, where people are encouraged, people are given food and [a] safe place to sleep, then they probably won't become unwell and end up having all these social issues where they have to use drugs to block out all these feelings.

– Female, Māori/NZ European, 45–54

Harm-reduction-centred goals

There was high support across most workshop groups for the goals that centred harm reduction. Participants shared the perspective that nothing exists in isolation – effective drug laws require investment across the entire system: from healthcare to early intervention services to the provision of education. As one participant summarised:

I think that none of those things [goals of drug policy] can be changed on their own. Like [to] reduce people in prison, [we] need people to be able to access the healthcare and people need to know where to access the information to know what they need to do … [it's] not a single problem; it's a multi-faceted solution [that] we need.

– Female, Māori/NZ European, 45–54

Discussion

This research was set out to document the aspirations of people adversely impacted by Aotearoa New Zealand drug laws, and to better understand how legal frameworks shape drug harms. We noted that the survey and workshop methods corroborated each other's findings, with no substantial divergence.

While participants did not agree on every issue and presented a diversity of views, overall, a clear pattern of responses emerged from both datasets, with both open-ended survey questions and workshops providing additional nuance to our findings.

Through this mixed-methods research, we found consistent evidence that current laws may compound harm rather than reduce it. Participants overwhelmingly called for a health-based response, grounded in harm reduction principles and equity, that addresses stigma, reduces barriers to care, and protects the whānau and future generations.

Harms under the Misuse of Drugs Act 1975

Across both research components, participants reported that the MoDA exacerbated the very harms it sought to prevent. Survey respondents highlighted how fear of criminalisation leads to reluctance to seek medical help during overdoses, to disclose drug use to a health professional, or to access support services early. Logistic regression analysis confirmed that those with lived experience of harm were significantly more likely to report stigma in healthcare and concerns about disclosing drug use to clinicians. These findings were echoed in workshops, where participants described being refused treatment, being labelled as 'drug-seeking', or receiving poor-quality care.

Criminalisation also created long-lasting collateral harms. Participants described the ongoing impact of criminal records on employment, housing, and whānau wellbeing. The perception that drug law enforcement was harsh, arbitrary, and disproportionately targeted Māori was widespread. In line with international evidence, our findings show that a punitive approach fails to deter use and entrenches stigma and disadvantage.

A health-based approach

A key theme was the desire for drug policy to focus on health rather than punishment. Participants supported policy goals such as reliable information, overdose prevention, and improved access to therapeutic drugs and health services – rated as "great" outcomes by over 70% of survey respondents. By contrast, preventing all drug use and a focus on punishing suppliers were widely seen as undesirable policy goals. Participants emphasised that Police should not be the default responders for drug-related crises and instead advocated for this response to be health based.

The workshops reinforced this vision, with many participants noting that decriminalisation that removed barriers to accessing information and help, coupled with harm reduction approaches are essential steps to improving outcomes of people affected by drug harms. Drug checking, opioid substitution therapy, and regulated access to certain medicines were described as positive examples of current measures. However, substantial limitations were noted, including limited harm reduction service provision, high thresholds to treatment access, stigma in healthcare, and, especially, criminalisation of drug use.

Regulation of substances and toxic supply

A number of participants contrasted cannabis with alcohol, questioning why a substance that caused less harm in Aotearoa New Zealand remained criminalised, while alcohol, which caused widespread and visible harm, was heavily marketed and normalised. Alcohol was consistently described as a driver of family violence, trauma, and community harm. Calls for greater regulation of alcohol – including restrictions on advertising and availability – were strong.

Participants also reported harms from an increasingly volatile illicit drug supply, including dangerous adulterants in – or misrepresentation of – substances that were considered lower harm, such as MDMA or psychedelics. Such experiences reinforced support for interventions such as drug checking and broader regulation of lower-risk substances to reduce the risks of toxic, misrepresented, or contaminated drugs.

Māori perspectives, equity, and intergenerational impacts

Māori participants and others in workshops stressed that the unequal application of drug laws exacerbates existing inequities. Participants described how Māori are disproportionately subject to enforcement and denied diversion opportunities. Many called for kaupapa Māori approaches that prioritise tino rangatiratanga, whānau voice, and intergenerational perspectives. Protecting rangatahi and mokopuna from harm was a shared aspiration across all workshops, though views diverged on how to best balance efforts to support prevention of youth drug use and a clear focus on youth-focused harm reduction.

Balancing regulation, profit, and public good

While many participants supported regulated access to a narrow or broad range of drugs, a theme emerged where people opposed a commercial model that prioritised profits over health, especially in discussions during the workshops. Heavily emphasising the need to protect community health, they argued that commercial income or tax should be directed towards health services, harm reduction, or whānau or community supports. This reflects a strong aspiration for drug law reform to align with broader determinants of wellbeing, and not only with individual-level harms.

Implications for drug policy in Aotearoa

Taken together, these findings reinforce that Aotearoa New Zealand's current drug laws are not seen as fit for purpose by people who have experienced drug harms. The overwhelming consensus among participants is that Aotearoa New Zealand's drug policy should shift towards a health-centred, harm reduction framework. While many detailed recommendations could be drawn from this engagement, the ones that resounded most strongly included:

- Decriminalisation of personal use and possession, alongside sustainable investment in health services.
- Development of approaches to reduce exposure to toxic adulterants and prevent illicit-market-related harms, including considering regulation.
- Greater consistency across substance classification under the MoDA based on evidence of relative harm.
- Strengthening kaupapa Māori approaches that address inequities and uphold te Tiriti o Waitangi.
- Ensuring that any savings or revenue from policy change or introduction of legal markets supports public health, not private profit.

Strengths and limitations

This study represents a large community engagement in Aotearoa New Zealand with people directly affected by drug harms. Its strength lies in combining survey data with in-depth qualitative insights, enabling a more complete picture of lived and living experience. However, the findings are not representative of all people who use drugs in Aotearoa New Zealand. Recruitment was targeted towards people with lived experience of harm, and thus the perspectives of those without such experiences may be under-represented. Additionally, while the survey sample was reasonably large and recruited a large proportion of Māori participants, Pacific and Asian communities were not represented relative to the general populations.

Conclusion

Participants overwhelmingly called for a future in which drug policy reduces harm, protects health, and supports hauora. In its current form, the MoDA is widely seen as compounding harm, creating stigma, and failing to protect communities. Reform that centres health, equity, and evidence has strong support from those most affected. In the next chapter we will explore some of the possible approaches by looking at international evidence from countries implementing drug law reform.

Chapter IV.
Alternative options for drug control: Lessons from other countries

What policy solutions could improve our drug harm outcomes?

A rational drug policy should strive to identify the actual and possible harms that substances may cause in people's lives and communities. In Aotearoa New Zealand, as in many other countries, the dominant model has been to predominantly concentrate (unsuccessfully) on supply control measures. However, this is only one possible strategy, and there are viable alternatives.

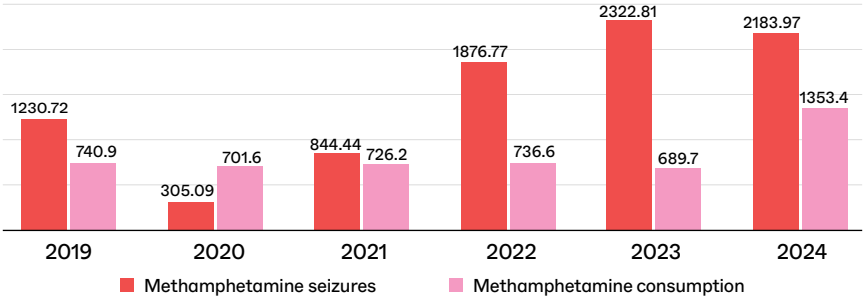
Aotearoa New Zealand's most recent National Drug Policy (2015–2020) outlines three central strategies: problem limitation, demand reduction, and supply control (Inter-Agency Committee on Drugs, 2015). As we have demonstrated in previous sections, the main area of state activity and, by far, the central focus of Aotearoa New Zealand legislative framework is supply control.

Supply control is undoubtedly an important part of good drug policy. It is commonly accepted that sensible regulation must counteract the inherent harms of an unregulated black market, while also preventing the risks of a possible inadequately controlled legal market.

Eradicating the supply of drugs is an unachievable goal. Interventions focusing on eradicating supply can, at best, only modestly reduce the availability of illicit drugs. For example, evidence shows that the black market is agile enough to meet the demand for methamphetamine, and without addressing other factors leading to methamphetamine harm, enforcement alone is likely to fail as a strategy. The graph below (Figure 24) presents the customs seizures of methamphetamine stopped from entering Aotearoa New Zealand, as well as estimated methamphetamine consumed domestically. While the amount of methamphetamine seized varied almost eight-fold between 2019 and 2024, actual domestic consumption was much more stable. Notably, between 2023 and 2024, when methamphetamine consumption nearly doubled, the volume of seizures was nearly identical to the previous two years' average.

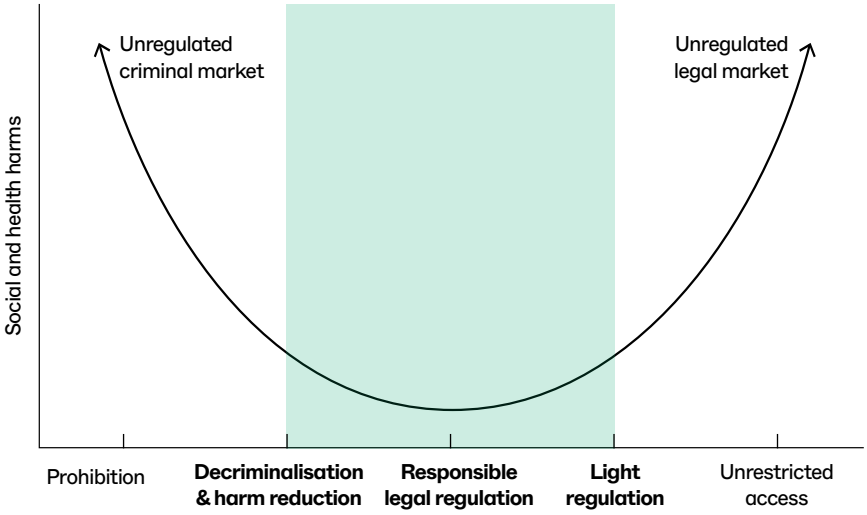
Figure 24

Customs methamphetamine seizures and total load of methamphetamine detected in wastewater testing (kg) (New Zealand Customs Service, 2025; New Zealand Police, 2025)



In this chapter, we describe policies that may offer an alternative to a prohibitionist approach. These policies may address different parts of the supply and demand chain, and may aim to achieve improvements in a diverse range of outcomes. Some policies may present levers targeting various elements of the market, including the customers of the markets (e.g., decriminalisation of personal possession), small-scale individual self-supply (e.g., legalisation of cultivation of cannabis or psychedelic mushrooms), networked supply (e.g., social supply), or, at the furthest extent, enabling the supply of drugs to the adult public (e.g., licensed bars or liquor stores for alcohol, or drug dispensing in pharmacies). Generally, it is thought that good drug policies should help avoid the harms associated with unregulated criminal market, as well as the harms that could stem from poorly regulated legal market (Figure 25).

Figure 25
Drug policy spectrum; adapted from Marks (1987) and Health Officers Council of British Columbia (2005)



The policy spectrum can range from extreme penalties to deter from substance use or supply, to an entirely legal system of substance supply, and no criminal penalties for substance use. Many of the approaches will be described in detail in this chapter.

No single policy option is likely to address all actual or potential risks and harms associated with drug use. Each of the policy options we describe here has specific aims, against which it can be reasonably evaluated.

For example, policies such as decriminalisation of personal possession or use of substances are likely to improve criminal justice outcomes of the population. However, they will not eliminate the risk of exposure to adulterated illicit supply. That said, decriminalisation could improve help-seeking behaviours, and make it easier for health and harm reduction information to be shared, if a substance causes adverse effects.

Furthermore, policy settings do not exist in isolation and different policy options influence one another. This means that the same single policy may be extremely effective at reducing drug harms in one policy environment, and harmful in another. For instance, alcohol and tobacco policies in most countries globally rely on decriminalised consumption and regulated supply. Despite this commonality, smoking and drinking harms vary substantially between countries, depending on specific policy settings and associated laws, such as whether public smoking is permitted or not.

In this chapter, we will focus on the rationale and outcomes of policy options that have been proposed or implemented overseas, and we will consider their benefits and drawbacks.

Drug use decriminalisation

What is drug decriminalisation?

Decriminalisation of personal possession or use of drugs is a widespread legal practice, currently adopted in a number of jurisdictions. Put simply, decriminalisation means that a jurisdiction has removed criminal penalties for possession or use of drugs. In some places, limited cultivation or non-profit 'social sharing' of cannabis is also exempt.

Decriminalisation does not mean that drugs are legal: criminal sanctions for drug supply, manufacture, and trafficking remain in place. In practice, approaches to decriminalisation differ. In some countries, criminal penalties have been replaced with civil sanctions such as fines, treatment referrals, or education programmes. In others, no penalties are applied at all.

Decriminalisation is not a single model but a spectrum of approaches that vary depending on local objectives and contexts. Some jurisdictions adopt decriminalisation as part of a wider shift towards treating drug use as a health issue, rather than as a matter for the criminal justice system (Eastwood et al., 2016). Others have pursued reform in response to rising overdose deaths, or to focus policing resources on serious offending rather than low-level possession (Zoorob et al., 2024).

Decriminalisation models worldwide are sometimes limited to cannabis or a specified list of substances, but sometimes all substances are included. Models can be broadly divided into two forms:

- De jure decriminalisation: enacted through legislation or court rulings. This is the most common approach and generally means that possession (typically, up to a defined threshold) carries no criminal sanctions, or may carry civil sanctions.
- De facto decriminalisation: where drug possession remains illegal but laws are not enforced in practice. The Netherlands is the best-known example of this model.

Implementation of decriminalisation varies, with outcomes shaped by how reforms are resourced and enforced. Despite a formal removal of criminal penalties for possession of small quantities of drugs in 2004 (Levinson, 2008), the Russian Federation continues to arrest and incarcerate thousands of people a year for drug possession or use.[10]

Decriminalisation outcomes

As of mid-2025, 34 countries and 36 sub-national jurisdictions have decriminalised cannabis, with more than half of these reforms introduced in

[10] Around 90,000 people are still prosecuted annually for drug use in Russia, and about 40,000 receive prison sentences of up to 15 days (technically, a non-criminal penalty in Russia). A strict 'zero tolerance' approach persists, alongside severe limits on public health measures and a ban on opioid substitution treatment (Golichenko & Elliott, 2021).

the past decade. Since 1973, 22 countries have also decriminalised possession of all substances. These diverse models have been studied for their effects on crime, illicit markets, and health and social outcomes, offering a growing body of evidence on the impacts of decriminalisation.

While some raise concerns that removing criminal sanctions could encourage drug use, particularly among young people, the evidence does not support this. Most studies find no increase in use, and in some contexts, decreases in problematic or high-risk use have been recorded. Importantly, advocates of decriminalisation emphasise that its goal is not necessarily to reduce drug use overall, but to minimise the harms associated with both drug use and impacts of criminalisation. In summary, international experience suggests that decriminalisation

- does not lead to significant increases in drug use;
- can reduce problematic use, particularly when coupled with treatment and harm reduction;
- reduces the burden on courts, prisons, and Police;
- is most effective when implemented clearly, resourced adequately, and paired with health and social support services.

Where reforms are poorly implemented or contradicted by enforcement practices, the intended benefits are undermined.

In the section below, we present an overview of the main impacts of decriminalisation from jurisdictions that have undertaken drug law reform.

1. Prevalence of drug use

While the aim of decriminalisation is to reduce harm associated with drug use, and especially the flow-on negative impacts of criminalisation, a lot of attention has been dedicated to examining the impacts on prevalence of substance use. Some of the key findings from this research include:

Portugal decriminalised possession of all drugs in 2001, which was followed by a reduction in drug use among 'problematic' users from 7.6 in 2000, to 6.8 per 1,000 population in 2005, as well as a significant decrease in injecting drug use. Portugal now has the third lowest rate of adult drug use in Europe (3.1%) (European Union Drugs Agency, 2025; Hughes & Stevens, 2010; 2012).

An analysis from five US states undertaking policy change has found that decriminalisation of cannabis use has not been associated with an increase in the past-30-day prevalence of cannabis use (Grucza et al., 2018).

In Australia's Northern Territory, prevalence of cannabis use has more than halved following decriminalisation in 1996 (from 36.5% in 1998, to 15.9% in 2019) (Australian Institute of Health and Welfare, 2020).

Since 2020, the Australian Capital Territory has decriminalised cannabis use. Since the policy change, there has been no increase in past-year cannabis use

rates among those aged over 14 (ACT Government, 2024).

Rates of regular or problematic drug use are lower in Maryland and Connecticut compared with other US states with civil penalties for drug use (Hughes et al., 2019).

2. Crime rates

The relationship between overall drug use and overall crime rates is nuanced, and complicated by the fact that crime rates in different jurisdictions are highly dependent on how crime is recorded. Jurisdictions that implement decriminalisation of drug possession often do so to ease the overall burden on the criminal justice system. While there is an obvious drop in the number of drug possession offences, resulting from no longer prosecuting them, a reduction in other crimes that may be 'linked' to drug use is more challenging to define and measure (Hughes & Stevens, 2007). Still, there are some clear examples of criminal justice outcomes associated with decriminalisation:

- Clear reductions in criminal justice system burden were observed in most programmes assessed in a study that examined alternatives to prosecution for drug use in nine different countries including the Czech Republic, the Netherlands, Australia, and Portugal (Hughes et al., 2019).
- The proportion of the prison population sentenced for drug offences in Portugal fell from 42.9% in 2001 to 18.5% in 2023 (Aebi & Cocco, 2023; Tournier, 2002).
- Compared to people who received a charge, those who engaged with diversion programmes in Australia were no more likely than other offenders to use cannabis or commit serious offences such as violence or drug trafficking. In the Australian context, diversion was considered a cost-effective option compared with pressing charges (Shanahan et al., 2016).
- The ACT Government has concluded that decriminalisation has had the intended effect of reducing the criminal justice system involvement of people who possess and cultivate small amounts of cannabis for personal use (ACT Government, 2024). Cannabis seizures have reduced significantly, by 39.3%, between 2019–20 and 2020–21. Cannabis-related referrals to drug diversion programmes were declining before decriminalisation, and continued to decline to single-digit figures in 2023.

3. Health outcomes, including drug overdose

The benefits of decriminalisation are seen in a reduction in the stigma of drug use, encouraging people to seek help. Criminalisation is seen as a major barrier to information, help, and treatment seeking. This has been demonstrated in the empirical section of this report (See Chapter III).

Other health benefits of decriminalisation can include lower rates of blood-borne virus transmission when possession of sterile injecting equipment is legal and available to people who inject drugs.

When decriminalisation is implemented in an unregulated illicit market, without robust harm reduction and other necessary regulatory and health measures, decriminalisation alone is unlikely to succeed in reducing overdose fatalities. Achieving this will require further policy interventions and resourcing, including treatment options, housing support, and other measures.

The clearest case for decriminalisation from the perspective of health outcomes comes from Portugal, where substantial enforcement savings were diverted to health interventions.

- Drug-related deaths in Portugal decreased from 76 deaths in 2001 to 12 in 2006. Numbers fluctuated in the following years, but as of 2019, Portugal had one of the lowest rates of drug-related deaths in the EU among people aged 15–64 (six deaths per million compared to the EU average of 23.7 per million). There have been particularly significant reductions in opioid-related deaths (European Union Drugs Agency, 2020; Hughes & Stevens, 2012).
- There were significant reductions in infectious diseases in Portugal following decriminalisation of drug use, including HIV and hepatitis C. Portugal's widespread investment in harm reduction interventions, such as NSPs and other health services, has been credited with helping achieve this reduction (Hughes & Stevens, 2012).[11]

While decriminalisation has consistently been found to reduce criminalisation harms, the beneficial effects on health outcomes have been less consistent across jurisdictions. For instance, an analysis of two-year post-decriminalisation outcomes in British Columbia, Canada, has found that the policy shift has resulted in marked reductions in criminal justice involvement of people who use drugs. However, decriminalisation did not result in a change in hospitalisations, or deaths related to opioid or stimulant use. The authors concluded that when delivered in isolation, decriminalisation policy may not be sufficiently effective in reducing health harms, at least in the short term (Gaudreault et al., 2025). These findings support the understanding that in order to reduce both criminal justice and health harms, decriminalisation should be implemented alongside other, health-focused interventions.

4. Social and economic outcomes

In decriminalised settings, fewer arrests for drug possession lead to fewer people with criminal records, which can have positive impacts on their access

[11] Portugal has experienced an increase in new HIV diagnoses in recent years. The vast majority of these new diagnoses are not linked to injecting drug use. In fact, the number who acquired HIV via injecting drug use fell from 65 in 2014, to 24 in 2023 (European Centre for Disease Prevention and Control & World Health Organization, 2024).

to education, housing, and employment (Eastwood et al., 2016; Shanahan et al., 2016). This has been posited to lead to positive economic impacts for wider society. Evidence from countries with decriminalisation models includes:

- The 2001 implementation of Portugal's National Strategy for the Fight Against Drugs combined decriminalisation with investment in prevention of drug use, as well as harm reduction, social reintegration, supply control, and demand reduction programmes and policies. Following the policy implementation, the social cost of drugs fell by an average 12% from 2000 to 2004. This was largely attributed to the reduction in indirect health costs from fewer drug-related deaths; individuals who die from drug-related causes can no longer earn an income or contribute economically. Between 2000 and 2010, an 18% reduction was observed, largely due to lower legal system costs and reduced indirect costs from lost income and productivity of imprisoned individuals (Gonçalves et al., 2015).
- In Australia, it has been estimated that expanding Police diversion schemes for all drug types could cut prosecution costs by over 51%, reducing costs per offence from AU$977 to AU$507 (Tran et al., 2023). Similarly, criminalised individuals in Western Australia were found to face greater negative impacts on employment, relationships, and housing, and were more likely to re-enter the criminal justice system than those in South Australia given Cannabis Expiation Notices (CENs)[12] (McLaren & Mattick, 2007).

Re-criminalisation of drug possession

There are some examples of jurisdictions that decriminalised drug possession, only to later re-criminalise it due to social and political pressures. In particular, moves to re-criminalise drug possession appear to be in response to perceived unfavourable changes in public drug use, overdose rates, and other matters of public concern. This can happen when an insufficiently resourced harm reduction and treatment system fails to cope with the increased risks emerging from the illicit drug market – as is often raised in analyses of Oregon's reversal of its decriminalisation policy (Drug Policy Alliance, 2024).

Table 15 presents jurisdictions that have undertaken re-criminalising policy change.

[12] The South Australia CEN scheme has been in place since 1987. Under this policy, the Police issue a CEN to an individual caught in possession of up to 100 grams of cannabis or found to be cultivating no more than one non-hydroponic plant for personal use. This requires the individual to pay a civil fine of up to AU$300, depending on the amount of cannabis found, within 28 days. If the individual pays the fine, no admission of guilt is recorded and there is no prosecution. If the individual fails to pay the fine, they will be sent a reminder notice and an additional fee for the notice will be added to the original fine. If they subsequently do not pay the expiation fee and the reminder fee, the matter will be referred to court, which will administratively issue an enforcement notice. This results in an automatic conviction and enforcement of the outstanding fine (Eastwood et al., 2016).

Table 15
Jurisdictions reversing decriminalisation policies

Jurisdiction	Decriminalisation year	Re-criminalisation year
Czech Republic	1990	1998 (reverted to decriminalisation again in 2010)
	In 1998 the Czech penal code was amended to make possession for personal use a civil offence if in 'small amounts' (Eastwood et al., 2016). Drug availability remained the same as during the pre-decriminalisation period. However, the economic and social costs of drug use (for example, the cost of enforcing criminal penalties for drug possession, and lost productivity as a result of early mortality from drug use) significantly increased (Zabansky et al., 2001). Drug possession was decriminalised again in 2010.	
Western Australia	2004 (civil penalties for possession remained)	2011
	Recriminalised due to a perceived increase in cannabis use following decriminalisation. However, this was not true, as, in fact, cannabis use decreased from 13.7% in 2004 to 10.8% in 2007. There was likewise no increased cannabis use among regular users or school students after one year of decriminalisation (Eastwood et al., 2016).	
Oregon (USA)	December 2020	2024
	After decriminalisation, there were significantly fewer drug possession arrests per population in the following month than in the neighbouring states (Davis et al., 2023). There was a sharp increase in fentanyl-related deaths, homelessness, and public drug use in the period following decriminalisation – this closely mirrored the general trend in most of the US during the Covid-19 pandemic in relation to the the widespread presence of fentanyl in the drug supply (Zoorob et al., 2024).	

Jurisdiction	Decriminalisation year	Re-criminalisation year
British Columbia (Canada)	January 2023	Planned in January 2026
	After around 15 months, drug consumption in public spaces was effectively re-criminalised following political concerns around 'public safety' (Singh Kelsall et al., 2025; Speed et al., 2025). The three-year decriminalisation pilot officially ends in 2026.	

Decriminalisation and the LCR

As we have outlined, internationally, many jurisdictions have reevaluated the role of the criminal justice system in responding to low-level drug offending. In Aotearoa New Zealand's context, in 2011 the Law Commission stated that due to international obligations, full decriminalisation was not a policy position open to them to recommend. At the time, this issue was controversial, and the Commission's terms of reference adopted a conservative (but at the time dominant) view that decriminalisation was not compliant with international treaties.

However, since the LCR's release, it has become a prevailing view that various forms of decriminalisation of personal possession are, in fact, compliant with the international drug treaties. Importantly, this understanding is now considered an orthodox interpretation by key international bodies. This has been fully expressed in a recent United Nations Office on Drugs and Crime (UNODC) policy note:

> *The international drug conventions limit the use of controlled substances to medical and scientific use, but do not require State parties to establish drug use for non-medical or non-scientific purposes per se as a criminal offence.*
>
> *The international drug conventions offer each State Party some degree of flexibility when dealing with possession of drugs for personal consumption or "in appropriate cases of a minor nature". This allows national law and policies to be adapted to its constitutional principles and basic concepts of its legal systems.*
>
> (UNODC, 2025, p. 6)

Regarding personal possession and use of drugs, the Law Commission discussed Portugal's approach, and its redirection towards educative and treatment responses (Law Commission, 2011, p. 223). While supporting many aspects of the Portuguese approach, the Commission considered it was inappropriate for Aotearoa, due to the model being relatively resource-intensive and the fact that a community-based panel was empowered to impose punitive sanctions.

It is difficult to speculate whether the Commission would have recommended

decriminalisation were they able to fully analyse such an option. Instead, the Commission recommended that Aotearoa New Zealand adopt a cautioning scheme,[13] involving cautioning people who are arrested for drug possession with enforcement interventions after a final caution. This would need to be accompanied by a drug classification system reassessment.

However, a cautioning system that culminates in a mandatory intervention carries the risk of reinforcing stigma, as well as unnecessarily burdening health services and Police. It is also clear that most people who use drugs will not substantially benefit from an immediate health intervention, as they do not have an immediate health need. A minority will, and it is important that this group has clear pathways to access support. Therefore, in a pragmatic approach, if people are found with small amounts of drugs, they could be provided with health and service access information, along with a non-mandatory (opt-in) health referral.

Social supply

Non-commercial sharing of small quantities of drugs between people in social situations has been referred to as 'social supply' or 'social dealing' (Law Commission, 2010). This usually involves people who use drugs together, or buy drugs from one source and share them with each other for convenience. In terms of criminal penalties, the MoDA treats small-scale supply of class C drugs (such as cannabis) to adults without profit the same as personal drug possession. However, there is no distinction between selling and socially sharing drugs that are class A or class B.

In 2011, the Law Commission questioned why social supply was treated differently than commercial supply for class C drugs, but not for class B and class A drugs (Law Commission, p. 198). Indeed, the circumstances of social supply are similar across drug classes, and vastly different from a commercial drug operation. In social supply, people are typically participating in shared activities, and there is no commercial element involved. Because this is normally simply part of the act of using drugs in a group of people, if there is no profit involved, it would be justified to treat it the same as personal use of drugs.

Based on the evidence that has amassed since the LCR and the contemporary interpretation of the confines of the international treaties, we strongly believe that decriminalisation of personal possession or use of a small amount of drugs presents a pragmatic approach and should be the preferred policy option for Aotearoa New Zealand.

[13] This was outlined in Chapter III, in the "Discretion for Prosecutions for Possession and Use" section of this paper.

Cannabis regulation

Regulatory change overseas

Cannabis is the only drug controlled under the Single Convention that is regulated for non-medical sale and supply in numerous jurisdictions.[14] While most nations continue to prohibit cannabis, there is a growing trend toward legal reform, focusing on how laws could change rather than whether they should (Cunningham, 2021).

Like decriminalisation, cannabis legalisation policies vary substantially between different jurisdictions. In Malta and Germany, cannabis is illegal to sell, but decriminalised for personal possession, able to be grown at home, and available via government-sanctioned social cooperatives. Medicinal use is permitted in many countries, including Aotearoa New Zealand, Australia, many European states, and many Northern and Southern American jurisdictions.

Globally, only Canada (in 2018), Uruguay (in 2013), and Thailand (in 2022; re-criminalised in 2025) have legally regulated the sales of adult-use cannabis at a national level, alongside 24 US states. Federal US law still prohibits possession and use. The Netherlands allows resident adults to purchase and consume cannabis in licensed coffeeshops.

A summary of the features of each model is presented in Table 16.

[14] Aside from traditional, small-scale coca cultivation in some South American countries, including Peru, Bolivia, some parts of Chile, and in northwest Argentina. In these jurisdictions, the coca leaf is legally cultivated for sale and supply for traditional use by Indigenous peoples living in those areas.

[15] In June 2022 the cannabis flower was effectively decriminalised in Thailand. Cannabis extracts and cannabis products (including edibles, food supplements, cosmetics, etc.) containing less than 0.2% THC were legalised; accessing products with a higher THC content continued to require a prescription. In June 2025, following an abrupt change of government, the cannabis flower was reclassified as a controlled herb, and advertising and sale for recreational purposes was prohibited. Medical sales remain legal by prescription only (Ratcliffe, 2025).

Table 16

Features of cannabis laws in countries where it is available commercially or socially

Country	Small number of plants can be grown at home for personal use	Non-profit social cooperatives (for adult citizens only)	State-controlled sales to registered adult citizens
Canada	✓ Except in Quebec and Manitoba. Up to four plants.	✓	
Germany	✓ Up to four plants.	✓	
Malta	✓	✓	
The Netherlands			
Spain (mainly Catalonia)	✓	✓	
Uruguay	✓ Up to six plants.	✓	✓
USA (certain states and territories only)[16]	✓ In most states with regulated cannabis. Between two and 15 plants.	✓ A minority of states.	

[16] As of mid-2025: Alaska, Arizona, California, Colorado, Connecticut, Delaware, Georgia (some cities), Hawai'i, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Rhode Island, Texas (some counties and municipalities), US Virgin Islands, Vermont, Virginia, Washington, Washington DC.

	Sales are taxed	Unregistered adult citizens or tourists may purchase legal cannabis	Commercial sales for profit	Advertising of cannabis products is allowed
	✓	✓	✓	
		✓ Some municipalities only.		
	✓			
	✓ At state level only.	✓	✓	✓

Selected USA states

Cannabis has been legalised for non-medical or recreational use in Colorado since 2012, and Washington State since 2014. More than half of the US population (approximately more than 170 million people) now live across the 31 jurisdictions where adults can access non-medical cannabis (Yimer et al., 2025). Many states have adopted a regulatory model that is similar to alcohol regulation. Cannabis possession, use, and sale remain illegal at a federal level, and it is only taxed at a state level.

These US examples are among the most commercial models of cannabis regulation globally. Cannabis is available in a range of forms, including herbal and edible products (such as confectionary, chocolate, and beverages), and extracts. While sales are restricted to adults over 21 years of age, advertising is permitted in every US state where cannabis is legal, with restrictions on exposing minors and avoiding unsubstantiated health claims.

Canada

Cannabis has been federally or nationally legalised for non-medical or recreational use since 2018 via the passing of the Cannabis Act 2018. Canada had multiple stated intentions at the time, including displacing the illicit market, increasing public awareness of the health risks associated with cannabis use, and reducing the burden on the criminal justice system by removing certain possession and use offences (Hall et al., 2023). Canada's initial focus on reducing public health harms has been described recently as more commercialised, and not in line with the initial aims of its legislative reforms (Cunningham, 2021).

Cannabis licensing and regulation of cultivation, processing, and production is controlled federally. Licensing and regulations concerning the distribution, sale, and consumption fall under provincial and municipal (city) regulation. Cannabis sales are taxed: 75% of tax revenue is earmarked for the province or territory of purchase, and 25% goes to the federal government (Cunningham, 2021).

Québec's minimum age of purchase is 21, and in other Canadian provinces it is 18 or 19. Québec has also restricted the THC content in edibles to 5 mg, and banned additives to any cannabis products that would increase their attractiveness, flavour (for example, chocolates or confectionary are not allowed), or enhance their psychoactive effects (Gouvernement du Québec, 2025; Hall et al., 2023).

Uruguay

The Uruguayan cannabis model is unique and vastly different from the commercial models operating in North America. Legislation was passed in 2013 that established state control of cannabis from growing to distribution (Cunningham, 2021).

The stated aims of Uruguay's strict approach to cannabis regulation include improving human rights, minimising the impact on public health, reducing illicit-market-based violence and criminal activity, and promoting public health through education campaigns. The price of cannabis is set by the state and is deliberately kept at a level to compete with the illicit market. Registered citizens over 18 years old can legally purchase up to 10 grams per week, or up to 480 grams a year. Cannabis production is controlled and supplied by the government. Registered citizens can also join non-profit cannabis social clubs by paying membership fees. No advertising is allowed.

Malta

In 2021 Malta introduced new legislation[17] allowing cannabis to be purchased from licensed cannabis clubs, called Cannabis Harm Reduction Associations (CHRA). The law was introduced to address negative consequences of criminalisation of people who use cannabis. It is illegal for commercial or retail organisations to supply cannabis (Authority for the Responsible Use of Cannabis, 2025).

Membership is capped at 500 members per club and is only available to residents of Malta who register and pay membership fees. Members can purchase up to 7 grams per day and 50 grams per month, and residents can grow up to four cannabis plants in their own homes. Public cannabis consumption is banned, as is possessing more than 7 grams at one time, which can result in being fined. Advertising of products is prohibited.

In May 2025 a new regulation was passed that can see people who emit a 'strong smell' of cannabis from themselves or their property subject to fines of between €50 and €100. Cannabis now must not be consumed within 250 metres of schools, youth centres, or sports facilities, and CHRAs that admit people under 18 can now face fines of up to €10,000 (Stevens, 2025).

Germany

Germany's Cannabis Act 2024 has partially legalised cannabis for personal use. Cannabis is not available commercially. Adults over 18 can grow three cannabis plants in their own homes and access cannabis via social cooperatives for personal consumption. Membership of a Cultivation Association is restricted to German adults who have resided in the country for at least the last six months. Membership fees are set by the individual associations.

[17] Malta enacted into law Chapter 628, *Act to establish the Authority for the Responsible Use of Cannabis (ARUC) and to amend various laws relating to certain cannabis activities*. This has not legalised the use of cannabis in Malta. The Maltese Government describes their system as 'partially decriminalising' cannabis (Authority for the Responsible Use of Cannabis, 2025).

Adults are also allowed to possess up to 25 grams in public, and 50 grams in their own residence. Young people aged between 18 and 21 may only possess 30 grams of cannabis with a maximum THC content of 10%. Advertising and sponsorship of cannabis and cannabis cooperatives is not allowed. Consumption in the presence of people aged under 18 is prohibited, as is consumption on public transport, and there are restrictions on consumption during daytime hours and within 100 metres of schools and facilities for children such as playgrounds.

Germany is considering regional pilot projects to explore the expansion of the commercial supply chain, but further approval would be required by the European Commission in order to do this.

Thailand

In 2022 Thailand became the first Asian country to legally regulate cannabis. The country legalised the sale and supply of cannabis products containing less than 0.2% THC, with products containing higher THC content technically being available only medically (in practice, dispensaries would often not require proof of prescription). In June 2025, following a political crisis, Thailand re-criminalised the sale and supply of all non-medical cannabis. Medicinal cannabis has been legally available in Thailand since 2018.

What can we learn from countries regulating the sale and supply of cannabis?

Global approaches to cannabis regulation vary widely, from strict prohibition with illicit supply, to decriminalisation of personal possession and non-profit cooperatives, to fully legal commercial markets. The central goals of cannabis regulation are to displace the illicit market and reduce criminal justice involvement at both individual and societal levels. Reforms aim to lower the harms of low-level drug convictions, including the lasting impact of a criminal record or imprisonment. In many jurisdictions, cannabis reform has happened alongside an acknowledgment of the disproportionate harms faced by communities of colour and Indigenous peoples, who are overrepresented in policing and incarceration. Removing criminal penalties for minor drug offences is seen as a way to reduce, or prevent, the over-criminalisation of these groups. Evidence from jurisdictions that have undertaken reform can allow us to appraise the outcomes of different policy settings. In this section we will describe the key areas that may be influenced by changing cannabis policy.

1. Disruption of the illicit cannabis market and organised crime

The speed and the extent of the disruption of illicit cannabis markets by

legalisation has varied across jurisdictions. Careful analysis of this variance can help inform policy settings that could best achieve these goals, with as few adverse effects as possible.

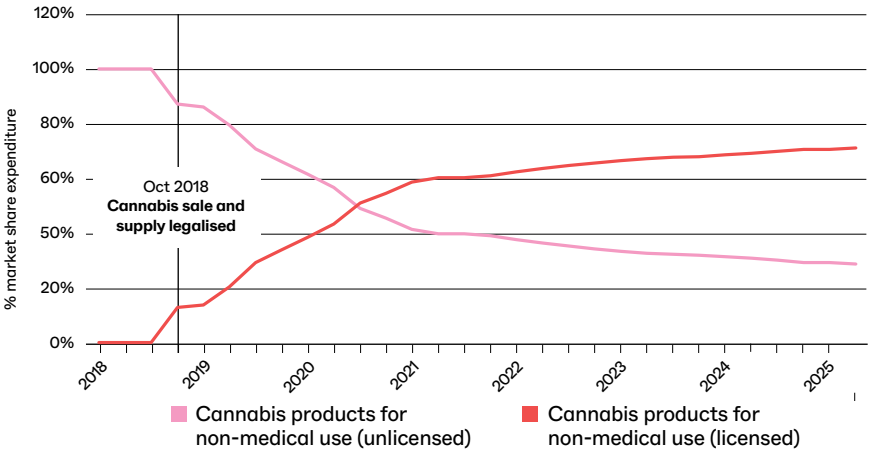
In Canada, legalisation has shifted consumer behaviour significantly, with more consumers buying from licensed outlets and fewer from illicit sources. The main reason some continue to buy illegally is the lower price. Between 2018 and 2022, the expenditure share from illegal sales dropped by 53%, and by 2020 the value of legal sales overtook illicit sales. Currently, 71.2% of expenditure on cannabis is spent in the regulated market (Figure 26). Similarly, by 2024, 73% of respondents to the Canadian Cannabis Survey reported usually obtaining cannabis legally, up from 36% in 2019 (Bouchard et al., 2025). Similar reductions in the illicit market have been observed in Colorado and Washington, though not in California (Manthey et al., 2023).

After more than a decade of cannabis regulation, just over half of cannabis consumers in Uruguay now obtain their cannabis from legal sources: 34% directly from the system, and 17% indirectly through others who purchase legally (National Library of Medicine, 2024). The tightly controlled model in Uruguay appears to have moderated the legal market's appeal, compared with the more commercial (and competitive) model seen in Canada.

This suggests that more restrictive regulatory frameworks and non-competitive pricing may reduce the pace at which consumers decide to purchase cannabis legally (National Library of Medicine, 2024).

Figure 26

Licensed vs unlicensed cannabis expenditure in Canada (Statistics Canada, 2025)



2. Differential impacts on communities of colour and Indigenous populations

Criminal justice outcomes

Evidence shows that positive impacts on criminal justice outcomes have not necessarily benefited disadvantaged communities as much as groups already holding more societal power. While cannabis regulation has reduced arrest rates and justice system involvement overall in North America, the decreases are less pronounced for Black people and other communities of colour. In Washington DC and California, racial disparities in cannabis possession arrests narrowed for all populations, yet Black people were still disproportionately arrested for public consumption (Joshi et al., 2023). In Colorado and Washington State, fewer motor vehicle drivers of all ethnicities were stopped and searched after legalisation, but Black and Hispanic drivers continued to face lower thresholds for Police searches than white drivers (Pierson et al., 2020).

Inequities in the cannabis industry

Ethnic disparities extend to cannabis industry participation. In Massachusetts, despite mandated equity measures, white individuals hold 75% of jobs and 84% of senior roles, while Black and Latino workers occupy only 5–7% of positions (Doonan et al., 2022). In Canada, First Nations' involvement in shaping cannabis regulations has been limited, with calls for greater autonomy over their own markets (Crosby, 2019). Research further shows that leadership within Canadian cannabis companies is dominated by white men (84% white, 86% male among 700 executives and directors in 222 firms), raising concerns that cannabis regulation perpetuates colonial authority structures (Crosby, 2019; Maghshoudi et al., 2022).

3. Crime rates

As expected, legalisation has clearly reduced the rate of cannabis-specific offences. The impacts on broader crime patterns have been less clear (Callaghan et al., 2021; Manthey et al., 2023). In both Canada and US states that have legalised cannabis, arrests for cannabis-related offences have dropped substantially. Studies from Colorado and Washington indicate that legalisation has not led to increases in minor crimes such as public disorder, trespassing, prostitution, or liquor violations (Hughes et al., 2020; Thacker et al., 2021).

In Canada, adult cannabis-related arrests fell by over 70% between 2015 and 2021, with youth offences also declining by more than 57% in the year following legalisation. There is no substantial evidence linking legalisation to changes in violent or property crime rates among adults or youth (Callaghan et al., 2023). Evidence from the US is mixed, with a few studies reporting increases in violent or property crimes in Colorado and Oregon. Other studies found no change (in

Colorado, Oregon) or decreases (in Washington) in property crime following legalisation (Manthey et al., 2023).

4. Prevalence of cannabis use among adults

Cannabis legalisation has been linked to increases in rates of adult cannabis use, though it is important to note that in many legalising jurisdictions a trend of increasing use was already present before legislative changes (Hall et al., 2023; Yimer et al., 2025). While establishing a causal relationship between the policy change and the increases, it appears that a commercial model of cannabis legalisation may increase cannabis consumption among the general population.

In Canada, self-reported cannabis use had been climbing since 2011 and continued to rise after the Cannabis Act was enacted in 2018. Annual prevalence increased from 9% pre-legalisation (1985–2017) to 25% in the three years after legalisation (2018–21) (Yimer et al., 2025). Recent data has shown that prevalence of cannabis use has been stable at 26% in 2023 and 2024, with daily or almost daily use reported by 6% of Canadians – up from 5% in 2018 and steady since 2023 (Government of Canada, 2024).

Trends in the United States mirror those in Canada. Past-year cannabis use among adults increased from 10.4% in 2002 to 15.3% in 2017, and further increases have been observed in states with legal medicinal cannabis (Manthey et al., 2023).

On the other hand, limited evidence from Uruguay shows the change in post-legalisation cannabis use rates mirrored trends in Chile, despite cannabis use remaining illegal in Chile (Manthey et al., 2023). Notably, Uruguay follows a more restrictive, non-commercial model of regulation that the US or Canada.

5. Prevalence of cannabis use among young people

Evidence on the impact of cannabis regulation on youth cannabis use is mixed. Overall, studies show no significant rise in youth cannabis use following legalisation (Yimer et al., 2025). Some studies suggest that exposure to cannabis advertising and proximity to retail outlets are associated with higher levels of youth use (Manthey et al., 2023). However, overall prevalence trends do not show consistent increases following legalisation (Hall et al., 2023; Yimer et al., 2025).

In Canada, cannabis use among school-aged children has remained largely stable since legalisation. Two studies report fluctuating or stable past-three-month or daily use among those aged 15–17 and 16–19 respectively (Government of Canada, 2024; Manthey et al., 2023). There has, however, been an increase in use among young adults aged 18–24, from 28% to 36% between 2018 and 2020 (Manthey et al., 2023).

In Uruguay, youth cannabis use was already rising prior to legalisation and has

continued on this trajectory, though there has been no increase among high-school students aged 12–17 (Manthey et al., 2023; Queirolo, 2020). In the US, it appears that there has been no increase in the prevalence of cannabis use among young people (Yimer et al., 2025).

6. Prevalence of cannabis use disorder

The evidence on whether cannabis legalisation leads to higher rates of cannabis use disorder (CUD) or dependence is mixed. In the US, the number of people seeking treatment for CUD has declined, possibly due to fewer mandatory treatment orders for cannabis-related offences. In Canada, CUD prevalence has remained stable or declined in Québec (which has the least commercialised model), but has increased in Ontario. One study found that self-reported CUD rose mainly among new cannabis users after legalisation, while those more experienced with cannabis reported fewer cannabis-related problems (Manthey et al., 2023).

Uruguay's experience shows that CUD trends may not be directly tied to legalisation. The country saw increases in CUD prevalence among people in treatment well before its reform, rising from 15.7% in 2006 to 20% in 2011, and reaching 38.7% in 2018. Importantly, Uruguay still reports relatively low rates of CUD compared to neighbouring Argentina and Chile, where cannabis remains illegal. This suggests that legalisation has not deterred treatment-seeking behaviour and that broader cultural or social factors may influence CUD prevalence more than legal status alone (Mauro et al., 2022).

7. Prevalence of mental health disorders linked to cannabis use

Evidence is inconclusive on whether cannabis legalisation is linked to increases in mental health diagnoses. Apparent rises have been suggested to reflect greater willingness among medical professionals to ask about cannabis use, and among patients to disclose it.

In Canada, cannabis-related hospitalisations increased 1.62 times between 2015 and 2021, including some hospitalisation for cannabis-related psychosis. However, patterns varied across provinces: those with less developed retail markets saw decreases, suggesting that commercialisation rather than legalisation itself may explain the rise (Myran, Gaudreault, Konikoff, et al., 2023; Myran, Pugliese, et al., 2023).

In the United States, analyses of health insurance claims data show no substantial increase in psychosis rates in states that have legalised either medicinal or non-medicinal cannabis (Yimer et al., 2025). This suggests that, while high-risk cannabis use may be associated with certain mental health outcomes, legalisation alone cannot be conclusively linked to increased rates of mental health disorders.

8. Prevalence of physical health disorders linked to cannabis use

There is no conclusive evidence that cannabis legalisation has led to an increase in physical health disorders related to cannabis use. While there is evidence linking cannabis smoking with conditions such as cardiovascular disease and certain cancers, these diseases typically take years to develop and may only become more evident as older adults in the legalising jurisdictions grow older.

Evidence on legalisation's impact on rates of cannabis use during pregnancy and adverse birth outcomes is also mixed. In the US, cannabis use during pregnancy has increased in some states that legalised cannabis but not others. However, studies across nine states found no rise in adverse birth outcomes such as low gestational age or birth weight. Similarly, in Canada, no short-term changes in cannabis use during pregnancy have been observed, though existing studies were conducted before the retail market expanded (Manthey et al., 2023).

9. Price and potency of cannabis

There is evidence that commercial models of legalisation have led to clear and expected declines in the price of legal cannabis, with prices falling sharply as retail outlets expand. In Washington State, for example, prices have fallen up to 50% since regulation, and similar downward trends are evident elsewhere, including most Canadian provinces (Hall et al., 2023; Yimer et al., 2025). In some jurisdictions, including Canada, there is clear evidence that the potency of legal cannabis has also increased alongside the decline in price (Hall et al., 2019).

At the same time, the variety and potency of available products have expanded in the highly commercialised legal markets of North America. Alongside flower products, US and Canadian consumers can now access edibles such as chocolates and gummies, cannabis-infused beverages, and highly concentrated cannabis products. Some products contain more than 70% THC. This combination of lower prices and greater availability has significantly broadened the legal cannabis market, but also the exposure to products which may be associated with an increase in cannabis use disorder and mental distress (Yimer et al., 2025).

10. Incidence of child poisonings

Evidence shows that emergency department visits for cannabis-related poisonings in children have increased following legalisation, largely linked to the availability of edible cannabis products that children could mistake for candy. This trend has been consistently observed in the US (for example, Massachusetts) and Canada (for example, Ontario, Alberta, and BC) since adult-use legalisation (Myran et al., 2022; Yimer et al., 2025). However, Québec has not experienced the same rise, likely because it prohibits cannabis edibles

such as chocolates or confectionery and sets a higher legal purchase age of 21 compared with 18 or 19 in other provinces (Yimer et al., 2025).

11. Incidence of motor vehicle crash injuries and deaths

Evidence on the impact of cannabis legalisation on motor vehicle crash injuries and deaths in Canada and the US is inconclusive. In the US, overall motor vehicle fatalities have not differed substantially between states that legalised cannabis and those that did not. Other studies have either found an increases or no change in cannabis toxicology among drivers involved in crashes following legalisation (Yimer et al., 2025).

Measuring cannabis impairment is complex, as THC blood concentrations do not always correlate with accident causation in a linear fashion. Some studies have linked emergency department attendances for cannabis-related crashes to access to legal retail outlets (Myran, Gaudreault, Pugliese, et al., 2023), while others found no significant change in insurance claim rates during Canada's first year of legalisation (Lyubchich, 2022).

Cannabis policy implications

In legalising jurisdictions, health, social, and crime outcomes have been mixed and are highly dependent on which policy levers are pulled. It appears clear that the higher the degree of commercialisation, the higher the burden of adverse effects of legalisation becomes. This requires careful balancing with the efficiency of black-market displacement in policymaking.

While further local research is needed to inform the specific policy settings that could best improve outcomes for New Zealanders in relation to cannabis legislation, there are lessons that can be used to make some general recommendations for policy here. Table 17 presents these lessons and their implications for cannabis policy development here.

Table 17

Observed outcomes following cannabis legalisation in Canada, Uruguay, and selected US states, and their potential implications for policy in Aotearoa New Zealand

Outcome	Observed outcomes following cannabis legislation	Policy implications to mitigate risks and maximise benefits
1. Disruption of the illicit cannabis market	Displacement occurs, yet often slower than desired; dependent on regulatory settings.	Maintaining and adjusting the balance between incentivising use and displacement of illicit market by appropriate policy levers, including price, availability, and restrictions to access.
2. Impact on communities of colour and Indigenous populations	Decrease in criminalisation for all populations; however, positive effects reduced for communities of colour and Indigenous people.	Māori leadership in policy making and ongoing co-governance of regulatory frameworks. Policies that improve participation in legal markets for Māori, e.g., through legacy markets. Support for Indigenous-led approaches. Amnesty for prior cannabis convictions. Avoiding corporate capture.
3. Crime rates	Substantial reduction in cannabis-related offences, mixed evidence for other types of crime.	Building alternatives for persons displaced from illicit markets, including considering amnesty for cannabis-related offences. Legacy market development.
4. Adult cannabis use	Increased prevalence of cannabis use.	Restrictions on product advertising, availability, and potency, social education, and pragmatic price controls (low enough to displace illicit market, but high enough to not incentivise new or increased uptake). Restricting commercial, profit-driven models.

Outcome	Observed outcomes following cannabis legislation	Policy implications to mitigate risks and maximise benefits
5. Youth cannabis use	No noticeable increase in youth cannabis use.	Effective age controls, and strict compliance controls. Product forms and packages should avoid appealing to young people (e.g., confectionery, attractive packaging, etc.).
6. Cannabis use disorder (CUD)	Possible increase in CUD in some jurisdictions.	Limits on product potency. Restrict public consumption of products to reduce exposure to products. Restrict outlet visibility and location to minimise opportunistic purchases. Increase access to education, early intervention, harm reduction, and treatment.
7. Mental health disorders	No conclusive evidence of changes in prevalence of mental health disorders.	Monitoring of prevalence and frequency of use at a population level. Limits on product potency and development of policies that limit excessive consumption – factors associated with increased risk of long-term harms.
8. Physical health disorders	No observed short-term increase in cardiovascular or pulmonary disease; no observed increase in adverse birth outcomes. Some adverse physical health effects may not be evident until many years after cannabis use.	Restrictions on product potency. Policies reducing excessive availability. Provision of public health information about risks of cannabis to health. Avoidance of combustible products. Product quality assurance.

Outcome	Observed outcomes following cannabis legislation	Policy implications to mitigate risks and maximise benefits
9. Price and potency of legal cannabis products	Increase in potency of legal cannabis products, and decline in price of legal cannabis products.	Responsive price controls (see outcomes 1 and 4). Potency restrictions, product type restrictions.
10. Child poisonings and emergency department visits	Increase in child poisonings from ingesting edibles.	Restrictions on edibles that are appealing to children or young people (e.g., sweets, confectionery, etc.), higher age limits on purchase. Plain/pharmaceutical packaging.
11. Motor vehicle crash injuries and deaths	No observed increase in motor vehicle crashes or fatalities.	Driver education. Ensuring impaired driving remains prohibited. Development in impairment testing technologies.

Regulating selected lower-risk substances

Classic psychedelics and MDMA

After cannabis, MDMA and psychedelics have the highest prevalence of use among New Zealanders (Ministry of Health, 2024b). These substances are associated with lower levels of harm compared to other substances in Aotearoa New Zealand (Crossin et al., 2023), and MDMA and certain psychedelics also have promising evidence for therapeutic applications. Despite this, psilocybin is classified as a Schedule I (Class A) drug, while MDMA is placed within Schedule II (Class B) under the MoDA. Lower risk does not mean that there are no potential harms, which means that pragmatic policies must be designed to ensure these harms are minimised.

Psychedelics[18] (sometimes referred to as hallucinogens) are a broad and diverse grouping of substances that can lead to pronounced changes in perception. The term 'psychedelics' is sometimes applied more broadly to refer to substances with many different modes of action, sometimes including substances such as MDMA or ketamine. More commonly, however, the term 'psychedelics' is used more narrowly to describe 'classic' or serotoninergic psychedelics that can markedly alter consciousness through action on certain serotonin receptors, such as psilocybin, LSD, or DMT (Nichols, 2016).

Entactogens (or connectogens/empathogens) are substances whose primary effect is to increase capacity for and feelings of connection with others (Stocker & Liechti, 2024). The mode of action of the most well-known representative of the class, MDMA, is thought to rely primarily on the elevation of serotonin, dopamine, and norepinephrine through increasing their release.

In this section we will focus on two lower-risk substances:

Psilocybin

Psilocybin is a serotoninergic (classic) psychedelic that has the most supporting evidence for treatment of psychiatric conditions, and especially for treatment-resistant depression (Yao et al., 2024), among the class, and that has been subject to the most substantial legal reform across different jurisdictions. Another unique characteristic of psilocybin among the class is its widespread availability in a number of psilocybin-containing mushroom species, including some that are native and endemic to Aotearoa New Zealand. This abundance means that a level of availability is assured without involvement of illicit markets, as individuals can forage for them independently in nature.

[18] The term 'psychedelic' derives from the Greek 'psychē' (ψυχή; soul/mind) and 'dēloun' (δηλείν, 'to make visible, to reveal'), to denote 'mind-revealing'.

MDMA

MDMA (3,4-Methylenedioxymethamphetamine, ecstasy) is an entactogen or empathogen, with stimulant and psychedelic characteristics. Its effects are often described as increasing the feelings of connectedness, as well as causing euphoria and the state of wakefulness. It has been trialled for treatment of PTSD, and despite recent rejection by the FDA and ensuing questions about its effectiveness (Stanicic et al., 2025), MDMA continues to hold promise for clinical applications (Shahrour et al., 2024). MDMA continues to be the second most commonly used illicit substance in Aotearoa New Zealand, with 4.8% of adults reporting its use within the previous 12 months (Ministry of Health, 2024b).

Harm reduction and possible models of regulation of psilocybin

At the physiological level, psilocybin is a substance characterised by a very low toxicity and a favourable safety profile (Yerubandi et al., 2024). Similarly, dependence does not appear to develop for classic psychedelics, and they are not associated with compulsive redosing (Schlag et al., 2022). However, due to its profound effects on human perception, certain psychological or context-related harms exist that require careful mitigation. These harms include:

Harm to self or others

The profound experiences and losing touch with physical reality may increase the risk of accidents or harm to others. While very rare in comparison to other substances (and notably alcohol), incidents of serious harm to self, including death, have been described. These risks can be reduced when consumers are avoiding using the substance in a poor state of mind, or in environments where their safety is not assured (set and setting). Driving under the influence of psilocybin is not safe.

Challenging experiences and long-term mental health risks

Feelings of anxiety, hopelessness, grief, and similar challenging experiences ('bad trips') are relatively common with psychedelics. They are often transient and are sometimes even considered cathartic by the individual (Schlag et al., 2022). Long-term negative sequelae of challenging experiences are considered uncommon, however, they may be underreported (Breeksema et al., 2022; McNamee et al., 2023). Despite certain misconceptions, the incidence of psychedelic-induced psychosis is generally considered low (Sabé et al., 2025), with one naturalistic study even pointing to a reduced risk of psychotic symptoms among adolescents self-reporting psychedelics use (Simonsson et al., 2024).

Hallucinogen persisting perception disorder (HPPD)

The so-called 'flashbacks' describe the occasional reoccurrence of experiences similar to the one experienced under the influence of psychedelics long after their effects have waned. Usually, these experiences are subtle and non-distressing. When they are distressing and prolonged in time they are classified as HPPD.

The prevalence of HPPD appears to be low among users of psychedelics (Schlag et al., 2022).

Misidentification of the substance

The natural occurrence of psilocybin-containing mushrooms motivates foragers to seek them out in nature. Identifying these species may, however, be challenging, especially when these are dried or ground, and accidental ingestion of another toxic species can lead to poisoning, with serious consequences, including liver failure or death.

Personal vulnerability in therapeutic or quasi-therapeutic contexts

Persons under the influence of psychedelics are vulnerable to the malevolent actions of others, including those who are offering therapeutic or quasi-therapeutic interventions (Tustison et al., 2025). This includes vulnerability to suggestion, but also coercion, and the risk of sexual harm.

Similar to any psychoactive substance, the presence of certain risks requires any regulation to consider a framework that mitigates these risks. A recently proposed framework (Rolles & Kincova, 2023) recommends a four-tiered approach for regulating psilocybin, designed to match different contexts of use. Importantly, it takes into account the potential benefits of psychedelic drugs for therapeutic reasons, if they are delivered appropriately. Table 18 summarises this framework.

Elements of these proposed models could be adopted in Aotearoa New Zealand, taking into consideration local practices and legal systems, and using an incremental approach with careful evaluation along the way. A reasonable starting point could be the decriminalisation of use, and a more streamlined approach to delivery of psychedelic-assisted therapy within medical settings.

One of the central considerations for Aotearoa New Zealand surrounds the rights of Māori to reclaim control over the use of taonga species of psychedelic fungi, in accordance with te Tiriti o Waitangi.

A recent report (Caddie et al., 2024) emphasises that Māori must retain authority over indigenous psychedelic fungi – such as *Psilocybe weraroa* – because current legal systems, including the MoDA, vest exclusive control over these taonga in the Crown, effectively excluding Māori from decision making. It has also been argued that the Crown may not have sufficiently considered protecting Māori interests in acceding to the CoPS and listing indigenous

Table 18

Models of regulation of psilocybin; adapted and modified from Transform UK (Rolles & Kincova, 2023)

Model	Primary context of use	Characteristics
Decriminalisation and private use	Home cultivation, foraging, non-profit sharing	Individuals are free to cultivate psilocybin mushrooms at home, forage them in the wild, or share them non-commercially within personal networks. This removes the harms of criminal penalties and creates a baseline of safe, low-barrier access, and supports access to harm reduction information and help if needed.
Not-for-profit associations	Community or ceremonial use	These community-led groups would allow members to collectively grow, prepare, and use psilocybin in controlled, supportive environments. Such associations are designed to reduce risks, respect cultural practices, and prevent large-scale commercialisation.
Licensed retail	Recreational or casual use	Licensed outlets could sell psilocybin products under strict rules covering age limits, product quality, labelling, and purchase quantities. These measures would reduce risks associated with the illicit market while providing consumers with reliable information and safer-use environments.
Supervised/ guided use	Therapeutic, wellness, or spiritual sessions	Licensed providers would offer structured experiences in controlled settings, overseen by trained facilitators. Standards for training, ethical practice, and duty of care would be essential to ensure participant safety and maximise potential benefits.

mushroom species as 'prohibited plants' under the MoDA. Furthermore, lacking a formal response to WAI 262 and the absence of Aotearoa New Zealand's involvement in the Nagoya Protocol, the current legal framework leaves most native species unprotected from exploitation by overseas researchers and companies.

To overcome these risks, te Tiriti o Waitangi principles of partnership, active protection, and tino rangatiratanga must be embedded in public policy and regulatory systems, rather than treated as optional considerations. This must include deferring decision making over these species to iwi Māori, and include the principle of non-criminalising Māori for using and developing native species of fungi.

Harm reduction and possible models of regulation of MDMA

MDMA is associated with relatively less harm than many other illicit or legal substances. In fact, despite being the second most commonly used illicit substance in Aotearoa New Zealand, it is ranked among the few that contribute to the least harm here.

As with most illicit substances, MDMA-related harms are dramatically increased by policies that limit access to pure, standardised products. In clinical trials, moderate doses of pure MDMA have been used with a very good safety profile (Colcott et al., 2024), but uncontrolled use carries greater risks due to product adulteration, polydrug use, and unsafe environments, as well as lack of access to harm reduction. Some of these harms include:

Physical harms

Acute harms include jaw clenching, nausea, dizziness, elevated heart rate and blood pressure, and dehydration. More serious, and substantially less common, risks are hyperthermia (exacerbated by dancing in hot, crowded venues) and hyponatraemia (dangerously low blood sodium from overhydration), both of which can be fatal; however, deaths from MDMA consumption alone are rare. MDMA can also trigger serotonin syndrome when combined with certain other serotonergic drugs.

Mental health and chronic harms

Some users report short-term low mood, sleep problems, and anxiety, especially the next day ('comedowns'), though these may also stem from alcohol, fatigue, or poor nutrition. Evidence of long-term neurotoxicity, liver damage, or cardiovascular disease attributed to MDMA use alone is uncertain.

Dependency risk appears low

MDMA use is typically self-limiting, with many users reducing or stopping use without interventions due to the increased tolerance to the desired effects.

Similar to the approach to psilocybin, a framework to reduce the risks of MDMA would focus primarily on reducing the known risks of the substance, as well as increasing the safety of the contexts in which it is used (Transform Drug Policy Foundation, 2022). A recent paper by the Beckley Foundation (Moore et al., 2019) proposes a regulatory framework that shifts control of MDMA from criminalised use to a public-health-oriented system. The central aim is to minimise risks, protect users, and ensure equitable access, while curbing the harms associated with the illicit market. Table 19 describes the selected aspects of such models.

Table 19

Models of regulation of MDMA, adapted and modified from the Beckley Foundation (Moore et al., 2019)

Model of regulation	Characteristics
Decriminalisation of personal possession and use	Individuals would no longer face criminal penalties for small amounts, reducing stigma, increasing access to harm reduction and health services, and preventing criminal justice harms.
Controlling production and supply	Licensed manufacturers would be required to meet strict standards of purity, quality, and labelling, ensuring products are consistent and accurately dosed. Plain packaging would include health warnings and harm-reduction advice.
Strict controls of access	Access would be possible only in strictly controlled licensed outlets, such as pharmacies or licensed not-for-profit associations. These would be subject to strict rules: minimum age requirements, purchase limits, trained staff, and mandatory provision of health information. Requiring registration for purchases could be considered to increase compliance. General retail shops would be excluded to prevent over-commercialisation.

Model of regulation	Characteristics
Medical and therapeutic use of MDMA	A dedicated medical access pathway should be developed, allowing MDMA-assisted psychotherapy to be provided within clinical and therapeutic contexts, distinct from recreational supply channels. This would require service monitoring, as well as workforce regulation and minimum requirements to ensure client safety.
Robust monitoring and flexibility	Usage patterns, health outcomes, and social impacts would be systematically tracked, ensuring that regulation could be adapted in response to new evidence or emerging risks. This model could be trialled at a small scale, and incrementally evaluated before decisions are made about its further development.
Increasing safety in environments of use through venue licensing, and health and safety requirements	All types of venues or events where unlicensed use is likely should be required to have a harm reduction policy. The Beckley Foundation also recommended considering licensing clubs and events that could ensure controlled environments with adequate ventilation, water provision, and medical support on hand. This could help address common risks such as overheating or dehydration.

International policy reform

While proposed models are innovative and have not been fully implemented overseas, elements of these models have seen a level of implementation. Many countries have decriminalised personal possession and use of psychedelics or MDMA, often as part of general policy to decriminalise drug use.

Beyond decriminalising possession, in some jurisdictions the supply of psychedelics has been increasingly shifting towards regulation through a mix of medical, research, and service-based models. A small number of countries (e.g., Jamaica) permit broader access to psilocybin-containing mushrooms.

Table 20 shows selected jurisdictions with different regulatory models for certain psychedelics.

Table 20
Selected jurisdictions enabling access to psychedelics

Jurisdiction	Substances	Model
Australia (Therapeutic Goods Administration, 2023)	Psilocybin, MDMA	Prescription from an approved specialist (psychiatrists only)
Canada (federal) (Health Canada, 2023)	Psilocybin, MDMA	Health Canada Special Access Program
Canada – Alberta (Alberta Mental Health and Addiction, 2023)	Psilocybin, MDMA, others	Licensed psychedelic therapy facilities; prescription required
Netherlands (Drug Science, 2021)	Psilocybin-containing truffles (only); whole mushrooms remain illegal	Legal retail and use
Czech Republic (Jaeger, 2025)	Psilocybin	Medical access under supervision
Switzerland (Krähenmann et al., 2024)	Psilocybin, MDMA, LSD	Compassionate-use exemptions (case by case)
The United Kingdom (Chu et al., 2025)	Psilocybin, MDMA, LSD	Narrow research exemptions – pilot; yet to be implemented
USA – Oregon (Oregon Health Authority, 2024)	Psilocybin	Licensed service centres, supervised non-medical sessions
USA – Colorado (Colorado General Assembly, 2023)	Psilocybin	Regulated healing centres

Countries such as Australia, Canada, the Czech Republic, and Switzerland have enabled access by prescription, setting different levels of requirements for prescribing clinicians. For example, in Australia approved psychiatrists are allowed to prescribe psilocybin for patients diagnosed with treatment-resistant depression, and MDMA for patients with PTSD. In Canada access is permitted for any licensed prescriber using a case-by-case Special Access Program, as long as standard treatments have failed and the prescriber can demonstrate sufficient evidence justifying the use of psilocybin or MDMA for the given condition. The rules are more relaxed in the Canadian province of Alberta, where a psychiatrist or another physician in consultation with a psychiatrist may prescribe psilocybin for any mental condition without requiring special permissions.

There are two state jurisdictions that have specific laws enabling provision of psilocybin or psilocybin-containing mushrooms through non-medical models:

Oregon

The State of Oregon was the first US jurisdiction to introduce legal psilocybin services, which include preparation, administration, and integration sessions. Clients may use services for any reason, and no prescription is required. Only people 21 years of age or older are permitted to use the service and everyone is required to complete a preparation session with a licensed facilitator. Supply of psilocybin outside of these sessions continues to be illegal in Oregon.

Colorado

The State of Colorado permits and regulates the provision of psilocybin-assisted therapy through licensed Healing Centres. These can provide facilitated psychedelic sessions to persons over 21, with the use of licensed facilitators. These must adhere to state rules, which include, for example, requirements for product testing, quality, and facilitator training. Selling products for use outside of facilitated sessions is not permitted in Colorado. However, Colorado also permits personal cultivation and possession of psilocybin-containing mushrooms for persons over 21, and non-commercial sharing of mushrooms with other adults is also considered legal in the state.

Psychedelic assisted therapy in Aotearoa New Zealand

Recently, for the first time in Aotearoa New Zealand, Medsafe granted approval for prescribing of psilocybin outside of a clinical trial for the treatment of depression by a named psychiatrist. Recently released guidance (Medsafe, 2025) clarified that other scheduled psychedelic substances can follow a similar process for approved use by a competent clinician, opening the door for more substances to be approved. Approvals are likely to continue to be granted for individual clinicians only on a case-by-case basis. This approach requires a high administrative burden and will likely result in only a very small number of providers being able to deliver these therapies to patients.

Unlike in Australia, it appears that consideration will be given to applications for any indication, clinical population, or mode of treatment. The onus is on the applying clinician to demonstrate that there is evidence to justify their proposed treatment protocol. There is also no limitation on the vocational scope of the applying prescriber.

One of the requirements is that the medical practitioner must conduct "administration and monitoring of the treatment in an appropriate supervised environment", which aligns with the Australian requirements. The need to cover the clinical time of a specialist physician supervising the patient through the psychedelic experience is likely among factors that contribute to the very high cost of treatment in Australia (as much as AU$24,000 per patient) (McClelland & Rudge, 2025).

When considering how to create a more sustainable system, analysis of the wins and drawbacks of the medicinal cannabis scheme may be useful. This is because both cannabis and psychedelics are controlled drugs that are used in a medicinal context despite there being no (or very limited) approved products.

Cannabis, and many psychedelics including MDMA, are either natural products, or substances that have been known for a long time. This limits the ability of the pharmaceutical industry to seek patent protection, reducing financial incentives to conduct registration trials and gain product approval.

Enabling therapeutic access to unapproved and controlled drugs currently requires regulatory intervention at ministerial level, which is inefficient and unnecessarily politicises decision making. It is clear that Aotearoa New Zealand needs a more streamlined, responsive system, where decision making is evidence based and apolitical.

The way forward – a flexible regime to allow regulation of lower-risk substances

Psilocybin and MDMA are relatively low-risk substances that are used frequently in Aotearoa New Zealand, yet they remain tightly prohibited under the MoDA. This disconnect between evidence of harm and restrictive scheduling suggests that regulation is not aligned with either scientific evidence or public health goals. Retaining criminal penalties for substances with comparatively low risk perpetuates unnecessary harms, including stigma, barriers to treatment, and exposure to unsafe, adulterated, misrepresented, or misidentified products.

With this said, it is important to acknowledge that evidence of the impacts of regulated access to these substances does not yet exist. Therefore, we propose Aotearoa New Zealand adopts a flexible drug classification system and legal framework that grants an appropriate health agency the power to review emerging evidence and strictly regulate lower-risk substances on a case-by-case basis. Where utilised, this system of regulation could:

- reduce the illicit market and associated crime as well as reduce the criminalisation of consumers;
- increase safety of people who use these substances and increase access to information and health services, if needed;
- mitigate certain risks inherent to these substances, through improving safety of the environments in which they are used;
- give effect to the principles of te Tiriti o Waitangi, including those relating to tino rangatiratanga and stewardship of indigenous biodiversity.

The regulatory model should include strict controls to increase consumer safety and reduce risks to others. These measures could include strict product controls, tightly controlled access, supervised venues, and separate clinical access pathways. It is essential that such models are implemented incrementally, with robust monitoring to enable evidence-based adjustments.

In Aotearoa New Zealand a pragmatic approach could begin with decriminalisation, expansion of psychedelic-assisted therapy, and community-led models adapted to local contexts. Importantly, any reform must recognise Māori sovereignty over native psychedelic species, ensuring regulation is grounded in te Tiriti obligations while protecting public health and reducing harms associated with prohibition.

Substance use disorders and medical models of supply

Strictly regulated access to drugs associated with a relatively higher risk of harm is already a reality. Many controlled substances are also approved medicines, and these include substances that have been involved in creating harm outside of clinical settings, including potent opioids, such as fentanyl. At the same time, they are widely used in clinical practice for a variety of indications and are essential for modern medicine.

In this section we will outline the role of controlled medicines that are prescribed in regulated medical settings to people with SUD, and we will describe some novel models for treatment of SUD or for prevention of serious harm among people with dependency.

Medication assisted treatment

Medication assisted treatment (MAT) is the use of prescribed medicines, generally in combination with psychosocial support, to treat substance use disorders. These medicines provide relief from withdrawal symptoms and substitute for some of the perceived benefits of the illicit substance.

Opioid substitution therapy and other MAT in Aotearoa New Zealand

The most recognisable example of MAT is opioid agonist treatment (OAT), commonly referred to as opioid substitution treatment (OST) in Aotearoa New Zealand. Patients with opioid use disorder (OUD) are titrated and stabilised onto an opioid agonist such as methadone or buprenorphine, with the aim of reducing (and then stopping) the use of illicit opioids (Chou et al., 2016). OST has been very successful in reducing harms and mortality from OUD (O'Connor et al., 2020; Sordo et al., 2017), and has been a critical tool in the response to the opioid crisis in parts of the world (Manhapra et al., 2017).

Global estimates show access to OST has grown significantly, and it is available in 94 countries as of 2024 (Harm Reduction International, 2024). While many OST programmes still operate under rigid treatment conditions, they provide people the opportunity to stabilise and improve their overall health, wellbeing, and quality of life (Ghaddar et al., 2017).

Opioid agonists provide pharmacological stabilisation, which reduces or eliminates the cycle of high and withdrawal. This stabilisation results in improved rates of treatment service retention (Mattick et al., 2003). Relapse rates for patients on OST range from 40–50%, compared to 90% for those not on OST (O'Connor et al., 2020). The benefits from stabilisation and sustained engagement with treatment services include greater access to health and social services, stable housing, reduced engagement with and exposure to illegal activities, and improved social functioning.

Another example of MAT is benzodiazepine substitution therapy (e.g., the Ashton protocol [Ashton, 2002]), where patients are titrated onto the dose of diazepam equivalent to the benzodiazepine they are taking (Brett & Murnion, 2015). Over time, doses are slowly reduced to avoid uncomfortable and dangerous withdrawal symptoms (e.g., seizures) (RACGP, 2015).

A well-known MAT intervention for the management of nicotine dependence is nicotine replacement therapy (NRT) in the form of patches, lozenges, gums, or similar. NRT improves rates of smoking cessation and reduces risks associated with tobacco use without the individual experiencing acute nicotine withdrawal (Sandhu et al., 2023). The provision of NRT can increase the rate of smoking cessation by 50 to 70% (Wadgave & Nagesh, 2016).

MAT in Indigenous communities

International evidence of MAT has shown marked differences in the effectiveness of these approaches for Indigenous peoples. Heavily medicalised approaches to SUD are often in contrast with the cultural values and needs of Indigenous communities. A holistic person-centred approach is considered to be much more appropriate (Venner et al., 2018). The impacts of colonisation and intergenerational trauma mean that MAT alone is often not effective and must be coupled with other trauma-informed interventions (Henderson et al., 2023).

Traditional features of MAT programmes (such as daily dispensing of medication) may be prohibitive for Indigenous communities, in particular those living in rural areas. For example, in Canada, the rigorous nature of OST dispensing has been found to be a major barrier to adherence for Indigenous people (Freeburn et al., 2022). This is an important consideration for Aotearoa New Zealand, where some of our poorest and most isolated communities see the highest concentrations of drug harm.

Diverse models of MAT

There are other diverse models for MAT internationally. One example is injectable hydromorphone, used as an alternative to heroin injecting (Oviedo-Joekes et al., 2016). This was piloted in Canada's SALOME trial as an alternative to traditional OST for those with more severe and unmanaged OUD. Similarly, injectable opioid agonist treatment (iOAT) is an approved treatment for OUD in specialised clinics in Canada (Health Canada, 2019). Other countries such as Germany, Austria, and Switzerland offer oral preparations of slow-release morphine. This has been found to be more effective than methadone in reducing cravings, increasing mental stability and tolerability (Lehmann et al., 2021).

Such programmes can also serve the purpose of reducing reliance on illicit opioids to prevent fatal overdose, especially in jurisdictions with high rates of adulteration with potent opioids, such as fentanyl. Prescribed safer supply programmes (PSSP) and safer opioid supply (SOS) exist in various forms in parts of the world, and they are offering a variety of pharmacological options such as hydromorphone or tramadol to treat OUD, underlining the need to increase product tolerability and patient adherence (Ivsins et al., 2024; Ledlie et al., 2024).

Unlike OST services that prescribe opioid agonists, iOAT, PSSP, or SOS programmes provide prescribed medications that can produce desirable effects or 'highs'. This can increase the intervention's effectiveness in replacing the illicit product, as the medications more closely replicate the desired effects of the substance. Injectable MAT such as iOAT allows individuals to administer their substance the same way they used illicit drugs, which can also improve efficacy and treatment retention (Haines & O'Byrne, 2021).

Stimulant substitution therapy

MAT approaches have been piloted for stimulant use disorders using psychostimulant medications (e.g., methylphenidate, dexamphetamine), sometimes referred to as stimulant substitution therapy (SST). The current body of evidence for SST is small, and most randomised control trials have had mixed findings on the impact of medications on sustained reductions in illicit stimulant use. A small number of studies have shown these medications may improve abstinence for specific groups (Minařík et al., 2015; Nuijten et al., 2016; Sharafi et al., 2024). However, it is difficult to generalise the findings to broader populations, particularly due to relatively small sample sizes and low participant retention in most trials (Castells et al., 2016).

Research has yet to identify a clearly efficacious pharmacological treatment for stimulant use disorder. This may be, in part, due to a lack of robust and consistent trials, and poor integration between clinical and preclinical stages in the study design (Brensilver et al., 2013). There have been no outward negative findings that would demonstrate futility or harm of these treatments, but more research is needed into how treatment protocols could enhance effectiveness. For example, standardised doses are unlikely to be experienced in the same way for all participants, due to different usage patterns and physical tolerance to the effects of the substance; therefore, tailoring dosage levels to patient need is more likely to show effectiveness.

Drug of choice treatment (DOC)

Other MAT approaches include 'drug of choice' treatment models. These approaches offer individuals with SUD medicalised access to the drug they use from the illicit market. These models are generally reserved for a subset

of individuals at the most severe end of SUD who have not responded to other treatments.

One example of DOC treatment is heroin-assisted treatment (HAT) (Poulter et al., 2024). HAT was pioneered in Switzerland in the 1990s and is available as a treatment option in countries such as Canada (Gartry et al., 2009), Germany, and the Netherlands. HAT provides people with severe OUD a prescribed supply of heroin as an alternative to accessing it from the illicit market. Evaluations of HAT show positive outcomes and greater retention in treatment compared to OST (McNair et al., 2023). Decades of HAT illustrate that it is feasible, safe, and effective as a treatment option for those most severely impacted by OUD (Fischer et al., 2007). The positive outcomes of HAT are broad, and include substantially improved health and wellbeing of participants, major reductions in use of illicit drugs, and disengagement with criminal activities and the illicit drug market (Transform Drug Policy Foundation, 2018). HAT also improves a variety of other social outcomes for the clients, including increased housing and employment stability (Haasen et al., 2010).

The effectiveness of HAT is attributable to the prescribed drug being the same as the illicit supply. Research suggests that to reach people most severely impacted, MAT must offer "the right drug, at the right dose via the right route" (Ferguson et al., 2023).

Switzerland recently announced that it is considering DOC treatment with cocaine for individuals severely affected by crack-cocaine use disorder. The Swiss Federal Commission for Addiction and Prevention of Non-Communicable Diseases stated that the process of setting up a sustainable and effective treatment service is likely to take considerable time, but that it is important to consider in the absence of a widely accepted solution to the growing cocaine problem in Switzerland (Swissinfo.ch, 2024).

Given New Zealand has significant harm from methamphetamine, the Swiss programme will be of great interest and could provide helpful indication of efficacy for stimulant use in SUD.

Safe supply

The term 'safe supply' (or 'safer supply') is not precisely defined. It can be used to describe substitution approaches, such as iOAT, or to refer to DOC treatment models. It is commonly defined as the provision of pharmaceutical versions of illicit drugs, available to people across the spectrum of drug use (not just those experiencing SUD) to prevent exposure to toxic illicit supply and prevent acute harms, such as fatal overdose.

Safe supply programmes (and the evidence of their effectiveness) are fairly limited worldwide, but have mainly been implemented in areas experiencing acute levels of opioid-related harm, particularly fatal opioid overdose. While Aotearoa New Zealand has concerning levels of overdose fatalities, our context

is quite different. However, it is helpful to understand this emerging evidence, so that if our drug supply continues to deteriorate, we can adapt and consider interventions that best suit our changing needs. This could also be considered in response to emergencies, such as a mass adulteration event.

Positively, in a Canadian programme there was an 89% reduction in overdose risk among people receiving safer opioid supplies for four or more days (Canadian Public Health Association, 2025). Likewise, patients participating in a safer stimulant (cocaine and methamphetamine) supply programme in Ottawa, Canada, in 2023 reported decreased use of unregulated stimulants, and increased access to wrap-around services such as housing support and primary care. After a median 9.5 months on the programme, where they were prescribed stimulant medications such as methylphenidate and lisdexamphetamine, all participants reported stopping using all illicit stimulants (Haines et al., 2023; Haines & O'Byrne, 2025).

However, there have been concerns voiced around safer supply programmes. Critics of poorly regulated programmes have pointed out that they may decrease opportunities for contact with health services, and may also risk adding to the volume of drugs found in the illicit market (Roberts & Humphreys, 2023).

Aotearoa New Zealand needs a regulatory environment that is well equipped to respond to sudden threats such as mass adulteration with bold interventions to prevent serious harm, including the likes of safe supply programmes where the evidence suggests they are needed.

Legal framework for MAT in Aotearoa New Zealand

Well-established MAT, such as OST, is used commonly for medical management of opioid use disorder in Aotearoa New Zealand. Treatment is delivered by licensed, specialist services. At the same time, s24 of the MoDA makes it an offence for anyone other than an authorised addiction specialist to prescribe controlled drugs for medical management of addiction. In 2011, the Law Commission recommended that s24 be retained (Law Commission, 2011, R118), and further recommended that general practitioners should also be able to prescribe opioids for patients when addiction is suspected, as long as they have consulted with addiction specialists.

Interventions to prevent acute harms from drug use

People who use drugs are at risk of various harms, depending on the substance and the method, dose, and frequency of use – all factors heavily shaped by the policy environments in which drugs exist. These risks range from mild to severe, with more serious harms including fatal overdose or transmission of blood-borne viruses such as HIV or hepatitis C. The volatile nature of the illicit drug market greatly increases the potential for harm, as people who use drugs cannot reliably know the potency or composition of a drug they have.

Potent or toxic adulterants, such as fentanyl and nitazenes, are well established in the drug supply in some jurisdictions, and have caused numerous overdose deaths, particularly in North America. They have also been found in the illicit supply in Aotearoa New Zealand, and have been found to contribute to overdose deaths here (New Zealand Drug Foundation, 2025a).

Public health interventions can mitigate some harms. NSPs reduce transmission of blood-borne viruses among people who inject drugs, and countries with robust NSP provision have seen dramatically improved outcomes (Csete et al., 2016). They have achieved major public health gains in Aotearoa New Zealand (Saxton et al., 2020), yet they are still restricted by law to providing a limited set of injection-related equipment, with other utensils prohibited. Prohibited utensils include those that would support alternative methods of administration and help people avoid injecting in the first place.

In this section, we present a brief overview of the measures to prevent serious harms from drug use.

Safer utensils, including needle and syringe programmes

NSPs have been used globally since the 1980s to prevent blood-borne virus transmission, particularly HIV, and reduce injecting-related harm among people who inject drugs. NSPs can be provided via specialist services, mobile services, pharmacies, and community services. In Aotearoa New Zealand, as in other countries, the required legislative reform came about in large part from the efforts of people who were directly affected by the spread of HIV and people who injected drugs (Harris, 2021).[19]

There is strong evidence that NSPs are effective at preventing transmission of blood-borne viruses among people who inject drugs. Exposure to NSPs has been shown to reduce HIV transmission by 58% (Aspinall et al., 2014), and high-coverage European NSPs have reduced the risk of acquiring hepatitis C by 56% (Bowring et al., 2025). Evidence is particularly strong that NSPs reduce the risk of HIV (by 47%) and hepatitis C (by 74%) when provided in combination with

[19] Note that in Aotearoa New Zealand the term Needle Exchange Programme (NEP) is used to refer to these services.

medication-assisted treatment (MAT) programmes to people who use opioids (Bowring et al., 2025; Palmateer et al., 2022; van Santen et al., 2023). NSPs also reduce needle sharing and reuse, particularly when sterile equipment is provided with adequate (≥100%) coverage for each individual (Iversen et al., 2012).

In Aotearoa New Zealand, the legislation[20] and regulations[21] that followed it enabled effective operation of NSPs in Aotearoa New Zealand. However, they have also cemented the boundaries of safer drug utensils provision. In restricting this to needles and syringes provided from licensed services only, Parliament established that the supply and possession of all other utensils is illegal, regardless of the potential health benefits. At the time of the law being passed (1987/1988), some community health workers and peer-led initiatives were informally providing safer use equipment with a degree of leniency from law enforcement, afforded by an increasing recognition of their necessity to prevent transmission of HIV. Once NSPs were enshrined into law in a particular way, this leniency no longer applied. This meant, for example, that providers of safe utensils have not been able to provide equipment that could discourage injecting in the first place (e.g., safer smoking equipment, or sterile snorting straws).

In the LCR, the Commission recommended that it no longer be an offence to possess utensils for the purpose of using drugs, but that the supply of utensils should remain an offence (Law Commission, 2011, p. 211). That said, the exception around the distribution of sterile needles through an NSP had strong support in the LCR report. Importantly, the Commission also recommended that consideration should be given to the possibility of exemptions for other harm-reducing utensils and equipment, including equipment for non-injecting practices (Law Commission, 2011, p. 212).

It is clear that contemporary developments in this area only strengthen the case for enabling harm-reduction-driven provision of safer-to-use utensils. There is now a consensus view that flexible models of harm reduction service provision increase access and reduce health risk to people who use drugs (Csete et al., 2016). Such programmes should be strongly supported by drug policy.

Drug consumption sites

Drug consumption sites (DCS), also called 'overdose prevention centres', or 'safe injecting sites', provide a safe environment to consume substances. They can also provide medical assistance to those who experience an overdose on site. Overseas evidence shows these spaces help keep people who use drugs safe, reduce harm from substance use, and prevent drug overdose and death (EMCDDA, 2018; Holland et al., 2022; Pardo et al., 2018). DCS provide an opportunity for evidence-based interventions (Holland et al., 2022), such as

[20] Misuse of Drugs Amendment Act (No 2) 1987 (1987 No 193).
[21] Health (Needles and Syringes) Regulations 1998.

administering naloxone and oxygen. In addition to overdose prevention, other support that may be offered includes: basic healthcare and health screening, particularly wound and vein care; HIV and/or hepatitis C testing; psychosocial support, including referral to treatment and other support services; needle and syringe provision; drug checking; resuscitation; laundry and shower facilities.

When established in partnership with law enforcement and health and social services (DeBeck et al., 2008), DCS can be used to promote engagement with drug treatment services and help support people to reduce or stop their drug use, and reduce harm (Kerman et al., 2020). There is evidence that they are cost effective, and can:

- reduce overdose-related mortality,
- reduce HIV and hepatitis C incidence among their clients,
- decrease numbers of ambulance callouts,
- decrease public disorder and drug-related litter (e.g., discarded needles),
- support people who use drugs to enter treatment (Keemink et al., 2025).

Globally, DCS operate in at least 18 countries across 150 sites (Kerr et al., 2025), including in Australia, Europe, and North America (Harm Reduction International, 2024; Schatz & Nougier, 2012). The earliest site opened in Bern, Switzerland, in 1986, and the first UK site, The Thistle, opened in Glasgow in January 2025 (Glasgow City Health and Social Care Programme, 2025; Kerr et al., 2025). Sydney's Uniting Church has operated a DCS since 2001. During this time, they have supervised more than 1.25 million injections without a single drug-related death, reversed more than 11,000 overdoses, and made 22,000 referrals for ongoing support for their clients (Uniting, 2023).

Insite, in Vancouver, Canada, has been operating since 2003 and similarly, has supervised three million injection room visits since its opening, with no acute poisonings or overdose deaths on its premises. Almost 12,000 overdoses have been reversed at the facility, and more than 71,000 referrals have been made to other services (Harm Reduction International, 2024).

Despite fears expressed in some overseas locations, DCS have not led to increased problems where they have been established. A systematic literature review looked at 75 studies, mostly analysing sites in Vancouver and Sydney. The review found that the sites did not increase the numbers of people starting to inject drugs, or the frequency of drug use. There was no increase in drug crime in the surrounding environments (Potier et al., 2014). In fact, DCS are associated with less public drug injecting and drug litter, an increase in drug cessations by enabling people to seek healthcare, and importantly, a decrease in fatal overdoses (Belackova & Salmon, 2017; Ng et al., 2017; Tran et al., 2021).

In Aotearoa New Zealand, section 12 (1) of the MoDA prohibits permitting the use of premises for the purpose of committing an offence under the Act.

Effectively, this clause prevents the establishment of DCS, as any such operator could risk serious criminal liability for allowing clients of the service to use illicit drugs.

A more informal means of supervised consumption is 'trip sitting', where friends or volunteers can provide support to people under the influence of drugs and seek medical help if necessary. As with DCS, this may also be an illegal activity if the person supervising is doing so in their own house (or a location they control). The risk of being discovered and subsequent prosecution is low, and we have not been able to identify a single prosecution under these circumstances. However, the legal risk creates a barrier to building networks of mutual support that could reduce harm and provide help in an emergency.

Considering the substantial possible public health benefits, we believe that this area of the law should be addressed to enable good-faith provision of safer spaces for people at risk of drug harm.

Naloxone

Opioids are the class of drugs most likely to be implicated in fatal drug overdoses internationally and in Aotearoa New Zealand (Office of the Chief Coroner, 2025; World Health Organization, 2025). This includes opioid medicines such as tramadol, codeine, and morphine, and illicit opioids such as heroin and nitazenes. Opioid overdoses can occur quickly, causing respiratory depression that can be fatal if not treated promptly.

Naloxone is an opioid antagonist medication that temporarily reverses the effects of an opioid overdose. Take-home naloxone programmes (THN) provide naloxone to communities at risk of experiencing or witnessing an opioid overdose. They have been found to reduce fatal opioid overdoses in communities (McDonald & Strang, 2016). THN programmes are cost effective and often cost saving when implemented successfully (Coffin & Sullivan, 2013). For example, for every 10,000 THN kits circulated in Alberta, Canada, there was a 23.9% reduction in total opioid-related deaths (Spackman et al., 2025).

At the time of writing this paper, intramuscular naloxone is available in Aotearoa New Zealand on prescription or for free from specific needle exchange sites. There is currently no approved intranasal naloxone product. The current national coverage of naloxone is insufficient; in particular, rolling out naloxone rapidly in the event of a larger-scale opioid adulteration incident would be difficult, or even impossible. With an increase in the prevalence of ultra-potent synthetic opioids such as nitazenes and fentanyl, there is an ever-present risk of such an event occurring in Aotearoa New Zealand.

While naloxone is not a controlled drug regulated under the MoDA (it is regulated under the Medicines Act, with some provisions from the MoDA having a role), the lack of availability and the persistent difficulties in expanding

access across the country demonstrate that there is an interplay of regulatory barriers that are impeding greater access. Should there be a dedicated agency empowered to addressing such barriers, increasing availability of naloxone would likely be easier.

Drug checking

The first formal drug checking service was the Netherlands Drug Information and Monitoring System, launched in 1992. Since then, most services have been based in Europe, though drug checking also operates in countries such as Australia, Canada, the UK, and Portugal, often through temporary or festival-specific licences or exemptions. In November 2021 Aotearoa New Zealand became the first country to fully legalise drug checking through the Drug and Substance Checking Legislation Act 2021, protecting both clients and harm reduction workers from prosecution for possession.

Drug checking has been shown to reduce high-risk practices. Evidence from 15 countries that operate drug checking services found that when test results were unexpected, people were more likely to take risk-mitigating steps, such as avoiding using the drug, taking less of it, or seeking more information. In the US, when fentanyl was detected, people reported safer behaviours, such as reduced use or using with others (Maghsoudi et al., 2022).

Self-use fentanyl test strips (FTS) can also support harm reduction and increase engagement in overdose risk reduction (Vickers-Smith et al., 2025). In one survey, 43% of people who injected drugs changed their behaviour after a positive result – five times the odds of people who did not receive a positive FTS result, indicating substantial behaviour change (Peiper et al., 2019). Other immunoassay testing strips are also available for harm reduction in different countries. These can detect substances such as benzodiazepines, nitazenes, and xylazine.

Drug checking also provides a unique means of monitoring of illicit drug markets, regularly identifying substances of concern, such as fentanyl, atropine, DOx (4-Substituted-2,5-dimethoxyamphetamines), PM(M)A (para-methoxy[meth]amphetamine), and levamisole (Maghsoudi et al., 2022). While there are hopes that consumers verifying their product contents in drug checking could improve the quality of products being sold in the illicit market, this remains a research gap (Maghsoudi et al., 2022). Demand for these services is strong: surveys in Europe show that most people in nightlife settings, as well as people who use drugs frequently or heavily, would use drug checking if widely available. Key motivations include avoiding contamination, avoiding unexpected substances, and preventing overdose (Betzler et al., 2021).

Overdose Good Samaritan laws

In response to rising opioid (particularly fentanyl) deaths, several US states

and Canadian provinces have enacted Overdose Good Samaritan laws. These protect people from drug or drug utensil possession charges when seeking medical help for an overdose. Some laws also cover breaches of parole or supervision conditions (e.g., Nevada and Oregon), which aims to reduce fear of criminal repercussions as a barrier to calling first responders (Evans et al., 2016). Studies have found a 10–15% reduction in opioid overdose deaths within one to two years of enactment (Hamilton et al., 2021; McClellan et al., 2018). A study from New York has found that hospitalisations for heroin overdoses increased, indicating that more people were reaching hospital in time to receive medical aid (Nguyen & Parker, 2018).

Other evidence on reducing drug-related deaths is mixed (Moallef & Hayashi, 2021), possibly because some people who use drugs are unaware of the law or they lack confidence in the protections against prosecution. Some jurisdictions, such as British Columbia, have adopted Police non-attendance policies at overdoses unless there is safety risk or the overdose is fatal. These limitations underscore the need for strong implementation, along with increasing community awareness of the law among people likely to experience or witness the overdose, and collaboration with law enforcement (Jesseman & Payer, 2018).

Overdose Good Samaritan laws do not exist in Aotearoa New Zealand. In the LCR, the Commission did not examine the issues of circumstance-driven protections from prosecution. At the time of the review, the overdose crisis had not yet escalated globally, and the need for such laws was not a major part of the drug policy discourse. Drug possession decriminalisation would very likely make the public feel more comfortable quickly calling for help in the event of an overdose. However, to be maximally effective, the law should also include protections from low-level drug supply offences (e.g., in a small group of friends), as well as offences like parole breaches. Such protections would likely increase the effectiveness of these laws by reassuring communities for whom the risk of fatal overdose is elevated, such as those leaving custodial settings (O'Connor et al, 2022).

Licensing for effective harm reduction

As we have highlighted throughout this chapter, many effective harm reduction measures are limited by regulatory barriers in Aotearoa New Zealand. This could be overcome by a regulatory framework that considers drug harm reduction a valuable aim on its own, and that empowers health agencies to support evidence-based harm reduction interventions. A good example of this working in practice is the Canadian system of exemptions managed by Health Canada to undertake activities prohibited under the Controlled Drugs and Substances Act (Health Canada, 2022). These are still, however, administered at a high, political level.

In Aotearoa New Zealand, the system for licensing or exemptions under the MoDA has little flexibility and has not been designed to enable harm reduction. In fact, it has never been used for this purpose. Under s14 of the MoDA, the Minister of Health may grant licences to undertake certain activities that are otherwise prohibited. However, certain restrictions on licensing make delivery of well-evidenced interventions impossible. For example, s14 (3) – which generally prevents the issuing of a licence that authorises the consumption of substances – creates a major barrier to setting up interventions such as DCS (see earlier in this chapter).

Furthermore, in general, licensing decisions sit with the Minister of Health, with some limited powers sitting with the Director-General. While the Law Commission did not consider reviewing restrictions on licensing in the Act in the LCR, it recommended that full responsibility for licensing be transferred to the Director-General, creating a more flexible and less politicised regime.

In the LCR, the Law Commission took a view in favour of enabling more flexible interventions. They recommended, for example, repealing the restrictions imposed under regulation 22 of Misuse of Drugs Regulations that require Ministerial approval before controlled drugs are prescribed. This recommendation has only become more urgent in light of evidence about medically assisted therapies, drug-of-choice interventions, and safe supply.

Granting these and broader discretionary powers to the Director-General of Health, alongside specifying the intent to increase access to harm reduction interventions, could be an effective measure to enable the development of more agile public health responses here.

Chapter V.
Te Tiriti o Waitangi and drug law reform

Detrimental impacts of punitive drug laws on Indigenous communities have been observed in many countries with settler-colonial histories, including the US, Canada, and – unsurprisingly – Aotearoa New Zealand. There is overwhelming evidence that Māori have been disproportionately affected by drug laws, both in terms of criminal justice outcomes, and health outcomes. We have highlighted these issues throughout this report.

In creating this report, we have engaged with our Māori partners – health, addiction, and harm reduction sector leaders – who have echoed these concerns, and discussed possible solutions. These conversations have also added another layer of understanding to the contributions from our Māori survey and workshop participants.

We have heard about the impacts of colonisation, such as economic disadvantage and intergenerational trauma, which have resulted in a heightened vulnerability of Māori to drug harm. And we have also heard about the disproportionate impacts of the MoDA. This is clearly reflected in outcomes for Māori today:

- The use of drugs among Māori is likely higher than among the general population. In 2023/24 Māori reported the highest rates of past-year cannabis use (33.4%) and at-least-weekly cannabis use (13.3%) of all ethnic groups. Māori were also 2.83 times more likely to report past-year cocaine use, and 2.19 times more likely to report past-year use of amphetamines/methamphetamine compared with non-Māori (Ministry of Health, 2024b).
- Māori are disproportionately affected by SUD, representing 39.2% of addiction treatment clients, despite constituting only 17.8% of the population. Recently, waiting times for Māori in addiction treatment have been becoming longer (Te Hiringa Mahara Mental Health and Wellbeing Commission, 2025).
- Between 2016 and 2024, the rate of fatal overdoses for Māori was 5.5 per 100,000 population compared to the rate of 2.7 per 100,000 population for non-Māori (Office of the Chief Coroner, 2025).
- In 2024, nearly half (48.1%) of people convicted of drug possession or use were Māori. In raw numbers, there was a higher number of Māori than European New Zealanders who received such a conviction, despite a much smaller population size. This disproportion is even higher for imprisonments, where Māori constitute over half (53.2%) of people imprisoned for drug offences (Ministry of Justice, 2025b).

These impacts have been repeatedly noted by the Waitangi Tribunal. In fact, several Tribunal claims have been made[22] relating to the failure to address methamphetamine harm among Māori.

[22] E.g., Wai 2635: Tairāwhiti Methamphetamine Claim; Wai 2641: Hastings Mongrel Mob Health Claim; Wai 2655: Ngā Kairauhii Nannies against P Claim.

In Wai 2575, the Waitangi Tribunal recognised that Māori are overrepresented in the legal system in relation to alcohol and other drugs, and that there are major barriers to accessing treatment for Māori.

International Indigenous experiences of drug law reform

Internationally, improved outcomes from drug law reform have not been felt equally by all communities. For example, in BC, Canada, the decriminalisation policies have been highly criticised by Indigenous organisations for including mechanisms that disadvantaged Indigenous people (BC Association of Aboriginal Friendship Centres, 2023). The issues raised stemmed from decriminalisation's limited reach, restrictions on public use, and the low quantity thresholds that contributed to continued disproportionate harms experienced by Indigenous people who use drugs. The policy was believed not to take into account the disadvantaging circumstances experienced by Indigenous people, such as high rates of homelessness (leading to higher likelihood of public use of drugs) or rural living (increasing the need for carrying larger amounts of drugs due to difficulty with frequent travel) (Michaud et al., 2024).

This experience of muted positive impacts of relaxing criminalisation policy on Indigenous people has also occurred in Aotearoa New Zealand. After the 2019 Amendment to the MoDA that directed the Police not to prosecute for personal possession offences, unless there is public interest to do so, the gap between Māori and non-Māori has only widened. In fact, prosecutions for drug offences against Māori have outpaced those against Pākehā (see Chapter II for data). Like the Canadian experience, the disparity is also due to systemic factors, such as Māori being more likely to have previous contact with law enforcement – considered to be an aggravating factor by the Police when considering prosecution.

For other communities of colour, research has found that in the US and Canada, communities of colour were substantially locked out from the economic benefits of cannabis legalisation, despite high historical involvement in the illicit market (Crosby, 2019; Doonan et al., 2022). At the same time, the positive impacts on reducing arrests for communities of colour have also been muted compared to the reductions among white Americans, effectively increasing ethnic disparities (Joshi et al., 2023).

There have also been concerns about Indigenous rights in relation to the emergence of mainstream psychedelic assisted therapies. This especially includes plants or fungi that have been traditionally used by Indigenous communities. Development of products from plants or fungi with psychedelic effects (such as ayahuasca, or psilocybin-containing mushrooms) creates a risk of biopiracy, locking out of the benefits of traditional medicine, and cultural

appropriation (Celidwen et al., 2022). This is also a clear risk for Aotearoa New Zealand in regard to the utilisation of indigenous psilocybin-containing fungi, as was recently outlined in a report by Tū Wairua group (Caddie et al., 2024).

Realising the right to protection from drug harm under te Tiriti

In our kōrero with Māori leaders, it was clear that the status quo is not working for Māori communities. We acknowledge that more research is needed to establish consensus about the specific policy settings that would prevent harm. Still, in our conversations there was a clear focus on the rights guaranteed under te Tiriti o Waitangi, and ensuring equitable funding mechanisms, commensurate to the harms experienced by Māori. Some of the key points raised included:

- The ongoing impacts of colonisation and intergenerational trauma are central drivers of drug harm among Māori, and the Crown should actively address these to reduce disproportionate impacts on Māori.
- Criminalising Māori is compounding harm and there was consensus agreement that decriminalisation is needed.
- Drug policy does not exist in isolation from other complex challenges Māori are facing. Without addressing social determinants of health – such as housing and income stability, access to education, health services, and social support, and connection with culture and whenua – any progress on drug harm will be limited.
- The Crown needs to enable Māori leadership in policy development and pass on decision-making capacity around funding for health support to whānau, hapū, and iwi.
- Policymaking should have a clear focus on intended and unintended impacts on Māori communities.
- Considering the extent of drug harm experienced by Māori, drug law reform must be accompanied by major investment in harm reduction and treatment services. The importance of self-determination over this investment was raised.

There is clearly work to be done by the Crown in relation to consultation with Māori communities about specific policy options to realise the right to protection from drug harm under te Tiriti o Waitangi. However, the principles outlined above can help guide policy development and be a starting point for further consideration.

Recommendations **for safer drug laws**

In creating this report, we wanted to take a pragmatic approach to propose policy solutions that could improve the outcomes of New Zealanders experiencing drug harm. We looked at the local data, explored the international evidence, and – most importantly – engaged with people with lived and living experience of drug harm.

Principles for drug law reform

Drug laws should follow the evidence, and work towards achieving goals that would make our society better.

Based on our engagement with the community and literature, we recommend seven overarching objectives to guide drug law reform:

1. Reduce social impacts of drug harm on all New Zealanders.
2. Reduce acute harms, such as overdose, and chronic harms, such as substance use disorder.
3. Reduce the impact of criminalisation, especially among communities disproportionately affected by it, and reduce the scale and profits of the illicit market.
4. Ensure people who use drugs can access health support and harm reduction information free from fear of prosecution, stigma, or discrimination.
5. Enable appropriate access for all New Zealanders to therapeutic drugs that can benefit their health.
6. Uphold te Tiriti o Waitangi and ensure Māori leadership and resourcing in policy development and service provision.
7. Prioritise health and social outcomes of regulation, and prevent excessive corporate influence on regulatory settings.

These objectives should be achieved by a law that is future proofed and can offer dynamic solutions to address harm, as guided by evolving available evidence.

A case for drug law reform

The evidence gathered in this report demonstrates that Aotearoa New Zealand's current drug laws do not serve their intended purpose. Instead of protecting health, they entrench stigma, expose people to unsafe illicit markets, and perpetuate deep inequities, particularly for Māori. People who use drugs (and those who support them) have told us repeatedly how criminalisation prevents

help-seeking, undermines hauora, and can disadvantage many aspects of their personal and professional lives. The impacts of criminalisation are stark: a criminal record for a drug offence, and the stigma associated with it, creates long-lasting barriers to critical components of everyday life – housing, jobs, and healthcare.

These lived realities resonate strongly with international evidence, which shows that countries adopting health-based approaches achieve better outcomes than those persisting with punitive models. Whether in Portugal, Switzerland, Uruguay, or Canada, the evidence points in the same direction: shifting from punishment to health works. Together, these insights form a clear justification for replacing the MoDA with a new framework that prioritises health, equity, and te Tiriti o Waitangi.

We do not believe that continuing with the status quo is a serious option. If we do, our warning is that we expect drug harms such as SUD, overdose, and crime to increase.

Our recommendations

The recommendations below are a suite of pragmatic options that both respond to the voices of those most affected in Aotearoa New Zealand and draw on the experiences of countries that have already made the shift. Together, they chart a course towards a legislative framework that honours te Tiriti, protects hauora, and ensures drug policy in Aotearoa New Zealand is grounded in compassion, equity, and evidence.

1. Decriminalise drug use as a foundation for change

One of the most consistent themes in our research was a call to end the criminalisation of people who use drugs. Survey and workshop participants described the fear of prosecution as a barrier to calling emergency services during overdoses, a reason to avoid disclosure of drug use to doctors, and a source of lifelong disadvantage through convictions that affect employment and housing. Māori participants spoke about the compounding effects of systemic bias in enforcement, which results in disproportionate criminal justice involvement.

International evidence confirms these experiences. Portugal's decision to decriminalise all drug use over two decades ago provides the strongest case for this to this day. After decriminalisation in Portugal, overdose deaths fell dramatically, HIV transmission rates plummeted, and the burden on the criminal justice system was eased – all without an increase in drug use.

Decriminalisation alone is not a panacea, but it mitigates some of the most harmful effects of punitive policy and creates conditions for health interventions

to succeed. For Aotearoa New Zealand, this means recognising that decriminalisation is not about promoting drug use, but about creating a legal environment where people can seek help without fear, and people are no longer locked in a revolving door of criminalisation.

i. Decriminalise personal possession and use of drugs, including utensils.
ii. Refocus enforcement away from policing use and possession offences and towards tackling supply and improving compliance with any new regulatory systems.
iii. Ensure that any regulatory changes are accompanied by monitoring of health and social outcomes.
iv. Put in place broad protections for people who seek help in the event of a drug overdose or acute substance harm, e.g., through Overdose Good Samaritan clauses.
v. Apply a clean slate to previous possession/use offences.
vi. Ensure pathways to regulated systems and away from illicit markets remain open for those impacted by criminalisation. This includes transition from illegal economy to legal supply.
vii. Decriminalise cultivation of a small number of cannabis plants for personal use.

2. Redirect resources to health in an equitable way

Ending criminalisation is only truly meaningful if paired with a shift in resourcing. Communities we engaged with were clear: they do not want to see money being spent on policing minor offences while health services remain underfunded. Addiction treatment, mental health services, and community support were repeatedly described as overstretched, inaccessible, or culturally inappropriate. Among Māori, the call was for kaupapa Māori approaches that empower whānau, hapū, and iwi to design and deliver their own solutions.

The international evidence reinforces this message. The key to success is not changing laws and stopping there, but rather allocating resource towards treatment provision and harm reduction interventions. Evidence from Canada has shown that reinvestment is key to achieving better outcomes.

Where decriminalisation has occurred without substantial service investment – as happened in Oregon – the benefits have been muted. Based on these findings, we believe that decriminalisation must be accompanied by deliberate investment into health, with dedicated funding for Māori services to address intergenerational inequities.

i. Substantially increase the provision of harm reduction, prevention, early intervention, and SUD treatment services.

ii. Increase access to specialist treatment interventions for people whose SUD drives their offending. These interventions must focus on reducing reoffending by addressing SUD within the context of criminal behaviour, rather than relying on imprisonment.

3. Establish harm reduction as responsive public health infrastructure

People who have experienced drug harms voiced deep frustration that evidence-based harm reduction measures remain constrained or unavailable under current law. Diversified and accessible drug checking services, safe consumption sites, and access to safer utensils were all seen as essential tools for reducing harm in an environment of an increasingly toxic drug supply. Stories of people too afraid to call an ambulance during an overdose underline the urgency of Overdose Good Samaritan protections. Yet the MoDA continues to stand in the way of harm reduction, leaving people vulnerable to preventable harms, including overdose deaths.

International experience offers powerful validation. DCS in countries such as Australia, Canada, and Switzerland have saved lives and connected people to treatment, all while reducing public drug use. Broad naloxone distribution and Overdose Good Samaritan laws in parts of the United States have demonstrably increased the likelihood of life-saving intervention during overdoses. Crucially, these measures have not increased use, but they have reduced deaths and improved safety.

But perhaps the most urgent concern evidenced by local and international experiences, and raised by survey and workshop participants, was the growing risk of toxic adulteration in the illicit market. Most alarmingly, people with dependence described being forced into unstable and dangerous supply chains, with serious consequences for their health and lives.

Evidence from overseas demonstrates the effectiveness of approaches where people can receive services and support in a way that works for them and meets them where they are, even if this means continuing to use their drug of choice. Switzerland's heroin-assisted treatment has, over decades, reduced deaths, improved health outcomes, and decreased drug-related crime. Canada's safer supply programmes, though still very limited, signal that reductions in overdoses and improvements in stability for participants are realistic goals. Flexible prescribing practices, aligned with international best practice, are critical to ensuring that people can access care that meets their needs.

In Aotearoa New Zealand, we should ensure that our legal framework is flexible enough to enable a rapid response to urgent threats like mass adulteration with bold interventions. Without such a framework in place, we risk being unable to respond quickly enough to prevent widespread harm in the face of changes brought about by the volatile international drug market.

i. Set clear goals to improve health outcomes and reduce drug harm in any new legislation.

ii. Enable more harm reduction and overdose prevention measures immediately, such as DCS, safer utensils provisions, and a more diversified and flexible drug checking regime.

iii. Ensure legislation enables ongoing adaptation and development of harm reduction and overdose prevention measures that are responsive to emerging risks and needs. Empower an appropriate health agency with discretionary powers and establish a rapidly responsive licensing system for harm reduction interventions.

iv. Ensure legislation enables treatment and prescribing for people with substance dependence to evolve with changing drug supply issues, in line with international best clinical practice guidance, in all appropriate settings.

v. Enable professional facilitation of psychedelic assisted therapies, including beyond medicalised settings. Prioritise participant safety by putting in place strict product quality controls, and workforce regulation.

4. Enable responsible regulation of lower-harm substances

We need a shift in approach to enable a safe, tight, and evidence-based system of regulation for lower-harm substances. Those who suffered from drug harms shared how ineffective the current classification system is at reducing harm, bearing little relationship to actual harms. Instead, people spoke of the need to protect people from toxic supply through regulated access. At the same time, people have reservations about models that prioritise profit over wellbeing, where aggressive marketing fuels oversupply, increasing the risk of SUD and harm.

For cannabis, international evidence shows that regulation can succeed – but design matters. Uruguay and Malta have implemented not-for-profit models of cannabis supply, controlled to displace the illicit market without ramping up undue industry influence. By contrast, commercialised models in parts of the US and Canada appear to have been more effective at quickly displacing the illicit market but have led to increased product potency, lower prices, and higher rates of adult use.

For other substances, evidence of the impacts of broad regulated access does not exist yet. Some jurisdictions are pioneering supervised access to psychedelics for therapeutic purposes, while many others have authorised prescribing of MDMA and psilocybin in strictly clinical settings. In Aotearoa New Zealand, these drugs rank well down the scale of drug harm, and indeed when harm does occur, it is often caused by misrepresented or adulterated substances in the unregulated market. While there has been progress here for strictly

medical provision, we believe Aotearoa New Zealand should adopt a more flexible drug classification system that takes into account a wide range of health outcomes and can adapt to new evidence as it emerges to prevent harm for non-medical consumers and reduce the illicit market. Regulation of any substance should be evidence based, shielded from excessive commercial influence, and aligned with community aspirations for health and equity.

i. Replace the drug classification system with a more flexible legal framework that grants an appropriate health agency the power to review emerging evidence and strictly regulate lower-risk substances for adults on a case-by-case basis, based on expert advice. Expert advice must meaningfully include the contribution of people with lived experience and ensure the rights of Māori are upheld.

ii. Regulate legal supply of cannabis through this framework via a non-commercial model, such as not-for-profit associations.

iii. Utilise regulatory measures to limit harms of any regulated substance, such as:
    - age restrictions, price and potency controls, warning signs, and requirements to provide harm reduction and help information;
    - limits on product appeal and availability;
    - bans or restrictions on advertising of products and suppliers;
    - measures to prevent influence of commercial groups on public policy or messaging.

iv. Amend the PSA and harmonise it with the new regulatory regime.

5. Uphold te Tiriti and protecting taonga

Central to the research findings was a call from both Māori and non-Māori participants for better recognition of te Tiriti. In our engagement, Māori spoke of the intergenerational harms caused by criminalisation, and of the need for well-resourced kaupapa Māori services to address these harms in ways determined by their own communities – and under Māori leadership.

These considerations are also essential for any possible regulation. Māori have a clear right for tino rangatiratanga over taonga species, including native fungi currently prohibited under the MoDA.

In our recommendations, upholding te Tiriti means more than consultation – it requires resourcing and leadership.

i. Ringfence part of the increased funding for harm reduction and SUD treatment for Māori to empower and resource whānau, hapū, and iwi to roll out appropriate interventions as they determine.

ii. Ensure Māori are able to exercise tino rangatiratanga over taonga fungi that are currently listed as prohibited plants under the MoDA.

How do we make the shift?

Drug law reform is not easy. The evidence we gathered paints a complex picture: numerous policy levers require adjusting, but how they each interact with one another can greatly improve or diminish their ability to achieve their goals.

This begs the question of how incremental policy change should be. On one hand, to maximise the impacts, it appears to be much more effective to implement progressive policies quickly and in swift moves. On the other hand, however, we have seen unintended effects of various new policies play out overseas, as well as backlash against changes that did not realise their intended impacts straight away. To balance this, we propose an approach that has flexibility and allows constant evaluation and adjustment.

In 2011 the Law Commission rightly pointed out that politically driven decision-making creates a risk of ineffective policy that side-lines the weight of evidence. Therefore, we recommend that significant powers in relation to drug policy are passed on to an appropriate health agency. Whether this is an appropriately resourced part of the existing health system, or a new, purposefully created entity, it is essential that this agency is advised by an expert body and meaningfully includes lived and living experience voices and Māori expertise. The powers of this agency should include adjusting regulatory settings to prevent and reduce harm, as well as timely and evidence-based classification of substances, including down-scheduling and de-scheduling. The law should enable the flexibility needed to respond to the volatility of global illicit drug markets, as there are no signs of this volatility decreasing in the foreseeable future.

With demand in the illicit market reduced, we would hope to observe fewer incentives for drug-related criminal activities. However, it is obvious that there would still be a key role for supply-control interventions and for enforcement agencies. With resource being redirected away from low-level offences, it would be essential that compliance with the regulatory settings is enforced, along with further efforts to continue to displace illicit markets.

In our paper, we do not focus on the international drug control treaties regime. There are two reasons for this. Firstly, we consider that a sufficiently detailed analysis of these issues is beyond the scope of this paper, and would rather warrant a standalone paper to grasp the complexities of this topic. Secondly – and more importantly – we do not propose any policy options that have not been tried in other jurisdictions in some shape or form. These jurisdictions are party to the same obligations as Aotearoa New Zealand, and some, like Canada, have similar colonial histories and comparable legal systems. They have succeeded at making progress in drug law reform, which strengthens the case for change here. Furthermore, we argue that the poor health and criminal justice outcomes experienced by some communities in Aotearoa New Zealand are exacerbated by our drug laws, which stands in clear contradiction to our international commitments in relation to human rights, and Indigenous rights.

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